‘A Salutary Lesson: Male Nurses and the Nursing and Midwifery Council

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Abstract

This thesis is the first sociological examination of sex-based differences in referral and outcome for nurses that are subject to Nursing and Midwifery Council (NMC) Fitness-to-Practise (FtP) hearings. Despite male nurses only accounting for 10.8% of the nursing population in 2017, they also accounted for 23.8% of all those referred to the NMC over concerns about their conduct and 36.6% of all those struck-off as a result (NMC, 2017b). To date there has only been a limited number of sociological studies that have analysed the regulation of healthcare professionals in the UK (Currie et al., 2018). This research therefore helps fills a gap in the current sociological literature concerning both male nurses and the way that nurses are regulated in the UK.

This was achieved by analysing the NMC FtP process through non-participant observations of NMC FtP hearings and the documentary analysis of the official hearing reports produced by NMC FtP panels that outline their decision. This observational fieldwork took place over a twelve-month period and was followed by the documentary analysis of one-month of official hearing documents produced by NMC FtP panels.

The findings of this research suggest that the quasi-legal nature of NMC FtP hearings is problematic for registrants when defending themselves against allegations. There also appears to be certain types of misconduct that male and female nurses are potentially more likely to commit. This research found that there is a highly prescriptive form of remediation required in order to remedy one's misconduct. The expression of emotion (or lack of expression) appears to play a key role in remediation and potentially contributes to male nurses being more likely to be struck-off compared to female nurses. The role of public interest was also examined and was found to potentially influence both the transparency present in the NMC FtP process and the subsequent

outcomes of NMC FtP hearings. The findings of this research suggest that the current model of state sanctioned bureaucratic regulation of healthcare professionals (Waring et al., 2010) may possibly contribute towards the over-representation of male nurses in the NMC statistics.

These findings contribute to the current knowledge on the role of male nurses in the nursing profession, the professional regulation of nurses and the wider knowledge concerning the sociology of health in this otherwise under researched. This thesis concludes by offering itself as a potential resource for reflection upon the current processes of nursing regulation in the UK.

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Chapter 1: Introduction

1.1: Male Nurses and the Nursing Profession

The position of male nurses within the nursing profession has been contested since nursing became recognised as a state regulated profession in 1919 (Abel-Smith, 1960). Prior to 1949 male nurses' practice was limited to primarily psychiatric and fever nursing, with general nursing being reserved solely for female nurses. These practice restrictions meant the number of registered male nurses remaining particularly low (Bendall and Raybould, 1969; Mackintosh, 1997). Since then, the number of male nurses has steadily risen, although male nurses still only account for 10.8% of the nursing population in 2017 (NMC, 2017b). Despite this increase, male nurses' position within the nursing profession presents somewhat of a paradox. There is evidence to suggest that male nurses earn more and are promoted faster within the nursing profession (Lorentzon and Bryan, 1997; Pudney and Shields, 2000; Simpson, 2004), yet they also account for 23.8% of all those referred to the Nursing and Midwifery Council (NMC) over concerns about their conduct, and 36.66% of all those struck-off as a result (NMC, 2017b).

The rise in number of male nurses within the nursing profession have also taken place within a rapidly shifting regulatory landscape. Prior to the 1960s, collegial self-regulation was typically employed as the primary form of professional regulation (Freidson, 1983; Moran, 1997; 2000). However, from the 1960s onwards public sentiment concerning the way in which professions were regulated began to change. There was an increasing perception amongst the public and political spheres that professionals were not acting within the public interest and that collegial self-regulation was self-serving in nature (Freidson, 1983; 1984). These perceptions were further fuelled at the end of the 20th Century by several high-profile scandals in the UK concerning the nursing and medical profession, such as the Allitt Inquiry (Clothier,

1994) and the Bristol Royal Infirmary Inquiry (Kennedy, 2001) (Waring et al., 2010; Cooke, 2012). Authors such as Waring et al. (2010) have argued that the changing public and political sentiment towards collegial self-regulation combined with these high-profile scandals has led to the regulatory systems governing healthcare professions being transformed from 'state-sanctioned collegial self-regulation' to that of 'state-directed bureaucratic regulation'.

However, changing models of regulation do not answer the question as to why male nurses are more likely to be promoted and paid more than female nurses (Lorentzon and Bryan, 1997; Pudney and Shields, 2000) yet are than twice as likely to be referred to the NMC over concerns about their conduct and more than three and half times more likely to be struck-off as a result (NMC, 2017b). Existing literature that has looked at the potential difficulties faced by male nurses has focused primarily on areas such as the problematisation of male touch (Evans, 2002: 441; Harding et al., 2008). There is also existing literature which has looked at the potential for role-strain caused by gendered stereotypes held by members of society, which includes the portrayal of male nurses as being homosexual and/or sexual aggressors (Bush, 1976; Simpson, 2005; Pullen and Simpson, 2009). Yet, at the time of writing there appears to be no published academic research which has sought to analyse NMC Fitness to Practice (FtP) hearings in relation to sex based differences in misconduct or the way in which gender identities and roles might be shaping interpretations within tribunals. [Removed Cowan citation and comment]

There is therefore a gap in the current existing literature concerning male nurses and the NMC. This exists within a wider context where authors such as Currie et al. (2018) have noted a general absence of literature addressing professional misconduct within the realm of the sociology of employment:

> "While professional misconduct links to traditional concerns and debates in work sociology, its coverage in

> *Work, Employment and Society* is less than one might expect given reporting of professional misconduct globally appears on the rise [italics in the original refer to a specific journal name]."
>
> (Currie et al., 2018: 150)

Thus, by examining male nurses' over-representation in the NMC statistics in more detail, my research will potentially shed further light on the issue of gender within the nursing profession, along with adding to the existing literature on the regulation of professions. There is some existing literature which has looked at the Trust (now Clinical Commissioning Groups) level disciplinary process (Cooke, 2006a; Cooke, 2006b; Cooke, 2014), which is often a precursor to a nurse being referred to the NMC. Thus, this research will examine the next-level process.

1.2: Motivations for this Study

My personal interest in this topic, however, comes from my own experience of applying, and being offered, a position on a postgraduate training course to become a nurse. Although external factors prevented me from undertaking the course, the somewhat negative responses that I received from individuals in my social network and the wider general public when I revealed that I was to begin a nurse training course led me to reflect on the role of male nurses in the nursing profession. It was then that I discovered that male nurses are more likely to be referred to the NMC over concerns about their conduct, and more likely to be struck-off as a result (NMC, 2017b).

It was at this point that I decided, with the support of my supervisors, and funding from the Economic and Social Research Council, to undertake a sociological study to explore what possible factors may influence the over-representation of male nurses in the NMC FtP statistics. However, my aspiration to conduct a sociological study comes from more than just a simple desire to explore the peculiarities

of social life. Having undertaken a BA (Hons) Sociology, I had the opportunity to engage with sociological literature ranging from Goffman's (1979) research which looks at the way that advertisements utilize gender, to Butler's (1990) compelling argument that gender is both socially constructed and 'performed'. It is here that I found myself becoming more and more interested in the role that gender plays in social life and how sociology offers a way for researchers to unpick the complexity of everyday experience, which is not always self-evident or simple (Marvasti, 2004: 2).

Yet, to look a little deeper, I think my true motivation for conducting a sociological study which examines the role of gender comes from my own experiences as a gay man. From a young age, I have been acutely aware of how my own masculinity is often seen as 'different' and/or 'other'. It was not until I came across the work of Connell (2000) and Connell and Messerschmidt (2005), who argue that there are multiple forms of masculinity that are contrasted and compared with a hegemonic form of masculinity which is reified by society, that I began to understand my own position in greater detail. The ability of a sociological approach to analyse the role that gender plays in society is a key strength and motivating factor for conducting a sociological study.

The long and established tradition of qualitative research techniques in sociology (Marvasti, 2004) also provides an opportune way to examine the NMC FtP process itself in order to investigate what might lie behind the differential rates of referral and outcome for male nurses subject to NMC FtP hearings. To this end, this thesis presents an analysis not only of what NMC FtP panels *say* they have done in the hearings, as evidenced by their formal documentation, but also of observations of the hearings themselves. By conducting this analysis in such a way, it provides an opportunity to understand the process of how outcomes are negotiated and produced.

Having established a field of study, I next needed to consider how to study it. My ESRC studentship was a 1+3 award, enabling me to spend

the first year undertaking an MA in Research Methods (Sociology) where I was able to engage with various philosophical schools of thought ranging from Positivism to social constructionism. Whilst social constructionism initially piqued my interest, I gradually found myself leaning towards critical realism. This was not only because of its use in mixed and multiple method research (Kessler and Bach, 2014) but because of its belief in the 'transformative' nature of the social sciences. Accordingly, I have taken a critical realist approach to this study, and in the chapters that follow I will both justify this approach and show how this has enabled me to shed light on some of the issues that may lie behind the phenomenon of male over-representation in NMC FtP hearings.

The overall aim of this research is therefore to conduct a sociological analysis that seeks to analyse the NMC FtP process with a particular focus on the disproportionate rates of referrals and outcomes for male nurses subject to NMC FtP hearings. This research will also seek to examine the possible factors that may influence these disproportionate rates. This will be achieved by utilizing a qualitative multiple methods framework involving interviews, observations and documentary analysis with data collection being conducted over a twelve-month period. The findings have the potential to advance current sociological knowledge of work and employment practices and offer a point of reflection on the current processes of nursing regulation in the UK. More practically, they may also provide nurse managers and the NMC with a greater understanding of the possible reasons for the over-representation of male nurses in FtP hearings and Striking-Off Orders. This in turn may offer suggestions as to how to reduce the number of male nurses being referred to the NMC over concerns about their conduct.

1.3: Structure of Thesis

The second chapter of this thesis will therefore begin with a review of the existing literature concerning the history of nursing, professional regulation and the role of gender in these two spheres. This will then

be followed by Chapter 3, which will provide a detailed rationale of the methodologies and methods employed during this research. This will include a detailed discussion regarding the philosophical standpoint underpinning this research, data collection, data analysis, and ethical considerations. Chapters 4-6 will outline and discuss the findings of my research. Chapter 4 will focus specifically on the quasi-legal nature of the NMC FtP process, and the impact this has on nurses who participate in it. Chapter 5 will then discuss the concept of misconduct and the role of remediation in both addressing and being seen to address these two areas. Chapter 6 will then focus on the role of transparency, shame and the public interest, and the resultant effects these have on how and to whom sanctions are applied. Finally, the concluding chapter will discuss the contributions this thesis has made to the field of sociology, reflect on the impact of my position as a researcher, consider the strengths and limitations of this research, and outline opportunities for further research. Since NMC processes were amended from those observed and analysed here in 2016, this chapter also contains a reflection on these changes, particularly with regard to the issue of transparency in NMC FtP hearings.

2.1: Early Forms of Nursing

The history of nursing is somewhat fragmented in that, whilst there is evidence demonstrating that organized nursing practice has been taking place for nearly a millennium, it was not until 1919 that nurses became recognized as a profession requiring state registration in the United Kingdom (Bendall and Raybould, 1969). Much of this evidence can be found in the records of the early monastic movement, such as the foundation of the St. Antonines in 1095, which was charged with nursing sufferers of erysipelas and the mentally ill. Other examples of earlier nursing practice included the Knight Hospitallers of St. John of Jerusalem, founded in 1200, and the Knights of Lazarus, established in 1490 to care for lepers (Mackintosh, 1997: 232). These early organizations were comprised solely of men, unlike present day nursing, due to gender norms and religious restrictions on women's participation in religious orders. However, with the dissolution of the monasteries in the 16th century under the Act of Dissolution of Smaller Monasteries (1536) and the Act of Dissolution of the Greater Monasteries (1539), "…any form of organized nursing activity disappears from available records" (Mackintosh, 1997: 232).

2.2: Nineteenth Century Nursing and Hospital Reform: Pre 1888

It was not until the development of the larger scale charitable, or voluntary, hospitals in the eighteenth century that nursing began to acquire a semblance of organization and a more distinct role from that of servants (Mackintosh, 1997:232). Yet, despite the creation of these large-scale institutions, the number of nurses remained relatively low until the inception of the Poor Law Amendment Act (1834). Amongst other legal changes, the act resulted in the attachment of infirmaries to many workhouses which, coupled with the growth of private asylums in the mid-19th century, led to a steady increase in the number of nurses required (Carpenter, 1978; Mackintosh, 1997).

However, despite the creation of the charitable hospitals, there was no clearly defined, state-sanctioned, form of nursing care until the 1919 Nurse Registration Act which did not come into effect until 1923 (Dingwall et al., 1988). Furthermore, whilst these institutions were, and still are, often referred to as 'charitable' institutions, their primary source of funds came from contributions or payments made by the patients and/or their family. Thus, there was a financial incentive for the larger scale charitable hospitals to only admit patients who were likely to recover from their ailments rather than those who were terminally ill or in most need of acute medical care to avoid developing reputations where patients were likely to die whilst in their care (Dingwall et al., 1988: 6). This financial incentive, coupled with the fact that modern day forms of medical diagnosis and treatment were a long way from being developed, meant that the primary duties of caregivers in these institutions were to assist patients with daily activities of living, not distinct from that of servants:

> "Then, as now, the greatest part of the care required by the sick involved some kind of assistant with activities of daily living that they were unable to carry out for themselves"
>
> (Dingwall et al., 1988: 6)

For those who were no accepted by the charitable hospitals, or who could not afford the fees charged by the charitable hospitals, care would primarily be provided by the patient and or their family. Although authors such as Dingawll et al. (1988) have highlighted how care would sometimes be provided by family members themselves, due to the adult population over the age of 60 remaining below 10% during the 1800s and the high rate of marital breakdown due to death, care tended to be provided by servants within the patient's own home (for those that could afford it) (Dingwall et al., 1988). This was also necessitated by the fact that if a family member were to provide the care, they would otherwise be unable to take up paid employment which could otherwise be shared amongst paid servants (Dingwall et al., 1998). For those that could not afford in-house care or have an able-bodied family member provide it,

Dingwall et al. (1998) have argued that the infirmaries attached to the workhouses swiftly became the primarily means of supporting the ill and infirm, according to authors such as Dingwall et al. (1988). Nevertheless, whilst women did act as nurses within these institutions, strict policies on gender segregation were enforced within the infirmaries, and even more so in the asylums, where the potentially violent and custodial nature of the work led to men being assigned these roles (Mackintosh, 1997). Thus, due to the custodial nature of the work, those who engaged in nursing practice were deemed to be of poor character. As Mackintosh has highlighted:

> "By the mid-19th century all spheres of nursing had earned a low and dubious reputation… [people] were assumed to have entered nursing because of their inability to be accepted for employment elsewhere"
>
> (Mackintosh, 1997: 233).

Indeed, prior to the hospital reforms spearheaded by Florence Nightingale, it was not thought that any special training or experience was required to nurse the sick (Abel-Smith, 1960: 9). This began to change, however, following Nightingale's experiences at Scutari, after which she dedicated forty years of her life to developing nurse education, hospital design and sanitary reform (Brown et al., 2000: 5). Another key, albeit lesser known individual who also participated in the Crimean war and contributed significantly to the development of nursing practice, was Mary Seacole. However, it is only recently that Seacole's work has been rediscovered, which has led some to describe her as the 'Black Florence Nightingale' (Cooke, 2008b: 125).

According to authors such as Dingwall et al. (1988), this need for special training and/or experience was further fuelled by the increasing professionalisation of medicine starting from the first half of the 19th Century. The increasing professionalisation of medicine was due to the medical profession's desire to provide medical treatment based on scientific principles. As a result, there was an increasing need to obtain

nurses with better educational backgrounds so that they could carry out duties which were otherwise carried out by doctors and/or their students. As Woodward highlighted when discussing a recommendation made by the Nursing Committee of Salisbury Infirmary:

> "…in future the wards be cleaned and scoured by persons engaged for that purpose and your nurses be kept in every particular distinct from the servants of that establishment"
>
> (Woodward, 1974: 33)

As can be seen in the above quote, the role of nurses and domestic servants began to separate, which is a clear indicator of the role of class within the nursing profession.

These changes took place alongside the formation of female religious orders in the middle part of the 19th Century. Examples of these religious orders include the Protestant Sisters of Charity, the Sisterhood of the Holy Cross and the Sisterhood of Mercy of Devonport and Plymouth (Dingwall et al., 1988: 28) all of which were formed between 1840 and 1856. These religious orders were charitable organisations whereby middle- and upper-class women provided both spiritual guidance and in-home nursing care to the poor (Dingwall et al., 1988).

At around the same time that these all-female religious orders began to form, Florence Nightingale began to turn her attention to nursing care. Nightingale's ability to wield such influence within the nursing sphere was greatly aided by Nightingale's upper-class status, which paved the way for the class divisions present in Nightingale trained hospitals (Dingwall et al., 1988: 36-38).

Nevertheless, as a result of Nightingale and a handful of others' continued campaigning, the first Nightingale trained nursing school was established at St. Bartholomew's Hospital in 1860 (Mackintosh, 1997: 233). By the late 1800s, twelve London hospitals had created their own schools of nursing (Helmstadter and Godden, 2011). Following the uptake of Nightingale's teachings within the voluntary hospitals, which

harnessed the notion of female-centred caring, both the practice of nursing and the social-demographic makeup of the profession began to change (Carpenter, 1978).

This, coupled with Nightingale's stringent requirements regarding high moral character for trainee nurses, helped contribute to a more positive image of the nursing profession (Abel-Smith, 1960). As a result, Nightingale's teachings led to the reproduction of the Victorian societal structure within the voluntary hospitals, whereby women were seen as inherently different from men, as well as other women of different social classes. This in turn led to the creation of both a gendered division of labour within the hospitals consisting of male physicians and female nurses, as well as a class-based division of labour within the nursing profession, with the more prestigious positions being granted to women of the middle-classes (Carpenter, 1978; Abel-Smith, 1960). These burgeoning notions of a gender difference between nursing and medicine meant that it was seen as appropriate for women to perform nursing activities based upon Victorian ideals of femininity. Thus, by the 1880s and 1890s, nursing had become "an acceptable and respectable work role for middle class Victorian females" (Mackintosh, 1997: 233).

This change in attitude towards women's employment within the realm of nursing can be seen in the following statistics where, at the turn of the century, female nurses accounted for nearly all nurses employed in the general hospitals, with their number being projected at around 63,500 in 1901 (Abel-Smith, 1960). Interestingly, it is also estimated that there were a further 5,700 male nurses practicing in England and Wales; of these 5,700 male nurses, 3,900 were directly employed in mental institutions, with the remainder being employed as mental health nurses in patients' own homes (Abel-Smith, 1960: 52). These statistics reflect the general consensus within the nursing profession at the time, where the only area of nursing considered suitable for men was psychiatric nursing. This was not only based on ideological grounds, but also on practical ones as well, as the nature of psychiatric nursing was such that male nurses were sought after due to their greater physical strength

being needed to restrain potentially violent and unruly patients (Evans, 2002).

However, rather than these changes being limited solely to the nursing profession, they in fact coincided with a general shift in attitude towards female participation within wider society in the late nineteenth and early twentieth century (such as the female ratepayer and the parliamentary franchise). However, as with the case of the female ratepayer and the parliamentary franchise, the issue of class was also deeply ingrained within the nursing profession from the very beginning of the hospital reforms and the subsequent development of the profession, with middle- and upper-class women being favoured by Nightingale and her companions (Witz, 1992). This was in part due to Nightingale's reforms and her overall aspirations for the profession, which in turn led to two types of trainee nurses being enlisted within the Nightingale training schools up until the early 1900s. These positions were the 'probationer' and the 'lady-pupil' [sic], which Abel-Smith has described as the following:

> "The difference between the probationer and a lady-pupil [sic] was that a probationer had to serve two years for a certificate, and a lady pupil had to pay a pound a week and was given a certificate at the end of the year"
>
> (Abel-Smith, 1960: 31).

Thus, despite the probationer having trained for longer, the paying trainees were usually fast tracked to the position of sister, and subsequently matron, albeit usually for an additional fee in return. Unsurprisingly, this 'superior' [sic] class of nurses often sought careers in high status voluntary hospitals or to work privately in the homes of patients who could afford to pay for their services. This in turn led to considerable emphasis being placed on the monetary and status-based rewards of the profession (Abel-Smith, 1960: 48). As a result, the nursing vocation that Nightingale had painstakingly sought to create gradually became tinged with the quest for professionalism (Witz, 1992: 136). In

the years that followed, this gendered and class divided aspect of nursing labour was to become a distinguishing factor in what Abel-Smith (1960) has referred to as the 'thirty years war' for the state registration of nurses, beginning in 1888.

2.3: The Battle for the Nurse Registration: 1888 to 1919

Prior to 1888, there had been little way for the general public to establish the quality of nurse training or indeed whether the nurse was actually qualified. As Abel-Smith succinctly states:

> "The public did not know what it was getting and often did not ask… in the crisis of sickness, the stricken family did not stop to check a qualification; the problem as they saw it was to get a nurse as quickly as possible"
>
> (Abel-Smith, 1960: 59)

Yet, despite these issues, the topic of nurse registration had in fact been discussed as early as 1870s by the General Medical Council (GMC). In 1872, the GMC appointed a special Committee on the Medical Qualification of Women, which was charged with considering the possibility of formulating regulations for the education and registration of nurses and midwives. However, it was not until the creation of the British Nurses Association (BNA) in 1887 that the issue of nurse registration came into the political spotlight (Witz, 1992: 126). In the same year as the formation of the BNA, the Hospital Association had also considered the idea of nursing registration, albeit in a much less restrictive form to that which the BNA later proposed. This in turn later led to the Hospital Association becoming staunchly opposed to the state registration of nurses. Due to these differing views as to what form nurse registration should take, a handful of nursing members formed the BNA as part of a breakaway organization from the Hospitals Association (Abel-Smith, 1960; Witz, 1992). The BNAs' primary aim can be summarised in the following statement from the Nursing Record, a nursing journal whose editor was Ethel Bedford-Fenwick, the president of the BNA:

> “The BNA declared that its objective was to obtain the legal status of a profession... [thus] placing nursing on a proper footing… and securing a royal charter to enable really trained nurses to be legally registered as such, and so distinguished from women who are not found worthy of the name”
>
> (Nursing Record, 1888: 15 cited in Witz, 1992).

A particular point to note is the wording used in the above quote in relation to both its presumption that nurses are *women*, and moreover only certain women who are *worthy* of the name, alluding to another more intrinsic quality that only true nurses can possess. Hence, from the outset the BNA became a pressure group for the state registration of nurses. The BNA subsequently created a voluntary register for trained nurses who met the required standard of training, personal character and possessed at least three years’ experience as a nurse (Abel-Smith, 1960: 70).

However, the issue of nurse registration proved to be a highly controversial one, with opposition coming from both the medical profession and the Hospital Association. The Hospital Association’s primary concern was that registration would lead to a shortage in the supply of nurses due to the fact that many hospitals were employing large numbers of probationers as a form of cheap labour (Abel-Smith, 1960; Witz, 1992). Yet, there was also considerable dissent from within the nursing profession itself, in which Nightingale played a key role. Witz (1992) argues that this was linked to her view of nursing as coming from an inner calling, where women of exceptional moral character seek to better themselves through the practice of it (Witz, 1992: 136). Thus, in Nightingale’s view, if registration was introduced, a test would have to be administered which would only assess the knowledge of a nurse, not the nurse’s character. This would therefore potentially diminish the reputation and character of the profession, as greater emphasis would be placed on the outcome of such a test (Abel-Smith, 1960).

Although Nightingale may have opposed nursing registration on the grounds that it could potentially interfere with the intrinsic qualities of the overall nursing workforce, a considerable amount of opposition also came from matrons working in the voluntary hospitals. Witz (1992) argues that this is because many matrons were concerned that the state registration of nurses would disrupt the balance of power that they had worked so hard to forge for themselves. This balance of power (that some matrons were concerned may be disrupted should nursing be made a state regulated profession) stems from the changing role of matrons following the widescale hospital reforms pioneered by Nightingale during the 19th century. Prior to these reforms, much of what contemporary nurses currently do now in their day to day practice was in fact undertaken by doctors. The role of nurse generally revolved around housekeeping and making the patient comfortable; if assisting with medical treatment, the nursing care was directed and prescribed solely by the physician (Abel-Smith, 1960). Thus, in order for matrons to distinguish themselves from domestic managers to managers of an independent nursing staff, they had to actively assume responsibility for some of the tasks performed by doctors and lay hospital administrators, all of whom were typically men (Witz, 1992: 134; Abel-Smith, 1960; Carpenter, 1977;).

On the other hand, the 'proregistration' campaign was headed by the key, albeit controversial, figure of Ethel Bedford-Fenwick, who sought to further the practice of nursing through professional registration (Abel-Smith, 1960). Witz (1992) argues that the proregistration campaign was based upon both usurpationary and exclusionary lines. In terms of the usurpationary element, they firstly sought to disrupt the employment relationship between the hospitals (which were primarily controlled by male doctors and lay administrators) and nurses. The purpose of such disruption was because up until that point "hospitals controlled both the standard and length of nurse training" (Witz, 1992: 123). Secondly, the proregistrationists sought to challenge the inter-occupational relationship between doctors and nurses, where doctors were seen as a potential

threat to an autonomous nursing body. Finally, Witz (1992) argues that the proregistrationist campaign sought to challenge gender relations with the aim of creating a female dominated profession.

2.4: Nurse Registration and Market Control

If a centralised governing body were to be created, issues such as nurse practice and training would no longer be governed by the hospitals and the matrons within them. This in turn would lead to the creation of an occupational monopoly by regulating the supply of trained nurses available to the market (Witz, 1992). In addition to this, the notion of a centralised governing body feeds directly into the final demand of the proregistration agenda which was for a one portal entry system into nursing (Witz, 1992). As Witz succinctly summarises:

> "This [one portal system of entry] hinged around centralised control over the curriculum, as well as the duration and standard of nurse education, and a single register"
>
> (Witz, 1992: 123).

This desire to control the standard and duration of nurse training by the means of a centralised body could, on the one hand, be seen as a way in which to ensure adequate training was given to someone granted the title of 'nurse', so as to ensure the public received a set standard of care. On the other hand, it could be seen as a way of dictating what actually constituted 'nursing practice', thus discrediting a large amount of alternative therapies provided by other practitioners in the process, all of which would serve as competition to a newly established nursing body. A key example of this kind of practice being utilized within the healthcare arena can be seen in Moran's (1999) work on the professional regulation of doctors by the GMC in the United Kingdom, following the Medical Act (1858). Although the GMC did not take an active role in the prescription of training, it nonetheless had the ability to do so if need be. The ability to do so, coupled with the fact that the GMC was self-regulated, meant that doctors had a vested interest in ensuring that what was deemed as 'medical care' could only be prescribed by themselves.

In short, the main objective of the proregistration campaign was for nursing to gain official status as a profession and the benefits that accompanied such status. As Moran succinctly states, professionalism is a regulatory strategy employed by private interests within capitalist democracies:

> "Regulation characteristically involves 'closure': restricting entry to markets, and limiting competition between those already in the market, in order to limit the destructive effects of competition on established interest"
>
> (Moran, 1999:99).

A key part of this professional 'closure' involves not just preventing market competition from others outside of the profession, but also in creating a self-regulatory system, which, although enshrined by the state, must also keep the state at arm's length. In other words, a profession must "manage the relationship with the state so as simultaneously to appropriate public authority without surrendering to public control" (Moran, 1999: 99). This need to ensure professional autonomy with the minimum amount of input from the state and/or public was keenly known to the proregistration campaign, as can be seen in the following quote from Bedford-Fenwick:

> "Now the moral which we desire to draw from this historical review of the constitution of the General Medical Council is that NO NURSING COUNCIL IS LIKELY TO PROVE PERMANENTLY ACCEPTABLE TO THE NURSING PROFESSION UNLESS IT IS CHIEFLY COMPOSED OF MEMBERS DIRECTLY ELECTED BY THE NURSES THEMSELVES". [capitalisation in the original]"
>
> (Bedford-Fenwick, 1895: 82 cited in Witz, 1992).

Whilst the BNA's primary aim was to secure state registration of nurses through an Act of parliament, due to the stiff opposition from the aforementioned parties, little headway was made in the early years on

this front (Abel-Smith, 1960). As a result, the BNA took the less preferred option of applying for a Royal Charter which it was granted in 1893, thus becoming the Royal British Nurses Association (RBNA), making it the first female led organization ever to be given such status (Abel-Smith, 1960; Witz, 1992).

However, perhaps a more noteworthy precedent that helped support the campaign for the state registration of nurses was the Midwives Act (1902). This Act resulted in a register for midwives being set up and a Central Midwives Board being created, comprised of four doctors and five other individuals selected by the RBNA (Abel-Smith, 1960: 78). Some have argued that this success in turn led to the RBNA aligning itself once again with the campaign for nurse registration, as the case of unlicensed midwives served as a prime example of what could befall a profession bereft of state sanctioned registration (Abel-Smith, 1960). In the years that followed the Midwives Act (1902), there were several unsuccessful attempts to pass bills on the issue of nursing registration, authored by both the RBNA and other organizations (Bendall and Raybould, 1969). However, as Bendall and Raybould have highlighted, despite these failures, these efforts did result in some success:

> "…their [the efforts of the RBNA and SSRN] effect was such that in June 1904 Parliament ordered that a Select Committee of the House of Commons be set up to report on the whole question of the registration of nurses"
>
> (Bendall and Raybould, 1969: 6).

Interestingly, as was the case with the campaign for the registration of midwives, proponents of nurse registration also collated a list of scandals committed by individuals claiming to be nurses, which were presented to the Select Committee during this time (Abel-Smith, 1960: 63). This tactic has since been used in subsequent years when reforms of healthcare regulation have been proposed, which will be discussed later on in this chapter. These tactics did have some success, with the Select

Committee eventually reporting in favour of nurse registration, however, as Abel-Smith pointed out:

> "…due to conflict within the committee, along with external pressures from nursing and hospital organizations, no bill was passed (Abel-Smith, 1960; Bendall and Raybould, 1969). Yet, this did not curtail the proregistration campaign, who used the committee's report to demand further action"
>
> (Abel-Smith, 1960: 81).

This eventually led to the government establishing the Central Committee for the State Registration of Nurses, a permanent committee which represented a large number of nursing associations, including the RBNA (Abel-Smith, 1960). This in turn led to there being a nurses' registration bill being placed before parliament annually between the years 1904-1914 (Witz, 1992: 130). Although these numerous attempts were unsuccessful, which authors such as Abel-Smith (1960) have argued is due to there being little interest from the government in satisfying a small number of professional elites within the nursing community, WWI proved to be a turning point. After WWI there was a renewed political interest in the issue of nursing registration, which Abel-Smith argues is due to the following three reasons:

> "First, the introduction of more untrained women to work in the hospitals [during WWI] united the professional nurses in a desire for registration. Secondly, widespread public sympathy and admiration were enlisted for the nurse's cause. Thirdly, women earned the vote."
>
> (Abel-Smith1960: 82-83).

Certainly, this notion of controlling the supply of a desired resource, in this case nursing labour, within a competitive market is another key tactic utilized by professions. By controlling the supply of labour, a profession

and its members can insulate themselves therefore protecting themselves from competitive market forces within a capitalist economy.

Returning to the example of the GMC, even up until the 1990s, the largest section within the Blue Book, the GMC's disciplinary code, was concerned with the advertising of doctor's services rather than the clinical treatment of patients (Moran, 1999: 103). However, when proposing greater regulation within the healthcare arena, professionals tend to couch their arguments not in relation to controlling the supply of labour, but rather in that of patient safety and public protection (Moran, 1999), as can be seen in the case of the Midwives Act (1902).

Nonetheless, due to the uneven supply of skilled and unskilled nursing labour caused by the recruitment of large numbers of unskilled nursing volunteers during WWI, coupled with the fact that Nightingale had since died, led to fertile ground for a renewed campaign for nurse registration (Abel-Smith, 1960: 87). This eventually culminated in Arthur Stanley, 1917 Treasurer of St. Thomas's Hospital, to propose that the various nurse training schools form a joint College of Nursing in order to further the advancement of the registration of nurses (Abel-Smith, 1960: 87-88). By 1916, the College of Nursing Ltd. had been formed and was registered with the Board of Trade. The College's principal objectives were as follows:

> "1) To promote the better education and training of nurses and the advancement of nursing as a profession…
>
> 2) To promote uniformity of curriculum
>
> 3) To recognize approved Nursing Schools
>
> 4) To make and maintain a register of persons to whom certificates of proficiency or of training and proficiency had been granted
>
> 5) To promote Bills in Parliament for any object connected with the interest of the Nursing Professions…"

(Abel-Smith, 1960: 89).

Through the development of the college, Stanley managed to garner the support of the major nurse training schools, albeit somewhat at the expense of the nursing associations whose support rested primarily with the RBNA. In the years that followed, there were a number of bills proposed by both the RBNA and the College of Nursing, both of whom were competing for the control of the new regulatory body (Abel-Smith, 1960). However, as a result of the political wrangling between the College of Nursing and the Central Committee on the State Registration of Nurses, the Government decided to introduce its own bill which received the royal assent in 1919.

This Government's bill created the requirement for all practising nurses to be registered with a newly established central body, the General Nursing Council (GNC), which was to be made up of nine lay members and sixteen nurses (Abel-Smith, 1960: 101; Bendall and Raybould, 1969). Whilst differing from the GMC which, up until the 1970s, had no lay representation (Moran, 1999), it nonetheless ensured that the Council was comprised of a professional majority, thus ensuring that the concept of self-regulation was enshrined in the beginning. However, Witz (1992) has argued that, like the Woman Suffrage Movement and the parliamentary franchise, the struggle that the nursing profession faced to become a self-regulated profession was based on societal attitudes towards women and the common belief among the general populace that women could not be trusted to manage their own affairs.

2.5: The Nurses Registration Act

Nevertheless, along with creating the new, centralised body of the GNC, the Act also laid out the way in which the registration of nurses was to be administered, with the register consisting of the following parts:

> "(a) a general part containing the names of all nurses who satisfy the conditions of admission to that part of the register;

(b) a supplementary part containing the names of male nurses;

(c) a supplementary part containing the names of nurses trained in the nursing and care of persons suffering from mental diseases;

(d) a supplementary part containing the names of nurses trained in the nursing of sick children;

(e) any other prescribed part."

(Abel-Smith, 1960: 96-97)

In addition to this, the Act also charged the GNC with the task of regulating nurse training and professional conduct, thus creating a 'one portal entry' into nursing via its registers, which only offered full membership to females who were general trained (Abel-Smith, 1960). The resultant effect of these legislative changes was therefore the creation of the first self-determining, female dominated occupation (Mackintosh, 1997: 234). Whilst a limited number of men were still practicing within the nursing profession, they were only allowed to remain on Part 2 of the GNC's register. This restriction, coupled with the fact that only eight hospitals in England were willing to accept men on a probationary basis, ensured that male nurses were very few in number (Mackintosh, 1997: 234). Yet, although the number of GNC certified male nurses remained relatively low, according to census data the number of men reporting themselves as being employed in nursing practice in actual fact rose (Abel-Smith, 1960). Between the years of 1901 and 1931 the number of men claiming to be working as nurses increased from a total of 6,000 in 1901 to 11,000 in 1921 and over 15,000 in 1931. A similar increase can be seen in the case of women, where in 1901, a total of 63,500 women reported themselves as being engaging in nursing practice. By 1921 this number had increased to 111,501 and by 1931, there was a total of 138,670 women reporting that they were engaged in nursing practice, despite only around 28,000 being able to satisfy the requirements of the GNC in 1925 (Abel-Smith, 1960: 116-

117). This increase in the number of individuals claiming to be engaged in nursing practice following the 1919 Act can be seen as an early symptom of the nurse shortages that occurred throughout the 1920s and 1930s (Abel-Smith, 1960: 117). Yet, despite these shortages male nurses were still not allowed to join Part 1 of the register designated for general nursing. In addition to this, male nurses were also not allowed membership to the College of Nursing (later the Royal College of Nursing) which was the largest professional nursing organization at the time (Abel-Smith, 1960).

Whilst the number of nurses had increased considerably, along with their standard of training, the demand for trained nurses increased further, which authors such as Abel-Smith (1960) have argued is due to both rising living standards and advances in the practice of medicine. As Moran (2000) points out, with the ever-increasing technological advances being made from the turn of the 20th century, more and more areas of medicine were aimed at curing the sick as opposed to managing them at the end of their life. These technological advances also meant that in many cases doctors preferred to treat patients in an acute hospital unit where they had the medical equipment readily available and could perform the more complex medical procedures as opposed to the patient's own home. These advances gradually led to a reduction in the stigma associated with hospital admission, which led to an increased demand for trained nurses and nurse tutors in order to teach nursing probationers (Abel-Smith, 1960).

This shortage of trained nurses also led to healthcare providers catering to the less popular areas of nursing, such as nursing homes. Many of these nursing homes employed untrained women to nurse the sick, which, according to Abel-Smith (1960), was resented by the nursing community and its professional organizations. This was illustrated by Essex County Council deciding to experiment with training nurse orderlies in 1935, with other counties soon following suit. The RCN did not respond positively to this development, with the Council of the RCN stating in their annual report that:

> "If developed throughout the country, [it] might prove a menace to the economic conditions of the nursing profession. They [the Council] also realized that it would be impossible for the General Nursing Council to recognize any standard of training lower than the basic standard prescribed for admission to the Register. They suggested, therefore, that the ideal method of caring for the patients would be to employ non-resident trained nurses" (RCN, 1935: 5-6 cited in Abel-Smith, 1960)

By their own admission, the RCN in the above statement demonstrates how professional regulation is used as an economic strategy aimed at controlling the supply of labour in order to create a monopoly within the market, to use Moran's (2000) argument. This is further demonstrated by the RCN arguing that it is not possible for the GNC to regulate nursing orderlies, as the Nurses Registration Act 1919 did not prescribe an additional section of the register for nurse orderlies at that time. The issue of non-resident nurses is also of import. Abel-Smith (1960) has highlighted how the average age of the nursing profession was steadily decreasing at the turn of the century and that the nursing population was primarily comprised of young, unmarried women who lived in hospital lodgings. In other words, the alleged solution to the problem of the shortage of trained nurses was to hire more nurses. From where these nurses could be found was not elaborated on. This shortage of trained nurses in turn led to an increased amount of pressure on the registered nurses working in the hospitals, which led to issues such as salaries, hours and other working conditions coming under particular scrutiny.

This eventually culminated in the Athlone Committee being set up in 1937 to consider the issue of hours, pay and working conditions for nurses. The Athlone Committee, with the support of the RCN (which had previously been against trade union activity in nursing), made wide-ranging recommendations in its report (unpublished due to WWII). This report included recommendations regarding nurses' salaries, the hours worked, levels of holiday leave provided and other such issues. A key

recommendation within their unpublished report was that a Roll should be created for a second type of nurse to assist state registered nurses in basic nursing activities in order to help alleviate the shortage of registered nurses (Abel-Smith, 1960). Yet, even within the Athlone Committee the issue of this second type of nurse was a contentious one, particularly with regard to what this second type of nurse would be called. As Abel-Smith summarizes:

> "…lay members of the Committee wanted to use the term 'assistant nurse' which was already in use. The four state registered nurses on the Committee, however, persisted in their desire to avoid the word 'nurse'."
>
> (Abel-Smith, 1960:158)

Eventually it was decided that the term assistant nurse would be used. However, a concession was made to the nursing profession in that it was to be made an offense for a nursing agency to supply anyone who was to be engaged in nursing the sick who was not on the Roll or the Register. Furthermore, it would also be an offense if the supply agency failed to highlight to employers that the woman they were supplying was an assistant as opposed to a state registered nurse (Abel-Smith, 1960). The British Journal of Nursing, however, was highly critical of this recommendation questioning whether nurse assistants were *'safe* attendants of the sick' who were not simply out to '*exploit* the suffering public', and that qualified nurses would be 'undersold in the open market' (Bedford-Fenwick, 1939: 29). As discussed previously, this use of patient safety as a justification for greater professional regulation is a key method employed by those within professions who have a vested interest in excluding others from entering (Moran, 2000).

However, there is a more insidious nature to the above argument as Bedford-Fenwick argued that 'highly intelligent women' would not enter the profession if the nurse assistant role was created. As Witz (1992) has shown, much of the proregistration campaign was developed along class lines where the proregistrationists sought to change the perception

of nurses from that of the working class to the middle/upper class. Nonetheless, a second portal was set to be opened for assistant nurses despite the fears from some within the profession about allowing another group entry to the GNC, albeit on a separate Roll (Abel-Smith, 1960).

On the note of the different groups within the nursing community, an interesting point to consider is that in 1937, which is the same year as when the Athlone Committee was established, the Society of Registered Male Nurses was also created (and allied with the Royal College of Nursing). Its aims were to maintain the traditions and dignity of the nursing profession among male nurses, to assist made nurses with professional issues where possible, and to encourage high standards of professional conduct amongst male nurses (Mackintosh, 1997: 234). However, the outbreak of the second world war effectively removed any control that the profession had over its immediate future as the government sought to prepare for the years to come (Mackintosh, 1997: 235).

2.6: WWII, the Beveridge Report and the Nursing Profession

During WWII, nursing began to undergo further changes, with the establishment of the Nursing Emergency Committee who were charged with assessing the number of available nurses and compiling a list of auxiliary nurses willing to work in emergency situations (Bendall and Raybould, 1969). A Civil Nursing reserve was created which recruited 7,000 trained nurses and a further 3,000 nursing assistants. In addition to this, untrained volunteers were also recruited to help with the war effort and were designated the status of ‘nursing auxiliaries’ (Abel-Smith, 1960). These nursing auxiliaries proved difficult to integrate within the hospitals with their strict discipline and hierarchies, all of which led to renewed calls for a second grade of nurse (Abel-Smith, 1960). There were also issues to consider regarding the status of individuals in the armed forces who were not registered nurses. In the early years of the war, nursing auxiliaries were granted ‘officer’ status within the military, although this was eventually withdrawn in 1943 (Abel-Smith, 1960).

However, as Abel-Smith has highlighted, another status anomaly occurred with regard to registered nurses in the Voluntary Aid Detachments that were deployed during WWII:

> "A newly qualified female nurse could enter the QAIMNS [Queen Alexandra's Imperial Military Nursing Service] and attain immediate officer status. A male qualified nurse, however, remained an 'other rank'. Thus, a female registered nurse could have working under her a male registered nurse who was senior in both age and experience"
>
> (Abel-Smith, 1960: 163).

Nonetheless, despite only accounting for less than 3% of the nursing population, arrangements were made for male student nurses that were called up for military service. These arrangements included allowing them to postpone examinations and to return to training after the war without the need to complete additional training (Bendall and Raybould, 1969: 123).

However, despite the massive recruitment effort during the war, there was still a shortage of nurses in certain areas, which was further exacerbated by the loss of nursing auxiliaries when the war ended in 1945. The mental hospitals were particularly badly hit during the war as they used such a high percentage of male nurses, which were then lost due to being conscripted to fight in the war. The wastage rate was also reaching an alarming level, with male wastage rates rising to 100% at one point (Abel-Smith, 1960). Thus, the Ministry of Health (MoH) began providing shortened courses for ex-service men and women to gain entry to the nursing registers. The MoH also began actively canvassing male nurses with recruitment literature specifically aimed at men both during and after the war (Mackintosh, 1997: 235). Although the GNC had initially agreed to this as a war time measure, the GNC began to object to these courses being run for longer than it deemed necessary. Nevertheless, undeterred by the dissatisfaction of the GNC, the MoH

continued to permit these one-year courses up until 1953 (Abel-Smith, 1960).

Yet, the most significant change for male nurses occurred following the Beveridge welfare reforms which created the NHS on the 5th July 1948. As Moran (2000) argues, the creation the NHS was a turning point for the British Government and the ways in which it regulated the 'healthcare state'. A year prior to the creation of the NHS, a Working Party had been established and charged with investigating the recruitment and wastage of nurses. Amongst the many recommendations that the Working Party's report made, which included completely separating nurse training schools from hospital management, the issue of male nurses was highlighted, as the following quote from the MoH, which was cited in Mackintosh (1997), demonstrates:

> "We suggest all nursing posts should be open equally to males and females. Experience in the services and elsewhere has shown that there is no valid reason for sex distinctions and we do find it incongruous that a male nurse of suitable personality, with the necessary qualifications, would be eligible for appointment as superintendent of nurses… But the success of such a scheme which is a departure from recognized practice will depend on the reaction of the profession and the Public"
>
> (MoH, 1947: 73 cited in Mackintosh, 1997)

Despite several aspects of the report receiving a considerable degree of criticism from both the professional organizations and the hospital association, the 1949 Nurses Registration Act was passed. This Act implemented several aspects of the report, including the general training of nurses and the agencies who supply them (Bendall and Raybould, 1969). The 1949 Nurses Registration Act also amalgamated Part 2 of the register, which was specifically reserved for male nurses, with Part 1, thus creating a single stream. As a result, male nurses were able to practice in general nursing for the first time in large numbers (Bendall

and Raybould, 1969). As a result of these changes, between 1939 and 1947 the male nursing population increased by 542%, with over 108 nursing schools allowing male nurses to enter training courses during this period (Mackintosh, 1997: 235). Yet, despite their increased number, male nurses still "faced a number of remaining difficulties, most notably the 'atmosphere' and decreased promotion prospects" (Mackintosh, 1997: 235). With the introduction of the Nurses Registration Act 1949, the GNC was also able to persuade the then Health Minister to ensure a minimum age of 18 for a trainee nurse. Prior to 1952, the GNC had had no power to restrict the age that hospitals could accept trainees, which in some cases was as young as 15 (Bendall and Raybould, 1969).

However, as the 1950s progressed issues surrounding nurse pay came to the forefront again. It had begun to be noted in government circles that senior nurses were falling behind other professionals, in particular, the teaching profession. The reason for this is that the teaching profession was the nursing profession's main rival for attracting young girls and had also secured substantial pay increases in line with the above. Hospital administrators had also obtained considerably large pay increases, all of which provided further impetus for nurses to make a claim for higher wages, which was eventually granted to all grades of nurses (Abel-Smith, 1960). Yet, the 1949 Nurses Act had also given the Standing Nurse Training Committees considerable flexibility with regard to the training of student nurses. With the exception of a two-year course trialed in 1956 by the Royal Infirmary, Glasgow, the standard training for a nurse never dipped below three years. However, 'dual' qualifications such as general and child nursing certificates were issued following a four-year training instead of the previous five years (Abel-Smith, 1960). Whilst these efforts did lead to a considerable increase in the number of registered nurses (with the number of male nurses increasing from around 1,300 in 1949 to over 2,700 in 1958) it did create the conditions that resulted in the ever-increasing calls for nursing reform during the 1960s and 1970s (Abel-Smith, 1960).

2.7: The Nurse Act, the UKCC and the Nursing Profession

During the 1960s, The Nurse Act (1964) was introduced in order to help try to further improve both nurses' standing and training. However, this did not stem the flow of criticism coming from both the nursing profession and those outside of the community. As Davis and Beech (2000) highlight, the publication of both the Platt Report in 1964, which emphasized the need for urgent changes to nursing education, and the publication of two reports by the RCN in the same year (*Administering the Hospital Nursing Service* and *A Reform of Nursing Education*) served to highlight the issues that the nursing profession still faced. As a result, in 1970 parliament established the Briggs Committee in order "to consider issues around the quality and nature of nurse training and the place of nursing within the NHS" (NMC, 2010).

These reports coincided with academic and sociological research looking at the way in which hospitals and similar institutions were organized and the effect that such organization had on patients. For example, Goffman (1958) conducted research analysing what he referred to as 'total institutions'. These total institutions included care homes for elderly and/or disabled patients, as well as mental health units, which were more commonly referred to as asylums at the time of Goffman's writing. Goffman (1958) found that patients in these institutions often underwent a *stripping process* as a result of institutional requirements, such as the removal of material items and loss of personal identity. This stripping process lead to the *mortification of the self* or, in other words, the loss of one's personal identity. This was reinforced by other processes such as *rewards and privileges* for compliance and *punishments* for infractions. However, Goffman (1958) was careful to point out that not all of these processes were present in all institutions. Nevertheless, despite these total institutions being designed to treat, cure and/or rehabilitate the individuals in their care, Goffman argued that this rarely took place:

> "Total institutions frequently claim to be concerned with rehabilitation, that is, with resetting the inmates [or patients] self-regulatory mechanisms so that he will maintain standards of the establishment of his own accord after he [sic] leaves the setting. In fact, it seems this claim is seldom realised and even when permanent alteration occurs, these changes are often not of the kind intended by staff [of these total institutions]"
>
> (Goffman, 1958: 64-65)

Findings such as this also coincided with the increased calls in the UK for hospital reform with one of the most vocal groups being the RCN. Yet, despite the RCN's demands that the educational standard of entrants to the nursing profession was increased (which were supported by many in the nursing profession) such changes were not recommended within the Briggs report (Davis and Beech, 2000: 17). Nevertheless, the Briggs report did result in the Nurses, Midwives and Health Visitors Act 1979 which created a completely new framework for the regulation of Nurses Midwives and Health Visitors, along with a new centralised body: the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC) (Davis and Beech, 2000: 24). The UKCC's duties encompassed "education, training, regulation and discipline of nurses, midwives and health visitors and the maintenance of a professional register" (Davis and Beech, 2000: 25).

Despite the sheer scale of the administrative task of assimilating the records and procedures of all three professions, the UKCC became fully established in 1983 (Davis and Beech, 2000: 36). The UKCC remained operational up until it was replaced by the Nursing and Midwifery Council in April 2002 under the Nurses and Midwives Act (2001) (NMC, 2010). In addition to this, the NMC also took over the functions of the English National Board (ENB) which was responsible for the design and regulation of nurse education. The ENB was then abolished shortly after (Davis and Beach, 2000). Furthermore, from the 1980s to the early

2000s, men's position and participation in nursing underwent further changes with the number of male nurses steadily increasing, with 21% of all nursing applicants being male by 2001 (Longley et al., 2007).

During this period there was also a growing body of academic literature looking at the changing nature of professions. Both Freidson (1983) and Moran (2003) have highlighted how professional regulation was typically conducted on an informal basis of collegial self-regulation during the first half of the twentieth century. As Freidson stated:

> "For almost half a century the professions enjoyed relatively uncritical public esteem, important influence on legislation, and economic rewards far less dependent on the normal marketplace than other occupations. But from the 1960s to the present, it has become apparent that a new arrangement is being worked out between the professions and the political economy upon which their survival depends."
>
> Freidson (1983: 279)

However, it is important to point out that although Friedson's (1983; 1984) work focuses on professional regulation in the US, there are strong similarities between the way in which healthcare professions are regulated in both the US and UK (Moran, 2003). However, it is important to point out that, when analysing the regulation of professionals both Freidson (1983; 1984) and Moran (1999; 2003) focused on professions such as medicine and law which were dominated by men during the 20th century. On the other hand, the nursing profession in the UK is a female dominated profession, which, since its creation in 1919, has had a considerable degree of parliamentary intervention, unlike medicine. This is evidenced by the fact that within ten years of the founding of the GNC there was an involuntary parliamentary inquiry, yet it was over 150 years before the GMC was subject to an involuntary inquiry (Abel-Smith, 1960; Moran, 2003). Nevertheless, Freidson (1983; 1984) argued that during the 1970s and 1980s, professions were becoming increasingly stratified

as a result of political pressure. This pressure was aimed at increasing the regulation of professionals as it was believed by some that professionals were not acting within the ‘public interest’. The issue of the public interest is of import because it was a key component in a tacit understanding between the state and professional organizations (Freidson, 1984). In return for protecting professionals from external market forces by restricting the practice of their given profession only to licensed professionals, the state expected professionals to act in the public interest. Acting in the public interest was mainly comprised of practicing ethically and competently rather than practicing in their individual or collective self-interest (Freidson, 1984).

From the 1960s onwards, however, there was a view that professionals were not always practicing in the public interest. These views resulted in increased political pressure demanding that professional bodies begin to regulate their members in a more proactive fashion (Freidson, 1983). Whilst there are many ways in which this political pressure manifested itself within the professions, Freidson (1983) argued that one of the main results (particularly within medicine) is what he referred to as ‘mandated collegial regulation’. Mandated collegial regulation requires the formal examination and evaluation of professionals by their colleagues, which would typically be conducted by disciplinary boards (Freidson, 1983: 288). According to Freidson, this mandate collegial regulation results in stratification within professions. This is because such evaluation and examination requires that there is an elite group of individuals within the profession who are deemed to possess adequate knowledge to perform such evaluations on ‘rank and file’ professionals (1983: 288).

However, Freidson also noted the presence of another type of regulation, ‘mandated bureaucratic regulation’, which he argued had the potential to further stratification within professions:

> “Bureaucratic regulation extends the formalization of stratification in the professions. Insofar as the professions monopolize a valued body of knowledge and skill, they also

> monopolize its application. Bureaucratization of professional work therefore requires members of the profession who can claim the *professional* authority to choose and formulate the criteria and methods by which the bureaucratization of work can take place."
>
> (Freidson, 1983: 288)

At the time of writing, Freidson found that although bureaucratic regulation was present, collegial self-regulation was the predominant manner in which professionals were regulated in lieu of direct state control (Freidson, 1983: 281).

2.8: Nursing Regulation, the NMC and Recent Regulatory Changes

However, since the 1980s there has been a considerable shift in the way in which professions are regulated in the UK. One example of this is the medical profession, which had been trusted to self-regulate prior to 2000. However, following a series of high-profile scandals, this sentiment began to change. As Waring et al. have highlighted:

> "Though the medical profession enjoyed a remarkably stable regulatory structure for most of the first 150 years of its existence, it has undergone striking transformation in the last decade. Its regulatory form has mutated from one of state-sanctioned collegial self-regulation to one of state-directed bureaucratic regulation."
>
> (Waring et al., 2010: 540)

Whilst the above quote concerns the medical profession, the way in which nurses are regulated has also changed considerably, with the rate of change being particularly pronounced in the last two decades (Traynor et al., 2014). Authors such as Waring et al. (2010) have argued that this is due to a series of high-profile scandals in both nursing and medicine, such as the Allitt Inquiry (Clothier,1994) and Bristol Inquiry (Kennedy, 2001), coupled with an ever-increasing political appetite for the control of public organizations. As a result, many of the regulatory systems

governing the healthcare professions have been transformed from 'state-sanctioned collegial self-regulation' to that of 'state-directed bureaucratic regulation' (Waring et al., 2010).

In the case of nursing, Cooke (2006a) has argued that these reforms were driven forward by the 2001 Labour government under the guise of being necessary due to the perceived deficiencies in self-regulation. Such deficiencies included an alleged lack of transparency and a vested self-interest within the then system of nurse regulation. Thus, according to the Department of Health (DoH, 2001 cited in Cooke, 2006a), not only did professional regulation need to be tougher and faster, but it also needed to be more open. Consequently, in 2002 the UKCC was replaced by the Nursing and Midwifery Council, which also took over the quality assurance function of the now defunct English National Board (NMC, 2010a). Amongst a number of changes that were introduced concerning the regulation of nurses, the NMC began distinguishing Fitness-to-Practise (FtP) referrals as either being conduct and/or competence related or health-related. The former are heard by the Conduct and Competence Committee (CCC) and the latter are heard by the Health Committee (HC). The CCC hears cases hear the following types of cases: misconduct; lack of competence; criminal offences; not having the necessary knowledge of English; and decisions made by other health or social care organizations (NMC, 2010c). The HC hears cases where a nurse suffers with a physical and/or mental health condition that the NMC deem to pose a risk to patients (and the nurse has continued to practice whilst suffering with the condition) (NMC, 2010c). However, it is important to note that as of 2017, the CCC and HC have been merged into a single NMC FtP Committee so that health allegations can be heard together with conduct and/or competence related allegations (NMC, 2017a). Thus, this new single FtP Committee hears the following cases: "misconduct; lack of competence; a conviction or caution for a criminal offence; not having the necessary knowledge of English; physical or mental health; a finding by any other health or social

care regulator or licensing body that fitness to practise is impaired" (NMC, 2019).

In addition to these new powers, Cooke (2012) has also highlighted how the Government has placed considerable emphasis on the need to weed out the 'bad apples' in recent years, as opposed to highlighting how institutional failings can lead to poor nursing practice. As Cooke succinctly summarizes:

> "During the 1990s attention shifted towards an individual professional's deviant behaviour with a series of inquiries focusing on the reckless, incompetent (Kennedy, 2001) or predatory behaviour (Smith, 2004) of individual professionals"
>
> (Cooke, 2012: 53).

This focus on the individual was in part due to a number of high-profile cases involving nurses deliberately harming patients, such as Beverley Allitt and Amanda Jenkinson. In the case of Beverley Allitt, the Allitt Inquiry found that she caused the death of several paediatric patients due to her alleged Munchausen by Proxy (Clothier, 1994), which is now referred to as Fabricated or Induced Illness (NHS, 2014). In the case of Amanda Jenkinson, the Jenkinson Inquiry found that Jenkinson had tampered with equipment in an intensive care unit resulting in severe harm to a patient (Bullock, 1997). However, it is important to note that Amanda Jenkinson was later exonerated by the Court of Appeal in 2005 (Cooke, 2012: 53). Nevertheless, both of these cases had a considerable effect on the public perception of the profession, in turn influencing the way in which blame was ascribed following adverse events in healthcare settings. As Cooke describes:

> "…the Clothier Inquiry into the Allitt case focused almost exclusively on the protection of the institution from the 'determined miscreant' heightening the focus on 'malevolence' as an explanation for adverse events"

(Cooke, 2012: 53)

The residual effects of such cases can be seen in the NMC's more recent focus on the individual attributes of a nurse. For example, the NMC's discussion on what it deems as a lack of competence, the NMC reminds the reader that "Attitude and character are just as important as competence" (NMC, 2010b; Santry, 2010). This is in contrast to the UKCC whose panels had been known to question employers during FtP hearings on staffing levels and staff training (Cooke, 2002; 2012). The UKCC was also known for criticising employers over what it deemed as inappropriate referrals, as can be seen in the following quote from Davies:

> "Later Annual Reports [authored by the UKCC] repeatedly rapped employers over the knuckles… for forwarding cases that could have been dealt with as disciplinary matters at local level. Individual representations were made to health authorities and trusts as a result of practices coming to light in conduct cases"
>
> (Davies, 2002: 102)

Similar regulatory changes were also attempted with regard to the General Medical Council. Under the Health and Social Care Act (2008), the Office of the Health Professions Adjudicator (OHPA) was established and tasked with, amongst other things, taking over the fitness-to-practise function of the GMC (Waring et al., 2010). However, the OHPA never became fully functional and was subsequently abolished as of June, 2012 under the Health and Social Care Act (2012) (OHPA, 2012). However, in the same year the General Medical Council (Constitution) Order (2008) paved the way for regulatory reforms within the GMC. These reforms included changes to GMC FtP panels so that they were made up of lay, professional and education members (with no professional majority) (McGivern and Fischer, 2010: 549). Furthermore, according to McGivern and Fischer (2010) these regulatory changes have led to what they refer to as 'spectacular transparency'. This

spectacular transparency is a result of political responses to high profile scandals, rather than due to any evidence of the beneficial effects it may have on clinical practice. McGivern and Fischer (2010) argue that, in the context of medicine, rather than having a positive effect, spectacular transparency has in fact had a perverse effect on clinical practice and patient care due to doctors practising defensively. This spectacular transparency is guided by what they refer to as the 'blame business', "in which media, lawyers, and even some patient organisations are fuelling transparency in a wider blame culture" (McGivern and Fischer, 2010: 597) in order to profit directly from such an environment.

However, whilst nursing has historically mimicked the developments of medicine, in the case of the most recent regulatory changes the nursing profession appears to have led the way with regard to the shift from state-sanctioned collegial self-regulation to state-directed bureaucratic regulation (Waring et al., 2010). Cooke (2010) has argued that this is primarily due to the nursing profession occupying a weaker position in terms of professional status and occupational autonomy in contrast to medicine. An example of this weaker status can be seen historically; during the creation of the NHS, General Practitioners were tasked with becoming the gatekeepers of medical treatment, whilst also retaining a large portion of their former pre-NHS salary compared to nurses (Moran, 1999; Abel-Smith, 1960). This weaker professional status, Cooke (2010) argues, has resulted in an increasing level of bureaucratisation and political control of the nursing profession. Indeed, in 2002 (the same year in which the NMC was a created) the Council for Healthcare Regulatory Excellence (CHRE) was also set up under the National Health Service Reform and Health Care Professions Act (2002). The CHRE's primary purposes was to oversee the various healthcare regulatory bodies, including the NMC. This current system, as Waring et al. (2010) point out, bears considerable resemblance to what Gunningham and Grabosky (1998) referred to as 'meta-regulation'; meta-regulation is where the state regulates self-regulating professional bodies both within the healthcare realm and outside of it.

Likewise, the previous discussion on the history of nursing is also a clear indication of the nursing profession's weaker status in comparison to medicine. A key example of this weaker status is that it was more than 60 years after the Medical Act (1858) (which was created in order to regulate medical doctors) that the Nurses Registration Act (1919) acknowledged nurses as a professional group (Mackintosh, 1997:232). The reasons behind this need for the nursing profession to reassert its professional credentials are clearly explained by Freidson's (1970) work, *Profession of Medicine*. Freidson (1970) has demonstrated how professions are reified within society as they are perceived to perform tasks of great social value as they possess both knowledge and skills that in some way set them apart from other workers. In addition to this, professionals are viewed as distinctive because they bring a special attitude of commitment and concern to their work (1984: 2). Freidson (1994) has referred to this view of professions and their accompanying attributes as the 'folk concept' of professions. Cooke has highlighted how these folk concepts, and the lists of traits associated with them, "became shopping lists for occupations that were aspiring to professional status" (2008a: 50). For example, nursing leaders began actively promoting things such as nursing theory, nursing degrees and a code of conduct in order to raise the status of the profession (Cooke, 2008a).

Nonetheless, according to authors such as Thomas (2012) and Simons and Mawns (2012), this oppressed occupational status has led to increasing levels of workplace bullying, or what Thomas (2012) refers to as 'nurse-to-nurse horizontal violence'. This, they argue, is due to nurses feeling powerless due to the sustained attacks that they receive from other occupational groups such as doctors and healthcare managers. In the case of the UK, Cooke (2006b) has demonstrated how this increased political intervention, presented under the guise of 'empowerment', has led to vertical violence within the nursing profession via what she refers to as 'seagull management'. The concept of 'seagull management' was derived from the succinct quote by one of Cooke's research participants who stated:

> "We have seagull managers here, they fly in from a great height, make a lot of noise, drop a lot of crap, then fly off again"
>
> (2006b: 223).

Cooke outlines how 'seagull management' is comprised of four key features; managerial distance, a distrust of staff, destructive criticism by management and a defensive culture within the healthcare Trusts (2006b: 223). This latter point is echoed by McGivern and Fischer (2010) in what they refer to as the growing 'blame culture' within the healthcare industry, as previously discussed.

2.9: Masculinity and Men in Non-Traditional Occupations[1]

Yet, the issue of blame within the nursing profession is not a genderless concept. As early as the 1970s, scholars such as Bush (1976) have highlighted how there is a tendency for members of the general public to attribute the failings of an individual male nurse to being as a result of the alleged failings of male nurses as a whole rather than the actions of an individual. This is in contrast to the 'bad apple' theory more generally seen to underpin poor practice (Cooke, 2006a).

Bush (1976) argues that such views are due to gendered stereotypes held by members of society that presume that male nurses are unable to provide adequate care to patients due to their gender. Evans (2002: 441) has also highlighted how male nurses are often presumed to be sexual aggressors and/or homosexual, leading to the 'role strain'. The experience of role strain amongst male nurses was also found by Bush (1976), along with others (*see* Egeland and Brown, 1989; Baker, 2001). Role strain occurs when gendered stereotypes held by members of society pertaining to female dominated professions come into conflict with the male nurse's perception of their own masculinity.

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[1] This section contains written work previously submitted by myself for the 'Contemporary Debates in Sociology' module that was undertaken as part of my MA Research Methods (Sociology) at the University of Nottingham. Whilst all attempts have been made to revise this work, there are some sections where this has not been possible.

The roots of modern-day masculinity can be traced back to a shift in perspectives beginning in the early 19th century as a result of the contributions from individuals such as Thomas Carlyle. Carlyle advocated for a very narrow form of masculinity which discouraged displays of care and emotion. As Brown et al. have highlighted:

> "A man, if he was a worthy example of his sex, should be silent, steadfast and have little to do with women or children [sic]"
>
> (Brown et al., 2000: 6)

Despite this, masculinity only came under focus in the 1970s onwards during what Edwards (2006) terms as the first, second and third waves of the critical studies of masculinity. The first wave of masculinity studies can be seen emerging in the 1970s in what has been loosely coined the *sex role paradigm* (Edwards, 2006: 2). Two of the key authors in the first wave of masculinity studies would be David and Brannon (1976) who proposed the 'Blueprint for Manhood' paradigm.

> "This commonly-cited gender role model proposes that there are four masculine themes with which men struggle to maintain the gender role of men"
>
> (Kahn, 2009: 55).

The four themes consisted of 'the no sissy stuff' [sic] theme, which involved men assessing what is deemed as feminine and thus avoiding such behaviour. A second theme was the 'Be a Big Wheel' theme, which Kahn succinctly summarised as referring "…to men needing to feel that they are in charge of a situation" (2009: 56). There was also 'the sturdy oak' theme , which is based on the idea of men being steadfast, unchanging and of independent thought. Finally there is the 'Give 'em Hell' theme, which Kahn defined as men's "…need to be courageous and a risk-taker, even when it is not in ones best interest" (2009: 57).

David and Brannon (1976) argued that these four themes were the key constructs to masculinity. However, due to their rigid nature, they argued that it led to role strain which could harm men both physically in terms of things such as risk-taking behaviour and emotionally, such as the sturdy oak theme, which involves the idea of repressing one's emotions. However, this paradigm, along with others around this time came under considerable fire from other feminists and other pro-feminist academics who argued that the sex role paradigm:

> "…not only poorly accounts for the observed data [from later studies], but also promotes the patriarchal bifurcation of society on the basis of stereotyped gender roles"
>
> (Worell, 2002: 721)

The second wave of masculinity studies were therefore based on a staunch critique of the first wave of masculinity studies; as can be seen in the following quote from Edwards:

> "More particularly, the sex role paradigm was now commonly seen as to be both dubious politically… and limited theoretically in its purchase on masculinities in the plural sense rather than in the singular sense of one, often white, Western and middle class, model"
>
> (Edwards, 2006: 2)

During the second wave of masculinity studies, the concept of 'hegemonic masculinity' was formulated through an amalgamation of early ideas in the 1980s (Connell and Messerschmidt, 2005: 829). Hegemonic masculinity incorporates both critical accounts of masculinity, such as feminist studies of patriarchy and culture studies of men and sociological models of masculinities. An example of this can be seen in Carrigan et al.'s work 'Towards a New Sociology of Masculinity', which criticised the concept of the 'male sex role' and outlined a model of multiple masculinities and power relations (Connell and Messerschmidt, 2005: 829).

Carrigan et al. (1985) argue that society reifies this particular form of masculinity, which typically distances itself from anything that is perceived as feminine and marginalizes any other alternative forms of masculinity, whilst reproducing patriarchal advantage. An example of this, according to Carrigan et al. (1985), is the criminalization and pathologization of homosexuality in the early 20th century. By describing homosexuality as a pathology and an illegal act, politicians and society are defining what type of masculinity is the 'correct' one whilst labelling alternative masculinities (in this case homosexual masculinity) as lesser, even deviant, form of masculinity. Carrigan et al. therefore argue that the ability to impose a particular definition of masculinity is part of what they mean by hegemony (1985: 592). Thus, hegemony is the dominant form of masculinity within society, subjugating alternative masculinities possessed by those who do not fit with the profile of the hegemonic dominant male (Carrigan et al., 1985).

Although there were multiple variations in the definitions and expressions of hegemonic masculinities espoused by academics, *power* as a concept and the overtly political nature of the accounts were both common denominators. This is because most of the authors that were involved were pro-feminist in how they viewed most issues and were seeking an alliance with feminism with the aim of defining themselves (Edwards, 2006: 2)

On the note of feminist accounts of masculinity, Christine Delphy also outlined her concepts of a single, dominant, patriarchal masculinity which reproduces and reinforces itself through the subjugation of women via mainly materialist forces. Delphy (1977) argues that men exploit women via their unpaid labour in order to further their own socially derived advantage, as men, within a capitalist system. Because of women being tied to the realm of unpaid labour and men in the realm of capitalist paid labour, Delphy argues that there are two modes of production: the *capitalist mode of production* and the *patriarchal mode of production*. However, as Aboim has pointed out:

> "In these earlier views, patriarchy as a concept did not surpass categoricalism. Men and masculinity were defined as a unified force of oppression"
>
> (Aboim, 2010: 27).

However, the notion of there being a single form of masculinity began to shift during the 1990s, with authors such as Butler (1990) and Connell (2000) arguing for a much more pluralistic approach. As Edwards (2006) has argued:

> "The third wave of masculinity studies, rather like the potential third wave studies of femininity, is clearly influenced by the advent of post structural theory"
>
> (Edwards, 2006: 2).

Butler (1990) was one of the key postmodern feminists in the third wave of feminism. Butler (1990) has argued through her concept of 'performativity' that gender is socially constructed and has no intrinsic meaning except for the meaning that the acts itself possesses. This is despite members of society often claiming that gendered performances are the *result* of gender, rather than the *cause* of it. As Butler succinctly summarises:

> "That the gendered body is performative suggests that it has no ontological status apart from the various acts which constitute it's reality"
>
> (Butler, 1990: 136).

Butler (1990) also discusses masculinity by citing the differences between *manhood*, which is seen as a 19th century social construction, and *masculinity*, which is a social construction found in the 20th century. As Floyd has pointed out when discussing Butler's (1990) and Kimmel's (1996) work, manhood was constructed in opposition to the concept of childhood and was therefore seen as an inner quality which had to be

developed, whereas masculinity is constructed not in opposition to femininity rather than immaturity (Floyd, 2009: 88).

Butler's performativity theory can be seen as an extension to Goffman's work concerning gender and identity, whereby he contends that culturally created gender constructs are used to justify the segregation of the sexes through things such as biological functions (Goffman, 1979 cited in Lemert and Branaman, 1997: 210). Butler's (1990) focus on the behavioural practices and the fragmentary nature of performative masculinity represents what many have argued to be the key features of post structural masculinity theory. However, post-structural masculinity theory is fragmented and does not consist of one neat concept (Edwards, 2006).

Connell (2000) further developed her concept of hegemonic masculinity in her work *The Men and the Boys* and outlines how hegemonic masculinity takes place within a gendered hierarchy, as can be seen in the following quote from Connell and Messerschmidt:

> "Multiple patterns of masculinity have been identified in many studies, a variety of countries, and different institutional and cultural settings… The hierarchy of masculinities is a pattern of hegemony, not a simple pattern of domination based on force"
>
> (Connell and Messerschmidt, 2005: 846)

In other words, the masculine ideals at the top of this hierarchal structure are reified by society. However, what Connell (2000) and Connell and Messerschmidt (2005) emphasize is that the hegemonic masculinity need not be the mostly commonly found form of masculinity. Hegemonic masculinity can just as easily be seen as being expressed in a select number of men, for example, international rugby players. Thus, even if the number of individuals who possess this hegemonic masculinity is small in number, society nevertheless still reifies the hegemonic masculinity.

However, whilst Connell's (2000) work received little criticism during the 1980s and 1990s, during the mid-2000s there was an increased focus on the potential problems concerned with the concept of hegemonic masculinity (Moller, 2007). Authors such as Demetriou (2007) have argued that, despite Connell's (2000) work having a multitude of applications within masculinity studies, the concept of hegemonic masculinity is nevertheless overly simplistic. In the following quote, Demetriou highlights how Connell's (2000) explanation of hegemonic masculinity argues that hegemonic masculinity simply subordinates alternative masculinities, which underplays the pragmatic nature of hegemonic masculinity:

> "Hegemonic masculinity [according to Connell (2000)] relates to non-hegemonic ones only by subordinating and marginalizing them and thus their potential pragmatic value in the construction of hegemonic masculinity is underplayed…"
>
> (Demetriou, 2007: 346)

What Demetriou (2007) is referring to here is the way in which hegemonic masculinity has changed over time by appropriating different traits from non-hegemonic masculinities, which Demetriou (2007) asserts is achieved via a *masculine bloc*. Demetriou's (2007) concept of a *masculine bloc* is based upon Gramsci's ([1930] 2011) *historical bloc*, which was not utilized in Connell's (2000) work. A *historical bloc* is where a particular social order is maintained through the consent of society by the hegemony of a particular dominant class of individuals being produced and reproduced via a range of societal institutions and relations, which ultimately changes and adapts over time (Gramsci, [1930] 2011). As Demetriou argues in the following quote:

> "The process through which a historic bloc is formed is characterized… by an attempt to articulate, appropriate, and incorporate rather than negate, marginalize and

> eliminate different or even apparently oppositional elements."
>
> (Demetriou, 2007: 348)

Demetriou (2007) asserts that hegemonic masculinity can be seen as forming a *masculine bloc* through its appropriation of different masculine traits from non-hegemonic masculinities in order to maintain its dominant position within society. Demetriou (2007) contends that hegemonic masculinity's need to appropriate different traits of non-hegemonic masculinities is to adapt to, and subvert, changing societal views and demands.

According to Demetriou (2007), three key examples of social movements that have led to changes in public perception over the last 50 years are the women's liberation movement; the gay liberation movement; and the civil rights movement. Using secondary sources, Demetriou (2007: 351) illustrates how editorial photoshoots shot during the 1960s and 1970s typically portrayed male models in a "sexless" and overtly masculine way. However, following the formation of the gay liberation movement and the increased visibility of gay men in popular culture, male models began to be portrayed in a more feminised way which would previously have been associated with homosexuality. Demetriou (2007) argues that these changes were dictated by the need for hegemonic masculinity to adapt to, and circumvent, the demands being made by both the women's liberation movement and the gay liberation movement. By displaying more feminized traits, Demetriou (2007) contends that hegemonic masculinity seeks to give the impression that it is no longer as potent as it once previously was. This correlates with the arguments made by Brown when discussing masculinity and the state in late modernity, which can be seen in the following quote:

> "…its [masculinity's] power and privilege operate increasingly through disavowal of potency, repudiation of responsibility, and diffusion of sites and operations of control."

(Brown, 1995: 194)

However, Demetriou (2007) argues that Connell's (2000) work does not account for hegemonic masculinity's appropriation of different traits from homosexual masculinities. Instead, according to Demetriou (2007) Connell's (2000) work simply labels homosexual masculinities as only ever being dominated and oppressed by the dominant hegemonic masculinity. Demetriou (2007) also highlights how hegemonic masculinity has appropriated certain traits from Afro-Caribbean masculinities following the valorisation of Afro-Caribbean sport stars and their physical prowess by the media and society. Although Demetriou (2007) acknowledges that Connell (2000) makes reference to this in her work albeit briefly, Demetriou (2007) contends that Connell (2000) fails to explore this in any great detail.

Demetriou (2007) asserts that the appropriation of these traits is not a benign occurrence or an indication of the gradual weakening of the dominant hegemonic masculinity. Rather, it is an attempt by the hegemonic masculine bloc to maintain its dominance within society by acquiring different traits in order to *appear* to meet the demands being made by women and other men that possess non-hegemonic masculinities. As Demetriou succinctly summarises:

> "In short, hegemonic masculinity, the masculinity that is culturally exalted and capable of reproducing patriarchy, is not constructed in total opposition to gay masculinities. Rather, many elements of the latter have become constitutive parts of a hybrid hegemonic bloc whose heterogeneity is able to render the patriarchal dividend invisible and legitimate patriarchal domination."
>
> (Demetriou, 2007: 354)

Thus, by appropriating these traits, hegemonic masculinity is not only able to dominate other non-hegemonic masculinities but also produce and reproduce patriarchy within society. This pragmatic nature, Demetriou (2007) argues, is one of hegemonic masculinity's greatest

strengths. Yet, according to Demetriou (2007), Connell (2000) fails to recognise this instead viewing the appropriation of non-hegemonic masculine traits by hegemonic masculinity as nothing more than contradictions and/or anomalies.

However, whilst Demetriou's (2007) work could be viewed as developing or extending Connell's (2000) concept of hegemonic masculinity, other scholars have been far more critical. In a more wide-ranging attack, Moller (2007) argues that Connell's (2000) focus on structure and the way in which hegemonic masculinity is produced and reproduced via macro-structures/institutions within society is both problematic and overly simplistic. Moller (2007) asserts that Connell's (2000) argument that hegemonic masculinity is reproduced by institutions within society, such as the media, the state, and the military, strips individual actors of their agency and complicity. According to Moller (2007), women and men who possess alternative masculinities allow themselves to be subordinated by the dominant form(s) of masculinity within society by affording it power which it ultimately relies upon to maintain its position in society. However, before we continue it is important to note that unlike scholars such as Demetriou (2007), Moller (2007) argues that both the term and the concept of 'hegemonic masculinity' needs to be replaced, which echoes calls made by a number of other scholars (*see* Donaldson, 1993; Collier, 1998; Whitehead, 1999; Hearn, 2000). Moller (2007) argues that this is because:

> "…the term and concept 'hegemonic masculinity' has subtle but important effects: not only on how men's practices are understood, but also on the way masculinity studies scholars think about themselves and the work they do."
>
> (Moller, 2007: 274)

Within this in mind, the term 'hegemonic masculinity will not be used when discussing Moller's (2007) own research and/or arguments Instead terms such as 'the dominant form(s) of masculinity' will be used

to refer to masculinities that, for example, seek to maintain the patriarchal structure of society. Equally, terms such as ‘alternative form(s) of masculinity’ will be used in instances which normally would call for the use of terms such as ‘non-hegemonic masculinity’.

Now, like Demetriou (2007) one of Moller’s (2007) main criticisms of Connell’s (2000) concept of hegemonic masculinity is that it leads to an almost exclusive focus on masculinity as a site of power and domination. As Moller (2007) succinctly summarises:

> “Beyond the appeal of arguments which are relatively easy to follow and substantiate, as well as a legitimisation of critique, I argue that Connell’s iconic concept of hegemonic masculinity encourages a critical and somewhat exclusive focus on certain forms of masculine power: domination, subordination and oppression… Hegemonic masculinity, then, is said to exist at sites where power is practised in an overt and excessive fashion.”
>
> (Moller, 2007: 266)

However, Moller (2007) contends that even the most exalted forms of masculinity are not simply just sites of domination and oppression, rather, they are also sites of vulnerability and weakness. Moller’s (2007) arguments here are based on the work of scholars such as Judith Butler (1990; 1993) and Susan Bordo (1994) who have both examined the way that gender operates within society, albeit in distinctly different ways. As mentioned earlier, through her theory of ‘performativity’ Butler (1990) has illustrated how gender is not only socially constructed but how masculinity is constructed in opposition to femininity. By doing so, Butler (1990) argues that masculinity is placing itself at constant risk. This is because if an individual’s performance of masculinity is associated with femininity or is seen to possess feminine traits, there is a risk that the performer’s, or the social actor’s, masculinity is seen to be somehow inadequate or inferior.

In her later work, Butler (1993) also contends that a significant component within the performance of gender is it's 'undecidability'. As Butler (1993) succinctly summarises:

> "Gender is neither a purely psychic truth, conceived as 'internal' and 'hidden', nor is it reducible to a surface appearance; on the contrary, its undecidability is to be traced as the play between psyche and appearance"
>
> (Butler, 1993: 234)

It could therefore be suggested that gender's undecided nature could be a sign of its vulnerability as there is no 'ideal type' for individuals to base their performance of gender on due to the undecided nature of gender. This lack of an ideal type, coupled with the constantly changing nature of gender and the need for masculinity to ensure that it is free of 'unacceptable' feminine traits, means that masculinity could have greater vulnerability than femininity. This is because those who practise masculinity do not have any way of ensuring that they do not inadvertently display feminine traits due to femininity also changing over time. Thus, if masculinity was not constructed in opposition to femininity there would be no risk of an individual being seen to possess an inferior form of masculinity because of their performance being associated with femininity if it was also comprised of some feminine elements as well.

In addition to Butler's work (1990; 1993) Moller's (2007) arguments are also based on the work of Susan Bordo (1994) who, like Butler (1994), argues that gender is socially constructed and is never fixed or determinable. Furthermore, Bordo (1994) contends that masculinity's dominant position within society is only possible because of the potency and power that society ascribes to the phallus. As Bordo states:

> "Rather than exhibiting constancy of form, it is [the phallus] perhaps the most visibly mutable of bodily parts; it evokes the temporal not eternal. And far from maintaining a steady will and purposes, it is mercurial, temperamental and unpredictable… Far fresher insights can be gained by

> reading the male body through the window of its vulnerabilities rather than the dense armour of its power – from the "point of view" of the mutable, plural penis rather than the majestic, unitary phallus"
>
> (Bordo, 1994: 266)

The above arguments made by Bordo (1994) clearly provide a basis for Moller's (2007) assertion that Connell's (2000) work fails to account for individual actors' agency and complicity in allowing themselves to be subordinated by hegemonic masculinity. Furthermore, Moller's (1997) contention that we need to examine masculinity/ies' vulnerabilities and weaknesses can be clearly seen as mirroring Bordo's (1994) claim that 'far fresher insights' can be gained by examining masculinity/ies vulnerabilities.

Moller (2007) therefore argues that we need to look beyond structure and these binary categories of domination, oppression, submission and subordination and look for ways to analyse hegemonic masculinity's vulnerabilities and weaknesses, as can be seen in the following quote:

> "Moving from the male body as a site of power/disempowerment to masculinity as a concept for articulating it, we need to go beyond the flatness, the self-obviousness, of masculine power and explore – exploit – those moments of vulnerability…"
>
> (Moller, 2007: 271)

By gaining a better understanding of how masculinity operates, researchers would be better equipped when formulating ways to reduce the dominance that some forms of masculinity possess within society and the patriarchal advantage that results from it, according to Moller (2007). However, Moller (2007: 265) stresses that if we are to analyse these vulnerabilities and weaknesses, researchers must examine the way that masculinities are practised in daily life including "…those 'boring' masculinities which populate our everyday".

This leads us on to the next criticism that Moller (2007) makes of Connell's (2000) work. Moller (2007) argues that Connell's (2000) focus on how macro-structures in society maintain and reproduce hegemonic masculinity fails to acknowledge, or account for, the complexities in the way that masculinity is both performed and practised, echoing scholars like Pattman et al. (1998). This, Moller (2007) argues, puts Connell (2000) at odds with other postmodern theorists on gender (*see* Butler, 1990; 1993; Bordo, 1994) despite Connell's (2000) being one of the first to recognise the socially constructed nature of gender and masculinity. Thus, as Moller succinctly summarizes:

> "In short, while much of Connell's work articulates a need for tools which will generate critical analyses of the way which masculinity is practised, it also tends to overlook the complexity of the phenomena it investigates: that is, masculinity *per se* [emphasis in the original]"
>
> (Moller, 2007: 265)

Connell (1998) has indeed argued that researchers need to cast their net beyond the 'ethnographic moment' and examine what she refers to as the 'world gender order', although Moller (2007) does not make reference to it in his work. The world gender order is based upon the hegemonic masculinity possessed by those who control the dominant institutions in the world, namely, business executives in large multi-national corporations and the political actors who interact with them (Connell, 1998: 16). Connell's (1998: 4) argument that researchers need to look past the 'ethnographic moment' and focus on the world gender order clearly illustrates how her work focuses on structuralism and macro-level structures in lieu of examining the micro-level practise of masculinity in daily life (1998: 4).

Moller (2007: 265) argues that the tendency for Connell's (2000) work to overlook the complex ways that masculinity is practised encourages other researchers who utilize her concept of hegemonic masculinity to only look for overt and 'nefarious' expressions of masculinist behaviour.

This in turn causes researchers to lose sight of the specificity of men's practices and also results in hegemonic masculinity being used "attributionally" (Moller, 2007: 265). Moller's (2007) assertion that hegemonic masculinity is used 'attributionally' is based upon the arguments made by Jefferson (2002). Jefferson (2002) argues that researchers who use hegemonic masculinity tend to do so in an attributional manner, as can be seen in the following quote:

> …for all Connell's emphasis on the relational nature of 'masculinity'… it is still common to see masculinity used attribution-ally, as if it referred simply to a list of 'manly' attributes—competitive, aggressive, risk-taker, strong, independent, unemotional, and so on, per-haps even more so once the term 'hegemonic' is added, given the usual considerable overlap between this list and some cultural norm, ideal or stereotype of masculinity.
>
> (Jefferson, 2002: 70)

Nevertheless, Jefferson (2002) does acknowledge that not all the blame can be laid at Connell's door given that it is the way that other researchers use the concept of masculinity. Despite these criticisms Moller (2007) does acknowledge that hegemonic masculinity can be useful in analysing certain situations. Moller (2007) highlights Connell's (2005) application of hegemonic masculinity to the Space Shuttle Challenger explosion. Connell (2005) argued that there was a particular form of managerial masculinity which led to excessive risk taking resulting in the explosion of the shuttle and the death of all of the crew on board.

Now, returning to the discussion of role strain experienced by male nurses and men in non-traditional occupations, role strain therefore occurs when individuals feel that others perceive them as possessing an inferior form of masculinity due to their occupation (Simpson, 2004; 2005). However, authors such as Simpson (2004) have argued that, in comparison to the quantity of research conducted on women in non-

traditional occupations, the experiences of men in non-traditional occupations still remains a somewhat under researched area. As Simpson succinctly summarizes:

> "The fragmentary nature of research on men in non-traditional occupations means that little is known about the motivations and experiences of men in 'female occupations' and how men manage any conflict between the feminine nature of their job and their gender identity."
>
> (Simpson, 2004: 350)

The majority of research on men in non-traditional occupations has instead focused on the potential advantages that men experience in non-traditional occupations (*see* Williams, 1995; Evans, 1997; MacDougall, 1997; Tracey, 2007; McMurry, 2011). For example, Pudney and Shields (2000) found that male nurses were paid considerably more during their career compared to female nurses. They found that the primary reason for this is due to the speed that male nurses are promoted, which amounted to between £35,000 and £48,000 in additional earnings over the course of their careers (Pudney and Shields, 2000: 824). Pudney and Shields (2000) suggest that this may be caused by male nurses being less likely than female nurses to take a break in their careers to raise a family. By not taking breaks during their careers, male nurses are promoted faster which in turn increases their salaried earnings. This finding has also been found by Whittock et al. (2002) when studying 'family friendly' policies and career progression. However, men's ability to avoid taking breaks in their career has not been the only advantage they possess that correlates with the various sociological theories of masculinity. Simpson (2004) has found that male nurses, primary school teachers, librarians and flight attendants are more often encouraged to take on additional training by their employers. In the case of male nurses and primary school teachers, Simpson (2004) also found that they were more often encouraged to apply for, and enter, management-based roles.

Yet, there is also a small but growing body of literature which highlights how men in non-traditional occupations such as nursing also experience negative effects due to gender stereotyping (*see* Lupton, 2000; Evans, 2002; Whittock and Leonard, 2003; Anthony, 2004; Simpson, 2004; 2009; O'Lynn, 2004; Harding, 2007; Harding et al., 2008; McLaughlin et al., 2010). Furthermore, some expectations of men in non-traditional occupations could also be seen to be in line with typical ideals of hegemonic masculinity. For example, Evans (2002) found that male psychiatric nurses were expected to deal with aggressive patients. However, it is important to note that nurses and/or NHS staff cannot restrain patients unless they have been trained in 'Control and Restraint' with a focus on de-escalation techniques. That being said, researchers such as Lavelle et al. (2016) have highlighted how, although there is evidence that de-escalation techniques in psychiatric settings can be beneficial for many psychiatric inpatients, it may not be as successful for those with a history of violence. As Lavelle et al. (2016) stated when summarising their findings:

> "These findings provide support for de-escalation in practice but suggest that nurses may lack confidence in using the technique when the risk of violence is greater. Providing evidence-based staff training may improve staff confidence in the use of this potentially powerful technique."(Lavelle et al., 2016: 2180)

Pullen and Simpson (2009) also found that male primary school teachers were expected to instil discipline (and were therefore typically given the more difficult classes). Male librarians were also more commonly asked to carry out duties that involved heavy lifting and male flight attendants were required to deal with uncooperative passengers (Simpson, 2004). All of these expectations were based on the ideals of typically hegemonic masculinity outlined by Connell (2000). An interesting consequence of this is that, in the case of male nurses, there is evidence from both the UK and other countries that male nurses choose to work in higher risk settings such as Mental Health and Accident and Emergency (*see* Evans, 1997; Stott, 2003; Winkelmann-Gleed and Seeley, 2005).

Lawoko et al.'s (2007) research has also shown that male psychiatric nurses are potentially more likely to be victims of violence perpetrated by acute psychiatric inpatients. This could hypothetically put male psychiatric nurses at greater risk of being complained about and potentially disciplined should the male nurse seek to physically restrain the patient.

Further support for hegemonic masculinity and hierarchy comes from the ways in which men in non-traditional occupations manage how wider society perceives them (*see* Fisher 2009; McDonald, 2013). Simpson (2004; 2009) has found that men in non-traditional occupations utilized three broad techniques in order to maintain their own perceived masculinity when the topic of their occupation came up when interacting with other men. For example:

> "…many men attempted to re-label the job to minimize feminine associations. For example, several librarians referred to themselves as 'information scientist'"
>
> (Simpson, 2004: 359).

Men also tended to emphasize the 'masculine' aspects of their job, for example, male cabin crew "highlighted 'male' safety and security demands of the job over and above the more 'female' service function" (Simpson, 2009: 360). Other examples involved distancing themselves from feminine aspects of the job (Simpson, 2009: 360), which correlate with Kimmel's (1996) and Butler's (1990) argument that masculinity is constructed in opposition to femininity.

This negotiation of traits between men in non-traditional occupations and men in wider society can be seen as an example of Butler's (1990) notion of performativity or 'doing gender'. When performing gender, men in non-traditional occupations are negotiating how they are perceived by other social 'actors' using social constructions of masculinity. This negotiation of one's masculinity also supports the idea that hegemonic masculinity is considered the ideal against which men in non-traditional occupations position themselves. These men actively try to possess this

hegemonic masculinity despite the conflict between their own perceived masculinity and their non-traditional job role, thus supporting Connell's (2000) idea of a hierarchy of masculinity. Furthermore, Pullen and Simpson (2009) also found that both male nurses and primary school teachers managed their 'Otherness' in their largely female dominated professions by emphasizing their 'rare' traits of caring and nurturing which they proclaimed were typically not found in the average man. This constant need to emphasize certain aspects and down-play others also adds weight to Butler's (1990) assertion that, because gender has to be performed, managed and ultimately repeated, "*gender* identities are never complete, *never finished*, [thus] they cannot be fully stable" (Moore et al., 1999: 27). However, this constant need to negotiate one's gender identity was a considerable source of anxiety for many men in these non-traditional occupations who reported frequent concern over how they were perceived by others (Simpson 2004: 361; Pullen and Simpson, 2009).

2.10: Conclusion

Altogether, this discussion on the role of male nurses in the development of the nursing profession, coupled with the subsequent discussion on the position and experiences of men in non-traditional occupations, demonstrates that there is somewhat of a paradox concerning male nurses. They are more likely to be paid more and promoted faster but may also experience difficulties due to being in a profession where they may experience gendered expectations and role conflict. In the next chapter, I will outline the purposes of this research, with the aims and objectives of this research being derived from this literature review. This will be coupled with an in-depth discussion on how I will seek to shed light on the fact that male nurses are twice as likely to be referred to the NMC and more than three times more likely to be struck off as a result (NMC, 2017b).

Chapter 3: Methodology

3.1: Introduction

The purpose of this chapter is to outline the methodology and methods employed as part of this research project. To do this, I will provide a detailed account of the rationale behind this research, the epistemological underpinnings on which it is based and the research design itself. Throughout this discussion, my role as a researcher and the reflexive considerations that were required to be undertaken during this research will be discussed. I will therefore begin by outlining the premise on which this research is based and the sociological and personal motivations that informed this research. Following on from here, I will then situate this research within the context of critical realism, which is the epistemological standpoint that this research was informed by. I will then move on to discuss the research design. This will include a justification for the use of a qualitative research framework, the data collection methods and analysis techniques utilized, the sampling methods and practical considerations that were evaluated, and the potential ethical issues that arose from this research.

3.2: Rationale

Over recent years, systems of professional regulation for health care workers in the UK have come under growing scrutiny (Davies, 2000). In a shift from what is seen as the 'behind closed doors' philosophy of the past, "professional regulation has, according to the Department of Health, to become 'tougher, swifter, and more open" (Cooke, 2006a). In response, the NMC chose to publish detailed reports of disciplinary proceedings concerning conduct and competence that were heard in the UK, along with the name and PIN of the nurse concerned. There has also been a considerable shift in recourse to disciplinary procedures from outside the health care system. For example, in 2009, only 131 cases were referred to the NMC by the general public (NMC, 2010d: 21)

compared to 835 in 2012 (NMC, 2012a: 9) and 1,537 in 2017 (NMC, 2017a: 14). However, what has not been so closely scrutinized is the disparities in the rates of referrals for male and female nurses reported in official statistics (Cooke, 2006; Evangelista and Sims-Giddens, 2008).

To date, the over-representation of male nurses comparative to the proportion of their numbers on the register in formal disciplinary procedures has not been studied specifically. However, there is a small, but increasing body of research demonstrating the negative effects that disciplinary referrals and proceedings have on healthcare professionals. Through the use of staff surveys, LaDuke looked at the effects of disciplinary proceedings on American Nurses in New York State and argued "that the consequences of discipline transcend the penalties imposed…" (LaDuke, 2000: 26). Tomlin has also made a similar point when highlighting how, statistically, doctors referred for disciplinary proceedings were more likely to commit suicide than the general public were to be bombed "during the height of the bombing" in WWII (2004 [no page number]). Concluding their identification of the broader negative effects of disciplinary proceedings, LaDuke has argued that:

> "…further research is needed to fully understand nurses' responses to accusations of misconduct, the events that can lead to being disciplined and the consequences thereof"
>
> (LaDuke, 2000: 26).

At the time of constructing the proposal for this research in 2012, the Nursing and Midwifery Council (NMC) had cited that 22% of all nurses in the UK who are referred to the NMC, and 33.15% of all those who are struck off the register as a result, are male (NMC, 2012a: 39). This is despite the fact that male nurses only accounted for 10% of the nursing population (NMC, 2012a: 16). As of 2017, male nurses accounted for 23.8% of all those referred to the NMC and 36.66% of those struck-off as a result, despite men only accounting for 10.8% of the nursing population (NMC, 2017b: 44). Similar statistics have also been found within the

profession of pharmacy concerning the over-representation of certain groups in disciplinary proceedings. Schafheutle et al. performed a cross-cultural analysis of pharmacists who experience performance and disciplinary related issues and concluded that:

> "…there was some evidence to suggest that pharmacists with certain characteristics (e.g. being male, being of ethnic minority origin, working in community pharmacy and having trained overseas) were more likely to experience performance problems [and potential disciplinary action]"
>
> (Schaffheutle et al., 2011: 178).

Although this study was not able to assess the reason why, it does suggest that there is some kind of relationship between personal characteristics and the regulatory process which requires further investigation.

In terms of wider literature, there was some initial focus in the 2000s on the experiences of individuals in the nursing profession, which a number of studies have examined through the prism of gender. Simpson (2005) has argued that the gendered stereotypes held by friends and family of men in nursing has led to these men experiencing 'role-strain' as a result. Other authors such as Evans (2002) and Harding et al. (2008) have looked at how gender stereotyping has led male nurses' touch to become seen as sexualized. Evans has argued that stereotypes of men as sexual aggressors and male nurses as gay has a negative effect on the ability of male nurses nurses to develop comfortable and trusting relationships with their patients (2002: 441). Yet, there have equally been studies such as Pudney and Shields (2000) and Lorentzon and Bryan (1997), which have demonstrated how male nurses are more likely to be promoted faster and earn more over the course of their careers.

This juxtaposition between male nurses being more likely to be promoted and paid more yet also far more likely to be struck-off for misconduct is what initially interested me as a researcher. This was fuelled by my own

personal experiences when applying for, and being offered, a position on a graduate nursing course. Although I did not accept the offer due to external factors, the negative responses I received from certain individuals when I revealed that I had been accepted onto a nursing course led to my academic interest in masculinity and nursing. This research therefore seeks to address this gap in the existing literature pertaining to nursing regulation and men's position within the nursing workforce. The aim of this research will be to explore why male nurses are more likely to be referred to the NMC over concerns about their conduct and struck off as a result. To do this, this PhD will employ the following three research objectives:

- *To analyse the NMC hearing records with a particular focus on disproportionate rates of referrals and outcomes for male nurses.*
- *To analyse the NMC FtP process and how it is conducted in relation to both male and female nurses.*
- *To assess what mechanisms may be influencing these disproportionate rates.*

However, before I outline how my research will seek to address these objectives, I will first discuss how critical realism, the epistemological position that this research is based upon, is the most appropriate standpoint for this research and how it facilitates my research design.

3.3: Epistemological Position

The question that is now before us is therefore 'what will be the ontological and epistemological stance that I, as a researcher, will take when researching this topic?' The short answer to that question is critical realism. However, it is important to note that whilst I am adopting a critical realist epistemology, I am not conducting a full critical realist review. This is because it would typically require a large, mixed method study in order to identify all possible generative mechanisms (Ackroyd and Karlsson, 2014). Instead I will be conducting a qualitative, multiple

methods study in order to try and identify *some* of the possible mechanisms that result in male nurses being more likely to be referred to the NMC and struck off as a result. Nevertheless, before I begin down the road of explaining how this project can be conducted using this philosophical school of thought, it is important to consider how I arrived at this decision. Whilst studying the philosophy of social science I will admit that I have always felt somewhat uneasy with both the Positivistic and the Social Constructionist schools of thought. Positivism is a branch of realist theory, which Philips has defined as:

> "…the view that entities exist independently of being perceived, or independently of our theories about them"
>
> (Philips, 1987: 205)

The Positivistic school of thought advocates that not only is there a concrete reality outside of the independent mind, but that such a reality exists on a single, ontological plain. According to Positivism, this reality can be observed and analysed empirically from an objective standpoint in order to discover universal laws and/or facts about the social world (Nightingale and Cromby, 2002). Epistemologically speaking, Positivism views the only true form of knowledge as coming from scientific enquiry that is aimed at uncovering these universal laws present in this external reality (Morgan and Smircich, 1980). Positivism did initially pique my interest when I was mulling over the idea of undertaking a PhD, however, there are inherent problems with such an approach which led me to decide against it.

Authors such as Falconer Al-Hindi (1997) have argued that one of Positivism's key pitfalls is its potential lack of ontological depth. This is because Positivism, by only focusing on a single, external and directly observable reality lacks the ability to be able sufficiently theorize social structures that may not be visible to the naked eye (Falconer Al-Hindi, 1997: 149). I would argue that this is a primary reason why Positivism often struggles to explain what caused a given phenomenon, as opposed to merely just describing it, thus making it a less attractive approach.

Furthermore, Positivism's epistemological underpinnings are also problematic for my purposes because if the only form of empirical knowledge is based solely on concrete, observable phenomena, it removes the need for any form of critical reflection. The reason for this is that Positivism operates on the proviso that, so long as the researcher has used the correct methods to observe and analyse a given phenomenon, the researcher's own thoughts and feelings should not alter the observable behaviour of the entities being researched within this concrete reality as such behaviour is based on universal laws (Bryant, 1985). This is problematic because, when researchers conduct research, they have *a priori* information concerning the topic that they are researching. This therefore requires researchers to engage in a reflexive process where they acknowledge and reflect on these views as it is not possible to expunge them/remain completely objective (Finlay, 2002).

At the other end of the philosophical spectrum, there is Social Constructionism, which is a branch of what is often referred to as anti-realist theory. Nightingale and Cromby define anti-realism as:

> "The belief that there are no grounds for necessarily postulating or investigating a reality independent of the knower"
>
> (Nightingale and Cromby, 2002: 702)

Anti-realism itself was first coined by Dummett as a critique to what he referred to as the "colorless reductionism" advocated by Positivism (1963: 145). One of the key concepts of anti-realism is 'relativism', which Baghramian (2015) succinctly summarises as:

> "Relativism, roughly put, is the view that truth and falsity, right and wrong, standards of reasoning, and procedures of justification are products of differing conventions and frameworks of assessment and that their authority is confined to the context giving rise to them."
>
> (Baghramian, 2015)

According to relativism, there can be no universal laws or 'truths' due to the contextual and subjective nature of events and actions in the social world; this critique then gave rise to the social constructionist movement within the philosophy of social science. In terms of ontology, the Social Constructionist school of thought argues that there is no external reality outside of the independent mind, thus Social Constructionism's focus is instead on epistemology. One of the key features of Social Constructionism is the concept of 'referentiality', which is concerned with whether discourse or language can be used to describe reality. Social Constructionists such as Gergen (2001) argue that when researchers attempt to describe an external reality, they revert back to using discourse, thus reinforcing the argument that there is no external reality outside of discourse and our own independent minds. Gergen (2001) summarises this in the following quote:

> "How should we answer questions about what is 'independent of language' save through language?"
>
> (Gergen, 2001: 425)

A further point of contention between Social Constructionists and Positivists (which is closely linked with referentiality) is the issue of 'objectivity and truth'. Pure Social Constructionists argue that as knowledge is socially constructed, it is impossible for researchers to make claims that there are objective facts or truth. This is evidenced by the fact that, even with the natural sciences, there can be shifts in paradigms, illustrating how science itself is a subjective process rooted within the social rather than natural world.

When considering ways of researching the issue of male nurses being more likely to be referred to the NMC and struck-off as a result (NMC, 2017b), Social Constructionism was initially an attractive epistemological standpoint. This is because I view the regulation of any kind of profession within society as a wholly social process. For example, nursing was not recognised as a profession in the UK until 1919 (Abel-Smith, 1960) despite certain members of society being responsible for nursing the sick

for centuries, if not millennia. However, I still struggled with the ontological underpinnings of Social Constructionism, namely, that there is no external reality outside of the independent mind. I was therefore stuck with the somewhat problematic task of deciding how I would approach this project from a philosophical standpoint, that is, until I studied critical realism during the MA year of my PhD award. Following this module, it became apparent that the most appropriate standpoint for this research was critical realism for a number of reasons. This is because critical realism is rooted in what authors such as Scott have described as a "triadic belief system of ontological realism, epistemological relativism and judgemental rationality" (Scott, 2010: 123). This decision was further strengthened by critical realism's notions of emancipation within its philosophy of the dialectical nature between society and individuals (Bhaskar, 1998b).

Bhaskar's (1978) original work on critical realism focused primarily on the natural sciences, however, subsequent debate from both himself and others have highlighted the practical application of critical realism within the social sciences (*see* Bhaskar, 1986; Collier, 1994; Steinmetz, 1998; Sayer, 2000). However, rather than allying itself amongst the two traditional schools of thought so hotly debated within the social sciences (radical constructivism and realist Positivism), critical realism has taken a multi-pronged approach (Steinmetz, 1998). Ontologically speaking, although it would be fair to argue that critical realism is a branch of realist theory, it is distinct from Positivism in that it rejects the naïve realism upon which Positivism is based (Groff, 2004). Bhaskar (1978) argues that naïve Positivism is based upon the notion of deriving evidence from a constant conjunction of events. What Bhaskar (1978) is referring to is Positivism's reliance upon the supposition of a closed system such as that found in a laboratory when experimentally testing, for example, the interaction between two chemical compounds. Thus, for the researcher seeking to apply positivistic notions of science to the social world, they become "caught in a terrible dilemma: for to the extent that the antecedents of law-like statements are instantiated in open systems, he

[sic] must sacrifice either the universal character or the empirical status of laws" (Bhaskar, 1978: 65). In short, Positivism is based upon the notion of a concrete, external reality, even within an 'open system' such as the social world. The result of this, according to Steinmetz, is that:

> "…science is thought to be built up through empirical generalizations expressed as universal statements of the 'covering law' type."
>
> (Steinmetz, 1998: 172).

At the other end of the ontological spectrum, there is constructivism and post-modernism. However, advocates of critical realism argue that both of these schools of thought:

> "…deny the existence (or the accessibility, which has the same consequences) of an external reality existing 'independently of our theoretical beliefs and concepts'"
>
> (Steinmetz, 1998: 173)

Critical realism's ontological stance, however, is different in that it is based upon what Bhaskar refers to as 'transcendental realism' (Bhaskar, 1979; Collier, 1994; Steinmetz, 1998). Transcendental realism is based upon the notion that there is not just a concrete reality (ontology) and our knowledge of this reality (epistemology), but that this reality is comprised of three ontological realms: the *real*, the *actual* and the *empirical* (Bhaskar, 1998), which will be addressed shortly.

However, as Collier has highlighted, the traditional view within the philosophical debates on ontology and epistemology is that one must first understand "how we can know, and only afterwards what it is that we can know" (Collier, 1994: 137). This, Collier argues, has led to the 'epistemic fallacy' of letting epistemology determine ontology. That is, "to let the question how we can know determine our conception of what there is" (Collier, 1994: 137). Critical realism, however, works on the basis that

there is indeed an external reality outside of our own mind and experiences. As Collier summarizes:

> "…those features of the world which make knowledge possible are not necessarily *a priori*: they are real features of the world, which could have been otherwise [own emphasis]"
>
> (Collier, 1994: 23)

It is therefore possible to illuminate the structures of the world, both within the natural and social world, through transcendental arguments. These transcendental arguments ask "not what must be true about categories of mind order for synthetic *a priori* judgements to be possible but instead what must be true about the world for science to be possible" (Steinmetz, 1994: 176). Thus, they are based upon what Bhaskar refers to as *retroductive* arguments, that is to say that a description of one particular phenomenon leads to a description of what produces it or the necessary conditions for it to exist (Collier, 1994: 22).

This duly leads on to Bhaskar's (1998) description of the three 'ontological domains' of reality: the *empirical,* the *actual* and the *real*. In relation to the above example, the 'real' would refer to the underlying mechanisms being studied, which may or may not be visible within the social system. The domain of the 'actual', then, would refer to the events they trigger and the domain of the empirical therefore refers to the resulting phenomena that can be observed (Steinmetz, 1998). However, Bhaskar goes further than this in that "he further distinguishes the actual from the empirical, noting that mechanisms may be realized (at the level of the actual) without being perceived (at the level of the empirical)" (Steinmetz, 1998: 176). The empirical therefore refers to what is immediately perceivable/observable, which is the third ontological domain. As Gorski summarizes:

> "The domain of the *real* consists of all the 'mechanisms' that exist in the world, which is to say, of all of the various levels and type of

> entities and their powers. The domain of the *actual* consists of all mechanisms that have been activated, even if they have not been observed. The domain of the *empirical*, finally, consists of all mechanisms that have been activated and observed" [emphasis in the original]"
>
> (Gorski, 2013: 665).

With regards to this research project, statistics have already been collected and published by the NMC (2012). The statistics highlight how, despite male nurses only accounting for 10% of the nursing population, they comprise 22% of all those referred to the NMC for FtP hearings, and 33% of all those struck off as a result. The statistics are therefore the *empirical* starting point for the research. However, in order to be able to explain how critical realism will be utilized in order to investigate such striking statistics, it is important to consider the epistemological underpinning of critical realism.

Critical realism argues that it is important to maintain a clear distinction between what Bhaskar (1998a: x) refers to as the *reality of being* or the 'intransitive' ontological dimension and the *relativity of knowledge* or the 'transitive' epistemological dimension. However, according to critical realism there is what is referred to as a 'logics of reference', that is, that 'knowledge' is comprised of two dimensions. As Al-Amoudi and Willmott succinctly summarize, these two dimensions are comprised of the following:

> "One transitive, artificial dimension constituted by the concepts we use as references to the world; the other [dimension], intransitive and constituted by the world qua referent [emphasis in the original]"
>
> (Al-Amoudi and Willmott, 2011: 29)

Critical realism has also pointed out that often these two dimensions are incorrectly interpreted, resulting in the two following situations: the first is where statements about the *reality* of being are interpreted as statements

about the *knowledge* of being, which has been referred to as an *epistemic fallacy.* The second is where statements about the *knowledge* of being are interpreted as statements about the *reality of being*, which is referred to as an *ontic fallacy* (Bhaskar, 1986: 6). This distinction between knowledge and reality, or the transitive and the intransitive realms, is a crucial requirement when conducting research/scientific enquiry. However, despite this distinction, critical realists argue that the transitive dimension is part of the intransitive dimension and that the two do not exist in a separate world, but rather, that the transitive is different but not exterior to the intransitive (Al-Amoudi and Willmott, 2011: 29). Thus, the abstractions that researchers make about a given phenomena are not subjective classifications, but are grounded in ontological reality, which attempts to understand the 'generative mechanisms' and 'causal powers' that influence the concrete phenomena being researched (Bhaskar, 1998a: xvi). By scrutinizing these generative mechanisms and causal powers, whilst ensuring to maintain a clear distinction between the transitive and intransitive dimensions, researchers are able to engage in 'judgemental rationality'. This is where researchers make rational judgements about which theory is correct about a given phenomenon. According to Al-Amoudi and Willmott:

> "Distinguishing the dimension of ontology from that of epistemology is essential, advocates of CR [critical realism] argue, if there are to be shared reference points for making rational judgements between alternative theories"
>
> (Al-Amoudi and Willmott, 2011: 30)

However, although critical realism argues that a researcher's abstractions about a given phenomenon are grounded in ontological reality, these abstractions are not necessarily infallible / not subject to change. In fact, a key tenet of critical realism is what is referred to as *epistemological relativity*. Epistemological relativity is the term used to refer to how the retroductive judgements made by researchers are

historically and culturally contingent. As Patomaki and Wight have argued:

> "…widely different theories can interpret the same, unchanging world in radically different ways. However, because it is knowledge of an independently existing reality, knowledge is not totally arbitrary and some claims about the nature of this reality may provide better accounts than others"
>
> (Patomaki and Wight, 2000: 224)

Thus, despite epistemological relativism, or in other words, the fact that knowledge is culturally and historically contingent, it is still possible to provide defensible grounds for selecting one theory instead of another (Patomaki and Wight, 2000: 224). An example of the historically contingent nature of knowledge can be seen in the creation of nursing. Nightingale believed that men were unfit to care for individuals due to their 'hard and horny hands' (Summers, 1988: 35). Yet, in the present day, it has been widely acknowledged that the reason why some men chose not to engage in caring professions may be as much due to the social construction of masculinity rather than as a result of their biology (Whittock and Leonard, 2003).

This triadic nature of ontological realism, epistemological relativity and judgemental rationality provides a good foundation for assessing what lies behind the aforementioned statistics on male nurses. This is further supported by critical realism's focus on the way in which different generative mechanisms and causal powers interact to produce different, observable phenomena. A critical realist approach also encourages use of multiple methods, which is a key part of my research design that I will now go on to outline.

3.4: Research Design

Prior to beginning this PhD research project, I undertook a MA Research Methods (Sociology) funded by the ESRC where, as part of my

dissertation, I carried out a pilot study. This involved an interview with an occupational therapist who sat on Healthcare Practitioners' Council FtP hearings as a Registrant Panel Member, along with the observation of one NMC FtP hearing. This was followed by the documentary analysis of ten official hearing documents within a given month. The pilot study provided me with both a foundation on which to base my PhD research on and an understanding of the practical issues that may arise throughout the research. From the beginning, it was decided that I would utilize a qualitative, multiple methods approach. The reasoning behind this was that, as statistics have already been collected and published by the NMC (2012; 2017b), there was already a quantitative empirical starting point on which to base the research. The decision was therefore made to carry out a qualitative investigation to assess the aforementioned statistics as qualitative research is:

> "…especially effective for studying subtle nuances in attitudes and behaviours, [and] for examining social processes over time"
>
> (Rubin and Babbie, 2010: 230)

The research was conducted over a twelve-month period beginning with five interviews with nurse managers in order to provide a contextual basis for the research. These interviews were then followed by twenty observations of NMC FtP hearings (many of which lasted several days) and the documentary analysis of all the hearings reported on the NMC's website within in a given month.

I will begin by describing the data collection process undertaken for each research method, the justification for the use of the aforementioned research methods, how I gained access to the participants and the way in which the participants and cases were selected. Whilst outlining the above, I will discuss the practical issues that were present when conducting the research and the way in which these issues were managed in order to comply with my ethical clearance. Once this has been completed, I will then discuss the data analysis techniques utilized

as part of this research followed by a wider discussion regarding the ethical considerations that apply to my research. The discussion regarding the ethical issues present in my research will cover consent, deception, harm, confidentiality and data storage and security.

3.4.1: Interviews

This research project did not require NHS Ethical approval as I would not be interviewing a vulnerable group or sourcing participants via the NHS (so long as none of the interviews were being conducted on NHS sites). Nevertheless, full UoN ethical approval was obtained for the interviews, as well as for the observations and documentary analysis (*see* Appendix B). Although it was originally envisaged that I would conduct interviews with affected nurses and NMC FtP panel members, it became apparent that this would not be possible or desirable. The reason for not interviewing affected nurses is primarily due to ethical considerations, namely, that the process of undergoing a formal investigation and FtP hearing is extremely distressing for healthcare professionals (LaDuke, 2000; Tomlin, 2004). It was deemed that the potential harm that could be caused to the participants outweighed the potential benefits of the research.

In the case of interviewing NMC FtP panel members, I originally tried contacting the NMC via telephone to make a request for access to the panel members. However, I was advised to email the press enquiries department, which I duly did yet received no response to my email or any subsequent ones. It could have been possible to contact NMC FtP panel members via social media sites such as LinkedIn, which is a professional networking website (LinkedIn, 2018). However, this was viewed to be unethical due to the unsolicited nature of such contact, thus it was not possible to interview NMC FtP panel members. Finally, I contacted a Trade Union to attempt to interview the legally qualified representatives that they hire to represent registrants in NMC FtP hearings. However, the Trade Union advised me that it would not be possible to interview the

barristers that they hired to represent the nurses as the barristers hired were not employed directly by the Trade Union.

Nevertheless, as I had access to senior gatekeeper in a hospital based in South East England, a decision was made to interview a small number of nurse managers, two of whom were Trade Union representatives at Trust level (now CCG) (*see* Appendix C). One Trade Union representative was male and the remaining four interviewees were female. The purpose of these interviews was to provide a contextual foundation for the research by helping me gain a greater understanding of employment level disciplinary process. This was important because the Trust level disciplinary process is often a precursor to nurses being referred to the NMC (although the interview data was not used in my final analysis). The interviews also provided me with the opportunity to investigate any potential topics that had yet to be identified as areas of research prior to the ensuing observations and documentary analysis. This was particularly important due to the fact that I was not, and am not, a qualified nurse. That being said, it has been argued that by being an outsider, a researcher is potentially able to provide “valuable perspectives on taken-for-granted assumptions” (Blee and Taylor, 2002: 97). However, it can also mean that a researcher may be unaware of certain contextual factors or processes that influence the phenomena being researched (Flynn and McDermott, 2016), which was a strong motivating factor behind my decision to conduct these interviews.

3.4.2: Access to Interviewees

In terms of accessing my interview participants, I was able to gain access to the first interviewee, a female nurse manager, via my academic supervisor who was supervising her PhD at the same time. The remaining four interviewees, including the two nurse managers who were also Trade Union representatives, were referred to me via the senior gatekeeper and were all based in the same hospital in South East England.

3.4.3: Selection of Interviewees

When recruiting interview participants, due to the fact that I was not a nurse and had limited access to nurse managers, I decided to utilize opportunity sampling. This involves the researcher using any available opportunities to source participants within a given population (Holt and Walker, 2009). Although opportunity sampling is considered one of the weaker forms of sampling due to the lack of randomization and potential bias, it is often used to research groups that are hard to access (Jupp, 2006) which is the primary reason for its use in my research. Whilst I would have ideally interviewed more than one male nurse, it was not possible for the gatekeeper to find another male nurse manager who was willing to be interviewed in the timescale.

3.4.4: Research Setting for the Interviews

The research setting for the interviews was governed by my ethical clearance, which stated that the research could only be conducted outside of hospital grounds. In accordance with the University's Lone Working Policy it was decided that the interviews would take place in a public setting (*see* Appendix B). In the case of the first interviewee, who was referred to me by my supervisor, the interview took place on University grounds in a common area away from students, staff and other members of the public. The remaining four interviewees were interviewed in pubs and cafes, again, in quiet areas away from other customers. These locations did potentially pose a problem with regards to the audio recording of the interviews, namely, that there may be background noise on the recording and that our discussion could be overheard and/or interrupted. However, none of these issues arose whilst conducing the interviews.

3.4.5: Structure of the Interviews

I made the decision to conduct semi-structured interviews as the interviews were to be more of an exploratory exercise with the aim of contextualising the way in which nurses are referred to the NMC by

management or others. Semi-structured interviews also offered a means of illuminating potential topics that had yet to be identified as possible areas of research. Furthermore, semi-structured not only permit a degree of structure but allow the participant to go into considerable depth regarding their own experiences (Schensul et al., 1999). Structured interviews, on the other hand, limit the way in which individuals can respond to questions, thus the researcher potentially imposes their own reality on to a participant creating potential bias and skewed results (Cargan, 2007).

The questions that I adopted were broad in nature so as to try and facilitate an open discussion about the disciplinary process prior to a nurse being referred to the NMC, along with any other unidentified areas relevant to my research. As two of my interviewees were Trade Union representatives, I chose to alter the questions slightly in order to account for, and to facilitate, a discussion about the interviewees' experiences as both nurse managers and Trade Union representatives (*see* Appendix C for the interview schedule). Prior to conducting the interviews, I would ensure that all participant consent forms were signed and that I read over all of the boxes that the participant checked before the interview started.

3.4.6: Outcome of the Interviews

Despite obtaining interesting information, it became apparent during the interviews that, of the five interviewees, all but one of the interviewees appeared to be cautious when answering questions, particularly when discussing their work place. Whilst none of the participants made mention of my 'outsider' status, there was a distinct possibility that my status aggravated this situation due to me not being in the same situation as them, that is, that I was not employed as a nurse in a healthcare facility. There was also the potential for the interviewees being concerned about themselves or the hospitals they work for being identified via the information they provided me. A possible reason for the less cautious nature of one of the interviewees may be due to the fact that, whilst I had never met her before, we were both aware of each other

through personal friendship networks. This familiarity certainly allowed me to go into more detail about the way in which her workplace handled disciplinary hearings. This was evidenced by her apparent comfort in providing me with specific examples of the way in which disciplinary action had been conducted in relation to individual (unnamed but potentially identifiable) members of staff. This did nevertheless present a possible ethical issue as I would be placed in a position where I was privy to information about individuals who had not consented to their information being discussed. In addition to this, it also meant that I was aware of considerable amounts of information that concerned the interviewee and her role within the disciplinary process. To counter these potential issues, I sought to emphasize to her, as I did with all other interviewees, that all names and other identifiable information would be anonymised and that the information would be stored securely in accordance with UoN storage procedures.

Despite the limitations outlined above, the interviews provided a useful perspective on the disciplinary process that is undertaken at Trust level prior to a nurse being referred to the NMC. Both of the Trade Union representatives cited examples of where nurses that they had represented were unaware that the Trade Union representatives were only present to ensure a fair disciplinary hearing. This instead of the Trade Union representatives representing the nurses in the form of advocacy, as a barrister or solicitor would in an NMC FtP hearing. This led me to pay particular interest to the differences in the way hearings unfolded dependent on the presence of absence of legal and/or Trade Union representation. Furthermore, three out of the four female nurses stated that they felt that in their professional experience male nurses were generally more caring towards patients than female nurses. This helped focus my attention on the types of misconduct committed by male nurses when analysing the official hearing documents. In terms of gender differences in the conduct of hearings, the male Trade Union representative stated that in his experience male nurses tend to withhold information during disciplinary hearings until they have no choice but to

reveal it. Female nurses, on the other hand, tended to “blurt it all out” from the beginning, according to the male Trade Union representative. It is important, however, to state that although this information was indeed interesting and helped inform the way in which I conducted the research, I did not include it as part of my detailed analysis. The reason for this is that, as there was such a small number of interviewees, along with the potential issues to do with sampling, the data obtained from these interviews could only provide a contextual foundation for the research and help identify potential areas of research. Furthermore, following the pilot study it was also apparent that I would have ample data available to me from both the observations of NMC FtP hearings and the documentary analysis of publicly available official hearing documents. This in turn helped to justify the exclusion of the interview data from my overall data set.

3.4.7: Observations

The observations were conducted over a twelve-month period and a total of twenty cases were observed; nineteen of which were nurses and one of which concerned a midwife. The reason that I observed a midwifery case (when the aforementioned statistic regarding male nurses and the NMC only concerns nurses) was to see whether NMC FtP hearings were conducted in the same way in relation to midwives. Three of the cases that I observed went part-heard/were adjourned to a later date part way through the hearing (one female nurse case; one male nurse case; and the female midwife case). A ‘part-heard’ hearing is where the hearing does not finish within the allotted time, thus the remainder of the hearing is heard at a later date (NMC, 2018a). Twenty observations was selected as a number as it was felt that this was the maximum number of hearings that I could observe without becoming overwhelmed with the amount of data (as well as not exceeding the funds allocated for this research project). This is in part due to the fact that NMC FtP hearings can go on for two weeks or more in some cases, although the longest hearing that was observed as part of this research was in fact eleven days. In total, twenty hearings were observed over the course of sixty-eight days, which

are listed in the ‘selection of hearings’ section below (*see* Appendix D for a more detailed table describing the participants in my observation sample).

As is the case for all individuals who observe NMC FtP hearing, at no point was I permitted to take part in the hearings or engage with any of the individual(s) involved in them, which meant that I had undertaken non-participant observation. Although there was no option for me to conduct participant observation, there were potential benefits to conducting non-participant observations. These benefits are primarily based on the fact that non-participant observation is typically utilized to gain an greater understanding of a situation, but without the researcher potentially influencing the behaviour of those being observed by taking part / being involved with the participants (Angrosino, 2007). By performing non-participatory observations of NMC FtP hearings, it would allow me to assess the ways in which the NMC FtP hearings are conducted. This included focusing on elements such as the way in which the affected nurse was questioned and if there were any observable differences in the way in which NMC FtP hearings are conducted in relation to male and female nurses.

The style of non-participant observation that was utilized during this research loosely fell under the category of ‘detached observations’ (Furze et al., 2012). The reasoning behind the loose application of detached observation is that it is important to try to minimize the risk that the researcher’s own subjectivity could unduly influence the data collection process. However, it would not be beneficial to engage in a ‘pure’ form of detached observation, where the only type of data collected has been predetermined.

It is important to reflect here that the default position is that NMC FtP hearings are held in public so observers (be they researchers, members of the media, or the general public) are commonly in attendance. This meant that my attendance was not remarkable or unusual. Whilst there is potential for a Hawthorne effect to occur whenever an observer is

present (Lewis-Beck et al., 2004) the routine presence of observers in this setting was likely to minimise this. However, there were a small number of occasions on which I was addressed directly or my presence was highlighted, and I reflect on these in the analytic chapters that follow. Another problem with this method of observation is that "the *meaning* of the observed behaviour may remain obscure to the researcher [emphasis in the original]" (Furze et al., 2012: 29), as mentioned earlier. This issue can be aggravated in situations where the researcher is in a different position to those being researched (Flynn and McDermott, 2016) which in this case would be the fact that I am not a nurse and have never taken part in an employment tribunal. Although this was a concern from the outset, the fact that the panel outline and publish their decision in the form of the official hearing documents (if a nurse's conduct is found to be impaired) meant that I would be able to ascertain at least a basic understanding of the panel's reasoning. In the event that a nurse's conduct was found not to be impaired, whilst the panel's findings would not be published on the NMC's website, NMC FtP panels' usual practice is to read out the document at the end of the hearing if observers are present.

3.4.8: Access to the hearings

With regards to access, at the time of conducting this research NMC FtP hearings were heard by one of two Practice Committees: the Conduct and Competence Committee (CCC), whose hearings were typically held in public, and the Health Committee, whose hearings were always held in private (NMC, 2018b). It is important to point out, however, that NMC FtP panels could make the decision (either as a result of an application or of their own volition) to hold a CCC hearing either in part or entirely in private should they deem it necessary (NMC, 2018c). Fortunately, this did not occur in any of the hearings observed. Furthermore, there were points where CCC hearings were temporarily called into private session, which typically occurred when there needed to be a discussion about the health of a non-anonymised individual. When this occurred, all members of the public (even friends and family of the individual whose health was

being discussed) were required to leave the hearing. As the NMC had failed to respond to my request to interview NMC FtP panel members, no request was made to observe the hearings when in private session. In addition to this, the NMC also forbid any form of audio or visual recording anywhere in the building (NMC, 2017d), thus notes were taken by hand, although this will be discussed further in due course.

3.4.9: Selection of Hearings

Prior to undertaking this research, it was decided that that I would focus solely on nurses who were subject to NMC FtP hearings that were heard in England. The reason for only observing cases in England was primarily because it would not have been practical within the confines of a PhD project for me to travel to Wales, Scotland or Northern Ireland to observe the hearings conducted there. At the time of this research, the NMC would list all upcoming hearings for the coming month, along with the nurse's name, PIN, area of residence and the charges against them. As of 2016, the NMC now no longer lists the charges against the nurse on the website until the day of the hearing for the following reasons:

> "We consider that putting such information into the public domain at this stage is disproportionate and can be prejudicial to a nurse or midwife, in that the charges may be subsequently amended and / or not ultimately proved by the NMC. Once the charges have been confirmed to the panel on the day of the hearing, these will be available upon request."
>
> (NMC, 2017c: 31)

As I was able to observe twenty hearings, and was looking to focus on a specific issue, that is, the disproportionate rates of referral and outcome for male nurses subject to NMC FtP hearings (NMC, 2012a), I made the decision to utilize purposive sampling:

> "This type of sample is selected on theoretical grounds, because the cases selected will be especially interesting and informative for the purposes of a particular study."
>
> (Roberts, 2009: 221)

By using purposive sampling there was a risk that any unconscious bias that I may possess would influence the selection of the cases (Roberts, 2009). However, the primary rationale behind the case selection was to ensure a broad spectrum of charges and case types so as to provide a wide overview, thus minimising this potential issue. Furthermore, as the documentary analysis sample would include every official hearing document published on the NMC's website over the course of a specific month, this would involve no *a priori* selection, again, offsetting the risk of bias.

In addition to this, at the time of data collection, the NMC's most recent Annual Fitness-to-Practise Report (NMC, 2016f) did not describe how the NMC categorised cases. However, in its subsequent Annual Fitness-to-Practise Report (NMC, 2017a), the NMC provided a table listing how the screening team categorise referrals and the number of referrals the NMC had received for each category between April 2016 and April 2017, which can be seen in the table below:

Allegation	**Number of allegations received**
Behaviour or violence	44
Communication issues	24
Criminal proceedings	56
Dishonesty	40
Employment and contractual issues	27
Information access	5
Investigations by other bodies	12
Management issues	24
Motor vehicle related	26
NMC registration and proceedings	20
Not maintaining professional boundaries	11

Other allegations	9
Other crimes and offences	14
Patient care	136
Prescribing and medicines management	126
Record keeping	53
Registrants health	58
Sexual offences	15
Social Media	6
Total	**706**

(NMC, 2017a: 28)

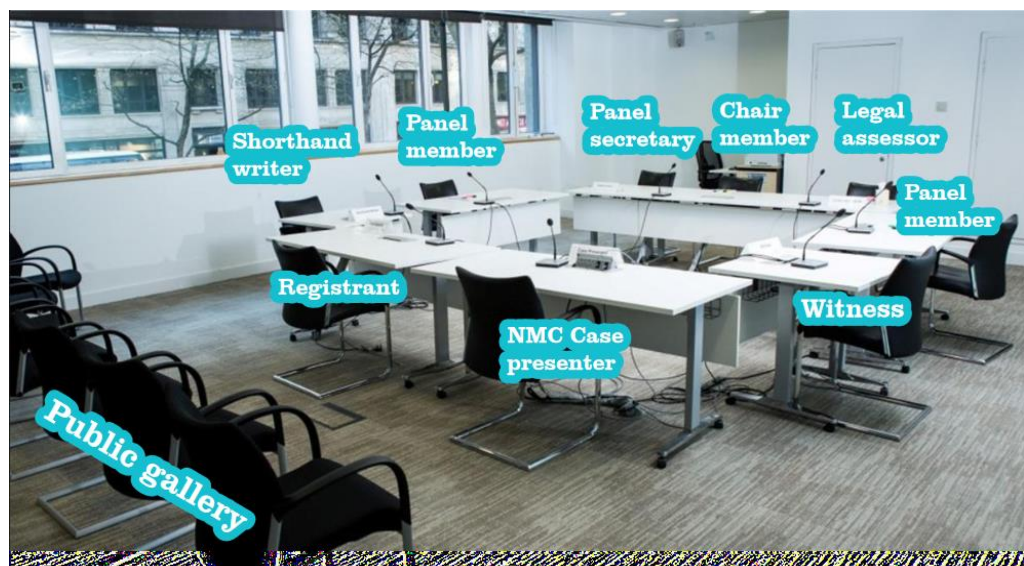
Having reviewed this table after completing my data collection, I was able to determine that the twenty cases observed as part of this research covered all categories with the exception of 'Registrant's health' and 'Social media'. With regards to the 'Registrant's health' category, my research is tasked with examining Conduct and Competence Committee hearings, thus I will not be analysing cases conducted by the Health Committee which hear this category. Although it would have been ideal to have observed a case concerning social media, it was not possible to identify a suitable case during my data collection period. It is worth noting, however, that there were only six referrals concerning social media between April 2016 and April 2017, thus denoting the rarity of such cases. Furthermore, many of the cases in my observational sample contained more than one category of allegation, which I have detailed in the table below (*see* Appendix D for a more detailed description of each case observed):

Name	Gender	Background	Allegation type	Outcome
Akinbote, Elizabeth	Female	Mental Health	Sexual offences; Behaviour or violence	FtP Impaired (Striking-Off Order)
Ansal, Ceylan	Female	Adult	Communication issues; Patient care; Prescribing and medicines management; Record keeping	FtP Not Impaired
Badjie, Alagie	Male	Mental Health	Patient care	FtP Impaired (Suspension Order)
Collier, Philip	Male	Mental Health	Patient care; Prescribing and medicines management; Communication issues	FtP Impaired (Suspension Order)
Fullerton, Katie	Female	Adult	Dishonesty; Other crimes and offences	FtP Impaired (Striking-Off Order)
Gilmour, Sarah	Female	Adult	Criminal Proceedings; Dishonesty; Employment and Contractual Issues	FtP Impaired (Caution Order)
Henry, Lois	Female	Adult	Behaviour or violence	FtP Impaired (Caution Order)
Heslop, Pauline	Female	Adult	Behaviour or Violence; Other allegations; Patient care	FtP Impaired (Conditions of Practice Order)
Holberry, Wayne	Male	Adult	Behaviour or Violence; Patient care	FtP Impaired (Caution Order)
McGill, James	Male	Adult	Dishonesty; Prescribing and medicines management	FtP Impaired (Suspension Order)

O'Brien, Mary	Female	Mental Health	Other allegations	FtP Impaired (Striking-Off Order)
Ofili, Frank	Male	Mental Health	Dishonesty; Employment and contractual issues;	FtP Impaired (Suspension Order)
Parker, John	Male	Adult	NMC registration and proceedings	FtP Impaired (Caution Order)
Peck, Kevin	Male	Adult	Behaviour or violence; Communication issues; Criminal proceedings; Investigations by other bodies; Management issues; Sexual offences;	FtP Not Impaired
Pinto, Arun	Male	Adult	Information access	FtP Impaired (Suspension Order)
Smith, Heather	Female	Adult	Dishonesty; Other crimes and offences	FtP Impaired (Suspension Order)
Stanton, Samantha	Female	Midwife	Behaviour or violence; Communication issues; Patient care; Record keeping	FtP Impaired (Striking-Off Order)
Tregay, Ian	Male	Mental Health	Behaviour or violence; Dishonesty; Record keeping	FtP Not Impaired
Warren, John	Male	Mental Health	Not maintaining professional boundaries	FtP Impaired (Suspension Order)
Zinyemba, Tendai	Female	Mental Health	Not maintaining professional boundaries	FtP Impaired (Suspension Order)

3.4.10: Research Setting

Nearly all of the hearings heard in England were heard in one of two London locations (the EL Centre and the CL Centre) run by the NMC. Both centres are located on a single floor within two different buildings that house multiple companies on the other floors. The EL Centre is the larger of the two centres, but the layout of the two buildings, including the hearing rooms, were similar in nature. The main lobbies for both centres were the central 'hub' where NMC staff and other individuals involved with the NMC would typically pass through and/or wait for the hearings to begin or resume. Furthermore, those involved in the NMC FtP hearings would typically dress in formal office attire, which was the primary reason why it was decided that I would dress in a similar way in order to 'blend in'. My attempt to appear less noticeable was affirmed by the fact that I was mistaken for being a shorthand typist present to record the hearing a number of times. There was also a separate 'Press Room', where members of the media are seated until the hearing begins, who will then be led out and escorted to the hearing room by the panel secretary. Upon entering the hearing room, observers are typically seated along one side of the room which is commonly referred to as the 'public gallery' in a similar way to a criminal court, which can be seen in the picture below:



(NMC, 2016e)

3.4.11: Note Taking

As stated earlier, the NMC forbade any form of audio or video recording anywhere in the two centres, which is stated on the NMC's website and displayed on a sign in the reception area (NMC, 2017d). I therefore had made the decision to record notes by hand. However, following the first hearing that I observed, it became apparent that some observers used tablets and laptops to type notes during the hearings. Going forward, I therefore decided to bring a laptop with me and, when seated in the hearing room, I would take out the laptop to begin typing. There were some hearings where the panel chair would instruct myself and other observers to put away any electronic equipment. In other hearings, however, the chairs appeared happy for observers to use electronic devices to type notes provided that they did not audio or video record any part of the hearing.

In the case of handwritten notes, I am fortunate in that I am able to write at a particularly fast speed. This is a skill which I have been able to develop primarily through having worked in call centres for over four years; I was required to note down information at a fast speed whilst a customer spoke in order to avoid the customer having to repeat themselves a second time. This meant that, whilst I was not able to record long quotes verbatim, I was able to keep a clear record of what transpired and was being discussed throughout the hearing. Despite my experience, I was able to record longer quotes verbatim and provide more detail in the hearings where I was allowed to use a laptop than I could when recorded hearings by hand. Alongside my record of what was being discussed, I would also be noting down facial expressions, body language and other such behaviours. As can be seen in the picture above, I had a relatively clear view of the panel and any individuals giving live witness evidence. However, I would only be able to see the side profile of the NMC case presenter, the registrant and/or their representative (if present) if they were to tilt their heads. Furthermore, whilst observing the panel members and other individuals involved in the hearing, there were points where they appeared to notice that I was

observing them; their facial expressions, when this occurred, ranged from curiosity to a degree of discomfort. I would always attempt to observe individuals in the most discreet manner possible. However, due to the open and high visibility layout of the hearing room, coupled with the fact that I was seated in a set position, this was not always possible.

Having carried out the pilot study during my Masters in Research Methods, I was also aware of the fact that there are a significant number of breaks during the hearings, such as when the panel would go into private session to read evidence bundles or to make a decision on a given application. This provided me with the opportunity to clarify and record additional notes during these breaks. Once the hearing had been concluded for the day, I would either type up my handwritten notes or re-type/clarify my typed notes once I had returned home. During these breaks, and when travelling home once a hearing had been concluded for the day, I would typically record my own thoughts and feelings alongside the notes that I had either written, or typed, during the hearing. Once home, I would then write up my personal thoughts into a separate private journal, as suggested by Angrosino (2007). By recording my personal thoughts, it allowed me to both reflect on my own position as a researcher whilst carrying out the research and also helped me keep track of any unnoticed bias present when recording the notes during the hearings. It would certainly be a fallacy to say that there were not cases where I found myself making value judgements about, for example, whether the case should have been referred to the NMC or whether the sanction imposed was satisfactory. Nevertheless, by recording my own personal feelings as I carried out the observations, I was able to review, account for, and exclude these thoughts and feelings when analysing and collecting further data. This reflexive process was also greatly assisted by my supervisors who I met with on a monthly basis and who helped ground my thought process and keep track of any potential analytic bias.

This reflexive process is an important part of any piece of qualitative research as “the researcher is a part of the world that she or he studies

and is affected by it" (Boyle, 1994: 165). Thus, a researcher's thoughts, feelings, emotions and prior knowledge can influence the way that data is both collected and analysed, which therefore needs to be considered. In terms of this research, when collecting my data, I had to be careful not to select cases because the content matter sounded interesting but instead select cases on the grounds that they would provide the best overall representation of the type of cases heard by the NMC's Conduct and Competence Committee. Reflexivity was also important when analysing my data as I am interpreting the interpretations made by the panel, thus I needed to pay close attention to my own position and my thoughts and feelings when analysing the data, which I will now move on to discuss.

3.5: Documentary Analysis

The final data collection technique that I decided to utilize was documentary analysis. My sample consisted of all hearing records published on the NMC's website during a given month; the month selected was the final month of my twelve-month data collection period. It is important to point out that, in terms of the CCC hearings, the NMC do not publish official hearing documents for hearings that have been held entirely in private session or where the nurse concerned was found to not have impaired conduct (NMC, 2017c). Although this meant I was not able to analyse the official hearing documents where registrants' misconduct was found not to be impaired, it did allow me to assess and analyse the cases that make up the aforementioned statistic concerning male nurses. As with the observations, I only analysed hearings that occurred in England and concerned nurses rather than midwives, as the aforementioned statistic on male nurses did not include midwives. This is coupled with the fact that, as of April 2017, there were only 114 male midwives in the UK and only 64 NMC FtP hearings were conducted in relation to midwives compared to 2,506 hearings concerning nurses (NMC, 2017b).

During the month analysed, there were seventy-one substantive hearings concerning nurses and thirteen substantive meetings. Substantive meetings are held in private where the panel are only provided with documentary evidence; there is no NMC case presenter and the registrant does not attend or give evidence (NMC, 2018d). As I was unable to observe substantive meetings, it was decided that I would analyse the official hearing documents for substantive hearings only. The documents themselves describe what occurred during the hearing at the various stages, which will be outlined in the following chapter, as well as any applications made and the resultant outcome of the hearing.

The objective behind the documentary analysis of the official hearing documents is three-fold; firstly, to gain a greater understanding of the typology of the cases that are referred to the NMC with a particular focus on gender. I was also able to examine along with the way in which the registrants respond to the charges against them (such as whether they admit the charges), whether they attend the hearings, and act with legal representation or are unrepresented. The second objective is to ascertain the ways in which the different types of cases are adjudicated by the NMC FtP panel and the way in which, for example, evidence from both the NMC and registrant are utilized and assessed by the panel, again, with a focus on gender. The final purpose of the documentary analysis of the official hearing documents is to help include or exclude potential factors that can influence the aforementioned statistic regarding the disproportionate rates of referral and outcome for male nurses subject to NMC FtP hearings (2012a). Examples of potential factors that I had identified based on results of the documentary analysis that I undertook during the pilot study (conducted as part of my MA Research Methods (Sociology)) were the rates of attendance and admittance of charges between male and female nurses.

3.6: Data Analysis

In terms of my data analysis techniques, prior to conducting the pilot study, it was thought that I would thematically analyse the interviews and

observations, and then utilize critical discourse analysis to analyse the official hearing documents. However, I discovered that, although the panel, with the assistance of the panel secretary, write the official hearing documents themselves, it appears that they are constructed according to a basic standard template. This template therefore made critical discourse analysis inappropriate as it is designed to analyse the ways in which those in power reinforce their dominance by utilizing the subtle and underlying meanings of discourse which encompass the 'mental model' of the text (Machin and Mayr, 2012: 30).

The most appropriate method of data analysis was therefore deemed to be thematic analysis, which has also been utilized by Traynor et al. (2014) in their scoping study of the nursing disciplinary process. Traynor et al.'s (2014) justification for the use of thematic analysis was that, in order to be able to analyse the diverse and varied data that they had collected, a broad analytical technique that could be applied to all the different data sets had to be utilized. The breadth of data was also an issue in this research due to the large amount of data being collected via a multiple-method approach, thus making thematic analysis the most appropriate choice. Whilst there was the potential that there would not be a lot of comparative data to analyse due to the standardised nature of the reports, the use of thematic analysis allowed me to be able to analyse the way in which the reports are constructed according to the different outcomes of the individual cases.

From here, I decided that I would utilize Braun and Clarke's (2006) method of thematic analysis, which involves the identification of themes through the codification of data. This process is comprised of six phases: familiarizing oneself with the data; the generation of initial codes; the locating of themes; the appraisal of said themes; defining and classifying these themes; and the production of the final account. The primary reason for selecting thematic analysis is that, as it is prohibited to audio/video record the observations, thematic analysis would be most appropriate as it is not concerned with the frequency of a theme unlike content analysis (Longhofer et al. 2013). If content analysis were to be

used, it could potentially result in nothing more than qualitative counting and cause the researcher to ignore important themes during the observation process due to reliance on memory. Likewise, methods such as discourse analysis and conversation analysis would be unsuitable as the data cannot be audio recorded.

The initial categorization that was used for the analysis of the observational and documentary analysis data began with distinguishing between male and female nurses, allowing for a comparative approach during data analysis. These cases were then categorized based on referral reason(s) such as misconduct, competence, criminal conviction and so forth. The cases were then categorised based on various outcomes; no sanction; caution order; conditions of practice; suspension order; and striking off order. Once this initial categorization was performed, my analysis then went on to focus on the different, but common, factors involved in the cases.

In order to map these factors, I created a spread sheet that detailed the following factors in each of the seventy-one official hearing documents analysed as part of this research. These factors included: Gender; Part of register the nurse belonged to; Hearing type (Substantive Hearing or CPD); Attendance; Representation; Type of charges (Misconduct, Conviction, Competence etc.); Admittance of charges; Impairment and public Interest (whether the nurse's conduct was judged impaired solely due to the public interest); Degree of remorse; Degree of insight; Risk of repetition, Level of remediation; Previously referred to the NMC; Sanction; Prior Interim Order; Structural deficiencies (whether acknowledged or not by the panel); Length of time between first alleged misconduct and hearing; and the Sections of the code violated (according to the panel). These categories allowed me to observe patterns within my data which helped inform the results of this research, which were then analysed in relation to the observational data collected.

3.7: Ethical Considerations

It as this juncture that I will now move on to discuss the ethical considerations that formed part of this research. Ethical issues as a whole have received longstanding and considerable attention within sociology, with “The initial attempts to develop codes of research ethics in the fields of sociology and anthropology occurring in the 1960s” (Kimmel, 2007: 45). More recently, the British Sociological Association (BSA) has provided updated guidance on the role of ethics and the ethical issues that need be considered by sociologists. The BSA’s guidance covers, amongst other things: Professional Integrity; Relationships with Research Participants; Data Storage and Archiving; and the Distribution and Publication of Research (BSA, 2017). The general principle behind these ethical considerations is whether the benefits of the research outweighs the potential harm that it may cause to participants or the populations being researched, as can be seen in the quote below:

> “Although sociologists, like other researchers, are committed to the advancement of knowledge, that goal does not, of itself, provide an entitlement to override the rights of others”
>
> (BSA, 2017: 4)

With this in mind, I will now move on to consider the various ethical issues that were presented when designing this research project, starting with participant consent.

3.7.1: Consent

The issue of consent in my research is somewhat multifaceted as I not only have used multiple data collection methods, but also because my data was collected in both the public domain and the private domain. In terms of my interviews, it was made clear to all of my interviewees exactly what the aims of my research were and the topic I was researching. All participants were provided with information on the potential benefits and

negatives of taking part in my research (*see* Appendix B). They were informed via the participant consent form, and verbally before the interview, that they had the right to withdraw at any time prior to the publication of my data. In order to reduce the risk of harm to the participants, it was decided that identifiable information about themselves, their workplace or colleagues that was discussed during the interviews would be anonymised in the transcriptions and would not be published in either my PhD thesis or any resultant publications.

However, the issue of consent is less clear cut with regards to my observational and documentary data. Firstly, it is important to point out that all of the hearings observed were held in public and that all of the official hearing documents analysed were available to the public via the NMC's website. Nevertheless, the individuals that I observed neither provided me with consent for me to observe their hearings nor, unless they asked directly, were they aware of the reason why I was present in the hearing. Although I did not approach any of the registrants of my own volition, if asked by either themselves, family or friends or their representatives, I would make clear that my presence was that of a researcher. If I were to be approached in relation to a case that I was observing, I would frame my presence in terms of a broader academic interest in the conduct of NMC FtP hearings.

In terms of my documentary analysis sample, although the documents were readily available on the Internet, the individuals involved, again, did not consent to their cases being analysed as part of this research. However, as the documents are already within the public domain, coupled with the way that my analysis focused on comparing what transpired during these cases (rather than specifically focusing on the individuals involved in the case) it was decided that the benefits of this research outweigh the potential ethical issues.

3.7.2: Anonymity, Privacy and Confidentiality

As briefly mentioned when discussing the issue of consent in relation to interviews, all interview participants were anonymised in the transcripts,

along with any identifiable information. This was facilitated by the fact that the interviews were designed to provide a contextual foundation for the research rather than to collect data that would be included in my analysis. However, this issue of anonymity is slightly more complicated in relation to my observational and documentary data, as the official hearing documents for the observations, and the official hearing documents that comprised my documentary analysis sample, are widely available on the Internet.

In terms of my observational data, it is first important to point out that all cases observed were held by the Conduct and Competence Committee. This meant that the hearings were held in public where both members of the public and the media can report the names of those involved including witnesses and other parties (unless the NMC has granted these individuals anonymity). In cases where there has been a finding of impairment, the official hearing document will be published on the NMC's website with the nurse's full name, PIN and geographical locality, which meant the registrant's information was subsequently placed in the public domain following the hearing. One of the key considerations was therefore whether the use of pseudonyms for participants' names would serve any purpose given that I would be directly quoting from the official hearing documents for these cases in my three analytical chapters. The reason why this is of concern is that these quotes could be placed in an Internet Search Engine in an attempt to locate the official hearing documents which list the participants' names. The only way this particular risk could be avoided would be to not quote any of the documents, which would significantly limit the arguments that I could make in my analysis. It was therefore decided that, as my data were already in the public domain, that I would not use pseudonyms for several reasons. The first reason is that, even if I were to use pseudonyms, the individuals concerned could still be identified. The second reasons is that this research would be unfeasible were I not to use any quotes from the official hearing documents. Finally, by not pseudonymising the participants names, it allows for other researchers to cross-check my

interpretation of individual cases, which, as mentioned, are already available to the public.

However, there were two cases within my observations sample where the registrants' conduct was not found to be impaired, thus the official hearing documents were not made available to the public. Thus, the registrants' concerned could not potentially be identified based on quotes from the official hearing documents being inputted into an Internet Search Engine. Yet, these hearings were also public and the media were free to report on them. It was therefore deemed that this information was also already in the public domain. Furthermore, the focus of this research is not to specifically analyse an individual registrant's actions, but to perform a comparative analysis of the various cases and what transpired within them. It was therefore decided that when reporting these cases in my thesis, it would be made clear that their conduct was found not to be impaired. In terms of the documentary analysis sample, as all of the documents were sourced from the NMC's website, they were also in the public domain and therefore the arguments made in relation to the observational data concerning anonymity also apply. Thus, like the observations, none of the participants names from my documentary analysis sample were pseudonymised.

3.7.3: Data Storage and Security

As mentioned earlier, in order to protect the confidentiality of my interview participants, upon transcription of the interviews, all names, locations, time periods and other identifiable information was anonymised. The original audio-recordings and transcripts were stored in encrypted documents that required access passwords. In terms of the observational data, all identifiable information in my typed notes were anonymised and the documents were, again, passworded. The key used to identify the anonymised transcripts was encrypted, required a password to access and was kept on a separate USB stick. With reference to the official hearing documents for the observations, the PDF files that the information was stored on were housed in a passworded

folder, alongside the official hearing documents that made up my documentary analysis sample. All of the aforementioned documents were then stored on a USB memory stick, as well as an external hard-drive, both of which required passwords to access

3.8: Conclusion

Now that I have outlined both the methods and methodology underpinning this research, along with the rationale behind the decisions made, I will now move on to the next chapter which is the first of my three analytical chapters. This chapter will seek to analysis the quasi-legal nature of the NMC FtP process and will provide a foundation for the two subsequent analytical chapters.

Chapter 4:

An Analysis of the Quasi-Legal Nature of NMC FtP hearings

"You are both judge and jury"

Legal Assessor, Case of Pinto

4.1: Introduction

This chapter will outline how evidence used in NMC FtP hearings is presented and governed in both similar and different ways to evidence used in criminal and civil court. This will be coupled with a commentary on what effects these similarities and differences may have on the registrants concerned, particularly registrants who are unrepresented or represented by non-legally qualified individuals. This chapter will therefore seek to make the following arguments: Firstly, the lack of rigidity in the NMC FtP process might be thought to be beneficial for registrants but may in fact hinder their defence, particularly when unrepresented. Secondly, panels are at pains to assist unrepresented registrants due to them facing particular difficulties during the NMC FtP process. Finally, even when the registrant is represented by a legally qualified individual, there are still at a considerable disadvantage due to the way that the *NMC (fitness-to-practise) Rules (2004) (SI 2004/1761)* have been drafted.

By organising the chapter in this way, it will provide a foundation for the next chapter, which will seek to analyse the finding of impairment, and the resultant sanction(s), in NMC FtP hearings. Furthermore, it will also assist the discussion of the role that public interest plays in NMC FtP hearings, which will be the primary topic discussed in the final analytic chapter. Thus, this chapter will not only engage in a comprehensive discussion on the particular nature of NMC FtP hearings, but also seek to demonstrate how NMC FtP hearings serve additional purposes other than simply being a quasi-legal process used to regulate healthcare

professionals. In order to achieve the above, this chapter will need to give space to outlining the *NMC (fitness-to-practise) Rules (2004)* and the relevant criminal and civil court processes.

To present the above arguments (and the relevant evidence supporting these arguments) in the easiest and most straightforward manner, this chapter will be structured by organising each point in accordance with the NMC Rule that the point applies to. These NMC Rules can be found in either the *Nursing and Midwifery Order 2001 (SI 2002/253)* or the *NMC (fitness-to-practise) Rules (2004)* and govern both the conduct of the parties involved, and the evidence presented, in NMC FtP hearings. Each argument will therefore begin by outlining and describing the criminal court process/law that relates to a given point, followed by the relevant *NMC (fitness-to-practise) Rules (2004)* that seeks to replicate the criminal/civil court process/law. From here, a description of how the NMC Rule differs from the criminal court process/law will then be outlined in order to demonstrate the quasi-legal nature of the particular NMC Rule. After this has been done, the impact that the quasi-legal nature of that specific NMC Rule confers will then be discussed. The discussion of the impact will be accompanied by example(s) that occurred in either the observations or the official hearing documents that were analysed as part of this research, along with the ways that the different parties within NMC FtP hearings seek to manage these advantage and/or disadvantages.

4.2: Non-Legally Qualified Representatives and the Standard of Proof

I will first look at the issue of unrepresented registrants and/or registrants represented by non-legally qualified representatives, as these registrants are potentially those most affected by the quasi-legal nature of NMC FtP hearings. Now, as alluded to above, registrants have the option to represent themselves or to have a non-legally qualified individual represent them in NMC FtP hearings should the registrant not wish to, or does not have the option to, be represented by a barrister or solicitor.

Equally, defendants in civil cases also have the option to either represent themselves or to have a non-legally qualified individual represent them, the latter of which is known as a McKenzie Friend (Assy, 2015). There are, however, specific rules that govern the use of McKenzie Friends in criminal court. If a defendant in a criminal case wishes to have the assistance of a McKenzie Friend, the defendant must ask the judge to grant the McKenzie friend the right to assist the defendant. The judge will also prescribe the scope and latitude of the assistance that is to be provided by the McKenzie Friend, as the aforementioned assistance can range from taking notes for the defendant to speaking on their behalf during the hearing. In terms of McKenzie friends speaking on behalf of a defendant, the defendant must ask the judge to grant the McKenzie Friend 'rights of audience', under the Legal Services Act (2007). 'Rights of audience' are granted to barristers and solicitor advocates upon qualification, which gives the barrister or solicitor advocate the right to address the court on their clients' behalf (Assy, 2015). Furthermore, as stated by Assy, criminal courts are reluctant to grant McKenzie Friends 'rights of audience' and only do so to ensure justice and a fair trial:

> "Such requests may be more readily granted when the proposed McKenzie Friend is a close friend or relative of the litigant. A more stringent standard is applied when the rights of audience or of conducting litigation are requested for habitual McKenzie Friends. Courts have held that laypersons who offer themselves as professional advocates or professional McKenzie Friends or who seek to exercise such rights on a regular basis, whether for reward or not, should not be granted such rights other than in exceptional circumstances."
>
> (Assy, 2015: 131)

There are, however, no provisions within the Legal Services Act (2007) that state when the court should grant a McKenzie friend 'rights of audience', leaving it solely down to the judge's discretion.

In terms of registrants represented by non-legally qualified individuals in NMC FtP hearings, under Rule 20 (2) of the *NMC (Fitness-to-practise) Rules (2004)*:

> "The registrant may be represented by –
>
> (a) solicitor or Counsel;
>
> (b) a representative from her professional body or trade union; or
>
> (c) subject to paragraph (4), any other person."

The use of non-legally qualified representatives in NMC FtP hearings therefore differs from the civil court process regarding McKenzie Friends. This is because the registrant does not have to ask the panel to give their non-legally qualified representative the right to address them or undergo a process akin to that which Mckenzie friends have to undergo in civil court in order to speak on behalf of an individual. However, under Rule 20 (4) and (5) of the *NMC (Fitness-to-Practise) Rules (2004)*:

> "(4) A person who represents or accompanies the registrant shall not be called as a witness at the hearing.
>
> (5) The Committee may exclude from the whole or part of the hearing, any person whose conduct, in its opinion, has disrupted or is likely to disrupt the proceedings."

It could be argued that paragraph (4) is a precautionary measure to prevent any contamination of witness evidence as a result of prior knowledge of other pieces of evidence used by either the NMC or the registrant. Paragraph (5), however, could be seen as a quasi-legal caveat in that, although the registrant does not have to ask for the panel's permission to have a non-legally qualified individual represent them (the registrant), the panel do have some control over the selection of non-legally qualified individuals. This is because the panel have the power to exclude "any person" from the hearing. Although it has not been possible to find any academic studies that demonstrate how the use of non-legally

qualified representatives can disadvantage registrants in employment tribunals, Assy has pointed out that those who use McKenzie Friends may be at a disadvantage:

> "Nevertheless, such a market [of McKenzie Friends] may still raise concerns about consumer protection. Encouraging a market in lay representation by people who are not required to undergo any professional training or pass any quality control may put clients at the risk of receiving poor advice which harms them (and others).
>
> (Assy, 2015: 136)

There is the same potential for this lack of experience or knowledge to have an impact in NMC FtP hearings, given that NMC case presenters are trained barristers and/or solicitors who will:

> "…act as a prosecutor in the case, on behalf of the NMC"
>
> (NMC, 2017h: 11)

It is important, however, to keep in mind that obtaining legal representation can be difficult for nurses who are not members of trade unions, which will provide them with free legal advice and representation at NMC FtP hearings (RCN, 2018b). The reason for this is that, if the nurse is not a member of a trade union or does not possess any form of liability cover, the nurse will have to fund their legal representation themselves. This particular problem has been highlighted in the Royal College of Nursing's guide for witnesses that are to give evidence at NMC FtP hearings:

> "Due to high legal fees it is quite common for a person to represent themselves rather than pay for legal support. In this scenario it can be a little more unsettling because the questions may be put to you directly by the person being charged rather than by their representative…"
>
> (Royal College of Nursing, 2018a)

Out of the nineteen NMC FtP hearings that were observed as part of this research, eight of the registrants were absent and unrepresented; out of the official seventy-one hearing documents that were analysed as part of this research, thirty-seven registrants were also absent and unrepresented.

Attendance and Representation in the Observation Sample

Absent and unrepresented	Absent, with legally qualified representation	Absent, with non-legally qualified representation	Present and unrepresented	Present, with legally qualified representation	Present, with non-legally qualified representation
6	1	1	1	10	1
30%	5%	5%	5%	50%	5%

Attendance and Representation in the Documentary Analysis Sample

Absent and unrepresented	Absent, with legally qualified representation	Absent, with non-legally qualified representation	Present and unrepresented	Present, with legally qualified representation	Present, with non-legally qualified representation
37	2	0	14	18	0
51.38%	2.77%	0%	19.44%	25%	0%

This supports the Royal College of Nursing's (2018a) assertion that it is 'quite common' for nurses to be unrepresented. As I will show, this can put the registrant at a particular disadvantage even when the panel do attempt to assist an unrepresented registrant, or a registrant represented by non-legally qualified individuals. This disadvantage is partly because the unrepresented registrant will be having to defend themselves against a trained barrister or solicitor, but also, as I will show, because of the way the *NMC (fitness-to-practise) Rules (2004)* are constructed, which significantly disadvantages registrants even when they are represented by legally qualified representative.

With this in mind, I will therefore move onto discuss the quasi-legal nature of how evidence is presented and governed in NMC FtP hearings in comparison to civil and criminal court. However, before we do so, it is

important to briefly outline the standard of proof in NMC FtP hearings. NMC FtP hearings use the civil standard of proof during the Fact-Finding stage, which is the 'balance of probabilities' (NMC, 2017h). The Fact-Finding stage is the first stage of a hearing where the panel are presented with the evidence pertaining to the NMC's case and the registrant's case (if the registrant is present) and then come to a conclusion as to what facts and/or events occurred (NMC, 2012b). The reason why NMC FtP hearings use the civil standard of proof in the Fact-Finding stage is based on the following case, *Dr Hosny v GMC [2011] EWHC 1355*. In this case, Dr Mona Hosny challenged the GMC regarding a finding of misconduct against her. A GMC FtP panel found that she had created a false reference from another registered doctor and intentionally withheld information pertaining to an ongoing investigation into her practice by the GMC. Dr Hosny's legal team therefore sought to challenge the GMC's decision on a number of different points. During the course of the ruling, the presiding judge clarified that GMC FtP panels are required to use the civil standard of proof in GMC FtP hearings, reiterating the following statement made by Lord Nicolls in *Re H (Minors) (Sexual Abuse: Standard of Proof)* [1996] AC 563:

> "…Built into the preponderance of probability standard is a generous degree of flexibility in respect of the seriousness of the allegation. Although the result is much the same, this does not mean that where a serious allegation is in issue the standard of proof required is higher. It means only that the inherent probability or improbability of an event is itself a matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred. The more improbable the event, the stronger must be the evidence that it did occur before, on the balance of probability, its occurrence will be established."

As can be clearly seen in the above quote, the sole consideration is the probability of whether a given act occurred, regardless of the severity of the alleged act. The standard of proof for civil cases is also considerably

lower than the standard of proof for criminal cases in the UK, which is ‘beyond reasonable doubt’ (John, 2013). When discussing cases of professional misconduct by healthcare professionals and potential criminal elements contained within them (albeit in Australia) Freckelton stated:

> “Proof on the balance of probabilities is much more feasible [than beyond reasonable doubt] for many kinds of improprieties – improprieties whose proof often ultimately depends on an assessment of one person’s word against another’s.”
>
> (Freckelton, 1998: 45)

When there is a dispute regarding the delivery of care, or lack of care, it often involves one person’s word against another due to nurses often working alone with patients or other members of staff. However, it is important to note that the civil standard of proof only applies to the Fact-Finding stage, where the panel decide whether the registrant committed the acts outlined in the charges. There is, however, no standard of proof for the Misconduct, Impairment and Sanction stages, so the panel must exercise their own ‘independent professional judgement’ as to whether the registrants practise is impaired. An example of a panel stating that they used their own judgement as there is no burden of standard of proof during these stages can be seen in the following quote from the case of Adenusi, who was a female general nurse whose case was analysed as part of my documentary analysis sample:

> “The legal assessor particularly drew the panel’s attention to paragraph 71 of Mrs Justice Cox’s judgement in *Grant*… The panel, in reaching its decision, accepted that there was no burden or standard of proof at this stage and exercised its own judgement [emphasis in the original]”

There is equally no statute or case law which defines the meaning of impairment. The NMC’s definition of impairment can be seen in the

following quote from *Professional Standards Authority v Nursing and Midwifery Council and Mason [2017] CSIH 29*:

> "The committee noted that the Council had defined 'fitness to practise' as a registrant's suitability to remain on the register unrestricted."

This definition of impairment is potentially very subjective as the NMC have not defined what 'suitability' actually is. Whilst it could be argued that breaching the NMC Code would potentially make someone 'unsuitable' for remaining on the register unrestricted, the NMC also acknowledge that not every act of misconduct results in the registrant's conduct being impaired (NMC, 2017g; NMC, 2017h). This, however, will be discussed further in the following chapter on Misconduct and Impairment. So far it is clear that, because NMC FtP hearings use the civil standard of proof (NMC, 2017h) in combination with processes similar to those used in criminal court, the fundamental tenets underpinning these hearings are indeed quasi-legal in nature. Likewise, this chapter will now proceed to discuss the way that evidence is presented and governed in NMC FtP hearings and the potential impact that can arise as a result of this patchwork of quasi-legal processes, starting with the disclosure of evidence.

4.3: Disclosure of Evidence

In criminal court, the prosecution is bound by law to disclose any evidence that it intends to use to support its case against the defendant. This also includes any unused evidence that the prosecution has collected during their investigation, including evidence which may weaken the prosecution's case. *The Crime and Disorder Act 1998 (Service of Prosecution Evidence) Regulations (SI 2005/902) reg.2* states that:

> "2. Where a person is sent for trial under section 51 of the 1998 Act on any charge or charges, copies of the documents containing the evidence on which the charge or

> charges are based, shall, no later than 70 days after the date on which the person was sent for trial or, in the case of a person committed to custody under section 52(1)(a) of the Act, no later than 50 days after that date, be:
>
> (a) served on that person;"

As can be seen in the above quote, there is a set statutory time period for the prosecution to disclose to the defence any evidence that they have gathered. Likewise, there are also specified time frames for disclosure in civil court under Rule 31.5 of *The Civil Procedure Rules 1998 (SI 1998/3132)*:

> "(1) In all claims to which rule 31.5(2) does not apply –
>
> > (a) an order to give disclosure is an order to give standard disclosure unless the court directs otherwise;
> >
> > (b) the court may dispense with or limit standard disclosure; and
> >
> > (c) the parties may agree in writing to dispense with or to limit standard disclosure.
>
> (2) Unless the court otherwise orders, paragraphs (3) to (8) apply to all multi-track claims, other than those which include a claim for personal injuries.
>
> (3) Not less than 14 days before the first case management conference each party must file and serve a report verified by a statement of truth, which –
>
> > (a) describes briefly what documents exist or may exist that are or may be relevant to the matters in issue in the case;
> >
> > (b) describes where and with whom those documents are or may be located;

(c) in the case of electronic documents, describes how those documents are stored;

(d) estimates the broad range of costs that could be involved in giving standard disclosure in the case, including the costs of searching for and disclosing any electronically stored documents"

In the above quote regarding civil procedure, it clearly makes reference to the requirement that there is a 'case management conference' prior to the hearing in civil court. The NMC do have a similar process, which the NMC refer to as a 'preliminary meeting' as specified in Rule 18 of the *NMC (fitness-to-practise) Rules (2004)*. However, whilst the *NMC (fitness-to-practise) Rules (2004)* do address the service of evidence used to support the NMC's case against the registrant and vice versa, it could be argued that the NMC Rules are not as clear cut as those used in a criminal court. The reason for this is that the time-period for the service of evidence (or indeed whether to enforce a time period at all) is determined by the chair in a preliminary meeting, as can be seen in Rule 18 (5):

"(5) Directions given by the Chair of the preliminary meeting may include, but shall not be limited to –

(a) time limits for the service of evidence and disclosure of expert evidence (if any)"

There is no reference in the *Nursing and Midwifery Order (2001)* or the NMC (fitness-to-practise) Rules 2004 as to how much time the NMC should be required to give when disclosing evidence to the registrant and vice versa. The only other mention of the service of evidence in the NMC (fitness-to-practise) Rules 2004 can be seen in Rule 31 (8):

"(8) Where a party has –

(a) failed to comply with any directions for service of evidence given at a preliminary

meeting under rule 18, including service of expert reports;

(b) shown no good cause for failure to comply with the directions given; and

(c) seeks to adduce such evidence at the hearing, a Practice Committee may refuse to allow that party to admit the evidence in question"

In the above quote from Rule 31 (8) in the *NMC (fitness-to-practise) Rules (2004)*, it states that the Practice Committee (the panel) "*may* refuse to allow the party to admit the evidence in question [own emphasis]". By using the word *may*, with no legal caveat attached outlining the situations in which the disputed evidence may be included, the decision is left to the panel's own interpretation. Clearly, this introduces variability, and interpretations may vary according to the composition of the panel, who are not required to have any legal knowledge or understanding themselves. This is evidenced by the fact that the panel are required, under the *NMC (fitness-to-practise) Rules (2004)*, to hear advice from the Legal Assessor at certain points, as can be seen in Rule 18 (6), which states:

> "(6) At the preliminary meeting, the legal assessor may give a preliminary opinion for the purpose of resolving questions of law or admissibility of evidence."

Furthermore, in situations where either the NMC or the registrant/registrant's representative are attempting to introduce evidence that is disputed by the other party, the panel will hear submissions from both sides in order to make a decision on whether to admit said evidence. An example of such submissions can be seen in the following quote from the official hearing document for the case of Gilmour who was a female general nurse whose case was observed as part of this research:

> "Mr Crammond [the registrant's legally qualified representative] told the panel that the witness statement of Ms 2 was served on you [the registrant] on 6 November 2015 and although there is no date specified for the service of evidence, this date falls outside of the usual 28 days' notice period for hearings. Mr Crammond informed the panel that the statement of Ms 2 was dated 2 November 2015 which compared to the statement of Ms 1, 5 May 2014, was substantially later. Mr Crammond also submitted that this matter has been investigated for two years and that this information was obtained very late."

In this particular case, the panel decided to allow the disputed witness testimony into evidence. However, the above quote not only demonstrates how legally qualified representatives seek to make admissions on the registrant's behalf, but also how legally qualified representatives seek to use other rules and precedents for the benefit of their client due to the lack of clarity surrounding the disclosure of evidence. This could be particularly problematic for unrepresented registrants or registrants represented by non-legally qualified representatives due to their potential lack of legal knowledge. Nevertheless, there are occasions in my data where this lack of clarity has been utilised by unrepresented registrants or registrants represented by non-legally qualified representatives, an example of which can be seen in the case of Pinto whose case was observed as part of this research.

Pinto was an unrepresented male general nurse accused of accessing confidential medical records of friends, family and work colleagues without their consent. During the Sanction stage Pinto stated that it was "too late" for him to obtain character references after the panel informed him that it was his responsibility to provide them with any relevant evidence pertaining to his defence. After the chair invited the Legal Assessor to provide advice on the matter, the Legal Assessor suggested giving Pinto some additional time so that Pinto could try and contact the

employment agency that he was employed by at the time of the hearing. The reason for the Legal Assessor suggesting to the panel that Pinto should be given additional time to contact the agency for a reference was because:

> "He [Pinto] is unrepresented and we are trying to be fair"

The panel decided to give Pinto additional time to contact the recruitment agency. As a result, Pinto was able to obtain the oral testimony (via telephone) of his recruitment agent who provided the panel with a character reference, which can be seen in the following quote from the official hearing document:

> "The panel heard oral evidence via telephone from Mr 1, an Account Manager at [recruitment agency], a healthcare recruitment company you are registered with. Mr 1 informed the panel that you were a very reliable nurse, and that you had not received any complaints about your practice from your placements during the four months that he has been in post. He stated that he would, on average, book you on 4 or 5 night shifts per week.

Both the above description of the case of Pinto, along with the subsequent quote from the official hearing document, demonstrate how the lack of clarity concerning time frames for the disclosure of evidence under Rule 18 (5) benefited Pinto. This is because the panel had the legal flexibility to admit the oral evidence from Pinto's recruitment agent, despite the NMC only becoming aware that this testimony was to be used on the day of the hearing.

The lack of clarity regarding the timeframes for the disclosure of evidence can therefore be utilized in two ways. Firstly, the lack of clarity can be used by either the NMC or the registrant/registrant's representative for arguing that disputed pieces of evidence should either be included or excluded, as can be seen in the case of Gilmour (described above). Secondly, the lack of clarity concerning the timeframes for the disclosure

of evidence can also be used by the panel should the panel wish to exercise leniency and/or discretion, such as when a registrant is unrepresented, as can be seen in the case of Pinto. Yet, this flexibility could potentially lead to inconsistencies in the outcome of a given case depending on who the panel is comprised of. This illustrates how some elements of NMC FtP hearings are not only quasi-legal in nature, but also highly subjective. This is because the NMC FtP panel have considerable flexibility as to whether to allow evidence to be admitted based on the panel's preferences and interpretation of the rules and/or law governing said evidence.

However, there is also the issue of what the NMC refer to as 'requesting disclosure', which is where the registrant requests that the NMC obtain documents on their behalf (NMC, 2017i) if they are unable to obtain the documents themselves. The reason why a registrant would request the NMC to do so is because, under Article 25 (1) of the Nursing and Midwifery Order (2001), the NMC have the power to do the following:

> "For the purpose of assisting the Council or any of its Practice Committees, the Registrar or any other officer of the Council carrying out functions in respect of fitness to practise, a person authorised by the Council may require any person (other than the person concerned) who in his opinion is able to supply information or produce any document which appears relevant to the discharge of any such function, to supply such information or produce such a document"

Put simply, the NMC have the power to compel individuals and/or organizations to disclose any information and documents that the NMC deem *relevant* to the case. The reason why the word *relevant* has been emphasized is that the NMC are not only the ones who deem whether a document is relevant to their case against a registrant, but whether a document that the registrant wishes to obtain is relevant to the registrant's case. The NMC make reference to this in the following quote:

> "Although there is no duty on us to gather evidence requested by a nurse or midwife, the nurse or midwife has a right to a fair hearing and *we* will consider what is *relevant, essential, and fair* to obtain [own emphasis]"
>
> (NMC, 2017i)

The above quote shows how the NMC FtP process uses processes from a civil court, but also alters these processes in the *NMC (fitness-to-practise) Rules (2004)*. The fact that the NMC can decide what documents are relevant to the registrant's case differs sharply from civil court processes as a litigant in a civil case would not be responsible for deciding which documents are *relevant, essential and fair* to the defence's case and vice versa. Furthermore, there is also a considerable power differential between the NMC and the registrant. The reason for this power differential is that the NMC have the power to compel individuals and organizations to provide documents and information whereas registrants do not. This allows for the possibility that the NMC are in possession of information not available to the registrant. Nevertheless, the NMC do state that they will disclose relevant documents, as can be seen in the quote below:

> "During the investigation of a nurse or midwife's case, we will provide them with the evidence we have obtained. This may include 'unused material', which is evidence we do not intend to rely on. We will disclose this information if it could undermine the case against the nurse or midwife or support their case. This makes sure that the process is fair and that the nurse or midwife is given sufficient information to properly respond to the allegations made against them. We will not disclose any material that is subject to legal privilege."
>
> (NMC, 2017f)

The above quote demonstrates how the NMC *may* disclose 'unused material', along with other information that could undermine the NMC's case against the registrant. However, the fact that the NMC are responsible for deciding whether a document is relevant or not means that the NMC are not only litigants in the case but are also acting in the same way that a judge would in a civil case. This is because in civil cases where the judge is responsible for determining whether a disputed document is relevant or not, as outlined in *The Civil Procedure Rules (1998) r.31.* In addition to this, the NMC do state that all of their panels are 'independent', despite these panels being selected, trained and paid by the NMC (2018e). Thus, the argument could be made that the preliminary meetings where the disclosure of such information and/or documents is discussed should be chaired by an independent panel.

However, whilst this lack of clarity is potentially a problematic issue, my data shows that these rules on disclosure do not always disadvantage registrants, as can be seen in the case of Heslop who was a female general nurse whose case was observed as part of this research. In this case, Heslop was accused of forcibly administering IV antibiotics post-surgery; however, the patient was not available to give evidence and had disengaged with the NMC. This left the NMC case presenter with only one piece of evidence, which was the witness testimony of a colleague who was working down the hall and did not witness the incident, merely hearing shouting. Whilst Heslop's legally qualified representative was outlining her case, the NMC case presenter was made aware of the patient's mental health records and criminal history by the NMC. This included the fact that the patient was currently imprisoned for over four years due to committing, amongst other things, a violent assault. After the NMC case presenter disclosed this to Heslop's legally qualified representative, she was able to successfully have all misconduct charges dismissed on grounds that the NMC's evidence was so tenuous that there was no case to answer for.

The case of Heslop is an example of a legally qualified representative being able to use flexibility around evidence disclosure to the benefit of

her client. In theory this same opportunity is present for an unrepresented individual or an individual with a non-legally qualified representation. However, it will likely be much more difficult for registrants in those latter two circumstances to be aware of all aspects of the process, and to act in the moment, to use the *NMC (Fitness-to-Practise Rules) Rules (2004)* advantageously. The disclosure of evidence is not the only quasi-legal process where a significant power differential exists between the NMC and the registrant, with another example being that of hearsay evidence.

4.4: Hearsay Evidence

In criminal law, hearsay evidence is defined as:

> "…a statement not made in oral evidence in the proceedings that is evidence of any matter stated"
>
> (Crown Prosecution Service, 2017)

Hearsay evidence is admissible in criminal court under the conditions laid down in the Section 114 (1) of the *Criminal Justice Act (2003)*:

> (1) In criminal proceedings a statement not made in oral evidence in the proceedings is admissible as evidence of any matter stated if, but only if—
>
> (a) any provision of this Chapter or any other statutory provision makes it admissible,
>
> (b) any rule of law preserved by section 118 makes it admissible,
>
> (c) all parties to the proceedings agree to it being admissible, or
>
> (d) the court is satisfied that it is in the interests of justice for it to be admissible."

The caveat, "…in the interests of justice for it to be admissible", is very subjective and broad in nature. Despite this, criminal court judges are still very reluctant to admit hearsay, as sitting High Court judge Mr

Andrew Thomas QC stated in his ruling for the case of *Thorneycroft v NMC [2014] EWHC 1565 (Admin)*:

> "It is now clear that in a criminal case hearsay evidence can be admitted, even if it is the sole or decisive evidence, but subject to a requirement for counterbalancing measures: it should be regarded as an option of last resort"

However, although the definition of hearsay in criminal and civil court is based upon the same common law principle (Edge et al., 2016: 158) the admissibility of hearsay evidence in civil court differs considerably compared to criminal court. Under Section 1 and 2 of the *Civil Evidence Act (1995)*:

> "(1) In civil proceedings evidence shall not be excluded on the ground that it is hearsay.
>
> (2) In this Act—
>
> (a) "hearsay" means a statement made otherwise than by a person while giving oral evidence in the proceedings which is tendered as evidence of the matters stated; and
>
> (b) references to hearsay include hearsay of whatever degree"

However, that is not to say that the admissibility of hearsay evidence in civil proceedings is without caveats. If hearsay evidence is admitted, the judge or adjudicator will have to take the following points into consideration when assessing the weight of said hearsay evidence, as outlined in Section 4 of the *Civil Evidence Act (1995)*:

> "(1) In estimating the weight (if any) to be given to hearsay evidence in civil proceedings the court shall have regard to any circumstances from which any inference can reasonably be drawn as to the reliability or otherwise of the evidence.

(2) Regard may be had, in particular, to the following—

(a) whether it would have been reasonable and practicable for the party by whom the evidence was adduced to have produced the maker of the original statement as a witness;

(b) whether the original statement was made contemporaneously with the occurrence or existence of the matters stated;

(c) whether the evidence involves multiple hearsay;

(d) whether any person involved had any motive to conceal or misrepresent matters;

(e) whether the original statement was an edited account, or was made in collaboration with another or for a particular purpose;

(f) whether the circumstances in which the evidence is adduced as hearsay are such as to suggest an attempt to prevent proper evaluation of its weight."

As can be seen in the above quotations, the laws/rules governing the admissibility of hearsay evidence in both criminal and civil court are quite precise and equally restrictive, particularly with regards to criminal court. However, Rule 31 (1) of the *NMC (fitness-to-practise) Rules (2004)* that governs the admissibility of hearsay evidence is far less prescriptive:

> "Upon receiving the advice of the legal assessor, and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings (in the

> appropriate Court in that part of the United Kingdom in which the hearing takes place)"

The above quote is extremely broad in comparison to the law governing hearsay evidence in both criminal and civil court. An example of hearsay evidence being used in NMC FtP hearings would be if the panel agreed to allow a witness statement of a registrant's colleague into evidence despite the colleague not being able to attend the hearing. The reason attendance is of import is because the witness cannot be cross-examined in relation to their witness statement either in person, by telephone or via video conferencing. Examples of successful applications to admit hearsay evidence can be seen in my documentary analysis sample such as in the cases of Boodoo and Maharaj (amongst others). However, the panel must also take into consideration the relevant case law, such as Thorneycroft v NMC (2014). In this particular case, Thorneycroft was a male nurse accused of making derogatory and inappropriate comments about patients with learning disabilities, which the NMC FtP panel subsequently found proven. Thorneycroft complained to the High Court that the NMC FtP panel had not taken all of the relevant evidence into consideration when deciding whether to admit hearsay evidence from two witnesses who had refused to attend the hearing. The High Court subsequently deemed that, as the panel had not been provided with all of the relevant evidence, they were unable to undertake the necessary considerations required when deciding whether to admit hearsay evidence. The sitting judge of the High Court, Mr Andrew Thomas QC, stated that, when deciding whether to admit hearsay evidence, the panel must take into consideration the following points:

> "1.1. The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.
>
> 1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a

> factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.
>
> 1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.
>
> 1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability."

The above quote highlights how, although hearsay evidence is admissible in both criminal and civil court, there are different conditions governing its use in NMC FtP hearings. Firstly, the admittance of hearsay evidence is not a "routine" matter. Thus, the panel must consider the issue of fairness' when admitting said hearsay evidence; this principle of fairness applies to all parties concerned, such as the registrant, the NMC and the public, as outlined in the above quote. The second point concerns the issue of witness attendance: in civil court cases, the judge must consider whether it would have been 'reasonable' and/or 'practicable' for the party wishing to admit the hearsay evidence to secure the attendance of the witness. In NMC FtP hearings, however, the panel need only consider whether there is a 'good' and 'cogent' reason for non-attendance. When considering the differences between the two criteria, it is important to keep in mind that only the NMC have the power to compel a witness to give evidence at the NMC FtP hearing, as laid down in Part 34A 2.1 of the *Civil Procedure Rules (1998)*, which states:

> "A witness summons may be issued in the High Court or the County Court in aid of a court or tribunal which does not have the power to issue a witness summons in relation to the proceedings before it"

Thus, if NMC FtP hearings were to use civil procedure, it would be difficult for the NMC to demonstrate that it was 'unreasonable' or 'impracticable' for them to secure the attendance of a witness as the NMC have the ability to compel the witness to give evidence. However, the guidelines laid down in *Thorneycroft v NMC (2014)* mean that the NMC, amongst other things, simply have to demonstrate that there is a 'good' and 'cogent' reason for the witness not attending. The requirements in *Thorneycroft v NMC (2014)* could therefore be seen as making it easier for the NMC to rely on hearsay evidence compared to civil court. However, and as with the other quasi-legal processes discussed above, that is not to say that Rule 31 (1) of the *NMC (fitness-to-practise) Rules (2004)*, along with the guidelines laid down in Thorneycroft v NMC (2014), always disadvantage the registrant.

An example of such can be seen in the case of Warren, who was a male mental health nurse accused of having an inappropriate relationship with a former patient. The NMC case presenter initially attempted to persuade the panel to allow the patient/complainants' witness statement, along with private email correspondence between the patient and Warren, into evidence despite the patient refusing to attend the hearing. After the panel rejected the NMC case presenter's first application, the NMC case presenter then made a second application. However, the panel decided to allow Warren's non-legally qualified representative additional time to formulate her argument, as well as suggesting that she (Warren's representative) speak with the Legal Assessor during the break. After the break, Warren's non-legally qualified representative thanked the Legal Assessor for "kindly pointing out" that there were little grounds for her to argue that the email evidence should not be allowed into evidence, due to the provisions of Rule 31 (1) of the *NMC (fitness-to-practise) Rules (2004)*. In this particular case, although the panel

allowed the email correspondence into evidence, the panel still refused to allow the patient/complainant's witness statement into evidence, which can be seen in the following quote from the official hearing document for Warren:

> Ms Jones [the NMC case presenter] referred the panel to the ruling of Mr Justice Singh in the case of The Professional Standards Authority for Health and Social Care v NMC and Jozi [2015] EWHC 764 (Admin) which made clear that the panel in regulatory proceedings should "play a more proactive role than a judge presiding over a criminal trial in making sure that the case is properly presented and that the relevant evidence is placed before it." Ms Jones [the NMC case presenter] submitted that she had not been given an opportunity to address the panel in relation to whether video or telephone evidence and the use of a witness summons had been considered…
>
> The panel noted that in his ruling in the case of Thorneycroft, Mr Andrew Thomas QC made clear that hearsay evidence should be regarded as "an option of last resort" and that the decision to admit hearsay evidence should be taken "with great caution". In the panel's judgment what was of particular significance to the current case was his ruling that "the evidence must be either demonstrably reliable or capable of being tested."
>
> The panel noted its previous determination that "Patient A's reliability and credibility are matters to be appropriately explored. This will not be possible if she is not present to give evidence." It also noted its determination that it was "not satisfied that Patient A's evidence was demonstrably reliable and concluded that there would be no means of testing its reliability if the application was granted." The panel concluded that none of the further information

> provided to it today caused it to conclude that Patient A's evidence is demonstrably reliable. It remains the position that there would be no means of testing her evidence if her witness statement was admitted. The panel remains satisfied that it would be unfair to admit her statement in evidence."

The above quote, firstly, demonstrates how the panel are expected to play a more "proactive" role than a criminal judge in ensuring that the relevant evidence pertaining to a given charge is put before them. However, despite two applications from the NMC case presenter, the panel still refused to allow the hearsay witness statement into evidence. Furthermore, the panel could also be seen as trying to reduce the disadvantage that Warren faced by having a non-legally qualified individual represent him for a number of reasons: firstly, the panel allowed Warren's non-legally qualified representative additional time to formulate an argument in response to the two applications put forward by the NMC case presenter. Secondly, the panel also allowed the Legal Assessor to provide Warren's non-legally qualified representative with information regarding the law, thus acting as a panacea to Warren's representative potential lack of legal knowledge. Equally, the above quote is also a clear demonstration of how the principles of *Thorneycroft v NMC (2014)* have been applied, that is, that the panel need to be sure that there is a way that they (the panel) can test the reliability of the hearsay evidence.

Nevertheless, that is not to say that all applications to admit hearsay evidence were unsuccessful, an example of which can be seen in the case of Maharaj who was a male general nurse whose case was analysed as part of my documentary analysis sample. Maharaj was a general male nurse accused of, amongst other things, deliberately submitting claims for payment for work when he had not attended work. During the hearing, the NMC case presenter made an application to admit the witness statement of a former work colleague who was not able to attend or give evidence via telephone due to ill health. Despite

Maharaj's legally qualified representative arguing that it would be "prejudicial" to admit the hearsay evidence, the panel granted the application to admit the hearsay witness statement for the following reasons:

> "The panel noted the letter from Ms 5's GP, dated [date], in which the GP clearly states that Ms 5 is too unwell to attend hearing. The panel accepted that Ms 5 was too unwell to participate in the hearing.
>
> The panel noted that it had seen notes from the Trust's internal investigation, admitted by agreement, which included Ms 5's statement (of which only one line was redacted) and therefore it was aware of her opinion about the general allegations you face. The panel concluded that admitting Ms 5's statement did not cause any unfairness to you as her statement was not crucial to prove any of the 18 charges, it may corroborate other evidence. In addition, the panel concluded that Ms 5's statement was relevant as it addressed whether you had been given an instruction to "shut down" a shift.
>
> Accordingly the panel granted the NMC application to admit the witness statement of Ms 5. It decided that it would attach appropriate weight to her untested statement."

Thus, by allowing the disputed witness testimony into evidence, it could potentially disadvantage Maharaj as his legally qualified representative would not be able to cross-examine the witness in relation to their witness statement. Nevertheless, there were also examples in my data where panels have allowed hearsay evidence to be admitted upon both parties agreeing to its admission. An example of hearsay evidence being admitted can be seen in the case of Boodhoo who was a male general nurse whose case was also analysed as part of my documentary analysis sample. Boodhoo was a male nurse accused of not escalating reports that a member of staff had assaulted a patient. During the hearing, two

of the witnesses were to give evidence via telephone, however, due to issues with the telephone technology, the telephone connections with two of the witnesses was lost. Thus, the NMC case presenter and Boodhoo's legally qualified representative agreed to certain redactions in the witness statements so that they could be admitted into evidence whilst minimising the potential disadvantage to any of the parties involved. This is despite neither side being able to cross-examine the witnesses regarding their witness statements, as can be seen in the following quote from the official hearing document:

> "Mr Mills [the NMC case presenter] invited the panel to consider whether further time could be allowed to re-establish the connection with Mr 6. He also suggested that this time could be used to see if parties could agree redactions to the witness statements of Mr 6 and Ms 7, which would allow their witness statements to then be admitted without objection. Following a further adjournment, Mr Mills [the NMC case presenter] thereafter told the panel that both parties had agreed to make further redactions to each witness statement to enable matters to proceed without further delay to the hearing.
>
> The panel therefore decided to accept the further redacted witness statements of Mr 6 and Ms 7. In doing so, the panel noted that these were hearsay statements and therefore, less weight may be given to such evidence than if the witnesses had been able to give live evidence to the panel."

The above quote demonstrates how both the panel, and the rules that govern NMC FtP hearings, can be seen as mimicking both criminal court and civil court in a number of ways. Firstly, by allowing the hearsay witness statements into evidence due to both parties agreeing to them being admitted (following redactions), the panel's decision could be seen as mimicking Section 114 (1) (c) of the *Criminal Justice Act (2003).* This is because Section 114 (1) (c) states that hearsay evidence can be

admitted into evidence in criminal court if both parties agree to it. Secondly, the *NMC (fitness-to-practise) Rules (2004)* and the relevant case law, such as *Thorneycroft v NMC (2014)*, could also be seen as mimicking civil court processes concerning hearsay evidence. This is because the panel are required to decide what weight to attach to hearsay evidence as Section 4 (1) of the *Civil Evidence Act (1995)* states that the judge presiding over a civil court case must consider what weight to attach to any hearsay evidence that has been admitted.

The decision whether to admit such evidence, along with other evidence that would be inadmissible in civil court, is always made by the panel as outlined in Rule 18 of the *NMC (fitness-to-practise) Rules (2004)*, which states:

> "(6) At the preliminary meeting, the legal assessor may give a preliminary opinion for the purpose of resolving questions of law or admissibility of evidence.
>
> (7) Notwithstanding paragraph (6), decisions as to whether or not any evidence is to be admitted at the hearing shall be taken by the Committee considering the allegation."

This dual requirement that the panel make decisions on matters of law whilst also being responsible for deciding whether a registrant committed any of the acts outlined in the charge(s) has led several Legal Assessors during the observations to describe the panel as being the following:

> "…you are both judge and jury"

However, unlike a jury in a criminal court, the panel are also privy to other types of information about the registrant, such as past criminal convictions, which will now be discussed.

4.5: Past Criminal Convictions

In criminal court, there are very specific guidelines as to how and when a defendant's criminal history can be disclosed to a jury. In order for the defendant's criminal history to be disclosed, the prosecution must make

a ‘Bad Character Application’ under Section 101 of the Criminal Justice Act (2003), which states:

> “(1) In criminal proceedings evidence of the defendant’s bad character is admissible if, but only if—
>
> > (a) all parties to the proceedings agree to the evidence being admissible,
> >
> > (b) the evidence is adduced by the defendant himself or is given in answer to a question asked by him in cross-examination and intended to elicit it,
> >
> > (c) it is important explanatory evidence,
> >
> > (d) it is relevant to an important matter in issue between the defendant and the prosecution,
> >
> > (e) it has substantial probative value in relation to an important matter in issue between the defendant and a co-defendant,
> >
> > (f) it is evidence to correct a false impression given by the defendant, or
> >
> > (g) the defendant has made an attack on another person’s character.
>
> (2) Sections 102 to 106 contain provision supplementing subsection (1).
>
> (3) The court must not admit evidence under subsection (1)(d) or (g) if, on an application by the defendant to exclude it, it appears to the court that the admission of the evidence would have such an adverse effect on the fairness of the proceedings that the court ought not to admit it.
>
> (4) On an application to exclude evidence under subsection (3) the court must have regard, in particular, to the length

of time between the matters to which that evidence relates and the matters which form the subject of the offence charged."

Whilst subsection (a), (b) and (g) are self-explanatory, sub-section (c) needs a little further clarification, which is covered under Section 102 of the *Criminal Justice Act (2003)*:

> "For the purposes of section 101(1)(c) evidence is important explanatory evidence if—
>
> > (a)without it, the court or jury would find it impossible or difficult properly to understand other evidence in the case, and
> >
> > (b)its value for understanding the case as a whole is substantial."

With regard to sub-section (d), Section 103 of the *Criminal Justice Act (2003)* states that a defendant's criminal history can be disclosed if the issue between the defendant and the prosecution concerns whether the defendant has a 'propensity' to commit certain types of criminal offences similar to the one that the defendant is charged with. There are however exceptions to this. The first exception is if possessing said 'propensity' makes no difference to whether or not the defendant would be guilty of the offence. The second exception is if the court deems that it would be unjust to disclose the previous offence(s) due to the length of time that has elapsed since the defendant was convicted of the previous offence(s).

Sub-section (e), however, holds less exceptions than the above, as can be seen in Section 104 of the *Criminal Justice Act (2003)*:

> > "(1) Evidence which is relevant to the question whether the defendant has a propensity to be untruthful is admissible on that basis under section 101(1)(e) only if the nature or

conduct of his defence is such as to undermine the co-defendant's defence.

(2) Only evidence—

(a) which is to be (or has been) adduced by the co-defendant, or

(b) which a witness is to be invited to give (or has given) in cross-examination by the co-defendant, is admissible under section 101(1)(e)."

The purposes of sub-section (f), however, are a little more complex than those of sub-section (e). According to Section 105 of the *Criminal Justice Act (2003)*, the defendant will be deemed to have given a false impression if he/she makes an express or implied assertion that would either mislead the jury and/or give the jury a false impression of the defendant. This is unless the defendant were to withdraw the assertion or to disassociate his/her self from the false impression. An example of a defendant creating a false impression of themselves would be if the defendant were to suggest that they were of good character, such as someone who does not or would not commit illegal acts, but had already been convicted of a criminal offence.

As can be seen above, the Criminal Justice Act (2003) provides very clear guidelines as to how and when a defendant's criminal history can be disclosed to a jury. However, the way in which a defendant's criminal history can be used in civil court differs considerably to criminal court. The reason for is that the purpose of civil court is not to punish an individual for committing an alleged act, as is the case in criminal court when an individual commits a criminal offence. The purpose of civil court is instead to compensate an individual should another person(s) or organization cause the claimant damages, as specified in law (Judiciary, 2018). Furthermore, in civil cases, a legally qualified judge is presiding over the proceedings who makes decisions on matters of law, such as whether a piece of evidence is admissible or not. The judge is also

responsible for deciding the outcome of the case, such as whether the defendant is liable for any damages and what those damages are (Judiciary, 2018). Thus, a defendant's criminal history can be used in two possible ways: firstly, to convince a judge that, on the 'balance of probabilities', the defendant is likely to have committed the alleged act (presupposing that the illegal act committed by the defendant is not the reason why the claimant is seeking damages). Secondly, if the illegal act committed by the defendant is the reason why the claimant is seeking damages, the defendant's criminal conviction could therefore be presented to judge as evidence that the defendant committed the act to which the claimant is seeking damages for.

In terms of the former, due to the requirement that both parties disclose any relevant information to the other party, as outlined in Section 31.5 of the *Civil Procedure Rules (1998)*, a defendant's, or claimant's, criminal history would need to be disclosed if relevant. If either side were to then to present the other sides criminal conviction to the presiding judge, the judge would decide what weight to attach to this information when making his/her ruling. In terms of the latter, however, the law is not as clear cut. The case of *Hollington v F. Hewthorn & Co Ltd [1943] KB 587* established the precedent that findings of other courts or tribunals are not admissible in other proceedings, regardless of whether the standard of proof is higher in the original proceedings. However, an exception to this rule was created in Section 11 of the *Civil Evidence Act (1968)*, which states:

> *"(1) In any civil proceedings the fact that a person has been convicted of an offence by or before any court in the United Kingdom of a service offence (anywhere) shall (subject to subsection (3) below) be admissible in evidence for the purpose of proving, where to do so is relevant to any issue in those proceedings, that he committed that offence, whether he was so convicted upon a plea of guilty or otherwise and whether or not he is a party to the civil*

proceedings; but no conviction other than a subsisting one shall be admissible in evidence by virtue of this section.

(2) In any civil proceedings in which by virtue of this section a person is proved to have been convicted of an offence by or before any court in the United Kingdom or of a service offence—

> *(a) he shall be taken to have committed that offence unless the contrary is proved; and*
>
> *(b) without prejudice to the reception of any other admissible evidence for the purpose of identifying the facts on which the conviction was based, the contents of any document which is admissible as evidence of the conviction, and the contents of the information, complaint, indictment or charge-sheet on which the person in question was convicted, shall be admissible in evidence for that purpose.*

(3) Nothing in this section shall prejudice the operation of section 13 of this Act or any other enactment whereby a conviction or a finding of fact in any criminal proceedings is for the purposes of any other proceedings made conclusive evidence of any fact.

(4) Where in any civil proceedings the contents of any document are admissible in evidence by virtue of subsection (2) above, a copy of that document, or of the material part thereof, purporting to be certified or otherwise authenticated by or on behalf of the court or authority having custody of that document shall be admissible in evidence and shall be taken to be a true copy of that document or part unless the contrary is shown."

What the above quote means is that, rather than a civil case concluding in favour of the claimant upon proof being shown that the defendant(s)

was convicted of the criminal offence in question, the burden of proof simply shifts from the claimant to the defendant. The defendant will then be required to prove that, on the 'balance of probabilities, he/she did not commit the criminal offence(s) in question'. Put simply, the defendant has the opportunity to disprove the findings of the Criminal Court. Yet, this is potentially very difficult to prove due to the significantly higher standard of proof in criminal cases. Nonetheless, the reason for the burden of proof shifting to the defendant, rather than the civil case simply concluding in the claimant's favour, is to ensure that the presiding judge is not bound by the findings of another court. This is to ensure that there is not a miscarriage of justice as outlined in *Hollington v E Hewthorn and Co [1943].* An example of a miscarriage of justice occurring in this situation would be if a defendant were to have pled guilty to a criminal offence, despite the defendant not having committed the offence, due to lack of evidence to the contrary. The reason this is of importance is because:

> "You can appeal against your conviction, sentence or both if you pleaded not guilty at your trial.
>
> If you pleaded guilty, you can only appeal against your sentence."
>
> (Crown, 2018)

Thus, even if new information were to come to light, the defendant would not be able to get the criminal conviction overturned if he/she pled guilty. Therefore, if a civil court were bound by the findings of a criminal court, the judge would have no option but to rule in favour of the claimant despite the defendant not having committed the offence.

In terms of the NMC, even if there has been a potential miscarriage of justice in the criminal court (and the registrant has maintained their innocence) the panel are not to take this into consideration, as stated in Rule 31 (2) of the *NMC (fitness-to-practise) Rules (2004)*:

> "(2) Where a registrant has been convicted of a criminal offence:
>
> > (a) a copy of the certificate of conviction, certified by a competent officer of a Court in the United Kingdom (or, in Scotland, an extract conviction) shall be conclusive proof of the conviction; and
> >
> > (b) the findings of fact upon which the conviction is based shall be admissible as proof of those facts.
>
> (3) The only evidence which may be adduced by the registrant in rebuttal of a conviction certified or extracted in accordance with paragraph (2) (a) is evidence for the purpose of proving that she is not the person referred to in the certificate or extract."

This directly disadvantages the registrant due to the registrant having no defence to a criminal conviction, even if the conviction has become spent under the Rehabilitation of Offenders Act (1974). On the other hand, there have been examples in my data, such as in the case of Gilmour, where the registrant gave detailed information about extenuating circumstances surrounding the offence. Nevertheless, an example of a past criminal conviction being disclosed to the panel can be seen in the case of Ofili whose case was observed as part of this research. Ofili was a male nurse accused of plagiarising two essays, one of which was for a Clinical Skills module. During the Fact-Finding stage, the NMC case presenter revealed to the panel that Ofili had previously been convicted of passport forgery in the early 2000s. In this case, Ofili was found to have committed the aforementioned plagiarism and was issued with a 6 months suspension order, although the panel did not make any direct reference to the past criminal conviction in the official hearing document. The disclosure of findings of other courts and/or tribunals in NMC FtP hearings does not end here. Under Rule 31 (4) of the *NMC (fitness-to-practise) Rules (2004)*:

> "(4) A certificate as to a determination about a registrant's fitness to practise made by –
>
> > (a) a body in the United Kingdom responsible under any enactment for the regulation of a health or social care profession; or
> >
> > (b) a licensing body elsewhere,
>
> signed by an officer authorised by the body to sign such certificates shall be admissible as prima facie evidence of the facts referred to in the determination."

The effect(s) of Rule 31 (4) on a registrant's case is not as straight forward as criminal convictions. Unlike in previous examples, the findings of another regulatory body/tribunal do not necessarily disadvantage a registrant. Neither is there any inherent disadvantage for registrants who are either absent, unrepresented or represented by non-legally qualified representatives beyond those already mentioned. The reason for this is that the findings of another regulatory body/tribunal could strengthen the NMC's case were the other regulatory body/tribunal to have found that the registrant committed misconduct and their conduct is currently impaired. However, if the other regulatory body/tribunal were to have found that the registrant had *not* committed misconduct and/or that their conduct is *not* currently impaired, this could strengthen the registrant's case.

An example of the latter occurred in the case of Peck whose case observed as part of this research. Peck was a male nurse accused of, amongst other things, smacking a female colleague on the buttocks during workplace banter. Peck, who had plead guilty to a reduced charge of assault by beating (Peck had originally been charged with sexual assault), had already undergone a FtP hearing held by the Welsh Care Council (now Social Care Wales). This regulatory body had issued Peck with a warning that he be mindful of his personal conduct in relation to other members of staff but found that Peck's conduct was not currently

impaired. The panel in Peck's NMC FtP hearing also found that, whilst Peck had committed misconduct, he had sufficiently remediated, thus the panel found that Peck's conduct was not currently impaired. Although the panel made no direct reference to being influenced by the findings of the other regulatory body, Peck's case serves as an example of where the disclosure of another regulatory body's/tribunal's findings could potentially assist the registrant. This is because, were the NMC FtP panel to come to a different finding, it would put the NMC at odds with the other regulatory body.

4.6: No Case to Answer

In terms of criminal court, once the prosecution has finished outlining their case against a defendant, the defendant can make an application to the judge arguing that there is 'no case to answer' due to insufficient evidence, as outlined in *R v Galbraith [1981] 2 All ER 1060*:

> "(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.
>
> (2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence.
>
> (a) Where the judge comes to the conclusion that the Crown's evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on a submission being made, to stop the case.
>
> (b) Where however the Crown's evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there *is* evidence on which a jury could properly come to the conclusion that the defendant is

> guilty, then the judge should allow the matter to be tried by the jury.
>
> There will of course, as always in this branch of the law, be borderline cases. They can safely be left to the discretion of the judge."

Furthermore, the standard of evidence is much higher in criminal court than in civil court, that is, beyond reasonable doubt compared to the balance of probability (Dyson and Randall, 2015). There is therefore more chance that applications for there being insufficient evidence are more likely to be successful in criminal court. However, due to the different purposes of criminal and civil court, whilst civil court judges do have the power to strike out a statement of case based on there being insufficient evidence, the test used in civil court differs considerably from the test used in criminal court. This test is outlined in Section 3.4 of the Civil Procedure Rules (1998) which states the following:

> "(1) In this rule and rule 3.5, reference to a statement of case includes reference to part of a statement of case.
>
> (2) The court may strike out a statement of case if it appears to the court—
>
> > (a) that the statement of case discloses no reasonable grounds for bringing or defending the claim;
> >
> > (b) that the statement of case is an abuse of the court's process or is otherwise likely to obstruct the just disposal of the proceedings; or
> >
> > (c) that there has been a to comply with a rule, practice direction or court order."

Section 3.4 of the *Civil Procedure Rules (1998)* is also supplemented failure by Practice Direction 3A of the *Civil Procedure Rules (1998)*, namely, amongst others, Sections 1.4, 1.5 and 1.6, which state:

> "1.4 The following are examples of cases where the court may conclude that particulars of claim (whether contained in a claim form or filed separately) fall within rule 3.4(2)(a):
>
> > (1) those which set out no facts indicating what the claim is about, for example 'Money owed £5000',
> >
> > (2) those which are incoherent and make no sense,
> >
> > (3) those which contain a coherent set of facts but those facts, even if true, do not disclose any legally recognisable claim against the defendant.
>
> 1.5 A claim may fall within rule 3.4(2)(b) where it is vexatious, scurrilous or obviously ill-founded.
>
> 1.6 A defence may fall within rule 3.4(2)(a) where:
>
> > (1) it consists of a bare denial or otherwise sets out no coherent statement of facts, or
> >
> > (2) the facts it sets out, while coherent, would not even if true amount in law to a defence to the claim."

As can be seen above, there are clear rules and guidelines governing both criminal court and civil court. However, unlike in previous examples, Rule 24 (7) of the *NMC (fitness-to-practise) Rules (2004)* mimics the wording of the criminal court test more so than the one for civil court:

> "(7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and—
>
> > (i) either upon the application of the registrant, or
> >
> > (ii) of its own volition,
> >
> > the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a

determination as to whether the registrant has a case to answer.

(8) Where an allegation is of a kind referred to in article 22(1)(a) of the Order, the Committee may decide, —

(i) either upon the application of the registrant, or

(ii) of its own volition,

to hear submissions from the parties as to whether sufficient evidence has been presented to support a finding of impairment, and shall make a determination as to whether the registrant has a case to answer as to her alleged impairment."

Yet, in saying this, there are still important differences between Rule 24 (7) of the *NMC (fitness-to-practise) Rules (2004)* and the test outlined in *R v Galbraith (1981)*. The fact that the panel can, on its own volition, demand to hear submissions from the NMC and the registrant on whether there is a case to answer for differs from criminal court. This is because in civil court a defendant must make an application before the judge can consider whether there is a case to answer for. However, in civil court the presiding judge does have the power to strike out a statement of case without the need for an application from either the claimant or the defendant. This demonstrates how the quasi-legal nature of the *NMC (fitness-to-practise) Rules (2004)* utilizes elements from both criminal and civil court. Furthermore, the fact that the panel can utilize Rule 24 (7) in the *NMC (fitness-to-practise) Rules (2004)* either as a result of an application or by its own motion, could be seen as benefiting registrants, particularly those who are absent and/or unrepresented. This is because the panel can dismiss any or all of the charges should they deem that there is no case to answer due to insufficient evidence. However, Rule 32 (4) of the *NMC (fitness-to-practise) Rules (2004)* states that the panel must keep in mind that there is a public interest in

the expeditious disposal of a case, albeit in relation to postponements and adjournments:

> "(4) In considering whether or not to grant a request for postponement or adjournment, the Chair or Practice Committee shall, amongst other matters, have regard to —
>
> > (a) the public interest in the expeditious disposal of the case;
> >
> > (b) the potential inconvenience caused to a party or any witnesses to be called by that party; and
> >
> > (c) fairness to the registrant."

An adjournment is where the hearing is interrupted part way through the case, for example, the hearing being adjourned so that all parties could take a lunch break or the hearing went part-heard so was adjourned to a later date. A postponement, on the other hand, is where the panel decides to delay the case from starting so the hearing is postponed to a later date and will be heard by a different panel from the same committee (CCC or HC) (NMC, 2012b). The fact that the NMC state that there is a public interest in minimising the use of adjournments or, in other words, concluding the hearing in as little time as possible, suggests that Rule 24 (7) (i) of the *NMC (fitness-to-practise) Rules (2004)* may be there to comply with Rule 32 (4) (a) (which is quoted above) rather than to assist absent and/or unrepresented registrants.

There have also been examples in my data where the panel have sought to assist unrepresented registrants when making applications of there being 'no case to answer', with one example being in the case of Tregay whose case was observed as part of this research. Tregay was an unrepresented male nurse accused of 'pushing' an elderly patient to the floor. Along with offering Tregay additional time to formulate his submission, the chair informed Tregay that he had been having a "legal chit-chat" with the Legal Assessor and suggested that, were the NMC case presenter not to object (which he did not), Tregay could make his

submission last. This is because the individual who is making the application is normally the one to go first as specified by the *NMC (fitness-to-practise) Rules (2004).* The chair did not state why it was legally possible to change the order of the submissions, however, it may be due to Rule 24 (7) of the *NMC (fitness-to-practise) Rules (2004).* The rules states that the panel have to hear submissions from both parties, without specifying the order in which the submissions should be made. This example demonstrates how the panel seek to assist unrepresented registrants by utilizing the quasi-legal nature of NMC FtP hearings.

Furthermore, whilst the chair did not state the reason why he thought it would be beneficial for Tregay to go last, were Tregay to have taken up the chair's offer (Tregay did not), Tregay would have been able to hear what laws and rules the NMC case presenter was citing and thus respond to them. Where as if he (Tregay) went last, he would not be able to make a second submission covering any additional points other than those pertaining to the NMC case presenter's submission. Nevertheless, Tregay declined this offer as well, stating that he wanted to make his submission "…the right way". Tregay's application was partially successful in that he managed to get all but one charge dropped. However, it is important to note that all three members of the panel heavily questioned the NMC case presenter during his submission in an almost critical manner, which was not altogether uncommon. This was evidenced by the panel rarely intervening in Tregay's submissions but consistently challenging the NMC case presenter on points that he was making in his submission in a similar way to that of a legally qualified representative. Whereas, in the normal course of events, were a registrant to be represented by a legally qualified individual, the representative would typically challenge such points either during or after the NMC case presenter had made their submission. Whilst this did not occur in the case of Pinto, which was the only other case in my observational sample where a nurse was present but unrepresented (although it is important to note that Pinto admitted to all of the charges), the panel did make considerable allowances for Pinto due to him being

unrepresented. This included the panel allowing Pinto to introduce live witness testimony without the NMC's prior knowledge as well as allowing Pinto considerable extra-time to collect evidence.

Furthermore, in the case of O'Brien, who was an unrepresented female nurse accused of attending work whilst under the influence of alcohol in my observation sample, the panel argued at length with the NMC case over points of law pertaining to the charges. In the cases of Badjie and McGill, both of whom were male nurses in my observational sample who were absent and unrepresented (*see* Appendix D), the Legal Assessors also challenged the NMC multiple times on points of law. Although the Legal Assessor in case of McGill did not state the reason why he challenged the NMC case presenter on points of law, in the case of Badjie the Legal Assessor stated that it was because "…the registrant [Badjie] is not present". This therefore suggests that both NMC FtP panels and the Legal Assessors tasked with assisting them are willing to take on functions that would have otherwise been carried out by a legally qualified representative in order to aid a registrant who is either absent or unrepresented.

However, in both of the cases in my observational sample where the registrant was represented by a non-legally qualified representative (Akinbote and Warren; *see* Appendix D), neither the panels nor the Legal Assessors took on any additional functions that a legally qualified representative would normally carry out. For example, neither of the panels, nor the Legal Assessors, actively challenged the NMC case presenter on points of law during their submissions. However, both of the panels and the Legal Assessors did explain the processes and the law pertaining to the hearing in considerable detail to the non-legally qualified representatives and allowed them extra time to formulate submissions.

This, again, highlights how the panel can utilize the quasi-legal nature of the *NMC (fitness-to-practise) Rules (2004)* to address the disadvantage faced by unrepresented registrants or registrants represented by non-

legally qualified individuals. That is not to say, however, that it is necessarily easy to successfully persuade a panel that there is no case to answer based on insufficient evidence relating to a given charge(s). An example of the difficulty in persuading the panel that there is no case to answer for in relation to a given charge can be seen in the case of Gilmour whose case was observed as part of my research. Gilmour was a female nurse convicted of driving with excess alcohol and accused of intentionally concealing the conviction from her employer. During the Fact-Finding stage Gilmour's legally qualified representative attempted to persuade the panel that there was insufficient evidence pertaining to the following charges:

> "4. On or about [date]:
>
> > (a) did not inform your employer and/or Line Manager that you had been convicted of drink driving until confronted about this;
> >
> > (b) told your employer that you had a mechanical issue with your car and were stopped for a random check by the Police, or words to that effect.
>
> 5. Your actions at charge 3(a) and/or 4(a) were dishonest in that you:
>
> > (a) knew that you were required to report such matters to your Line Manager and/or employer but failed to do so;
> >
> > (b) attempted to conceal your arrest and/or charge and/or conviction from your employer
>
> 6. Your actions at charge 3(b) and/or 4(b) were dishonest in that:
>
> > (a) the information you provided was not true; and/or

> (b) you were attempting to conceal your arrest and/or charge and/or conviction from your employer”

Whilst Gilmour’s representative was able to have one of the charges dismissed, the panel still found that there was a case to answer for the remaining charges, as can be seen below:

> “In considering 5a the panel noted that you are an experienced and competent nurse, and you must have known that you were under a duty to disclose the incident to your employer and you failed to do so. The panel considered that, at this stage the evidence suggests that your failure to disclose the incident indicates an element of dishonesty in your actions and therefore finds a case to answer in relation to 5a.
>
> The panel considered that the wording of Charge 5b suggests a positive action made by you in an attempt to conceal your conviction. The panel considered that your failure to disclose was not sufficient to indicate that you had actively tried to conceal. The panel noted that both witnesses conceded that your responses in relation to the mechanical issue was an attempt to explain the incident rather than an attempt to mislead, and that you never denied the conviction. Accordingly, the panel finds no case to answer in respect of 5b.”

Nevertheless, although Gilmour was found to have committed some of the acts outlined in the charges, the panel decided that she did not intentionally conceal the driving conviction from her employer, resulting in Gilmour only being issued with a Caution Order. The reason why Gilmour could have received a more severe sanction is that misconduct involving dishonesty is a serious offence in NMC FtP hearings (NMC, 2017i). Even so, the fact that Gilmour still had a number of charges to

answer demonstrates that such applications are not easy to succeed in for a number of reasons.

Firstly, as the standard of proof used in NMC FtP hearings is the civil standard, 'the balance of probabilities' (Dyson and Randall, 2015), it means that even a small amount of evidence is enough to demonstrate that there is a case to answer. This differs from criminal court where a judge can dismiss a case not only when there is *no* evidence, but also if there is not *enough* evidence for a jury to be able to properly convict as established in *R v Galbraith [1981]*. This is further exacerbated by the fact that evidence that would be inadmissible in a criminal or civil court can be used in NMC FtP hearings under Rule 31 (1) of the *NMC (fitness-to-practise) Rules (2004)*, thus potentially giving the NMC a larger pool of evidence to demonstrate to the panel that there is a 'case to answer'. Equally, case law governing the use of evidence in NMC FtP hearings, such as *Professional Standards Authority v NMC and Jozi [2015] EWHC 764 (Admin)*, makes clear that the panel need to be more 'proactive' than a criminal court judge in their approach to ensuring that all evidence pertaining to a case is put before them.

This, coupled with the fact that there are no set timeframes regarding the disclosure of evidence under the *NMC (fitness-to-practise) Rules (2004)*, can cause further difficulty for the registrant when making applications of there being no case to answer. The reason for this is that the registrant may not have sufficient time to obtain, or retain, evidence that contradicts a new piece evidence that has been introduced. For example, a witness may be claiming that the registrant was in a certain location, however, as the registrant was not aware the witness would be giving evidence, they (the registrant) may have disposed of evidence, such as a receipt, which would have demonstrated that the registrant was in a different location. If this new piece of evidence was the primary or sole piece of evidence for a given charge (which can be changed at any time prior to hearing), the notice given of disclosure could make the difference between being able to successfully, or unsuccessfully, argue that there is no case to answer.

Finally, there is also no rule specifying that, after a given period of time, the panel should attach less weight to a previous criminal conviction (even convictions obtained prior to the registrant becoming a nurse). This means that the conviction could be used to support otherwise tenuous evidence, which would have been insufficient for a given charge. These examples, again, support the argument that, although many panels seek to alleviate the disadvantage faced by unrepresented registrants or registrants represented by non-legally qualified individuals, the way in which the NMC Rules are constructed significantly disadvantages the registrant nonetheless. These disadvantages are potentially exacerbated when registrants seek to persuade a panel that there is insufficient evidence that their conduct is currently impaired. The reason for this is that, not only is there no standard of proof in the impairment stage, there is no definition as to what impairment actually is in law.

4.7: Conclusion

In conclusion, although the NMC recommend that nurses take legal advice prior to representing themselves (NMC, 2017s), it is also made clear to registrants that they should engage with the NMC FtP process even in the event that they do not have legally qualified representation. This is encouraged both explicitly in the information that the NMC provide to registrants and through the quasi-legal nature of the NMC FtP process with its inherent flexibility. However, this flexibility can in fact make it more difficult for unrepresented registrants to defend themselves due to many of the rules and/or guidelines governing the NMC FtP process being open to interpretation. Nevertheless, NMC FtP panels do appear to try and assist unrepresented registrants in order to reduce the disadvantage that they face by not having legally qualified representation. However, even when registrants have legally qualified representation, they are still at a considerable disadvantage in comparison to the NMC due to the way in which the *NMC (fitness-to-practise) Rules (2004)* have been drafted. With this in mind, we will now

move on to the next chapter, which will analyse the role that remediation plays in both the finding of impairment and the resultant sanctions.

Chapter 5:
An Analysis of the Role of Misconduct and Remediation in NMC FtP Hearings

"Is there a set way to show remorse?"

Legally Qualified Representative, Case of Ofili

5.1: Introduction

This chapter will analyse the role of misconduct in NMC FtP hearings, along with the gendered differences in the types of misconduct committed by male and female nurses. This chapter will also analyse the role that these events and/or mechanisms play in the aforementioned statistic of how male nurses are twice as likely to be referred to the NMC, and more than three times more likely to be struck-off as a result (NMC, 2017b). This chapter will therefore begin by discussing the definition of misconduct, the way in which it is utilized by the NMC in NMC FtP hearings, along with the gendered nature of it. This chapter will then discuss both proficiency-related misconduct and conduct-related misconduct and the issues concerning the remediation of the different types of misconduct. This chapter will therefore provide a foundation for the following chapter which analysis the role of remediation and the autonomy that the panel possess when assessing whether a registrant has successfully remediated their misconduct.

5.2: Definition of Misconduct

Prior to assessing whether the registrant's conduct is impaired, the panel must first determine whether the registrant has committed misconduct as specified by the *Nursing and Midwifery Order (2001)*. Unlike the fact-finding stage, there is no burden or standard of proof in the Misconduct, Impairment and Sanction stages. An example of there being no burden or standing of proof during these stages can be seen in the following

statement from the official hearing document produced by the panel in the case of Cimbacruz who was a female mental health nurse whose case was analysed as part of my documentary analysis sample. Cimbacruz was a female nurse who was accused of forcibly administering oral medication to a dementia patient against their will as well as deliberately, and dishonestly, recording incorrect observations. In the following quote from the official hearing document, the panel make reference to the fact that there is no standard or burden of proof during the Misconduct, Impairment and Sanction stages:

> "Having announced it's finding on the facts, the panel then moved on to consider, whether the facts found proved amounted to misconduct and if so whether your fitness to practise is currently impaired…
>
> The panel, in reaching its decision, accepted that there was no burden or standard of proof at this stage and exercised its own judgement."

Yet, unlike terms such as 'negligence', which have a specific legal meaning (as outlined in *Donoghue v Stevenson [1932] AC 562*) misconduct for the purposes of professional regulation is deemed as a word of 'general effect'. This can be seen in *Roylance v GMC (No. 2) [2000] 1 AC 311* which states:

> "…misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances."

This definition is extremely broad and very subjective as what one panel may see as 'misconduct' another panel may see as an 'error of judgement', the latter of which will be discussed in due course. Nevertheless, the NMC have created a Code of Conduct for Nurses which is updated periodically, thus if a nurse breaches any sections of the NMC Code (NMC, 2004; 2008; 2015), it could be deemed as misconduct.

However, before discussing the various sections of the NMC Code (NMC, 2004; 2008; 2015) in more detail, I will briefly discuss the role that the NMC Code (NMC, 2004; 2008; 2015) plays in relation to the NMC as a professional group. When looking at professional groups, Moran has argued that:

> "Regulation characteristically involves 'closure': restricting entry to markets, and limiting competition between those already in the market, in order to limit the destructive effects of competition on established interest"
>
> (Moran, 1999: 99)

This 'closure' of the market or, in other words, the restriction on others performing tasks that are carried out by a specific profession or group of people has meant that there is a tension between the professional and the general public who rely upon the services provided. Frankel (1989) has argued that this tension between a professional group's desire for autonomy and the general public's demand for accountability has led to the formulation of professional codes of practice. Due to the nature of nursing and the history of the nursing profession, much of the NMC Code (NMC, 2004; 2008; 2015) not only focuses on clinical conduct and competence but also what has often been referred to as 'soft skills', such as treating patients with 'care' and 'compassion'. Such traits are both highly subjective and are closely linked with social morality. This element of social morality can be seen as relating to Durkheim's ([1893] 1984) original work on collective solidarity and how social norms and morals help to both define a group and maintain collective solidarity amongst its members. Thus, it could be argued that the nursing profession is based upon its shared values, which are espoused in the NMC Code (NMC, 2004; 2008; 2015).

In the last fifteen years, there have been three iterations of the NMC Code (NMC, 2004; 2008; 2015), which are as follows:

Valid to	Code Name

November (2004) to May (2008)	*The NMC Code of Professional Conduct: Standards for Conduct, Performance and Ethics*
May (2008) to March (2015)	*The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives*
March (2015) to Present	*The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives.*

Whilst the majority of cases in my documentary analysis sample (fifty-six cases) were covered solely by the 2008 edition of the NMC Code (NMC, 2008), there were also eleven cases which were covered solely by the 2015 Edition of the NMC Code (NMC, 2015). Furthermore, there were an additional two cases in my documentary analysis sample where some of the charges were covered by both the 2004 and 2008 Editions of the NMC Code (NMC, 2004; 2008). Finally, there were two cases where some of the charges were covered by both 2008 and 2015 Edition of the NMC Code (NMC, 2008; 2015). The version of the NMC Code (NMC, 2004; 2008; 2015) which applies to a given case depends solely on when historically the actions contained within charges occurred.

Before we continue, however, it is important to outline the difference between misconduct and 'error(s) of judgement'. Again, however, there is no statutory definition or case law that defines the difference between 'misconduct' and an 'error of judgement'. There have been examples in my data where a panel has decided that specific acts committed by a registrant were errors of judgement rather than misconduct. An example of an act being deemed as an error of judgement can be seen in the case of Boodhoo whose case was analysed as part of my documentary analysis sample. Boodhoo was a male nurse accused of, amongst other things, not escalating thefts from the home to the Care Quality Commission and other bodies. In the official hearing document, the panel state that the acts contained within one of the charges were

deemed to be errors of judgement rather than misconduct, as can be seen in the following quote:

> “As to Charge 4, the panel considered that you had a responsibility to escalate thefts in the Home to Safeguarding and the CQC, which you have now accepted (and have taken full responsibility for.) However, the panel has found that you did report matters to the police and Head Office and therefore considered that the failure to escalate the thefts to Safeguarding and the CQC [Care Quality Commission] were an error of judgment on your part. The panel determined that this charge on its own was not sufficiently serious to amount to misconduct.”

Although the panel did not state the reason why they believed that Boodhoo’s decision not to notify the Safeguarding team and/or the CQC was an ‘error of judgement’ rather than an act of misconduct, this example does possibly suggest that the panel are looking at the mindset of the registrant. In this particular case, the panel make clear that Boodhoo’s actions show that he did intend to draw the thefts to the attention of external bodies rather than cover the thefts up. This argument is supported by the fact that the NMC state that NMC FtP panels need to consider the mindset of the registrant when assessing cases involving dishonesty, as can be seen in the quote below:

> “When making decisions on charges involving dishonesty, panels of the Fitness to Practise Committee look at whether or not the conduct took place, and if so, with what state of mind. Any dispute over whether a nurse or midwife behaved dishonestly usually means that the panel’s findings will depend on what conclusions they can draw about the nurse or midwife’s state of mind from the basic facts.”
>
> (NMC, 2017q)

This links with the legal concept of *mens rea*, which is the defendant's knowledge of wrongdoing that comprises part of the offence (Loveless, 2016). It is also important to keep in mind that misconduct can result from of an individual act or be the result of multiple acts which individually would not be considered misconduct, but taken in aggregate, amount to misconduct. An example of aggregate misconduct can be seen in the case of Cochlin who was a male general nurse whose case was analysed as part of my documentary analysis sample. Cochlin was a female nurse accused of, amongst other things, not carrying out observations of a patient. In the following quote taken from the official hearing document, the panel high how some of the acts committed did not amount to misconduct individually but taken in aggregate do result in misconduct:

> "The panel found that the omissions outlined in Charges 1, 2 and 4, taken individually fall short of good practice but, on their own, do not amount to serious misconduct… However, the panel found that the acts and omissions outlined in charges 1, 2 and 4 were serious failures in good nursing practice and in aggregate amounted to misconduct."

As can be seen in the above quote, the panel clearly take the view that it was the misconduct in aggregate that led to Cochlin's impaired practice rather than an individual offence reaching the threshold for impaired practice. However, there are issues with the concept of misconduct in aggregate, which will now be discussed.

5.3: Misconduct, Fishing Expeditions and Delays

As mentioned above, NMC FtP panels do have the option to find that a registrant has committed misconduct on the grounds that the registrant has committed multiple acts that, individually, would not amount to misconduct, but taken in aggregate do amount to misconduct. During both the observations and documentary analysis, it became apparent that the NMC often accumulate a large number of charges over a significant period of time. An example of a possible fishing expedition

can be seen in the following charges against Nahoor who was a male dual qualified mental health and learning disabilities nurse whose case was analysed as part of my documentary analysis sample (who had charges against him dating back as far as 2005):

> 1. On 5 September 2014 when dispensing take-home medication to Patient A:
>
> > *a.* Incorrectly dispensed from the ward stock. ***PROVED BY ADMISSION***
> >
> > b. Incorrectly gave the patient a seven day supply of medication.
> >
> > ***NOT PROVED***
> >
> > *c.* Failed to get another registered person to check and/or counter sign the dispensing. ***PROVED BY ADMISSION***
>
> 2. On one or more occasions in around September 2014, you acted inappropriately in that you:
>
> > *a.* Physically cornered Colleague A. ***PROVED***
> >
> > *b.* Made inappropriate comments of a sexual nature about a patient. ***PROVED***
> >
> > *c.* Obtained Colleague A's mobile telephone number from the staff contacts book and telephoned her when you were not at work. ***PROVED***
>
> 3. On an unknown date in September 2014 in respect of Patient B:
>
> > *a.* Acted contrary to Patient B's care plan by allowing her to be in her room unsupervised following mealtime. ***PROVED***
> >
> > *b.* Failed to conduct a risk assessment when allowing Patient B in her room unsupervised. ***NOT PROVED***

4. On one or more occasion in respect of Patient C:

a. Incorrectly recorded Patient C's weight. ***PROVED***

b. Your actions at charge 4a above were dishonest in that you falsified Patient C's weight to make it appear as though she was engaging with her treatment. ***PROVED***

c. Advised Patient C how to water load / tank up so that she appeared as though she had gained weight. ***NOT PROVED***

d. Your actions at charge 4c above were dishonest in that you were assisting Patient C to appear as though she was engaging with her treatment. ***NOT PROVED***

e. Failed to check Patient C's bags upon return from home leave. ***NOT PROVED***

f. Inappropriately gave Patient C a razor blade. ***NOT PROVED***

g. Administered medication without it being prescribed. ***NOT PROVED***

h. On an unknown date advised Patient C that she could conceal her evening snack in her pocket. ***NOT PROVED***

i. On an unknown date in August 2014 failed to respond appropriately to signs of Patient C's self-harming. ***PROVED***

j. On an unknown date in August 2014 stated to Patient C that you would incorrectly record her time out sheet. ***PROVED***

k. On an unknown date in 2014, stated to Patient C that she could leave the unit by using the garden chairs to go over the fence. ***PROVED***

l. On an unknown date stated to Patient C that you would not tell anyone about the paracetamol you found in her possession. ***PROVED***

5. On one or more occasions breached your professional boundaries by:

a. On an unknown date in 2009 or 2010 gave Patient C your personal phone number. ***PROVED BY ADMISSION***

b. On an unknown date, telephoned Patient C when there was no clinical reason to do so. ***PROVED BY ADMISSION***

c. On an unknown date, asked Patient C to meet up with you outside of the unit. ***PROVED***

d. On various dates between approximately 2005 and 2014, engaged in inappropriate conversations with Patient C of a sexual nature. ***PROVED***

e. Said words to the effect of 'you owe me' to Patient C. ***PROVED***

Not only do some of the charges date back to the years 2005 and 2009, there are also charges where the NMC state that the acts occurred on an 'unknown date'. The referrer in the case of Nahoor was not revealed by either the panel, the NMC or Nahoor's legally qualified representative. However, the length and breadth of these charges suggests that, upon receiving an allegation(s), the NMC can investigate and seek to prosecute as many charges as possible, even if they are unsure of the date the offences occurred on. Furthermore, the fact that some of the charge(s) date back to 2005 and 2009 suggest that the NMC discovered the alleged misconduct when carrying out a retrospective assessment of Nahoor's practice rather than waiting between seven to eleven years to prosecute said allegations. This in turn could be described as engaging in a 'fishing expedition' where the NMC seek to find further charges beyond just the first allegation. Whilst the NMC have not stated that they

seek to prosecute as many charges as possible to ensure that there is a finding of misconduct (whether it be individually or in aggregate), the variety of the above charges and the lack of specificity about when the acts occurred illustrates an attempt to build a significant aggregate case for misconduct and impairment.

However, that is not the only issue present in cases such as Nahoor. Another key issue, or event, is the length of time between the NMC becoming aware of the allegations and the date of the hearing and the effect that this has on witnesses' recollection. The NMC statistics for 2016-2017 state that on average seventy-five percent of cases were heard within fifteen months of the NMC becoming aware of the first allegation (NMC, 2017a). The above statistic, however, is extremely broad as it does not expound upon the length of time taken to organise Consensual Panel Determination (CPD) hearings and full Substantive Hearings. A CPD agreement is where the registrant and the NMC come to an agreement on the facts of the case, the misconduct committed, and the registrant's current impairment and the resultant sanction with the full range of sanctions available including Striking-Off Orders. This is then either accepted or rejected by an NMC FtP panel (NMC, 2016b). The reason why this of importance is that, in CPD cases, the registrant has admitted to the facts of the case. In Substantive Hearings, however, the NMC are required to prepare a case to present to the panel that proves that the acts outlined in the charges were committed by the registrant (if the registrant denies them). Following this, the NMC will then need to demonstrate to the panel that these acts amount of misconduct, that the registrant's conduct is impaired and that the registrant has not been able to fully remediated (NMC, 2012b). In my documentary analysis sample, the average length of time in both Substantive Hearings and CPD hearings was between two to four years, as can be seen in the two tables below:

<u>Length of Time since Earliest Charge and a Full Substantive Hearing in the Documentary Analysis Sample</u>

0-1 years	1-2 years	2-3 years	3-4 years	4-5 years	5+ years
0 nurses	13 nurses	20 nurses	11 nurses	3 nurses	6 nurses

Length of Time since Earliest Charge and CPD hearing in the Documentary Analysis Sample

0-1years	1-2 years	2-3 years	3-4 years	4-5 years	5+ years
1 nurse	5 nurses	8 nurses	1 nurse	3 nurses	0 nurses

As can be seen above, there are often considerable time periods between the earliest dated charge and the full Substantive Hearing or CPD hearing. It could be argued that because CPD cases are an agreement between the NMC and the registrant, the length of time it takes to hear the case is not such a pressing issue. However, the time delay could potentially have a detrimental effect on cases referred for a full Substantive Hearing. One particular issue pertaining to the time it takes to hold a full Substantive Hearing is that witnesses, including the registrant, may struggle recalling the events. It could also be argued that if there is a significant period of time between the alleged act and the full Substantive Hearing, it could be difficult to demonstrate insight and remorse when an individual cannot recall the details of all, or part of, the alleged act.

5.4: Misconduct not covered by the NMC Code

So far this chapter has analysed what constitutes misconduct, however, there are cases where a registrant is found to have committed misconduct even when the acts committed by the registrant are not covered by the NMC Code (2008). A key example of a case where the acts committed were not covered by the NMC Code can be seen in the case of Benyu who was a female mental health nurse whose case was analysed as part of my documentary analysis sample. Benyu was both a qualified nurse and solicitor who worked as a Mental Health

Commissioner and a solicitor in private practice, who was charged with (by the NMC), and who admitted to, being struck-off the Roll of Solicitors. Whilst working as a solicitor in private practice, Benyu, amongst other things, withdrew over £300, 000 from several vulnerable clients' accounts and used the monies as "cash flow" for the solicitor's practice, all of which resulted in Benyu being struck-off the Roll of Solicitors. Although Benyu's actions were not covered by the NMC Code (2008), the panel still found that Benyu had committed misconduct. The panel found that Benyu had violated Paragraph 61 of the 2008 Edition of the NMC Code (NMC, 2008), which states that a nurse '…must uphold the reputation of your [their] profession at all times'. The panels reasoning can be seen in the following quote from the official hearing document for Benyu:

> "You breached paragraph 61 of the NMC Code, in that by not being honest and by not acting with integrity, albeit in your capacity as a solicitor, you failed to uphold the reputation of the nursing profession in which you were jointly qualified and practised concurrently. This would mean that people in your care as a nurse would not be able to trust you with their health and wellbeing which is a fundamental tenet of the nursing profession.
>
> The panel noted that misconduct was not defined in the applicable statutory framework governing the regulatory process of the NMC.
>
> The panel was satisfied that your conduct fell far below what would be expected from a registered nurse and represented a serious departure from the standards expected, whether contained within the Code or not…
>
> The panel therefore found that in being struck off the Roll of Solicitors you did fall seriously short of the conduct and standards expected of a nurse and that amounted to misconduct [own emphasis]"

As can be seen above, the panel clearly acknowledge that Benyu's misconduct was not covered by the 2008 Edition of the NMC Code (NMC, 2008) when they state that Benyu's actions amounted to misconduct "whether contained within the [2008 NMC] Code or not". The use of Paragraph 61, which was the only section of the 2008 Edition of the NMC Code (NMC, 2008) that the panel found Benyu had broken, also demonstrates the flexibility that the panel possess when making decisions on misconduct and impairment and the highly subjective nature of Paragraph 61. In fact, Paragraph 61 was the most commonly violated section of the NMC Code (2008; 2015), with thirty out of the forty-eight female nurses and sixteen out of the twenty-three male nurses in my documentary analysis sample being found to have violated this particular section. However, the purpose of Paragraph 61 will be discussed further in the following chapter.

There have also been cases where registrants have been found to have committed misconduct where they have not violated any section of the 2008 Edition of the NMC Code (NMC, 2008), including Paragraph 61. An example of this can be seen in the case of Whyte who was a female general nurse whose case was analysed as part of my documentary analysis sample. Whyte was a female nurse who was accused of, amongst other things, refusing to grant the NMC access to the documents pertaining to a censure she received from the Nursing and Midwifery Board of Ireland. A Censure is similar to an NMC Caution Order, although the Nursing and Midwifery Board of Ireland also have the option of imposing a fine of up to €2000 alongside the censure:

> "These sanctions demonstrate the Board's disapproval of the nurse or midwife's conduct and are a warning that this conduct should not occur again. The imposition of these sanctions may be appropriate in circumstances where the findings made against the nurse or midwife by the Committee are at the less serious end of the scale or at the lower end of the spectrum."

(Nursing and Midwifery Board of Ireland, 2018: 13)

Despite the 2008 Edition of the NMC Code (NMC, 2008) not having any provision stating that registrants are required to disclose any findings against them by other regulatory bodies, the panel still found that Whyte had committed misconduct. By not notifying the NMC of the aforementioned censure the panel stated that Whyte had committed misconduct on the following grounds:

> "…the provisions of the 2008 Code which, although they do not specifically refer to a duty to notify the NMC of findings by another regulator, make clear that registered nurses are required to be open and honest, and to act with integrity to uphold the reputation of the profession. It is clear to the panel that the importance of nurses being open, honest and acting with integrity are founding principles of the profession. The expectation is that a registered nurse will be proactive in disclosing information potentially relevant to their on-going registration and not to passively await action by some third party or body. In this case, you chose to return to practise in the UK, after a break of some three years following the 2011 incidents. Your return to practice coincided with the Irish Board's decision."

What the panel are referring to (when they say that "nurses are required to be open and honest, and to act with integrity to uphold the reputation of the profession") is the Preamble of the NMC Code (2008), which states:

> "**The people in your care must be able to trust you with their health and wellbeing**
>
> **To justify that trust, you must:**
>
> • make the care of people your first concern, treating them as individuals and respecting their dignity

• work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community

• provide a high standard of practice and care at all times

• be open and honest, act with integrity and uphold the reputation of your profession."

As can be seen above, the Preamble of the NMC Code (2008) is highly subjective with regards to what is required in order to be 'open and honest' so as to 'uphold the reputation of your profession'. In the case of Whyte, the panel utilised the Preamble to act in place of a clause that otherwise did not exist to allow for them to find that Whyte had committed misconduct. The ability to do this allows for a high degree of variability between the outcome of cases depending on the panel's preference, as illustrated in the previous chapter.

5.5: Gendered Violations of the NMC Code and the Subsequent Effects on Remediation

In addition to this, there also appears to be a gendered difference between the sections of the NMC Code (2008) that are broken by male and female nurses in my documentary analysis sample. For the purposes of clarity, I will now list the sections of the 2008 Edition of the NMC Code (NMC, 2008) that male and female nurses in my sample most commonly broke. The following sections of the 2008 Edition of the NMC Code (NMC, 2008) that are listed in the two tables below were violated by a significant proportion of male and female nurses in my documentary analysis sample. As mentioned earlier, whilst the vast majority of cases in my documentary analysis sample concerned the 2008 Edition of the NMC Code (NMC, 2008), there were some cases which involved both the 2004 Edition of the NMC Code (NMC, 2004) and the 2015 Edition of the NMC Code (NMC, 2015). I therefore mapped the different sections

of the 2004 and 2015 Editions of the NMC Code (NMC, 2004; 2015) onto the 2008 Edition of the NMC Code (NMC, 2008) when calculating the statistics (*see* Appendix E).

Code Violations Committed by Male Nurses in the Documentary Analysis Sample

Paragraph	**Description**
Paragraph 1	*You must treat people as individuals and respect their dignity.*
Paragraph 3	*You must treat people kindly and considerately*
Paragraph 24	*You must work cooperatively within teams and respect the skills, expertise and contributions of your colleagues.*
Paragraph 26	*You must consult and take advice from colleagues when appropriate*
Paragraph 32	*You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.*
Paragraph 35	*You must deliver care based on the best available evidence or best practice.*
Paragraph 42	*You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.*
Paragraph 49	*You must adhere to the laws of the country in which you are practising.*
Paragraph 61	*You must uphold the reputation of your profession at all times.*

Code Violations Committed by Female Nurses in the Documentary Analysis Sample

Paragraph	**Description**
Paragraph 21	*You must keep your colleagues informed when you are sharing the care of others.*

Paragraph 22	*You must work with colleagues to monitor the quality of your work and maintain the safety of those in your care.*
Paragraph 26	*You must consult and take advice from colleagues when appropriate.*
Paragraph 32	*You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.*
Paragraph 35	*You must deliver care based on the best available evidence or best practice.*
Paragraph 42	*You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.*
Paragraph 43	*You must complete records as soon as possible after an event has occurred.*
Paragraph 49	*You must adhere to the laws of the country in which you are practising.*
Paragraph 61	*You must uphold the reputation of your profession at all times.*

As can be seen above, there are several sections of the 2008 Edition of the NMC Code (NMC, 2008) that a significant proportion of male nurses in my documentary analysis sample broke, but female nurses in my documentary analysis sample did not (*see* Appendix F for a full list of all code violations by male and female nurses). The Paragraphs that were most commonly broken by male nurses in my documentary analysis sample, but not by female nurses (at least not in significant numbers), were Paragraphs 1, 3, 24; the first two Paragraphs relate to the concept of care, and the last Paragraph relates to working within a team. Neither Paragraph(s) 1 or 3 state what is required to treat patients *individually* and/or with *dignity*, nor is there any explanation as to what is required to treat people *kindly* and/or *considerately*. Thus, due to the subjective nature of these qualities there is a distinct possibility that the panel may interpret and/or analyse such qualities through a gendered lens.

The fact that male nurses in my documentary analysis sample are more likely to be deemed to have violated Paragraphs 1 and 3, which clearly relate to the concept of care, could be seen as correlating with the gendered views held by the early nursing reformists. A common view held at the time was that male nurses were unable to provide adequate care compared to female nurses, which has persisted in present day society. This was highlighted by Summers who highlighted how Florence Nightingale believed:

> "…men whose hands were hard and horny through labour… were not fitted to touch, bathe, and dress wounded limbs, however gentle and considerate their hearts might be"
>
> (Summers, 1988: 35)

This mention of men's 'hard and horny' hands correlates with studies such as Evans (2002) which have found that the male touch is deemed as problematic within the nursing sphere. It is also clear by looking at the existing nursing literature (*see* Simpson, 2004; Pullen and Simpson, 2009; Keogh and Gleeson, 2006; O'Lynn and Krautscheid, 2011) that male nurses are expected to adhere to, and assimilate with, a highly gendered form of care. However, there is also literature to suggest that male nurses are expected to carry out tasks such as lifting heavy patients or restraining aggressive ones, particularly in mental health nursing, due to the assumed differences in physical strength between men and women (*see* Holyoake, 2001; Evans, 2002; Harding, 2007). Both of these tasks, especially the restraint of aggressive patients, are high risk in that, if performed incorrectly, they can result in harm and/or patient complaints. These types of tasks are also are problematic within a gendered sphere of care as they involve physical assertion rather than, for example, the caring touch.

Whilst the impact of gender cannot be conclusively determined from my documentary analysis, observationally there are examples in my data where a male nurse's gender has been brought up when testifying to their

behaviour in a clinical setting. An example of a nurse's gender being brought up during an NMC FtP hearing can be seen in the case of Henry. Henry was a female nurse accused of, amongst other things, spiking a colleague's drink with lactulose, offensive and xenophobic language towards colleagues, sexually inappropriate behaviour and competence related issues. One of the first witnesses called was a former colleague who was a male nurse that Henry worked with in her previous employment, and whose drink was the one that she allegedly spiked with lactulose. When cross-examined by Henry's legally qualified representative, the witness stated that he was outraged when he discovered that his drink had been allegedly spiked with lactulose. When framing a question about the witness' actions, Henry's legally qualified representative stated to the witness that he was a "grown man" who was "solid" and "not easily flustered". Henry's legally qualified representative then stated to the witness that, as he was presumably all of these things, why did he not have a "quiet word". This was suggested instead of doing what he actually did which was to continue about his day and then raise it with management later on, despite the witness having no authority over Henry. Regardless of whether the witness' actions were correct, this example is a clear demonstration of embedded assumptions about male nurses; firstly, that they should be robust and secondly, that male nurses should seek to sort out their own troubles or issues before seeking recourse elsewhere.

Both this example, and the previous literature discussed, highlight how male nurses are expected to provide a highly gendered form of care, but also engage in practices which could potentially clash with the NMC's gendered nature of care. This could be seen as creating a double standard for male nurses where they must deliver a female orientated form of care but also carry out tasks and behave in ways that are aligned with more traditional views of masculinity. Yet, if male nurses make mistakes in the delivery of care, and these mistakes are deemed to be caused by lack of care, male nurses as a group are often blamed rather than the individual nurse, as Evan's describes:

> "The notion of blaming all men nurses for the transgressions of a few is also raised by Bush (1976). She notes the tendency of some patients to blame individual men nurses when they are perceived to fail in the performance of a technical skill. When a man nurse is perceived to fail in an *affective* area, however, men nurses as a group are blamed. This situation can be understood as a consequence of traditional gender stereotypes and the belief that men are inappropriate and unable to function as well as women in caring roles [own emphasis]."
>
> (Evans, 2002: 447)

It could therefore be suggested that the individuals or organizations that make allegations against a registrant, and that the NMC FtP panels who preside over a registrant's case, may have less confidence in the affective skills of a male nurse from the outset.

It is also important to highlight that there were sections of the 2008 Edition of the NMC Code (NMC, 2008) which a significant number of female nurses in my documentary analysis sample have broken, but male nurses have not (except for in small numbers). These paragraphs were Paragraphs 21, 22 and 43 (*see* Appendix F). The first two Paragraphs relate to issues of competence, and the final paragraph relates to record keeping, which, again, is a form of proficiency-related misconduct. This is also reflected by the fact that in my documentary analysis sample, all four cases involving competence related issues concerned female nurses. However, it is possible that there are other factors that influence this statistic. According to authors such as Simpson (2004) and Pudney and Shoulds (2000), men are more likely to be promoted faster than female nurses. This could potentially mean that female nurses spend more time working in lower grade positions, such as staff nurse, where recording keeping and drug administration play a significant part in their roles, thus potentially putting them at greater risk of making errors of this nature.

5.6: The Gendered Differences in Criminal Convictions Committed by Male and Female Nurses

Another commonly violated section of the 2008 Edition of the NMC Code (NMC, 2008) was Paragraph 49, which states:

> "You must adhere to the laws of the country in which you are practising."

Out of the twenty-three male nurses in my documentary analysis sample, five male nurses were referred for NMC FtP hearings due to being convicted of a criminal offence(s). This is compared to only seven female nurses (out of the forty-eight female nurses in my documentary analysis sample) who were referred for a full Substantive Hearing for the same reason. The disproportionate number of male nurses in my documentary analysis sample who were convicted of criminal offences is not all that surprising given that it reflects wider societal trends in the UK. For example, in 2017 seventy-four percent of defendants prosecuted were men and twenty-six percent were women (with successful convictions standing at eighty-eight percent for women and eighty-six percent for men) (Ministry of Justice, 2017). Furthermore, there are also differences in the type of criminal offences committed by male and female nurses in my documentary analysis sample (*see* Appendix G), again, mimicking wider societal trends where men are more likely to be the perpetrators of violent and/or sexual offences (ONS, 2017). Out of the five male nurses who received criminal convictions, two of the nurses were convicted of offences involving sexual assault (both of whom received a Striking-Off Orders). The remaining three male nurses were convicted of dishonesty related offences; one of whom received a Striking-Off Order, and the other two being issued with Suspension Orders (*see* Appendix G). Out of the seven female nurses, three of them received convictions for driving with excess alcohol (one received a Caution Order, another received a Conditions of Practice Order and the final one received a Suspension Order). Of the remaining four female nurses who received criminal convictions, their convictions ranged in scope. For example, one female

nurse was convicted of being drunk whilst in charge of a child, which resulted in a Striking-Off Order whilst another female nurse was given a police caution for stealing medication, which resulted in a Suspension Order (*see* Appendix G for a full list of convictions). None of the female nurses in my sample were convicted of violent or sexual offences, although one of them was convicted of cruelty to a child, resulting in a Striking-Off Order. With regards to the sanctions received by nurses in my documentary analysis sample who were convicted of criminal offences, three out of the five male nurses received Striking-Off Orders compared to only two out of the seven female nurses (*see* Appendix G).

The above statistics regarding criminal convictions potentially go some way in explaining the reason why male nurses are twice as likely to be *referred* to the NMC than female nurses, as male nurses in my documentary analysis sample are more likely to be convicted of a criminal offence. The above statistics also potentially go some way in explaining why male nurses are more than three times more likely to be *struck-off* as a result compared to female nurses (NMC, 2017b). This is because male nurses in my documentary analysis sample were convicted of more serious offences, such as sexual assault, rather than other offences such as driving convictions. However, even if you were to exclude sanctions received for criminal convictions, male nurses in my documentary analysis sample are still considerably more likely to receive striking-off orders compared to female nurses, as can be seen in the tables below:

<u>Sanctions received by Male Nurses (excluding those received from criminal convictions) in the Documentary Analysis Sample</u>

No Sanction	Caution	Conditions of Practice Order	Suspension	Striking-Off
None	3 male nurses	4 male nurses	3 male nurses	8 male nurses
0%	16.66%	22.22%	16.66%	44.44%

Sanctions received by Female Nurses (excluding those received from criminal convictions) in the Documentary Analysis Sample

No Sanction	Caution	Conditions of Practice Order	Suspension	Striking-Off
None	7 female nurses	10 female nurses	18 female nurses	6 female nurses
0%	17.07%	24.39%	43.90%	14.63%

As can be seen above, even when criminal convictions are excluded, male nurses still account for over half of all Striking-Off orders in my documentary analysis sample. Therefore the next question that needs to be addressed is whether there are other sections of the 2008 Edition of the NMC Code (NMC, 2008) that male nurses often break, which could potentially contribute to the statistic that male nurses are more than three times more likely to be struck off than female nurses (NMC, 2017b).

5.7: Gendered Differences in Proficiency-related Misconduct and Conduct-related Misconduct

As can be seen above, there is a disproportionate number of male nurses in my documentary analysis sample who have been convicted of criminal offences, which are of a more serious nature compared to most of the convictions received by female nurses in my documentary analysis sample (*see* Appendix G). This goes some way in potentially explaining the reason why male nurses are more likely to be referred to the NMC and more likely to be struck off as a result (NMC, 2017b). However, male nurses in my sample are also more likely to be deemed as having broken sections of the 2008 Edition of the NMC Code (NMC, 2008) that pertain to the concept of care. On the other hand, female nurses in my documentary analysis sample generally committed more minor criminal offences and were also more likely to violate sections of the 2008 Edition of the NMC Code (NMC, 2008) that were related to competence.

However, at this point it is important to outline the terms that I will be using to refer to the different types of misconduct. As previously mentioned, the Conduct and Competence Committee hear cases where the registrant has been accused of either having committed misconduct or that they are lacking in competence or both. The NMC define a lack of competence as:

> "…an unacceptably low standard of professional performance, judged on a fair sample of the nurse or midwife's work, which could put patients at risk"
>
> (NMC, 2017v)

On the other hand, the NMC define misconduct as:

> "If nurses and midwives fall short of the [NMC] Code, what they did or failed to do may be serious professional misconduct."
>
> (NMC, 2018g)

Due to the varied nature of the different sections of the NMC Code (2004; 2008; 2015), misconduct can take many forms. Nevertheless, the different types of misconduct can be loosely grouped into the two following categories: *proficiency-related misconduct* and *conduct-related misconduct*. Proficiency-related misconduct concerns acts such as drug administration errors, failure to record observations, the incorrect application of a wound dressing and so forth. Conduct-related misconduct concerns acts such as criminal offences, inappropriate relationships with patients, theft, assault of a patient and so forth. However, it is possible for proficiency-related misconduct to become conduct-related misconduct. This is because NMC FtP panels assess the nurse's attitude and their thought process at the time of the act (NMC, 2017j; NMC, 2017l). An example of this would be if a nurse deliberately provided inadequate care to a patient. The inadequate provision of care would normally be classified as proficiency-related misconduct. However, should a nurse *intentionally* provide inadequate care, the act

would be classed as conduct-related misconduct as it was an intentional act that was not the result of the nurse's proficiency.

The reason the type of misconduct is important (such as whether it pertains to care or clinical competence) is that certain types of misconduct are harder to remediate than other types, which has been noted in the case of *Yeong v. GMC [2009] EWHC 1923 (Admin)*. In this particular case, Yeong, who admitted to having a sexual relationship with a patient, sought to argue that the GMC should have allowed him the opportunity to address his misconduct through remediation. The presiding judge, however, upheld the GMC's decision to impose a Suspension Order and stated:

> "Where a FTPP [fitness-to-practice panel] considers that the case is one where the misconduct consists of violating such a fundamental rule of the professional relationship between medical practitioner and patient and thereby undermining public confidence in the medical profession, a finding of impairment of fitness to practise may be justified on the grounds that it is necessary to reaffirm clear standards of professional conduct so as to maintain public confidence in the practitioner and in the profession. In such a case, the efforts made by the medical practitioner in question to address his behaviour for the future may carry very much less weight than in a case where the misconduct consists of clinical errors or incompetence."

This clearly illustrates how conduct-related misconduct can be considerably harder to remediate than proficiency-related misconduct. For example, there may not be courses that can be undertaken by a nurse to address dishonesty compared to courses that can be undertaken to address proficiency-related misconduct such as drug administration errors. There is also the issue of whether a character attribute or personality disposition can be remediated as opposed to a lack of clinical knowledge. The NMC have stated that attitudinal issues

can be particularly difficult to remediate, as can be seen in the quote below:

> "…in cases where the behaviour suggests underlying problems with the nurse or midwife's attitude, it is less likely the nurse or midwife will be able to remedy their conduct."
>
> (NMC, 2017q)

In terms of my documentary analysis sample, female nurses were twice as likely to have at least one or more charge(s) pertaining to proficiency-related misconduct compared to male nurses in my documentary analysis sample, as can be seen in the table below:

Proficiency-Related Misconduct by Gender in the Documentary Analysis Sample

Male	**Female**
6 male nurses	27 female nurses
26.08% of male nurses in sample	56.25% of female nurses in sample

The above table demonstrates how female nurses in my documentary analysis sample appear more likely to commit misconduct that is potentially easier to remediate. The question therefore is whether this perceived difference in remediability plays a significant role in male nurses being more than three times more likely to be struck-off compared to female nurses (NMC, 2017b)?

5.8: Misconduct that Can and Cannot be Remediated

The NMC literature has stated that there are some types of misconduct which cannot be remediated (NMC, 2017q). However, prior to any deliberations on sanction, the panel must first consider whether the registrant's conduct is impaired in accordance with the *Nursing and Midwifery Order (2001)*. A registrant's conduct can be found to be

impaired on the grounds of *public protection* and/or *public interest*, as can be seen in the quote below:

> "The concept of impairment of fitness to practise has been informed by a number of judicial decisions. As a result, there are two key considerations for NMC decision makers.
>
> The NMC must protect the public. Appropriate action should be taken to restrict the registration of a nurse or midwife who presents a risk to the health, safety and/or welfare of the public.
>
> The NMC must act in the public interest, maintaining confidence in the professions and declaring and upholding proper standards of professional conduct."
>
> (NMC, 2017p: 2)

When deciding whether the registrants conduct is *currently* impaired on one, or both, of the above grounds, the panel must assess whether the registrant has remediated their conduct. However, what is required to remediate a registrant's practice differs depending on the type of misconduct/what sections of the NMC Code (NMC, 2008; 2015) the registrant has violated. Although the different sections of the code vary considerably, misconduct can be loosely grouped into the two following categories: *proficiency-related* and *conducted-related errors*. An example of a proficiency-related error can be seen in the case of Ciocan. Ciocan, whose case was analysed as part of this research, was a male general nurse who was accused of the following charges (amongst others):

> "1) On [date] administered insulin to Resident A when you should not have.
>
> 2) On [date] did not escalate that you had not carried out an essential blood sugar check on Resident A when you should have."

When discussing misconduct that cannot remediated, the NMC highlight how certain offences are easier to remediate, particularly proficiency-related misconduct, which can be seen in the following quote:

> "Generally, issues about the safety of clinical practice are easier to remedy, particularly where they involve isolated incidents. Examples of such concerns include:
>
> - medication administration errors
> - poor record keeping
> - failings in a discrete and easily identifiable area of clinical practice
> - concerns about incidents that took place a significant period of time in the past, especially if the nurse or midwife has practised safely since they occurred."
>
> NMC (2017p)

Conversely, an example of a conduct-related error that was deemed to be so egregious that it could not be remedied can be seen in the case of Maharaj whose case was analysed as part of my documentary analysis sample. Maharaj was a male nurse accused of the following charges (amongst other things):

> "1. Failed to attend for work on one of more occasions set out in Column A of Schedule 1;
>
> 2. Submitted claims for payment for work when you had not attended for work in respect of one of more occasions set out in Column A of Schedule 1 when you had not attended for work;
>
> 3. Were dishonest in your conduct at charge 2 in that you knew had not attended for work"

In this particular case, Maharaj denied the charges only to later admit during the misconduct and impairment stage that he was guilty of all of

the charges, thus the panel deemed his dishonesty so severe that the only sanction that would satisfy the public interest would be a Striking-Off Order. This difficulty with remediating certain types of misconduct has been acknowledged by the NMC who state in the following quote that there are certain offences that cannot be remediated due to the misconduct being so fundamentally incompatible with the values of the profession:

> "Examples of conduct which may not be possible to remedy, and where steps such as training courses or supervision at work are unlikely to address the concerns include:
>
> - criminal convictions that led to custodial sentences
> - inappropriate personal or sexual relationships with patients, service users or other vulnerable people
> - dishonesty, particularly if it was serious and sustained over a period of time, or directly linked to the nurse or midwife's practice
> - violence, neglect or abuse of patients."
>
> NMC (2017p)

Although the NMC have given specific examples in the above quote, it could be argued that all of the above examples concern attitudinal issues which, as mentioned earlier, is considered particularly difficult to remediate (NMC, 2017q). However, the NMC do not state what constitutes an attitudinal issue instead leaving it up to the subjective assessment of the NMC FtP panel. This focus on attitudinal issues correlates with O'Neill's (1986) work which utilizes Foucault's (1979) analysis of workplace power to make the following argument regarding the value that organizations place on workers attitudes:

> "Analytically, there occurs a kind of progression in industrial discipline moving from paternalistic controls to… bureaucratically imposed discipline [in modern day

> society]. What is involved is a shift from heteronomous paternalist controls to autonomous, internalized discipline… To achieve this, worker evaluation is concerned less with physical productivity than with workers' attitudes to the corporation".
>
> (O'Neill, 1986: 56)

The NMC's focus on attitudinal issues can be seen as correlating with the above quote. The above quote from the NMC regarding attitudinal issues links with the case of Maharaj who was found to have claimed payment on multiple occasions for shifts that he did not work despite having denied all charges. After the panel announced their findings with regards to the facts of the case, Maharaj then admitted that he had lied to the panel under oath and that he did in fact claim payment for all of the aforementioned shifts outlined in the charges when he hadn't worked on those days. Due to the charges involving dishonesty and the fact that Maharaj lied under oath, the panel decided to issue a Striking-Off Order which can be seen in the following quote taken from the official hearing document:

> "The panel reminded itself that you have admitted that you lied under oath when contesting the NMC charges. It was deeply concerned that a senior nurse, who took advantage of their position for financial advantage, would then maintain their dishonest position in order to escape the consequences of their actions…
>
> In these circumstances the panel concluded that the public interest can only be satisfied by a striking off order."

As can be seen in the quote above, certain types of offences are deemed so egregious, such as lying under oath whilst denying one's dishonest actions, that they cannot be remediated, thus resulting in a Striking-Off Order. However, the role of remediation in the NMC FtP process has not yet been examined; the following chapter will examine the way in which

remediation is assessed by NMC FtP panels and the effect this has on registrants.

5.9: Conclusion

This chapter has demonstrated how there is considerable flexibility when deciding whether a registrant has committed misconduct. The use of 'fishing expeditions' to look for instances where the registrant may have committed misconduct in the past also poses a problem for registrants due to the amount of time that has elapsed since the alleged misconduct occurred. Furthermore, there also appears to be a gendered difference in the types of misconduct committed by male and female nurses in my documentary analysis sample. Male nurses were more likely to be found to have committed care-related misconduct and have received criminal convictions. Female nurses, on the other hand, were more likely to be charged with competence related offences. In the next chapter, I will assess the role of remediation in the NMC FtP process and the different factors that can affect it. This will include an analysis of the role of the independent panel and how they use their professional judgement to assess remediation.

Chapter 6: An Analysis of the Role of Remediation in NMC FtP Hearings

6.1: Introduction

This chapter will analyse the role of remediation in NMC FtP hearings. This will involve assessing the different factors that can influence whether an NMC FtP panel decide that a registrant has successfully remediated their misconduct. The remediatory factors that will be analysed are *insight* and *remorse* and how the successful display/performance of these emotions influence the panel's decision. This chapter will then analyse the *independent* panel and the way that they are selected by the NMC. This will include an analysis of whether the panel are truly independent. From here, the panel's *professional judgement* will be examined. This will include an in-depth discussion of the Ethics of Care and Ethics of Justice and how these concepts apply to the panel and their professional judgement. Following this, interim orders and the effect that they have on the successful remediation of misconduct will be assessed. Finally, this chapter will explore the effect that aggravating and mitigating factors have on whether a registrant is found to have remediated their misconduct. This was also include an analysis of the high degree of flexibility that the panel have when deciding the aggravating and mitigating factors of a given case. This discussion on the role of remediation will therefore provide a foundation for the following chapter. This chapter will look at the role that transparency and shame play in the successful remediation of misconduct and how it potentially influences the aforementioned statistics on referral and outcome for male nurses subject to NMC FtP hearings.

6.2: Features of Remediation

In order to assess the role of remediation, it is important to first outline the legal definition of impairment as remediation is aimed at correcting any current impairment. At present, there is no statute or case law which

defines the meaning of impairment; the NMC state that their definition of impairment is the following (as stated in *Professional Standards Authority v Nursing and Midwifery Council and Mason [2017] CSIH 29*):

> "The committee noted that the Council had defined 'fitness to practise' as a registrant's suitability to remain on the register unrestricted."

Impairment is therefore defined by the absence of suitability to remain on the register unrestricted for whatever reason. This definition of impairment is both very broad and highly subjective as, amongst other things, the NMC have not defined what they deem 'suitability' to be. This is despite 'suitability' being a key factor in assessing whether a registrant has sufficiently remediated to the point that their conduct is not currently impaired. On this note, this chapter will now discuss remediation beginning with a discussion on what it involves and the different forms it can take. Whilst remediation can take many forms, the most commonly cited feature of remediation was insight and whether the registrant possessed sufficient insight into their misconduct to ensure that the risk of the misconduct being repeated was minimal. The following quote from the NMC outlines what the NMC look for when assessing insight:

> *"A nurse or midwife who shows insight will usually be able to:*
>
> - *step back from the situation and look at it objectively*
> - *recognise what went wrong*
> - *accept their role and responsibilities and how they are relevant to what happened*
> - *appreciate what could and should have been done differently*
> - *understand how to act differently in the future to avoid similar problems happening.*
>
> *Decision makers do more than simply look at whether a nurse or midwife has shown 'any' insight or not. They need*

> *to assess the quality and nature of the insight. There may still be a public interest in restricting a nurse or midwife's right to practise, even if they have shown 'some' insight into what happened."*
>
> NMC (2017a)

The above quote demonstrates how insight is a key consideration for the panel, which is supported by the fact that, out of the seventy-one cases in my documentary analysis sample, in all but one case the panels made reference to the amount of insight that they felt the registrant possessed. Furthermore, the one case where insight was not mentioned involved a male nurse being convicted of sexually assaulting two male patients in a clinical area, with the NMC and the registrant forming a CPD agreement (with a Striking-Off Order being the agreed sanction). Thus, in this instance it could be argued that the panel felt no need to address the issue of insight.

Another key factor that panels consider is the issue of remorse, however, unlike insight, there is no current literature provided by the NMC which discusses what remorse is or how panels should assess remorse, making the assessment of it a purely subjective process. Nevertheless, in sixty out of the seventy-one cases analysed in my documentary analysis sample, the panels discussed the degree of remorse that they felt the registrant had demonstrated regarding their alleged misconduct. That is not to say that the way in which NMC FtP panels assess remorse has no clear correlation with existing literature, which can be seen in the work of Weisman (2009). Drawing on the work of Goffman (1972), Weisman has argued that the demonstration of remorse, particularly within courts and tribunals, requires not just a verbal apology but a performance:

> "The very expression – 'showing remorse' – suggests that, in conventional usage, it is through gestures, displays of affect, and other paralinguistic devices that remorse is communicated. Both the apology and the expression of

> remorse may rely on the same verbal formulae such as ‘I am sorry for what I did’ but the work of remorse is to call attention to the feelings that accompany the words even more than the words.”
>
> (Weisman, 2009: 51)

The performance of remorse is comprised of three key factors: the first is an admission of responsibility that acknowledges one’s agency when committing the act. The second is the expression of ‘true’ emotion, such as guilt and contrition (when relaying one’s remorse). The final one is the process of self-transformation, where the offender demonstrates that they have made significant changes to their character that would prevent such misconduct from happening again (Weisman, 2009). Within this definition, insight is clearly a feature of remorse. This can be seen in the admission of responsibility, where the offender has to reflect enough to be able to take responsibility for their actions, and through the process of transformation where the offender has to able to recognise the flaws in their character in order to be able to change them. To successfully ‘do’ remorse, the registrant is typically required to display a range of emotions and actions, which must be turned into a ‘remediation portfolio’ for the panel.

An example of a registrant acknowledging their guilt but, according to the panel, failing to acknowledge their own agency in relation to their misconduct can be seen in the case of Burnett who was a female general nurse whose case was analysed as part of my documentary analysis sample. Burnett was a female nurse who admitted to having failed to take adequate observations and failing to carry adequate reviews of a number of patients ongoing health problems (whilst denying several other charges of a similar nature). When outlining their decision on whether Burnett’s conduct was impaired in the official hearing document, the panel stated:

> “Mrs Burnett told the panel prior to the appointment of Ms 1 that there had been no previous concerns in her practice.

> The panel found that she appeared to attribute the identified shortcomings as being linked to the appointment of Ms 1. When asked how she might avoid similar problems in her practice in the future Mrs Burnett stated that she would chose her employer carefully, ensuring that the employer supported their staff. The panel concluded that at this time Mrs Burnett lacks the insight to take accountability for her practice."

In the above quote, the panel can be seen as clearly stating that Burnett, in their opinion, lacks insight into her misconduct. The reason for this is that she chose to respond to the panel's question of how she would avoid similar problems occurring, not by stating something that she would change about herself, but rather, how she would ensure that someone or something else, her employer in this instance, would be different.

On the other hand, an example of where an NMC FtP panel have deemed that a registrant has displayed 'genuine' emotion when relaying their remorse to the panel can be seen in the case of Panaikkal John. In this particular case, Panaikkal John was a female nurse who admitted to plagiarising an essay required for her clinical mentorship qualification, although Panaikkal John did not form a CPD agreement with the NMC. In this case the panel made direct reference to Panaikkal John's admissions of guilt, both with regard to the charges and her current impairment, along with what they deemed as her "genuine" expressions of emotion. According to the panel, the admissions of guilt and genuine expressions of remorse play a key role in Panaikkal John having remediated her misconduct, which the panel make reference to in the following quote taken from the official hearing document:

> "In the panel's judgment, dishonesty may not be easily remedied.
>
> However, in the panel's judgment, your insight into your misconduct, given its nature and extent, and your remorse

> and shame for your actions have greater relevance to the risk of repetition than remediation.
>
> Your admission to all the charges and acceptance that your fitness to practise is impaired at the start of this hearing, together with your genuine expressions of remorse and apology are indicative of insight and that is to your credit."

As can be seen above, the panel clearly situate what they deem as Panaikkal John's genuine expressions of remorse within her admissions of guilt and impairment, which, according to the panel, has reduced her risk of repetition significantly. Although the panel do not state what they deem as 'remediation', a common form of remediation is where registrants have undertaken courses, even those who have committed misconduct which is not of a clinical nature. Panaikkal John had stated that one of the reasons she committed the plagiarism was due to her fear that her command of English was insufficient for writing academic essays. So when the panel stated that her remorse, insight and shame played a more important role in reducing the risk of repetition than remediation they may be referring to the completion of an essay writing or English language course. The outcome of the case was that, despite committing dishonesty-related misconduct, which is considered particularly egregious by the NMC (NMC, 2017q), Painaikkal John only received a five-year Caution Order. On the other hand, Ofili, whose case was observed as part of this research, and who was accused of plagiarising two essays but denied the charges, ended up receiving a six-month suspension primarily as the panel felt that he had only 'developing' insight and remorse.

This also relates to Weisman's (2009) final criteria: self-transformation. Possibly the clearest example of 'self-transformation' can be seen in the case of Peck whose case was observed as part of this research. Peck was a male nurse who admitted to slapping a female colleague on the buttocks as part of work-place banter, which resulted in him being convicted of assault by beating, as well as swearing at a work colleague,

albeit without being in the presence of any patients. As part of his 'remediatory portfolio', Peck undertook a stress management course. Throughout his oral evidence, he was extremely self-deprecating and, when asked by the panel about alternative ways that he manages stress, he referenced the fact that he had met, and since married, his wife. Peck stated to the panel that she had helped him to think about his actions and provided him with support when in stressful situations. The completion of the stress management course could be seen as part of an overall transformative process. However, Peck's decision to officially describe his wife (who he had met after the incidents occurred) as a key part of his support network and overall factor in his new thinking/character, can be seen as a clear demonstration of how registrants seek to demonstrate self-transformation. This is supported by the fact that, although the panel found that Peck had committed misconduct, the panel felt that Peck had sufficiently remediated his misconduct, thus his conduct was deemed not to be *currently* impaired.

6.3: The *Independent* Panel and the Assessment of Remediation

As mentioned earlier in this chapter, there is no burden or standard of proof during the Misconduct, Impairment and Sanction stages. This in turn grants the panel with a high degree of flexibility, even more so than the Fact-Finding stage, where the burden of proof is on the NMC and the standard of proof is the balance of probabilities (NMC, 2017l). Furthermore, when stating that there is no burden of proof in the Misconduct, Impairment and Sanction stage, it was often stated that the 'independent panel' must use their own 'professional judgement' when making decision on Misconduct, Impairment and Sanction. An example of an NMC FtP panel stating how they used their own 'professional judgement' can be seen in the case of Sherwin who was a female general nurse whose case was analysed as part of my documentary analysis sample. Sherwin was accused of providing inadequate standards of resident care and nursing practice in a residential care home. In the

following quote from the official hearing document for this case, the panel make reference to their ‘professional judgement’:

> “When determining whether the facts found proved amount to misconduct the panel had regard to the terms of ‘The code: Standards of conduct, performance and ethics for nurses and midwives 2008’.
>
> The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own *professional judgement* [own emphasis].”

Yet, like impairment, there is no special definition of what ‘independent’ or ‘professional judgement’ actually means, although this notion of the independent panel is often cited throughout the NMC literature (*see* NMC, 2017l; NMC, 2017s). However, it is important to note that both the Lay Panel Members and the Registrant Panel Members are selected, trained and paid by the NMC (NMC, 2018e). It could be argued that by selecting the panel members themselves, the NMC are seeking individuals who share a similar ideology to them and their view of professional regulation. This in turn raises the question of whether NMC FtP panel members are truly independent, which is supported by the application criteria/competencies required to become a Lay Panel Member. An example of some of the criteria required to become a panel member can be seen in the following quote from a job description for a Lay Panel Member position:

> Takes into account the aims of the organisation, as well as the priorities of its key stakeholders, when making decisions.
>
> Contributes to the organisation’s work through understanding of governance, regulation, healthcare delivery, consumer engagement, audit and risk, finance and assurance, the commercial sector, community or

> voluntary sector, professional/higher education, professional ethics and standards…
>
> Understands systems of internal governance. Analyses and interprets performance data and identifies key trends. Demonstrates the organisation's openness, integrity and accountability and personally upholds the principles of public life…
>
> **Competency 5 -** Board/senior level experience of leading/overseeing major organisational change.
>
> **Competency 6 –** Board/senior level financial expertise and understanding of exercise of good financial management and ideally expertise in audit and risk."
>
> (NMC, 2016d: 12-13)

The selection criteria/competencies set out above clearly demonstrate how the NMC are seeking individuals who share the same ideology and views of professional regulation. This specific criteria for Lay Panel Members can be seen as echoing Moran's (2000) argument that patient safety is often cited as a means to increase regulatory control and exclude others from entering the profession who they deem unfit to do so. The exclusion of others from the profession grants it with a monopoly over its defined services, thus demonstrating a possible ulterior motive to regulation.

6.4: The *Professional Judgement* of the Panel and the Assessment of Remediation

I will now move on to discuss the concept of *'professional judgement'*. The notion of a professional panel providing professional judgement has referenced frequently throughout all four stages of the NMC FtP hearings in both my observational and documentary analysis sample. However, like impairment, there is no definition of what constitutes 'professional judgement' or what is required of a panel member when exercising their

professional judgement. Furthermore, the term ‘professional judgement’ has also been used in other situations, such as when the panel are privy to information which, in a criminal court, would have resulted in the jury being dismissed due to potential prejudice. There have also been occasions within my observational sample where, despite the NMC case presenter and the registrant’s representative having agreed to exclude or redact certain parts of the evidence, errors have occurred. These errors have resulted in the panel being exposed to information that should have been redacted. An example of a panel being exposed to information that should have been redacted can be seen in the case of Heslop whose case was observed as part of this research. Heslop was the aforementioned female nurse who was accused of, amongst other things, forcibly administering intravenous antibiotics against the patient’s wishes. At the beginning of the hearing, both the NMC case presenter and Heslop’s legally qualified representative requested a short adjournment. This adjournment was so that they could negotiate what evidence would be included in the evidence ‘bundle’ presented to the panel, as well as which parts of evidence would be redacted.

As mentioned in the previous chapter, the evidence ‘bundle’ refers to the documents that the NMC case presenter gives to the panel at the beginning of the hearing which outlines the NMC’s case against the nurse. What is contained within these documents is negotiated between the NMC case presenter and registrant’s legally qualified representative. If the registrant is either represented by a non-legally qualified representative or is unrepresented, they still have the option to include information that they feel is relevant to their case. However, given that the NMC case presenter is legally qualified, this could potentially be problematic for them. This is because the registrant may not be able to identify what can and cannot be included, such as if a piece of evidence would be deemed to be ‘hearsay’, which would require an application to the panel before it was admitted into evidence. Returning to the case of Heslop, after the hearing resumed the NMC case presenter proceeded to call the first witness and question the witness in relation to her witness

statement, followed by the Heslop's legally qualified representative. Following cross-examination, the panel then went into private session so that they could decide upon what questions they would ask the witness. Upon returning, the Registrant Panel Member asked both the NMC case presenter and the registrant's representative whether a certain sentence should have been redacted. It then transpired that the sentence should have been redacted, yet the NMC case presenter, or those assisting him, had failed to do so. Heslop's legally qualified representative made it clear through her tone, facial expressions and body language that she was extremely displeased that this had occurred. In response to her displeasure, the panel chair stated:

> "I assure you that we are a *professional panel* [own emphasis]"

In this situation the chair made this statement to Heslop's legally qualified representative to reassure her that this erroneous information would not be taken into consideration. Multiple other NMC FtP panels in both my observational and documentary analysis samples have cited that they are a 'professional panel' when outlining their decision(s) in the official hearing documents. The term has also been used by several Legal Assessors in different cases when providing advice to the panel. Equally, some NMC case presenters and legally qualified representatives have also stated to the panel that they are a 'professional panel' when making their submissions at any point during all four stages of the NMC FtP hearing.

As demonstrated above, one of the contexts that the term 'professional panel' has been used in is when proper legal process has not been followed, which could potentially influence the panel. In a criminal case, however, were the jury to become aware of a piece of evidence(s) that should have been excluded or redacted, the judge would have to discharge the jury if the judge felt that the jury could not exclude the disputed evidence from their deliberations (Thomas, 2012). It could be argued that jury members are not always 'professionals' who have been

trained to assess cases in a similar way as a judge would, as is the case with NMC FtP panel members (NMC, 2018e). However, it is also important to note that said panel members do still require legal advice from the Legal Assessor suggesting that they are not as legally fluent and/or as qualified as a trained solicitor, barrister or judge.

Yet, despite panel members not always being legally qualified, they are still responsible for making decisions on matters of law (usually after receiving legal advice from the legal assessor) (NMC, 2017t). This was made clear in the case of Gilmour where the NMC case presenter asked whether any of the panel had a legal background prior to him making submissions on points of law. Furthermore, if the professional nature of NMC FtP panels is adequate enough to prevent any bias from being created upon being exposed to information which should have been redacted, the question could therefore be asked: why is there a need to redact the information in the first place? It is important to consider, however, that the burden of proof is considerably higher in a criminal case, which is beyond reasonable doubt (John, 2013) compared to an NMC FtP hearing, which is the balance of probabilities (NMC, 2017l). This higher burden of proof in criminal cases potentially makes it less likely that the effect of reading redacted information will disadvantage the defence, as opposed to an NMC FtP hearing.

Nevertheless, as stated above, if the jury were exposed to such information in a criminal case, the judge would have to discharge the jury if the judge felt that they could not exclude the disputed information from their deliberations (Thomas, 2012). In NMC FtP hearings, however, the 'professional panel' would not be discharged. It could be argued that the reason for a jury dismissal in criminal cases is because a criminal conviction, and the resulting sentence, is more serious than a finding of misconduct and impairment, and the resultant sanction, from an employment tribunal. However, it important to point out that some criminal offences can become 'spent' after 2-5 years and 'protected' after 11 years under the Rehabilitation of Offenders Act (1974). A nurse, on the other hand, will have to declare that they have been investigated

and/or undergone an NMC FtP hearing on *every* future employment application that asks for this information. This could therefore potentially have a severe and long-term effect on the registrant's career and/or their earnings, even if they were found to have not committed misconduct. The negative effect that a finding of impairment can have on a registrant's career and/or reputation was acknowledged by the panel in the case of Panaikkal John whose case was analysed as part of my documentary analysis sample. When outlining their decision to impose a Caution Order after Panaikkal John admitted to plagiarising an essay required for mentorship qualification, the panel stated:

> "A Caution Order will be in the public domain and will alert anyone who inquires about your registration to the panel's findings of fact and impairment and to the misconduct which led to this case. The panel's findings of misconduct and impairment are, in themselves, significant marks on your registration history."

Returning to the concept of the 'professional panel', its use within NMC FtP hearings does link with existing literature based on morality or, more specifically, what Benhabib (1985) has coined the 'Kohlberg-Gilligan controversy'. Kohlberg (1958) has argued that morality is based on the notion of rights and rules in an objective and universalistic sense. Gilligan (1977; 1982), on the other hand, has heavily critiqued Kohlberg's work and argued that his theory of moral development pays no attention to role of care, with its focus on relationships and responsibilities in a subjective and contextual manner. The two different standpoints have been loosely labelled as the Ethics of Justice and the Ethics of Care. However, Gilligan (1986) has argued that Kohlberg's (1983) response to these criticisms simply stated that the Ethics of Care was separate from the Ethics of Justice, but still dependent on it.

The reason this of importance is because of the way that the panel conduct themselves when assessing a nurse. As has been previously mentioned, when panels have been exposed to information that would

normally result in a mistrial were it to occur in a criminal court, the panel have emphasized that they are a 'professional panel'. The panel state this to reassure others that they can be trusted to not let the disputed information unfairly influence them. This can be seen as NMC FtP panels not only asserting that they are objective, but that they will ensure a fair trial for the nurse, all of which correlates with the Ethics of Justice, which is also utilized in criminal and civil court. However, in NMC FtP hearings, the panel are not simply assessing objective criteria. Instead they are engaging in highly subjective reasoning process as to whether the registrant has committed misconduct and whether their conduct is impaired, particularly in relation to care-related misconduct. Thus, it could be argued that the panel view themselves as acting according to the Ethics of Justice, but they are judging the registrant and their actions according to a gendered Ethics of Care. This is evidenced by the fact that the panel are required to assess how the registrant behaved towards a patient, colleague or any other individual, and the relationship between them, which Tronto (1987) argues is a key part of the Ethics of Care.

That being said, Tronto (1987; 1993) has highlighted how, due to the Ethics of Care being defined by relationships and responsibilities, it is very much based on an individual's position within society and their previous experiences. This is because the Ethics of Justice is primarily aimed towards white, heterosexual men who are less likely to engage in caring activity. White women and minority men and women, on the other hand, are the ones who undertake the majority of caring activity within society. It is therefore unsurprising that the Ethics of Justice is seen as superior to the Ethics of Care given that white, heterosexual men are those who benefit the most from the patriarchal structure of society therefore meaning that their moral sense is deemed as superior (Tronto, 1987). However, as white women and minority men and women carry out the majority of caring practices, privileged men (such as white, heterosexual, middle class men) are 'deprived' of this moral sense (Tronto, 1987: 652). However, as the Ethics of Care concerns the private sphere, it is typically seen by advocates of the Ethics of Justice as being

of less import than the public sphere. Yet, Tronto (1993) has highlighted how feminist literature such as Elshtain (1981) and Young (1987) has long argued that society needs to reject this alleged split between the 'public' and 'private' sphere. This is because the public and private spheres are interrelated, albeit separate, morally equal realms. Thus, the Ethics of Care is a relational ethic tied to who one is and what position they occupy in society (Tronto, 1993: 654). From the perspective of this research, whilst the Ethics of Care and the Ethics of Justice are certainly interlinked in ways, they are separate concepts and of equal importance, rather than the Ethics of Care being dependent on, and subservient to, the Ethics of Justice.

Linking with this, NMC FtP panels tend to be comprised of older, middle class individuals, at least one of whom has not worked as a nurse. Yet, these panel members are required to judge registrant(s) who are potentially in very different positions within society. Furthermore, Kohlberg's (1982) argument that the Ethics of Care is dependent on the Ethics of Justice is equally borne out in NMC FtP hearings, evidenced by the fact that the public interest is of paramount importance to the panel both when making decisions in all four stages. Although I will not go into a detailed discussion as to what constitutes the public interest (this will be discussed in the next chapter), it is clear to say that the public interest is very much based on social morality and notions of justice (James, 2002). This in turn demonstrates that there is a link between the Ethics of Justice and the Ethics of Care.

6.5: Interim Orders, Panel Autonomy and Remediation

The high degree of flexibility possessed by NMC FtP panels can also lead to varying outcomes, which can be seen in the way that different panels assess remediation undertaken by a registrant(s), particularly when a prior interim order has been imposed. Interim orders issued prior to a Substantive Hearing are usually based on the grounds of public protection, or risk. Should the panel feel that, until the allegations are resolved, there is a too greater risk to the public to allow the registrant to

practice unrestricted they will therefore impose either an Interim CoPO or Suspension Order (NMC, 2017s). Interim Orders can also be applied on the grounds of public interest however the threshold for interim orders on public interest grounds is higher than those applied on the grounds of public protection, as can be seen in the following quote from the NMC:

> “The primary purpose of an interim order is to protect the public. As part of their assessment of risk, decision makers will consider all elements of the public interest. This includes promoting and maintaining public confidence in nurses and midwives, but it will be relatively rare for an interim order to be made only on the ground that an order is otherwise in the public interest. If there is no evidence of a risk of harm to patients, the threshold for imposing an interim order is high.”
>
> (NMC, 2017o)

This is supported by the fact that in all of the cases in my observational and documentary analysis sample where the registrants conduct was impaired solely on the grounds of public interest, the panel chose not to impose an Interim Order after the hearing had concluded. The reason why the panel sometimes apply Interim Orders after the hearing has concluded is to cover the eighteen-month appeal period were the registrant to appeal the panel’s decision within twenty-eight days of the hearings conclusion.

By their very nature, Interim Orders restrict the registrant’s ability to practice up until the registrant’s Substantive Hearing or the Interim Order is lifted at a review hearing. Yet, a key part of demonstrating sufficient remediation to the panel, particularly in cases concerning proficiency-related misconduct, is for the registrant to be able to demonstrate that they can put in to practice any additional learning and/or insight that they have developed since the incident occurred. An example of an Interim Order interfering with a registrant’s ability to be able to demonstrate that they have been able to successfully remediate their misconduct can be

seen in the case of Ciocan whose case was analysed as part of this research. Ciocan was a male nurse who admitted to not carrying out an essential blood sugar check, and then administering unnecessary insulin to the same patient, resulting in a hypoglycaemic attack (although no long term harm was caused to the patient). Since the incident, Ciocan had undergone additional training in the area of diabetes. However, due to a prior Interim Conditions of Practice Order, which was lifted less than two months prior to Ciocan's Substantive Hearing, the panel deemed that Ciocan had not been able to demonstrate sufficient remediation. In the following quote from the official hearing document, the panel make clear that Ciocan's inability to demonstrate adequate remediation was a key concern of theirs:

> "The panel's primary concern was that you have so far been unable to practically demonstrate that you have remediated your past failings in relation to diabetic patients."

This also occurred in the case of Adenusi whose case was analysed as part of my documentary analysis sample. Adenusi was a female nurse accused of, amongst other things, dishonesty related offences (misconduct) and failing to demonstrate knowledge of basic nursing skills (competence). When outlining their decision in the official hearing document, the panel summarised Adenusi's representative's arguments, which were as follows:

> "Ms Stephenson [the registrant's legally qualified representative] outlined the mitigating factors in this case. She told the panel that as you have been subject to an interim suspension order for some time, you have not had the opportunity to remediate the deficiencies in your practice, whilst working as a registered nurse. Further, she submitted that at the time the incidents occurred, you were a newly qualified nurse and had not had the time to

> establish yourself in a new role, working as a registered nurse."

As can be seen above, the use of both Interim Conditions of Practice Orders and Interim Suspension Orders can result in considerable problems for registrants when attempting to demonstrate adequate remediation. This is particularly acute in cases involving proficiency-related misconduct, even when additional training has been undertaken. In the case of Adenusi, the panel took the view that, despite Adenusi having undertaken additional training to remediate practice, she had not put her training into practice (due to her Interim Suspension Order). The panel therefore deemed that she had not sufficiently remediated her practice in these areas, which can be seen in the following quote from the official hearing document:

> "Whilst your misconduct involving poor record keeping which might be capable of remediation, through relevant training and reflective practice, the panel noted that you completed the online training courses in record keeping and infection control relatively recently… and have not had sufficient opportunity to put this theoretical knowledge into practice. It therefore has no evidence of your current clinical practice in these areas."

There have been other cases in my documentary analysis sample where the panel have decided that, despite the registrant not being able to practice, they have kept their knowledge up-to-date via journal subscriptions and additional reading. An example of this can be seen the case of Fox-Cobham who was a female general nurse who admitted to ordering and administering yellow fever vaccinations (YFV). That is despite Fox-Cobham knowing that the clinic she worked in was not certified to provide the vaccinations nor did she have the authorisation from the clinic or the training to do so in any event. Yet, despite being under an Interim Suspension where she could not practice, the panel decided that she had kept her training up-to-date via journal

subscriptions and peer contact, which can be seen in the following quote from the official hearing document:

> "The panel also took into account that you have maintained an up to date knowledge of nursing skills and practice via subscriptions to relevant journals. You have kept up with nursing peers and meet up and discuss up to date nursing practice with them. Although you have been unable to practise as a nurse, you have been working at a nursing Agency since July 2015 in a non-clinical role running the on-call service which involves placing nurses and dealing with administration inquiries. You had previously worked through the Agency as a nurse and the panel had sight of the positive reference from your employer attesting to the high regard in which you are held."

This demonstrates the highly variable nature of the way that panels assess remediation, which is exacerbated by the fact that there is no burden or standard of proof during the Misconduct, Impairment or Sanction stages.

6.6: Panel Autonomy and the Interpretation of Aggravating and Mitigating Factors

Once an NMC FtP panel decides that a registrant's conduct is impaired, they are then required to decide what sanction, if any, is applied. When considering which sanction to apply, the panel are required to list what they deem as the aggravating and mitigating factors of the case. Although the NMC provide some examples of what they deem as aggravating and mitigating factors, the list itself covers broad categories rather than specific examples, thus making the interpretation of such factors particularly subjective. In terms of aggravating factors, the NMC provide the following examples:

> "…the panel will need to consider any aggravating features of the case, such as:

- any previous regulatory or disciplinary findings
- abuse of a position of trust
- lack of insight into failings
- a pattern of misconduct over a period of time.
- conduct which puts patients at risk of suffering harm"

(NMC, 2017l)

The first example regarding any previous regulatory findings could be considered the least subjective of the five examples. However, it is worth noting that the NMC do not state that the panel can only take previous regulatory action into consideration if it resulted in a sanction or a finding of impairment. This means that the panel can draw inferences from regulatory investigations even if they did not result in the registrant being referred for an NMC FtP hearing. In fact, according to Rule 6C (3) (b), even if a registrant is cleared of any allegations prior to a hearing, should the NMC receive any further allegations against the registrant within three years, the NMC may reinvestigate said allegations. Thus, what is deemed as 'regulatory findings' is also relatively subjective.

The next four examples are both broad and highly subjective, which demonstrates the degree of autonomy that the panel possess when deciding on the aggravating factors of the case. The quote below demonstrates how the NMC make clear that when an NMC FtP panel is deliberating on sanction, the panel must treat each case individually:

> "The guidance sets out our approach to the various sanctions. It is not intended to be an alternative source of legal advice. When appropriate, the independent legal assessor will advise the panel on questions of law, including questions about the use of this guidance and the approach it should take. *Panels must always have in mind that each case is different and should be decided on its own particular facts.* [own emphasis]"

(NMC, 2017p)

This, again, not only suggests but actively encourages NMC FtP panels to engage in highly subjective reasoning. However, the list provided above is not intended to be exhaustive, thus providing the panel with considerable autonomy when deciding what they deem to be aggravating feature of a case. An example of an aggravating factor which does not fall within the above examples set out by the NMC can be seen in the case of Allsebrook who was a male learning disabilities nurse whose case was analysed as part of my documentary analysis sample. Allsebrook was a male nurse accused of using inappropriate handling techniques on a vulnerable patient, namely, that he put his arm out across a door to prevent the patient from going through it, followed by Allsebrook placing his hand on the patient's chest and pushing the patient backwards. Although Allsebrook formed a CPD agreement which resulted in him being issued with a three-month Suspension Order, the panel stated in their decision to accept the CPD agreement that they found that the registrant's senior position aggravated the offence:

> "When considering impairment, the NMC have had regard to protecting the public and the wider public interest, the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Though there have been no concerns raised with regards to the Registrant's clinical practice as a nurse, his position as PMVA [Prevention and Management of Violence and Aggression] manager at the time was one of significant responsibility and such misconduct was a serious contradiction to his role. Accordingly, the Registrant agrees that he is impaired by reason of the wider public interest…"

The above example demonstrates how there can be a variety of factors that can aggravate an offence. This degree of flexibility in how the panel assess and/or interpret the aggravating factors of a case can make it

difficult for registrants, even when represented by legally qualified individuals, to prepare for and counter such views. This links back to the previous chapter's argument that the quasi-legal nature of NMC FtP hearings can significantly disadvantage registrants, even when represented by legally qualified individuals.

Similarly, in relation to mitigating factors, the NMC only list a few examples that are also very broad and subjective in nature, which are as follows:

> "Mitigation can be considered in three categories:
>
> - evidence of the nurse or midwife's insight and understanding of the problem, and their attempts to address it. This may include early admission of the facts, apologies to the complainant or the person(s) affected, any efforts to prevent reoccurrence or any efforts to correct the difficulties.
> - evidence of the nurse or midwife's observance of the principles of good practice. This may include a demonstration of keeping up to date with their area of practice, or their previous good character or history.
> - personal mitigation, such as periods of stress or illness, personal and financial hardship, level of experience at the time in question, level of support in the work place (the list is not exhaustive).
>
> (NMC, 2017l)

The above examples, again, denote the high degree of autonomy that the panel have when interpreting the mitigating factors of a case. Possibly the best example of the degree of autonomy that a panel can exercise when assessing mitigating factors can be seen in the case of Wood who was a female general nurse whose case was analysed as part of my documentary analysis sample. In this particular case, Wood was a female nurse who was accused of, and who admitted to, falsifying

a colleague's temperature when returning from a West African country that was suffering with an epidemic of an extremely virulent disease, which Wood and her colleagues had travelled to volunteer in. Wood and colleagues were responsible for taking each other's temperatures once they returned to the UK in order to assess whether they had to potentially developed the aforementioned disease. However, Wood, along with a registered doctor, recorded her colleague's temperature as lower than it was so that they could exit the airport due to the poor conditions present there (with the intention of dealing with their colleagues raised temperature afterwards). Unfortunately, before Wood and the doctor could get their colleague's temperature addressed, Wood's colleague began displaying symptoms (and was later found to have contracted the disease). In the following quote from the official hearing document, the panel acknowledge the degree of flexibility that NMC FtP panels possess (whilst stating that Wood's case was unique):

> "The panel has had careful regard to the ISG [Indicative Sanctions Guidance]. *It is a guide and no more.* It is for the panel to exercise its own independent judgment having had the opportunity to see and hear from you and assess all the evidence [own emphasis]"

The statement "it is a guide and no more" demonstrates the panel do have the option to disregard some or all of the NMC's guidance on sanctions. Nevertheless, the fact that the panel felt the need to make the above statement suggests that they feel that they were under considerable pressure to justify their reasoning, particularly as this was a very high-profile case with heavy media coverage. This continues as follows:

> "Further, the panel concluded that an honest person can, in certain rare circumstances, act in a dishonest manner without it implying that they have a propensity to be dishonest…

> Whilst the panel considered that dishonesty is extremely serious and unacceptable, the panel found that the dishonesty in your case was not premeditated but a momentary lapse of judgment. The panel did not have evidence of any deep-seated attitudinal problem."

Wood's case is the only case in both my observation and documentary analysis samples where a panel have acknowledged that an individual can have acted dishonestly, but not have a "propensity to be dishonest". There is also no regulatory case law that has made such an acknowledgement. Equally, there is no reference to this in the Indicative Sanction Guidance (ISG), in fact, the ISG argues that:

> "Dishonesty, even where it does not result in direct harm to patients but is related to matters outside of a nurse or midwife's professional practice, for example, fraudulent claims for monies, is particularly serious because it can undermine the trust the public place in the profession. Honesty, integrity and trustworthiness are to be considered the bedrock of any nurse or midwife's practice."
>
> (NMC, 2016a: 6)

In the case of Wood, it is also worth considering the fact that her dishonesty was for the benefit of someone else rather than for her own gain although the panel did not make reference to this. Despite not providing the panel with a reflective piece, the panel still came to the conclusion that Wood would most likely have reflected on her actions. It is worth noting, however, that Wood's colleague did end up developing the aforementioned virulent virus (and had been displaying early symptoms of the infection), which led the panel to conclude:

> "The panel has also taken into account your hitherto impeccable character and clinical practice. You have provided character evidence and testimonials as to your integrity and professionalism that are superb. The

> references you have provided are from an impressive range of senior nurses, doctors, line managers, and peers. Whilst you have not provided a reflective piece, the panel has no doubt that given your character you will have reflected on the panel's findings about what went wrong, your role and how you should do things differently in the future."

This, again, demonstrates that the panel do have the option to disregard the guidance laid down by the NMC regarding sanctions and can also opt to ignore the usual expectation of a demonstration of insight and remorse via a reflective statement. This could be seen as the panel opting to use their own judgement on whether Wood had demonstrated insight and remorse. This is instead of the panel relying on an expression of 'performed remorse', or as Case (2011) has labelled it, 'contrived remorse', which a written reflective piece could be argued to be.

However, the panel does make note that Wood provided them with what they deemed as an 'impressive' list of references from senior doctors and nurses. This tendency for NMC FtP panels to be impressed by the status of the referee is a common occurrence in NMC FtP hearings, yet it also potentially disadvantages ethnic minority nurses. The reason for this is that ethnic minority nurses are underrepresented in senior positions within the nursing profession, which academics such as Likupe (2006) and Larson (2007) have argued is due to discrimination. This means that, due to their poor career profession, ethnic minority nurses have less chance of working with and developing professional relationships with other senior nurses and doctors whom could be used as references in NMC FtP hearings.

6.7: Conclusion

As can be seen so far, not only do the panel have a high degree of flexibility in the Misconduct, Impairment and Sanction stages, but what is seen to constitute misconduct can vary considerably. This chapter also highlighted sex-based differences in the types of misconduct committed

by male and female nurses in my documentary analysis sample, such as male nurses being more likely to be found to have committed care-related and conduct-related misconduct. However, in the next chapter I will argue that the types of misconduct committed by male nurses is not the sole reason for the aforementioned statistic; transparency and shame are also potential mechanisms that contribute towards male nurses over-representation in the NMC statistic.

Chapter 7: An Analysis of the Role of Transparency, Shame and Public Interest in NMC FtP Hearings and the Resultant Sanctions

"It was clear to the panel that the experience of *appearing in public* at a regulatory hearing was a deeply *distressing* and shaming experience*. I concluded that the whole process of exposure and investigation, with which you have fully engaged, has been a salutary lesson for you."*

NMC FtP Panel, Case of Panaikkal John

7.1: Introduction

The purpose of this chapter is to continue to analyse the various factors that contribute to male nurses being more than three times more likely to be struck off than female nurses (NMC, 2017b). The key question is therefore to assess what other mechanisms are present in NMC FtP hearings that influence this statistic. This is in addition to the already established fact that male nurses in my sample were more likely to be convicted of criminal offences, particularly those of a violent and sexual nature. It will be argued that the key aspects influencing this statistic are not only the type of misconduct committed by male nurses, but also the way in which male and female nurses are seen to be remediating their misconduct via the concept of shame. However, in order to achieve this, it is important to first rule out other potential variables that could influence this statistic, namely, a lack of attendance, a lack of legally qualified representation and the forming of Consensual Panel Determinations (CPD) agreements.

Once these topics have been discussed, this chapter will then examine how *shame* influences the statistics. Throughout this discussion, the topic of transparency will be discussed and broken down both in relation to shame and public interest. The role that shame plays in society will first be looked at, followed by a discussion on the transparency present in NMC FtP hearings and how it relates to public interest. We will then go on to discuss the issue of shame specifically in relation to male nurses

and the role that shame plays in the aforementioned statistics of how male nurses are more than three times more likely be struck-off than female nurses (NMC, 2017b. Finally, this chapter will analyse the role that public interest plays both in relation to transparency and the application of sanctions.

7.2: Attendance at NMC FtP Hearings

The first area that needs to be addressed when ruling out potential mechanisms that could contribute to male nurses being more than three times more likely to be struck off than female nurses (NMC, 2017b) is the issue of attendance at hearings. Whilst carrying out the observations, it became apparent that some nurses chose not to attend their NMC FtP hearing(s) and, in some cases, completely disengaged from the NMC FtP process altogether. However, the effect that a lack of attendance can have on a case depends on whether the nurse has formed a Consensual Panel Determination (CPD) agreement or is due to undergo a full Substantive Hearing. A CPD agreement is where the registrant and the NMC come to an agreement on the facts of the case, the misconduct committed, the registrant's current impairment and the resultant sanction, with the full range of sanctions being available including Striking-Off Orders. This CPD agreements is then either accepted or rejected by an NMC FtP panel (NMC, 2016b). A Substantive Hearing, on the other hand, is where the NMC present their case to a panel and the registrant has the opportunity to present their own case/a defence to the charge(s), (if they have denied the charge(s)), as well as giving evidence during the Misconduct, Impairment, and Sanction stages. Although the NMC have not explicitly stated that there is any expectation that registrants attend CPD hearings, it became clear in my observational sample and my documentary analysis sample that, should a registrant choose to not attend a CPD hearing, it would not necessarily disadvantage their case. This is evidenced by the fact that so few nurses attend CPD hearings as can be seen in the table below.

Attendance at CPD Hearings in the Documentary Analysis Sample

	Present	Absent
Female nurses	0 female nurses	10 female nurses
Male nurses	1 male nurse	7 male nurses

Furthermore, out of these eighteen CPD cases, fifteen of the CPDs were accepted by the panel with no amendments. With reference to the remaining three CPD agreements, in the first case, the panel increased the length of the Suspension Order for one of the CPD cases, which involved a female nurse. In the second case, the panel decreased the length of a Suspension Order for another CPD case, which also involved a female nurse. In the third case, the panel added an additional term to a Conditions of Practice Order that concerned a male nurse. All of these amendments were agreed to by the NMC and the registrants, despite none of the registrants being present, although all three registrants confirmed their consent via telephone.

The next question that needs to be answered is whether a lack of attendance at Substantive Hearings contributes to the reason why male nurses are more than three times more likely to be struck off than female nurses (NMC, 2017b). If you exclude CPD hearings from the statistics on attendance, all but one male nurse was in attendance at their Substantive Hearings, unlike female nurses who, in my documentary analysis sample, were often absent, as can be seen below:

Female and Male Nurses Attendance at Substantive Hearings (SH) in the Documentary Analysis Sample

	Absent	Present
Female nurses	13 female nurses	25 female nurses
Male nurses	1 male nurse	14 male nurses

As can be seen above, just over a third of female nurses in my sample were absent, yet only one male nurse was absent. This raises the question: Why is it that such a large number of male nurses attend Substantive Hearings where they have the opportunity to give live evidence attesting to their insight, remorse and remediation, yet are still more than three times more likely to be struck off than female nurses (NMC, 2017b)?

7.3: Legal Representation at NMC FtP Hearings

The next potential factor then that needs to be considered is whether legally qualified representation at hearings, or a *lack* of legally qualified representation at hearings, is a possible mechanism in male nurses being more than three times more likely to be struck off than female nurses (NMC, 2017b). However, before discussing the number of male and female nurses who were represented in my sample, it is important to highlight that there are two types of representation: legally qualified representation and non-legally qualified representation. There was only one female nurse who was represented by a non-legally qualified representative in my documentary analysis sample (none of the male nurses in my documentary analysis sample were represented by a non-legally qualified representative). Equally, there were two female nurses who were absent but represented at the hearing by a legally qualified representative in my documentary analysis sample, although both cases were CPD hearings.

Present and Legally Represented in Substantive Hearings (SH) by Gender in the Documentary Analysis Sample

	Number of nurses present and legally represented	**Total number of nurses in my DA sample by gender**
Male Nurses	11 male nurses	23 male nurses
Female Nurses	11 female nurses	48 female nurses

Present and Unrepresented in Substantive hearings (SH) by Gender in the Documentary Analysis Sample

	Number of nurses present and unrepresented	**Total number of nurses in my DA sample by gender**
Male Nurses	3 male nurses	23 male nurses
Female Nurses	10 female nurses	48 female nurses

As can be seen above, nearly three quarters of male nurses who participated in Substantive Hearings were represented by legally qualified representatives, yet less than a third of female nurses were present and represented by a legally qualified representative. The remaining male and female nurses that attended were therefore present but unrepresented. Again, this raises the question as to why male nurses are three times more likely to be struck off the register than female nurses, despite the fact that, in my documentary analysis sample, male nurses are nearly three times more likely to be represented by a legally qualified representative than female nurses.

7.4: Male Nurses' Over Representation in Consensual Panel Determinations

The final possible mechanism that needs to be analysed prior to discussing the role of shame and transparency in NMC FtP hearings is whether the forming of CPD agreements has led to male nurses being more than three times more likely be struck off than female nurses (NMC, 2017b). CPD agreements can include the full range of sanctions, including Striking-Off Orders (NMC, 2016b). In my documentary analysis sample, male nurses formed a higher number of CPD agreements on percentage compared to female nurses, as can be seen below:

CPD agreements by Gender in the Documentary Analysis Sample

	Male Nurses	Female Nurses
Number of CPD Agreements	8 male nurses	10 female nurses
Total Number of Nurses in DA Sample by Gender	23 male nurses	48 female nurses

As can be seen above, male nurses in my sample are significantly more likely to form CPD agreements. One consideration could be that, as male nurses are more likely to form CPD agreements, they do not have the same opportunity to demonstrate insight and remorse. This is because they may not be able to demonstrate the same degree of insight and remorse that they would otherwise have been able to were they to go through a full Substantive Hearing, thus potentially causing male nurses to be more likely to be struck off than female nurses. As mentioned in Chapter 3 (Methdology), the official hearing documents appear to be constructed via templates, as a result panels tend to refer to the degree of a registrant's insight and remorse as being one of the following: Significant; Partial; or Little/None. By using such set criteria for describing the degrees of insight and remorse possessed by a given registrant, it has allowed me to collect statistics on the number of male and female nurses and their degree of insight and remorse in both CPD agreements and full Substantive Hearings. The degree of insight displayed by male nurses in my documentary analysis sample can be seen in the two tables below, which detail the degree of insight that male nurses are deemed to have possessed in CPD hearings and full Substantive Hearings:

Insight Displayed by Male Nurses in CPD Hearings in the Documentary Analysis Sample

	Little/None	Partial	Significant	No Mention

Male Nurses	2 male nurses	1 male nurse	4 male nurses	1 male nurses
Female Nurses	1 female nurses	1 female nurse	8 female nurses	0 female nurses

The CPD hearing where the panel failed to mention the degree of insight possessed by the registrant resulted in a striking-off order, which could suggest that the panel felt that the registrant had shown little or no insight.

<u>Insight Displayed by Male Nurses in Substantive Hearings (SH) in the Documentary Analysis Sample</u>

	Little/None	**Partial**	**Significant**	**No Mention**
Male Nurses	8 male nurses	3 male nurses	4 male nurses	None
Female Nurses	17 female nurses	9 female nurses	8 female nurses	4 female nurses

As can be seen above, with the exception of the 'Partial' insight category, male nurses have been deemed as showing more insight in cases when they have formed CPD agreements rather than undergone full Substantive Hearings. This therefore suggests that, in my documentary analysis sample, the forming of a CPD agreement does not prevent male nurses from demonstrating insight and remorse. This can be seen in tables below, which detail the degrees of remorse displayed by male nurses in CPD hearings and full Substantive Hearing.

<u>Remorse Displayed Male Nurses in CPD Hearings in the Documentary Analysis Sample</u>

	Little/None	**Partial**	**Significant**	**No Mention**
Male Nurses	1 male nurses	1 male nurse	3 male nurses	3 male nurses

Female Nurses	1 female nurses	1 female nurses	8 female nurses	0 female nurses

Remorse Displayed Male Nurses in Substantive Hearings (SH) in the Documentary Analysis Sample

	Little/None	Partial	Significant	No Mention
Male Nurses	7 male nurses	1 male nurse	5 male nurses	3 male nurses
Female Nurses	18 female nurses	9 female nurses	7 female nurses	4 female nurses

In two of the Substantive Hearings where the panel failed to mention the degree of remorse demonstrated by the registrant the sanctions received were Striking-Off Orders, which could suggest that the panel felt that the registrant had shown Little/No remorse.

As can be seen above, male nurses were, again, deemed to have displayed more remorse in cases where they formed CPD agreements than in cases where male nurses underwent full Substantive Hearings. This therefore raise the question as to whether giving live evidence during the impairment and sanction stages in a full Substantive Hearing disadvantages male nurses. However, it is important to note that the higher degrees of insight and remorse displayed in CPD agreements in my sample are most likely as a result of the varying admissions of guilt in CPD hearings as a registrant must admit all charges to form a CPD. Furthermore, unlike female nurses, there were no male nurses in my documentary analysis sample who admitted to all of the facts but chose to go through a full Substantive Hearing where they would give evidence during the impairment and sanction stage. Instead, all of the male nurses who admitted all of the charges against them formed CPD agreements, as can be seen below:

Admission of All Charges in Substantive Hearings by Gender in the Documentary Analysis Sample

	All charges admitted to	Some charges admitted to	No charges admitted to
Male nurses	No male nurses	6 male nurses	6 male nurses
Female nurses	8 female nurses	9 male nurses	21 female nurses

By not admitting to all or some of the charges that the panel then found proved in the Substantive Hearings, it would therefore follow that the nurse in question would struggle to demonstrate the same degree of remorse and insight into the acts detailed in the charges had they admitted to the charge(s) in the first place. However, if you combine the statistics in my documentary analysis sample for CPD hearings and full Substantive Hearings where male and female nurses have admitted to all of the charges against them, it would come to a total of eight male nurses and nineteen female nurses.

Admission of all Charges in CPD Hearings and Substantive Hearings (SH) by Gender in the Documentary Analysis Sample

	Male nurses	Female nurses
Admittance of All Charges (CPD & SH) in DA Sample by Gender	8 male nurses	19 female nurses
Total Number of Nurses in DA Sample by Gender	23 male nurses	48 female nurses

Although the proportion of female nurses in my sample who have admitted all charges against them is slightly higher than male nurses, it would be difficult to argue that this would account for the reason why male nurses are more than three times more likely to be struck off than

female nurses (NMC, 2017b). This therefore leaves us with two remaining possible mechanisms that could possibly influence the aforementioned statistic: the type of misconduct being committed and the way in which male and female nurses remediate such misconduct, the latter of which we will now discuss. As mentioned in the previous chapter, male nurses are more likely to commit criminal offences, particularly ones of a violent and/or sexual nature which was a causal mechanism for male nurses in my documentary analysis sample being more likely to be struck-off. However, I will now argue that another key factor that influences the above statistic is the concept of *shame* and the role it plays in remediating misconduct.

7.5: Shame and Society

Shame is a long-established emotion that can be found in a variety of societies. However, as Scheff (2003) has pointed out, shame itself is considered a taboo emotion within everyday life, which is partly why it has received little attention in academic literature, although that has begun to change. Sociological work, such as Goffman's (1956) work on embarrassment and social organisation has looked at the way embarrassment is caused and played during social interaction. However, shame in NMC FtP hearings itself goes beyond embarrassment, although this does occur at points. Authors such as Retizinger (1991; 1995) both conceptualised shame and came up with a methodology for assessing it. Retzinger's (1991; 1995) methodology for assessing shame advocates for in-depth qualitative case studies which are analysed using discourse analysis. As the quote from Retzinger below states:

> "…in the initial stages of exploration, microscopic analyses of individual cases may be more useful than aggregate studies in understanding emotion and social relationships"
>
> (Retzinger, 1995: 1104)

Through her own work, Retzinger (1991; 1995) identified hundreds of words and gestures that she argues are expressions of shame, which in turn can be used in future research. However, due to the fact that the methodology developed by Retzinger (1991; 1995) was based on discourse analysis, this methodology would be inappropriate given that much of the research is based on observations and documentary analysis. For this reason, I will utilize Scheff's (2003) work which states that shame is a *class of affects*, which include emotions such as embarrassment and humiliation, along with his conceptual definition of shame which can be seen below:

> "Conceptual Definition: Drawing on the work of the pioneers reviewed here, I define Shame as the large family of emotions that includes many cognates and variants, most notably embarrassment, guilt, humiliation, and related feelings such as shyness that originate in threats to the social bond. This definition integrates self (emotional reactions) and society (the social bond).
>
> (Scheff, 2003: 244)

Furthermore, it is also important to note that the cognates of shame can vary in duration, from *embarrassment*, which can be seen as weak and transient, *shame*, which is stronger and more durable, and *humiliation*, which is powerful and of long duration (Scheff, 2003). It is important to note, however, that shame itself can be seen as both an external *and* internal process in that it is the perceived judgement of others that elicits internal feelings of shame (Scheff, 2003). As discussed in the previous chapter, the demonstration of insight and remorse are key features of remediation, however, I argue that shame is the key emotion that is both elicited and utilized within the NMC FtP process, particularly in relation to Substantive Hearings.

7.6: Transparency and Politics

Shame, or the feeling of being ashamed, is present within the NMC FtP process, particularly in relation to Substantive Hearings. However, it is important to point out that whilst NMC FtP panels acknowledge that nurses have and will feel humiliation when undergoing a full substantive hearing, there is no evidence to suggest that the panel actively try to humiliate the nurse. NMC FtP panels do, however, expect the registrants to be ashamed of their misconduct as this can assist the registrant in demonstrating that they have remediated their misconduct. However, before we go onto discuss the various cases where shame has played a role, it is important to first discuss what causes this high degree of shame.

Perhaps the most obvious example of how the NMC FtP process creates feelings of embarrassment and shame is the fact that full Substantive Hearings are held in public when heard by the Conduct and Competence Committee (only Health Committee hearings are held in private). This fact in itself is the reason why I was able to carry out this research, as both the media and general public can attend these hearings. Although the public nature of the hearings potentially increases feelings of humiliation and embarrassment, it would be unfair to suggest that this is the sole reason why the hearings are held in public. One of the main purposes for the hearings to be held in public is to demonstrate transparency, which is something that the former UKCC, who governed the nursing profession prior to the creation of the NMC in 2002, was accused of lacking (Cooke, 2006a). Thus, according to the Department of Health in 2001, the new professional regulator had to not only be tougher but more transparent in nature (DoH, 2001 cited in Cooke, 2006a). This intervention in the way in which nurses are regulated is not altogether surprising, given that within ten years of the General Nursing Council being created in 1919, the government conducted an involuntary investigation. This compares with the General Medical Council, who did not undergo an involuntary investigation for just under 150 years from its creation in 1856 (Abel Smith, 1960). Since 2001, the government, according to Cooke (2006a), therefore charged the NMC with using the 'bad apple' model where the NMC focuses on identifying and punishing

individual nurse wrongdoings rather than organizational issues or failures. Indeed, there has been considerable evidence within my documentary analysis sample which show that although NMC FtP panels do acknowledge organizational issues, their conclusions tend to focus on the nurse instead. This, however, may begin to change as the NMC (2018f) have published the results of their recent consultation stating that they wish to reorganise their approach and, amongst other things, not prosecute nurses who have made errors that any other nurse would have done in the same situation. This potentially acknowledges ongoing organizational issues. Authors such as Mansour et al. (2012) have also highlighted how much of the current patient safety research focuses on accident causation rather than organizational factors. Nevertheless, by holding the hearings in public in order to demonstrate transparency, the NMC could be seen as trying to appease the public interest at the expense of the registrant and the considerable discomfort that the public nature of Conduct and Competence Committee hearings causes them.

Yet, the issue of transparency is not simply a passive feature of NMC FtP hearings that causes in indirect side effects such as shame and embarrassment, rather, transparency can in fact generate public interest of its own accord. An example of how transparency can generate public interest can be seen in cases involving conduct-related errors, such as in the case of Dass. Dass was a male general nurse in my documentary analysis sample accused of, and who admitted to, making multiple inappropriate and highly offensive comments to colleagues whilst at work (although never in the presence of patients). There were equally no concerns regarding Dass' clinical competence and/or delivery of care. The Healthcare Trust (now CCG) which Dass worked for conducted an investigation and held a disciplinary hearing which recommended that Dass undergo supervision and training. Dass fully engaged with the investigation and training, the latter of which Dass had almost completed on the date of the hearing. Dass retained his position and was not suspended from practice at any point during the investigation, simply just relocated whilst the investigation was undergoing. Nevertheless, the

NMC chose to pursue the case, which resulted in Dass and the NMC forming a CPD agreement with a five-year Caution Order. When ratifying this CPD agreement, the panel stated that the sanction was based solely upon (and was necessary to appease) the public interest, as demonstrated in the following quote from the official hearing document:

> "The panel was mindful that there is no suggestion that any of Mr Dass's conduct was witnessed by or directed towards a patient. However, in the particular circumstances of this case, the panel determined that a finding of impairment is necessary to uphold the public interest by maintaining public confidence in the profession and by declaring and upholding proper standards of conduct and behaviour. The panel considered that confidence in the profession and in the NMC as its regulator would be undermined if a finding of impairment is not made in in light of the serious attitudinal and behavioural concerns which are evident in this case and which caused distress to his colleagues."

The reason this is of importance is that, although it could be argued that the public expect nurses to behave appropriately towards each other, prior to the hearing there were no media reports on the issue nor was there any mention of patients becoming aware of how Dass had behaved. It is therefore questionable why it would have undermined the public confidence were the NMC not to pursue the case if there was no public knowledge of these events occurring in the first place. Again, it could also be argued that the NMC are under a duty to be 'transparent' about the cases that they have referred to them, yet this case nevertheless demonstrates that transparency itself can create the necessary conditions for the public interest to be invoked. This can often result in sanctions being issued against clinically competent nurses who have already been disciplined by their employers solely to appease the public interest. This creates a highly punitive method of regulation; however, this will be discussed later on in the chapter.

7.7: Contradictions in how Information is Managed in Public Hearings

There are, however, other tensions that can occur due to the issue of transparency. As mentioned earlier, medical information is meant to always be heard in private yet there have been examples in my observational sample where medical information pertaining to both the registrant and witnesses has been revealed. An example of witness' and/or patient's medical information being released can be seen in the case of Heslop whose case was observed as part of this research. Heslop was the aforementioned female nurse accused of forcibly administering intravenous antibiotics to a patient who had withdrawn consent for them to be administered, amongst other charges. Throughout the hearing, a considerable amount of the patient's medical information was released as the patient's name was anonymised. However, when it later transpired that the patient had not attended the hearing due to being in prison, the panel were provided with a copy of a newspaper article which both named the patient and outlined the patient's actions which resulted in his custodial sentence. It was possible, by putting the information discussed in the hearing in to a search engine (in this case, Google), to locate the article and therefore the patients name. This initial attempt to retain anonymity in this hearing was therefore easily overridden. Furthermore, Heslop's legally qualified representative provided a copy of the article to one of the other observers who was observing the hearing prior to starting a job as a legally qualified representative for a nursing Trade Union. It could be argued that the article was in the public domain and so therefore could be provided to members of the public. However, it does raise the question as to whether the public interest is seen in this setting as trumping an individual's right to privacy, given that the patient was not subject to NMC disciplinary procedures.

An example of a nurse's medical information being revealed can be seen in the case of Smith whose case was observed as part of this research. Smith was the aforementioned female nurse who admitted to stealing

prescription antiemetic medication. In the charges listed on the NMC's website, the name of the medication was including in the charges and it later transpired during the hearing that Smith stole the medication to help treat a medical condition that she was suffering from at the time of the theft. Although the name of the medication was later redacted from the charges, it nevertheless meant that part of Smith's medical information was indirectly released to the public. Furthermore, Smith had also formed a CPD agreement with the NMC, which would have involved detailed discussions surrounding the circumstances of the misconduct between Smith, her legally qualified representative and the NMC. Thus, the NMC would have most likely been aware of Smith's medical history and the reason why the medication was stolen when drafting the charges/placing them on their website.

It was equally clear that Smith was both uncomfortable with the level of transparency during the hearing. This was evidenced both by her look of discomfort when seeing myself seated in the public gallery and her subsequent application to have the entire hearing held in private. The reason for this application, according to Smith's legally qualified representative, was due to the considerable amount of medical information which was to be discussed during the hearing. Her representative therefore made an application under Rule 19 of the *NMC (fitness-to-practise) Rules (2004)* to have the full hearing held in private on medical grounds, which, were it successful, would have had all information concerning Smith removed from the NMC's website. However, in this particular case, the panel rejected the application instead opting for allowing the hearing to go into private periodically whenever medical information was to be discussed.

There were also a large number of applications made under Rule 19 of the *NMC (fitness-to-practise) Rules (2004)* to have the hearing held in private in both my observational and documentary analysis sample. Out of the twenty cases observed as part of this research, in ten of them there were applications to hear evidence in private and out of the seventy-one cases in the documentary analysis sample, in twenty-nine of them there

were applications to hear evidence in private. However, although all of the panels allowed the medical information to be discussed in private, there were no instances where the panel agreed to have the whole hearing held in private in my observational sample. However, it is important to note that if this were to occur in my documentary analysis sample, this information would have been removed from the NMC's website. As a result the specific case would not appear in my sample making it impossible for me to be able to identify whether a panel had granted an application for the full hearing to be held in private.

Nevertheless, there have been cases where the panel have called the hearing into private of their own volition both on medical and non-medical grounds. An example of the panel calling the hearing into private on medical grounds can be seen in the case of Ofili whose case was observed as part of this research. Ofili was the male nurse accused of, amongst other things, plagiarising two essays for a Masters course paid for by his employer. When Ofili went to discuss his mother's ill health, the Registrant Panel Member cut over him and stated that he would need to go into private should he wish to discuss her ill health. Interestingly, at this point the NMC case presenter, who I had briefly spoken to following another hearing, interjected and suggested to the chair that I could be allowed to remain in the hearing room whilst the hearing was in private as I was a researcher. Although the Chair decided that he would not allow this, it again shows another interesting facet regarding the degree of flexibility that the panel have both in relation to the issue of transparency and how the hearing is conducted.

An example of the panel calling a hearing into private on the grounds of non-medical information can be seen in the case of Henry whose case was observed as part of this research. Henry was the aforementioned female nurse accused of, amongst other things, spiking a colleagues drink with lactulose, making racist and sexually inappropriate comments to colleagues, and competence related issues. When hearing evidence from a witness who had accused Henry of making sexually inappropriate comments towards her (the witness), Henry's legally qualified

representative began to discuss the witness' bisexuality. However, the panel chair immediately intervened and called the hearing into private so the panel could decide whether they should hear this information in private. Once everyone returned to the hearing room, the panel chair advised me and the other observers (some of whom were media employees) that this information was to be heard in private and stated:

> "Please be responsible in your reporting"

Henry's legally qualified representative did not object to the hearing going into private. However, his facial expression and sigh when the chair intervened suggested that he was frustrated and surprised by this intervention. This potentially suggests that, again, there is a tension between the way sensitive information is handled by both NMC FtP panels and other actors involved in NMC FtP hearings.

7.8: Transparency and Shame during NMC FtP Hearings

Throughout the observations conducted as part of this research, it became clear that the transparency of the NMC FtP process, coupled with the public nature of Substantive Hearings, often resulted in clear and obvious discomfort. This became clear from the very first hearing that was observed as part of this research. In this particular case, Gilmour, who was a female nurse who had been found guilty of driving with excess alcohol, appeared visibly shaken at my presence in the room. This could be seen by her face slightly reddening upon seeing me sitting in the public gallery followed by her frequent nervous glances in my direction during the hearing. These physical effects have been described by Keltner and Buswell (1997) as being directly linked to both embarrassment and shame based on their experimental research. Yet, in the case of Gilmour, there was no application for the case to be held entirely in private session. Gilmour's legally qualified representative instead would periodically make applications under Rule 19 of the *NMC (fitness-to-practise) Rules (2004)* for parts of the case to be heard in private on the grounds that medical information was to be discussed. During the case, the NMC case presenter also made reference to the fact

that he would not read out certain information as there an observed (me) in the room. That is not to say, however, that there have not been cases where applications have been made for the entire hearing to be heard in private. In the case of Smith, who was a female nurse who admitted to stealing medication (and had formed a CPD agreement with the NMC), Smith's legally qualified representative made an application under Rule 19 of the *NMC (fitness-to-practise) Rules (2004)* for the entire hearing to be heard in private due to the large amount of medical information. This request was denied by the panel who instead stated that they would go into private when medical information was to be discussed, but the rest of the hearing would remain public. Although Smith accepted this, the look of disappointment on her face suggested that she would have been considerably more comfortable were the entire hearing to be held in private.

However, not all applications for the hearing to go into private were made on the grounds of medical, with an example being the case of Pinto whose case was observed as part of this research. Pinto was a male nurse accused of accessing hundreds of medical records of colleagues, family members and friends without permission. At the beginning of the hearing, Pinto, with the help of the Legal Assessor, asked for the entire hearing to be held in private as his children were being harassed as school after he had been sacked from the hospital. Although the panel did go into private session to discuss this further, they nevertheless rejected the application and allowed the remainder of the hearing to continue in public. From a reflexive standpoint, I did find myself at these points experiencing discomfort at the fact that my presence was distressing to the registrants. This may have been exacerbated by the fact that I would dress in suit trousers and a formal shirt in order to blend into the setting, which often led to me being asked whether I was a member of the media.

As mentioned earlier, the panel do appear to be aware of the discomfort that the registrants are feeling going through such a process, as can be seen in the case of Panaikkal John whose case was analysed as part of

my documentary analysis sample. Painaikkal-John was a female nurse who admitted to plagiarising an essay for her mentorship course. In this particular case, the panel stated that the following:

> "It was clear to the panel that the experience of *appearing in public* at a regulatory hearing was a deeply *distressing* and shaming experience. It concluded that the whole process of *exposure* and investigation, with which you have fully engaged, has been a *salutary lesson* for you. In the panel's judgment this will have been a *highly effective deterrent* against future dishonesty. [own emphasis]"

As can be seen above, the panel acknowledge that the appearing in public at the hearing was a distressing and *shaming* experience. The panel also made it clear that they feel that appearing in public has been a *salutary lesson*, which they assume works as a strong deterrent against future dishonesty. This element of NMC FtP hearings can be seen as having a punitive element.

As well as acknowledging the registrant's discomfort when undergoing a full Substantive Hearing in public, some panels have also acknowledged the fact that the hearings become somewhat of a public spectacle as can be seen in the case of Warren. Warren was the aforementioned male nurse accused of having sex with a former mental health patient on multiple occasions whose case was observed as part of this research. During the hearing, the panel chair stated to myself and the other observers in the room:

> "Sorry to those spectating, but we're going to go into private"

This notion of NMC FtP hearings being a public spectacle can also be seen clearly in the case of Stanton. Stanton's case was observed to see if there was any difference in the way that midwifery cases were conducted, which there were not. The reason for selecting Stanton's case was due to the nature of the charges which, prior to observing the

hearing, I had predicted would attract considerable media attention. Thus, this case was observed to act as an extreme type of midwifery cases put through a full Substantive Hearing. The charges against Stanton included speaking inappropriately to a woman in labour and not numbing the area of her vagina that she was to cut in order to aid delivery of the baby. The case itself was so popular among the media and other observers that around thirty seats were set up in three rows so close to the tables where the different actors sat that Stanton's legally qualified representative turned around and asked me whether I was 'press'. After I informed her that I was not, Stanton's legally qualified representative appealed to the panel chair stating that I was so close that I could potentially see her clients notes on the computer. However, the chair simply shrugged and said there was nothing she could do about it. Stanton's legally qualified representative was from then on very careful about shutting the lid of her laptop after she had finished typing any notes during the case. The presence of such a large number of observers and members of the media correlates with Canetti's (1962) argument that newspapers and the media mirror the 'baiting crowd' present during the 'spectacle of the scaffold' through the reporting of events and judgement of the individuals being reported.

The transparent nature of the NMC FtP hearings is not the only issue relating to visibility which is prioritised at the expense of the registrant, an example of which can be seen in the case of Peck whose case was observed as part of this research. However, in this case the anonymity of the witnesses was prioritised at the expense of Peck's legally qualified representative's ability to question two of the witnesses. Peck was the aforementioned male nurse who was accused of, amongst other things, slapping a work colleague on the buttocks as part of work place banter. The NMC had made a decision to allow the first and second witness to give evidence from behind a screen so that the public, and Peck, could not see them. In addition, both their names were anonymised during the hearing (witnesses' names are not normally anonymised during the hearing, only later in the panel's official hearing document). Due to the

layout of the room and the placement of the screens, it was not possible for the NMC case presenter and Peck's legally qualified representative to see the witness at the same time whilst they were being questioned. The NMC case presenter and Peck's legally qualified representative eventually came to an arrangement where the one asking the questions was seated where they could see the witnesses whilst the other could not. Yet, at no point was there a suggestion of sending out the public and/or Peck to allow for the removal of screens, despite Peck's legally qualified representative highlighting that it is important for 'lawyers' to be able to see a witness' facial expressions and body language when being questioned. Although it is vital for victims of sexual abuse and/or assault to receive anonymity, the fact that there was no mention or exploration to going into private session to hear the evidence suggests that the NMC prioritising visibility related issues over procedure designed to ensure a fair trial, despite the fact that the outcome of the case could result in the registrant losing their right to practice and hence their livelihood. Interestingly, however, the use of screens, along with the potential issues surrounding their placement and the resultant procedural issues was not mentioned at any point in the official hearing document produced by the panel. As Peck's conduct was not found to be impaired, the official hearing document was not placed on the NMC's website, however, the chair did decide to read out the official hearing document at the end of the case.

As can be seen in the above examples, despite the considerable discomfort felt by the registrants and the potential for embarrassment and shame, NMC FtP panels appear to actively defend the public element of Substantive Hearings heard by the Conduct and Competence Committee. During the observations, there was not a single case where the panel allowed the entire hearing to be held in private, although it was not possible to ascertain whether this was the case in the documentary analysis sample as the case would have been removed from the NMC's website (NMC, 2017c). However, it is important to note that the public nature of full Substantive Hearings heard by the Conduct and

Competence Committee is enshrined in the *NMC (fitness-to-practise) Rules (2004)*. Thus, it could be argued that although NMC FtP panels acknowledge the shaming effect that can occur as a result of holding Substantive Hearings in public, their hands are tied nonetheless.

7.9: Transparency and Panel Discomfort

NMC FtP panels also appeared to vary in their feelings and attitudes towards observers in the room. For example, in the case of Badjie whose case was observed as part of this research the panel chair openly acknowledged the observers in the room at the beginning of the hearing whilst introducing everyone present:

> "…and there are observers in the room who are very welcome"

On the other hand, some panels demonstrated thinly veiled displeasure at the presence of observers, such as in the case of Gilmour whose case was observed as part of this research. Gilmour was the aforementioned female nurse who had been convicted of driving with excess alcohol and was accused of deliberately not disclosing this information to her employer. In this instance the panel secretary gave me the option of reading the panel's decision on an application made by Gilmour's legally qualified representative. When the panel secretary informed the panel chair of this, the chair pursed his lips and directed an obvious look of displeasure towards me whilst sharply nodding his head in agreement. Equally, when some hearings had gone into private session and then returned to public, the panel chairs would stop the hearing until observers returned. Whereas in other cases, such as in the case of O' Brien whose case was observed as part of this research, the chair would simply allow the hearing to continue whilst the panel secretary went and found the observer.

Displeasure was not the only emotion displayed by some NMC FtP panels. Some panels appeared to be uncomfortable with the public nature of the hearing, but for their own interests rather than the

registrant's. An example of such panel discomfort can be seen in the case of Henry the female nurse who was accused of, amongst other things, spiking a colleagues drink with lactulose, the female nurse who, amongst other things, admitted to smacking a colleague on the buttocks as part of a practical joke. When waiting outside in the lobby, the Legal Assessor approached me and asked whether I was 'press'. After informing him that I was PhD researcher, the Legal Assessor stated that he would inform the panel as the presence of members of the media tends to make NMC FtP panels "nervous". This was then confirmed as the chair himself later approached me outside the hearing and began a conversation with me about my research. This discomfort is not surprising, however, as there has been considerable criticism of the NMC in the media. When the NMC insisted on putting nurse Pauline Cafferkey through a full NMC FtP hearing for actions taken in relation to her voluntary work. The panel found that, as the Cafferkey was suffering from, and under the influence of, a virulent disease she contracted during her voluntary work, Cafferkey had not committed misconduct (NMC, 2016c), Nonetheless, there was considerable criticism from the media as to why the NMC chose to put the nurse/registrant through a full substantive hearing (Cramb, 2016). Nevertheless, the fact that the panel are overly concerned with the media is somewhat paradoxical given that they themselves are granted far more privacy when making decisions than the nurse has when the decision is handed down.

That being said, it is not hard to understand why the media presence has an effect. There have been a number of cases that were observed as part of this research where the media published articles detailing events in the hearing. An example can be seen in the case of Henry, who was the female nurse who was accused of, amongst other things, making inappropriate comments towards staff members, along with competence-based issues. One of the particular phrases that Henry was accused of having said to a female colleague during routine work place banter was: "I would love to suck your nipples". The next day *The Daily Mail* published an article on their website with the headline:

> "Nurse accused of telling a colleague 'I would love to suck your nipples' claims she must have misunderstood his Scouse accent"
>
> (Daily Mail, 2016)

When in the hearing room waiting for the hearing to restart after lunch, Henry's friends, who were attending the hearing to provide support, stated to me that she had been devastated when she realised the way she had been portrayed in this (and other) articles. In accordance with Scheff's (2003) notion of shame, the circumstance that these articles are still present and available on the Internet for all to see could in fact amount to humiliation, not just shame. This is because humiliation differs from shame in that humiliation is a powerful and *long-lasting* emotion, whereas shame is typically shorter in duration and has less impact (Scheff, 2003). As the media articles covering Henry's case are still readily available on the Internet, it could be argued that they act as a source of humiliation due to their continued availability. Although the NMC may not intend for registrants to be humiliated, the use of shame as a method of control does correlate with the arguments made by authors such as Sennett (1980) who has demonstrated how managers, on a micro level, have and do use shame as a way controlling workers.

7.10: Shame and Male Nurses

As can be seen so far, shame is a key factor in full Substantive Hearings conducted as part of the NMC FtP process. It has been argued by scholars such as Lutwak and Ferrari (1996) and Lutwak et al. (1998) that whilst most individuals find shame a particularly difficult emotion to deal with, men are less likely to admit to experiencing feelings of shame and guilt compared to women. It could be argued that this is in part due to the way that masculinity is constructed in the West. Authors such as Butler (1990) and Floyd (2009) have argued that masculinity is not only constructed in opposition to femininity, but as superior to it. Consequently, it could be suggested thenceforth that when men experience shame, not only does their shame pose a threat to their social

bond with society, but also threaten their supposed masculinity. The reason for this is because shame is characterised by one's feelings of inferiority in comparison to a superior 'other' who is passing judgement upon them (Kaufman, 1993). Thus, as masculinity is based on superiority, when said superiority is stripped away, so too potentially is one's supposed masculinity. Furthermore, as highlighted in the previous chapter, 'professions' are a state certified occupational group of individuals who adhere to a professional code of practice and/or ethics. This code is enforced by the professional group as a whole through the use of processes such as disciplinary committees (Frankel, 1989). Thus, when one receives disciplinary action, such as being found to have impaired conduct in an NMC FtP hearing, it could be argued that the individual, or in this case the registrant, is deemed to be an inferior practitioner in comparison to their occupational peers. Moreover, authors such as Hinshaw (2007) and Elison et al. (2006) have argued that another key purpose of shame is not only to make another individual feel inferior, but to also bolster oneself as the superior individual. Therefore, by conducting full Substantive Hearings in public, the NMC could be interpreting as attempting to bolster the profession a whole in the eyes of the public by striking out the inferior practitioner.

There is also considerable evidence within both my documentary analysis sample and the observational sample that male nurses struggle with this process of public shaming. Out of the forty-eight female nurses in my documentary analysis sample, five of them admitted to all charges but opted to go through a full Substantive Hearing where they gave evidence during the Impairment and Sanction stage. Four out of the five female nurses admitted that they had committed misconduct and that their conduct was impaired. On the other hand, only one male nurse in my documentary analysis sample admitted all of the charges and chose to undergo a full Substantive Hearing, although the registrant denied that his conduct was currently impaired. This particular case concerned Ciocan, who was a male nurse accused of, and admitted to, the following charges:

> “1) On 19 April 2015 administered insulin to Resident A when you should not have.
>
> 2) On 28 April 2015 did not escalate that you had not carried out an essential blood sugar check on Resident A when you should have.
>
> 3) Do not have the necessary knowledge of English to practise safely as a nurse.“

However, despite Ciocan admitting to the above charges, he stated to the panel that whilst he had committed misconduct in relation to the diabetes charges, his conduct was not currently impaired. Ciocan did admit to the third charge concerning his lack of proficiency with the English language (in that he had failed to achieve the required 7.0 on the International English Language test, instead achieving 4.5). However, Ciocan still stated to the panel that he felt that his proficiency in the English language was adequate to practice as a nurse in the UK, as can be seen in the following quote from the official hearing document:

> “With regard to the standard of your English language you accept that your English is not perfect, but you consider it to be good enough to practise nursing in the UK. You said that you received a letter from the NMC in August 2016, which required you to sit an IELTS in September 2016. You told the panel that at this time you were working 4 – 5 twelve hour nightshifts per week. You said that this made it very difficult for you to concentrate the following day if you needed to study. In light of this you said that you did not have enough time to prepare for the IELTS. Since taking the test you have been planning to enrol in an ESOL course, but have been awaiting the outcome of this hearing. In order to improve your English language you spend your free time watching English language films with subtitles and regularly read English magazines and books.”

The panel nevertheless still found that Ciocan's conduct was impaired both due to Charges 1 and 2 which concerned misconduct, and Charge 3 which concerned his proficiency with the English language. Furthermore, upon the hearing adjourning at the end of the first day of the hearing, Ciocan did not attend in person on the second day, instead only giving evidence via telephone. The reason given by Ciocan was that he did not feel able to attend the hearing due to stress, which was also acknowledged by the panel. This refusal to attend the hearing after the panel found that the registrant's conduct was impaired or, in other words, deficient, could be deemed as a result of shame. I argue that this is because one particular way that male nurses deal with feelings of shame is by disengaging with Substantive Hearings conducted as part of the NMC FtP process.

An example within my observational sample where the issue of shame occurred, particularly around admissions of guilt and attendance, can be seen in the case of Warren who was the aforementioned male nurse accused of the following charges:

> "That you, a Registered Nurse,
>
> > 1. Between September 2013 and January 2014, engaged in an inappropriate relationship with Patient A;
> >
> > 2. On or around 10 January 2014, engaged in inappropriate sexual activity with Patient A;
>
> And, in light of the above, your fitness to practise is impaired by reason of your misconduct."

At the beginning of the hearing, Warren's non-legally qualified representative made an application under Rule 28 of the *NMC (fitness-to-practise) Rules (2004)* to have the charges against Warren amended to the following:

> "That you a registered nurse had an inappropriate relationship with Patient A a service user for whom you had formerly acted as key worker in that:
>
> > 1. In or around [date] you invited her to become a connection on LinkedIn;
> >
> > 2. Between [date] and [date] you exchanged emails and text messages and had telephone conversations with her;
> >
> > 3. On two occasions, on [date] and again on [date] or [date], you met her for coffee at a cafe;
> >
> > 4. On the night of [date] you engaged in sexual activity with her."

Warren's non-legally qualified representative contended that the above amendments would properly emphasize the following: firstly, that Patient A was a former patient of Warren's. Secondly, that he was no longer in a professional relationship with her at the material time of the events. Thirdly, that the amended charges also represented the fact that Warren was prepared to admit. The panel summarise Warren's non-legally qualified representative's argument in the following quote taken from the official hearing document:

> "Ms Percival [Warren's non-legally qualified representative] submitted that the proposed amendments properly reflected the fact that at the material time, you were no longer in a professional relationship with Patient A. She asserted that this was important since the charges as drafted by the NMC did not particularise that fact. She contended that the fact that you were no longer in a professional relationship with Patient A was relevant and would mean that the NMC would be required to establish a broader basis to prove its case and this would include your knowledge of Patient A's history. Ms Percival stated that

> the proposed amendments also represented the facts which you would admit."

Nevertheless, the NMC opposed the amendments on the grounds that it would constrain the NMC on being able to establish what was "inappropriate" conduct on Warren's part. The panel agreed with the NMC and rejected Warren's application. Although it could be suggested that the application made by Warren's non-legally qualified representative was based on point(s) of law and/or to assist in Warren's defence, what later transpired brings this notion into question. After the NMC case presenter finished outlining the NMC's case, Warren's non-legally qualified representative then called Warren to give evidence in his defence under oath. Once Warren's non-legally qualified representative and the NMC case presenter had finished questioning Warren, the panel then took over. After initially questioning him about the events, the Lay Panel Member then confirmed that Warren admitted to contacting Patient A via LinkedIn and later exchanging emails with her. Following these Internet-based conversations, Warren then admitted that he met the patient for coffee, and engaged in sexual intercourse with her after having met her in a pub where he encouraged her to consume alcohol. This is despite Warren having treated the patient for a dual alcohol and opiate addiction, which Warren did not deny. The Lay Panel Member then asked Warren:

> "…tell me, you deny the charges?"

Warren then confirmed that he did deny charges, which led to the Lay Panel Member to ask Warren several times why he was denying the charges when he admitted to the facts of the case. Warren stated several times that it was because he objected to the way the case was laid out and the way the charges were worded. The Lay Panel Member then stated:

> "I struggle to understand what it is you say is not admitted"

At this point, the chair intervened and stopped any further questioning, which was supported by the Legal Assessor on the grounds that Warren

had been asked the same question multiple times. Nevertheless, it became clear throughout this exchange that Warren objected to the suggestion that he had engaged in sexual misconduct with the patient, which could be explained on the basis of shame. Warren also showed many of the physical signs that Keltner and Buswell (1997) described as denoting shame, such as blushing and remaining quiet whenever possible, whilst utilizing an almost submissive style of speech during this particular exchange. Warren equally appeared to be uncomfortable with my presence throughout the hearing, eyeing me uneasily when entering the hearing room and avoiding eye contact when outside of the hearing room. Although Warren did not state clearly that his denial of the charges were because they invoked potential shame, Warren made it clear that he objected to the NMC's interpretation of his alleged sexual misconduct. It has been widely acknowledged in sociological and criminological literature that sexual misconduct, whether in an occupational or criminal setting or in a purely moralistic sense carries a particular stigma (*see* Jenkins, 1998; Knoll, 2010; Dixon-Woods et al., 2011; Trammell, 2012). Thus, the fact that the charges were denied despite all facts being admitted by Warren suggest that, again, male nurses struggle with the issue of shame, particularly given the public nature of full Substantive Hearings in NMC FtP hearings. Warren's case also went part-heard and, when the hearing reconvened, Warren chose not to attend despite his non-legally qualified representative being present. This, again, could be seen as denoting the avoidance of shame. Similarly, in the case of Langford who was a general mental health nurse (who was also accused of having an inappropriate and sexual relationship with a former mental health patient who he had been providing psychological counselling to), not only did he deny the charges, but he also chose not to attend. This, again, suggests a link between attendance and shame, particularly in relation to contentious charges such as those of a sexual nature.

This potential issue of male nurses struggling with the public nature of full Substantive Hearings and the resultant shame is also borne out in my documentary analysis data. This evidenced by the fact that eight out of

the twenty-three male nurses in my documentary analysis sample opted to form a Consensual Panel Determination where they are not expected to attend, as mentioned in the previous chapter, as can be seen in the table below:

CPD Cases by Gender in the Documentary Analysis Sample

	Number of CPD agreements	**Total Number of Sample by Gender**
Male Nurses	8 male nurses	23 male nurses
Female Nurses	10 female nurses	48 female nurses

The above results from my documentary analysis sample therefore suggest that it isn't usual to attend the hearing when a CPD agreement has been formed. Nevertheless, as mentioned earlier, the fact that all other male nurses attended their hearings with legally qualified representation to dispute the charges suggests that male nurses in my documentary analysis sample will opt for the less public option of a CPD agreement if they do not intend to contest the charges.

7.11: Shame and Sanctions

I will also argue, based on the analysis of my research, that shame also plays an important role in relation to public interest and that both are potential mechanisms which influence why male nurses are more than three times more likely to be struck off compared to female nurses (NMC, 2017b). As mentioned in the previous chapter, male nurses are my documentary analysis sample are considerably more likely to commit conduct-related offences. This is evidenced by the fact that nearly three quarters of male nurses in my documentary analysis sample committed conduct-related offences compared to less than half of female nurses). In addition to this, it has also been acknowledged in the case of *Yeong v. GMC [2009] EWHC 1923 (Admin)* that conduct-related misconduct can be considerably more difficult to remediate than proficiency-related

misconduct, which can be addressed through retraining or undertaking additional courses in the registrants impaired area of practice. On the other hand, in cases where the registrant has committed conduct-related misconduct, there are often far fewer avenues available for the registrant to take in order to demonstrate that they have sufficiently remediated their practice. This is particularly true if the misconduct could be deemed as being the result of an attitudinal issue(s). An example of the difficulty in remediating attitudinal issues can be seen in the case of Despard who was a male mental health nurse whose case was analysed as part of this research. Despard was a male nurse accused of, amongst other things, subjecting patients to verbal abuse, allowing them to remain in dirty clothes throughout the day and shutting patients in their room when it was clinically unnecessary to do so. When outlining their decision on whether Despard's practice was impaired, the panel stated in the official hearing document:

> "In its consideration of whether Mr Despard has remedied his practice, the panel acknowledged that attitudinal and behavioural characteristics can be difficult to remediate. In any event, the panel had no evidence before it that Mr Despard has attempted to remediate his misconduct."

This can also be seen in the case of Langford, who was the male nurse in my documentary analysis sample who was accused of engaging in a sexual relationship with a former patient who he had been providing psychological therapy to. In this case, the panel made the following statement when justifying their decision to issue Langford with a Striking-Off Order in the official hearing document:

> "This is not a case which could be remedied by way of supervision or training as it involves poor behaviours and attitudinal issues. The panel noted that Mr Langford has shown limited insight and has not taken any constructive steps to demonstrate that he has learnt from his actions."

The above quote clearly highlights how, in cases involving attitudinal issues, retraining and/or additional course are deemed as unsuitable by the panel for the purposes of remediation. Thus, successful remediation of conduct-related misconduct often falls down to the degree of insight and remorse that the registrant displays. However, I will argue that in addition to insight and remorse the degree of shame that a registrant conveys to the panel for their actions can make a crucial difference to the sanction imposed.

A key example of shame materially altering the outcome of a case, or at least, the sanction imposed by the panel, can be seen in the case of Panaikkal John whose case analysed as part of the documentary analysis sample. Panaikkal John was a female general nurse who admitted to plagiarising an essay that she was required to submit in order to qualify as a clinical mentor. Along with admitting all of the charges against her, Panaikkal John chose to give evidence during the Impairment and Sanction stage (whilst admitting that her conduct was impaired due to her misconduct from the outset). An extract from the official hearing document produced by the panel adjudicating Panaikkal John's case is reproduced below:

> "In the panel's judgment, dishonesty may not be easily remedied.
>
> However, in the panel's judgment, your insight into your misconduct, given its nature and extent, and your remorse and shame for your actions have greater relevance to the risk of repetition than remediation…
>
> Your admission to all the charges and acceptance that your fitness to practise is impaired at the start of this hearing, together with your genuine expressions of remorse and apology are indicative of insight and that is to your credit…
>
> It was clear to the panel that you are thoroughly ashamed of your dishonesty. You are a nurse whose commitment to

> the profession and to her patients is evident. The panel accepted that you had not sought to qualify as a mentor for financial reasons; there was a shortage of mentors and it was your wish to be "useful". In your evidence you described how you have let down your colleagues and, in particular, the friend whose work you submitted as your own. You also told the panel of your embarrassment and shame in accepting positive feedback from patients who did not know what you had done.
>
> You have not sought to avoid your personal accountability and have taken full responsibility for your actions. Even when you described the lack of support you felt you experienced at the University, you did not seek to use this to justify your behaviour."

The above quote clearly demonstrates how the panel not only acknowledge the difficulties in remediating dishonesty, but clearly equate Panaikkal John's shame as being the key contributory factor in reducing her risk of repetition. The risk of repetition is also a key consideration when deciding which sanction to impose (NMC, 2017l). As a result, Panaikkal John was only issued with a three-year Caution Order, which is of import as it is widely acknowledged that dishonesty is considered one of the most serious forms of misconduct (and an aggravating factor), which can be seen in the relevant case law, namely, *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin). In this case the sitting judge, Justice Cox, stated that any nurse and/or healthcare practitioner accused of misconduct always runs the risk of permanent erasure from the register.

Coincidentally, there was another case involving plagiarism which was observed as part of this research prior to the data collection for the documentary analysis sample. Ofili was the aforementioned male nurse accused of, amongst other things, plagiarising two essays for a Masters

degree which was paid for by the Healthcare Trust (now CCG) that he was working for at the time. However, despite strong evidence suggesting that he had plagiarised the essays, Ofili initially denied the plagiarism. After being cross-examined by the NMC case presenter and the panel, Ofili later admitted that he had in fact plagiarised the two essays. Both the witness who conducted the internal investigation for the Trust, as well as the NMC case presenter, argued that Ofili showed little remorse or concern for the fact that he had plagiarised these essays. The panel themselves stated that at the beginning of the hearing Ofili showed little insight or remorse, however, over the course of the hearing, the panel felt that he had begun to show 'developing insight':

> "Throughout these proceedings you have demonstrated a developing understanding of the nature of your misconduct…
>
> Although your insight into your dishonesty is at this stage limited, the panel does consider that you are capable of developing it further, as indeed you appear to have begun to do in the course of this hearing…
>
> The panel did give serious consideration to whether a striking-off order would be appropriate in your case…
>
> Your case does involve serious dishonesty. However, the panel was not satisfied that a striking-off order was the only sanction which would be sufficient to protect the public interest. The panel considered that the public interest could be sufficiently met with the imposition of a suspension order."

The panel found that Ofili had plagiarised the two essays and was dishonest in his actions. However, the remaining charges (that he deliberately concealed his actions from the Healthcare Trust) were found not proved. This therefore means that Ofili was found to have committed the same acts as Panaikkal John (albeit that he plagiarised two essays rather than one). Nevertheless, based on the misconduct committed and

the fact that Ofili had initially denied all of the charges, compared with his alleged lack of insight and remorse, the panel decided to impose a six-month suspension order. Although there was no reference to shame in the case of Ofili, it was clear by the way in which the panel addressed Ofili when questioning him that they felt he possessed little shame with reference to his misconduct. This could be seen by the fact that half way through the hearing, the panel stated to Ofili that if registrants show remorse, they tend to receive lesser sanctions. As a result, Ofili's behaviour became more submissive and less confrontational, particularly in relation to the NMC case presenter. His answers to questions posed by the panel, NMC case presenter and his legally qualified representative also involved greater admissions of wrongdoing on his part. This is further evidenced by the following statement taken from the official hearing document where the panel stated that Ofili had shown developing insight over the course of the hearing:

> "The panel acknowledges your regret and remorse for your actions, and notes your appreciation that you had *"let down"* your work colleagues and the Trust… The panel concluded that while you have demonstrated the beginnings of some insight, particularly during these proceedings, this is far from adequately developed."

However, that being said, Scheff (2003) has argued that a common response to shame is anger and resentment. When being questioned by the NMC case presenter who frequently alluded to how Ofili's conduct was not the conduct of both a 'good' and/or 'honest' nurse, Ofili became both combative and even angry at points. This could be seen in his tone of voice, his facial expressions and the way in which he leaned towards the NMC case presenter who was seated next to the witness stand. Thus, it could be argued that there is a set way in which panels expect shame, along with insight and remorse, to be displayed by registrant's (as argued in the previous analytical chapter).

7.12: Punitive Tactics and Transparency

Another key feature of NMC FtP hearings, which is interlinked with transparency and shame, is the role that public interest plays in the applications of sanctions. As I will now argue, the way in which sanctions are applied by NMC FtP panels correlate with traditional forms of discipline and punishment outlined and analysed by scholars such as Foucault ([1975] 1979). Nietzsche ([1887] 1996), whose work heavily influenced Foucault, was one of the first authors to distinguish between the dramaturgy of punishment and the social function that it plays. Nietzsche ([1887] 1996) also highlighted the relationship between punitive displays of punishment and the operation of power (Carney, 2015). Utilizing the work of Nietzsche's ([1887] 1996), Foucault ([1975] 1979) conducted a detailed analysis of the link between punitive action and the exercise of sovereign power, particularly during the medieval period up until the Victorian era. Foucault ([1973] 2015) argues that those in power utilize 'punitive tactics' to maintain their power. According to Foucault ([1973] 2015), these punitive tactics fall within four key categories which can be present both individually or collectively within a given society. When describing the four categories of 'punitive tactics', Foucault ([1973] 2015) typically used examples from historical societies, however, the examples that I will provide will be taken from present day society in the United Kingdom.

The four categories are as follows: exclusion, such as being banned from a certain geographical area; organised redemption, such as the issuing of a fine following a criminal conviction; marking, such as a criminal conviction remaining on an individual's record for a set period of time; and confinement, with the most obvious example being imprisonment. The above categories can also be seen within the NMC FtP process, particularly in relation to remediation and the application of sanctions: Striking-Off Orders and Suspension Orders are clear examples of permanent and/or temporary exclusion from the profession, which also 'mark' the registrant. A Conditions of Practice Order 'confines' a registrants' practice by restricting what they can or cannot do either independently or at all. Furthermore, if the panel specify in the

Conditions of Practice Order that a registrant must complete additional training, it can be seen as 'organised redemption'. Finally, a Caution Order functions solely as a 'mark'.

As mentioned above, 'marking' can be said to apply to all of the above sanctions. In Foucault's ([1975] 1979) widely cited work *Discipline and Punish,* there was little discussion of the process of marking beyond what Foucault referred to as the 'spectacle of the scaffold', which he illustrated during the discussion of the execution of Damiens. Although the examples given were primarily of a physical nature, such as the amputation of a convicted thief's hands or the branding of a vagabond, in his later lectures, Foucault (2013) also argued that marking could be 'virtual' in nature. In other words, it could mark one's reputation rather than one's anatomical body (Foucault, [1975] 1979; Carney, 2015). As can be seen in the following quote from Carney (whilst citing Foucault's (2013) recently published lectures from Collège de France):

> "The mark, which is also 'something like a trace' (Foucault 2013: 9), may be left on the body itself or on the status of the person. Thus, it includes not only amputating the hand of the thief but also exposing the face at the pillory. Moreover, if power cannot seize the actual body, it may nevertheless mark its reputation, 'inflict a symbolic stain' on its name, on its character (Foucault 2013: 9)."
>
> (Carney, 2015: 235)

I will argue that this 'virtual marking' is a key feature of the NMC FtP process, primarily because there is no legislation or case law which restricts employers from asking whether a registrant has been investigated by the NMC or has had their conduct found impaired by an NMC FtP panel. Equally, there is no provision within the *Nursing and Midwifery Order (2001)* or the *NMC (fitness-to-practise) Rules (2004)* stating that, after a set period of time, details of any findings or investigations conducted by the NMC will not be disclosed to employers. An example of the panel acknowledging how their findings can 'mark' a

registrant can be seen in the case of Panaikkal John whose case was analysed as part of my documentary analysis sample. Painaikkal-John was the aforementioned female nurse accused of, and who admitted to, plagiarising an essay as part of her mentorship qualification, resulting in her receiving a three-year Caution Order. When justifying their decision to impose a Caution Order rather than a Suspension Order, the panel made the following statement in the official hearing document:

> "A Caution Order will be in the public domain and will alert anyone who inquires about your registration to the panel's findings of fact and impairment and to the misconduct which led to this case. The panel's findings of misconduct and impairment are, in themselves, *significant marks* on your registration history [own emphasis]."

As can be seen in the above quote, the panel's statement that their findings of misconduct and impairment are significant *marks* on Panaikkal John's registration history is direct evidence of the way in which the NMC FtP process is used to mark the individual. Furthermore, by publishing the official hearing documents for all cases where the registrant's conduct is found to be impaired on their website, along with their full name, PIN and County of Residence, the NMC can, again, be seen as 'virtually' marking the registrant. [2] This is also supported by the fact that Substantive Hearings heard by the Conduct and Competence Committee are held in public, which also acts as a process of marking similar to the baying crowds present during the 'spectacle of the scaffold'. As Carney (2015) argued when discussing the punitive nature of the photograph:

> "Departing from the Foucauldian example of the direct gaze, we can extend this concept of the virtual to speak of

[2] In saying this, it now appears that the NMC do not keep the official hearing documents online indefinitely although the official policy according to the NMC is that they are still available on their website. Nevertheless, the fact that they are made available online for the general public to view for at least three months or until the sanction has expired could still be seen as publicly marking the registrant.

> iconic marks on the body of the individual in the realm of imagery. Here, a mediated gaze of spectators is fixed on an identifiable representation of the body… The stain [mark] then becomes symbolic as it shifts from the register of the iconic to affect social status and become inscribed in memory”
>
> (Carney, 2015: 235)

An example of how NMC FtP hearings can mimic the ‘baying crowds’ described in Foucauldian analysis can be seen in the case of Stanton, who was a female midwife whose case was observed as part of this research. Stanton was accused of, amongst other things, making inappropriate comments to a patient whilst she was in labour, as well as performing an episiotomy that was medically unnecessary and without offering or providing pain relief to the patient prior or during the procedure. In this particular case, despite the NMC stating on their website that they cannot have more than ten observers in a room due to health and safety (NMC, 2017n), there were just under thirty observers in the room sitting along three rows of chairs. In fact, my chair was so close to Stanton’s legally qualified representative, she first questioned whether I was part of the media and, after finding out that I was not, she stated to the panel chair that she was concerned that I was close enough to see the notes she was writing on her screen. Despite Stanton’s legally qualified representative’s concerns, the panel chair simply shrugged her shoulders with an apologetic look on her face and indicated that there was nothing she could do.

This is an example of how Substantive Hearings conducted as part of the NMC FtP process somewhat mimic the ‘spectacle of the scaffold’ in that over thirty people were present, watching and judging the registrant throughout the process. This similarity between the observers present in the NMC FtP hearings (including myself) and the baying crowds present during the spectacle of the scaffold is both supported, but also

differs somewhat, from Foucault's original arguments, which can be seen below:

> *"In a disciplinary regime… individualization is 'descending': as power becomes more anonymous and more functional, those on whom it is exercised tend to be more strongly individualized; it is exercised by surveillance rather than ceremonies, by observation rather than commemorative accounts…"*
>
> (Foucault, [1975] 1979: 193)

As can be seen in the above quote, Foucault argues that power becomes more anonymous and more functional. This is indeed the case for NMC FtP hearings because although the panel are responsible for assessing and sanctioning a registrant, the NMC itself is a large faceless, bureaucratic organization. The NMC also rely on surveillance from employers, police and the public to refer nurses to them, again, correlating with the above quote. However, NMC FtP hearings could be seen as being ceremonies in themselves, particularly due to the attendance of observers and the quasi-legalised way in which they are conducted. The fact that the official hearing documents are published online and made available to the public therefore act as commemorative accounts as well, again demonstrating the way that the NMC FtP hearings both correlate but also diverge from Foucault's ([1975] 1979) own analysis.

7.13: Public Interest and the Application of Sanctions

Yet, the question still remains: Why do the NMC need to create a public spectacle of the NMC FtP hearings, along with committing the hearings and their outcomes to public memory via the official hearing documents? I will argue that the reason for this is due to the public interest, which also correlates with the way that the sovereign leaders discussed in Foucault's ([1975] 1979) work felt the need to enact punitive displays of punishment to reinforce their own position of power. However, before

these similarities are discussed, I will first outline what the NMC deem to be the public interest. In nearly all of the official hearing documents in both my observational and documentary analysis samples, the following statement was made, as can be seen in the case of Kasumba was a female mental health nurse whose case was analysed as part of my documentary analysis sample. Kasumba was a female nurse who admitted to failing to begin resuscitation efforts on a collapsed patient who had stopped breathing. In the official hearing document, the panel made the following statement regarding the public interest:

> "The panel bore in mind that the purpose of a sanction is not to be punitive. Although it may have that effect, its intention is to protect patients and the wider public interest. The wider public interest includes maintaining public confidence in the profession and the NMC as the regulator, and declaring and upholding proper standards of conduct and behaviour."

Not only does the above statement define the three key components of what the NMC refer to as the 'public interest', but it also states that the purpose of a sanction is not to be punitive. This is, again, stated in nearly all of the aforementioned hearing documents produced by NMC FtP panels in both my observational and documentary analysis samples. However, based on the literature already discussed in this chapter, I will argue that the above three criteria pertaining to the public interest, which are used to justify a finding of impairment and/or sanction, are punitive in nature.

It could be argued that, in cases concerning proficiency-related misconduct, the panel and the NMC are seeking to protect the public. This is reflected by the fact that Conditions of Practice Orders, Suspension Orders and Striking-Off Orders all restrict a registrant's ability to practice. However, in cases where a registrant's conduct is found to be impaired, and they are issued a sanction as a result, solely due to the public interest, it is hard to argue that the purpose of the

sanction is anything but punitive. In fact, out of the seventy-one cases in my documentary analysis sample, fifty-four of the cases involved at least one charge of conduct-related misconduct.

The clearest example of a case where a sanction has been imposed to *declare and uphold proper standards of conduct and behaviour* can be seen in the case of Whyte whose case was analysed as part of this research. Whyte was the aforementioned female nurse accused of, amongst other things, not granting the NMC access to the records pertaining to her previous censure from the Nursing and Midwifery Board of Ireland. Despite the 2008 Edition of the NMC's code (NMC, 2008) stating that there is no requirement for a registrant to disclose such information to the NMC, the panel still found Whyte guilty of misconduct based on the 2008 Edition of the NMC Code's (NMC, 2008) Preamble. The Preamble for the 2008 Edition of the NMC states that nurses should be 'open and honest'. The panel then found that Whyte's conduct was impaired solely based on the public interest, with a focus on 'declaring and upholding proper standards of professional behaviour' and issued Whyte with a three-year caution order. By applying a sanction to declare and uphold proper standards of conduct and behaviour, the panel and the NMC can be seen as making an example, or a public spectacle, of a nurse. Thus, the NMC are letting the nursing profession know that if they engage in certain behaviours, they will be punished as a result. Furthermore, the fact that Whyte was punished despite there being no provision within the 2008 Edition of the NMC Code (NMC, 2008) outlawing her behaviour enables the sanction to be seen as a punitive display of power.

An example of the NMC imposing a sanction to *maintain public confidence in the NMC as the regulator* can be seen in the case of Parker. Parker, whose case observed as part of this research, was a male nurse who was accused of, and admitted to, the following:

> "(1) On one or more occasions between the period [date] and [date], offered to refund money to Patient A as an

> incentive to withdraw a referral to the Nursing & Midwifery Council"

Parker had previously been issued a Caution Order in an unrelated case due to misleading the previous panel by stating that he had completed his Masters when he was awaiting the grade for a resit that he had sat for a prescribing module. In this particular case, Parker had performed another cosmetic procedure on a different patient who was dissatisfied with the results, namely, that it did not result in any observable change in her appearance, according to the patient. Parker had initially refused to refund the amount the patient had paid, resulting in the patient contacting both the NMC and Trading Standards. When mediating between Parker and the patient, a representative from Trading Standards suggested to both Parker and the patient that, if Parker were to refund the monies concerned, the patient could withdraw her complaint from the NMC, which both Parker and the patient agreed to. Parker refunded the monies and the patient then no longer engaged with the NMC. However, the NMC then decided to put Parker through a full NMC FtP hearing as, in their opinion, he had attempted to 'oust' their authority, to use Parker's legally qualified representative's words. The outcome of the case resulted in Parker receiving a second, three-year Caution Order which was to run concurrently with his first Caution Order. This is a clear example of the panel imposing a sanction to maintain the public's confidence in the NMC as a regulator.

Furthermore, out of the seventeen cases that solely concerned proficiency-related misconduct, six nurses were judged to have had fully remediated their misconduct yet were still issued with sanctions due to the public interest. In some of these cases, the registrant(s) concerned had remediated their proficiency-related misconduct (through attendance at courses etc) to such an extent that the panel were left with either a Caution Order or a Suspension Order as the only available sanctions to satisfy the public interest. This is because in this situation a Conditions of Practice Order would serve no purpose as it is designed to restrict the practice of a registrant in area(s) of nursing where they are deficient. In

cases such as Dookie who was a female general nurse, the panel found that the public interest was so great that they could not justify the issuing of a Caution Order, but due to a Conditions of Practice Order serving no purpose, the panel instead opted for a three-month Suspension Order. Although Dookie's employer had made it clear to the panel that they would find an alternative role for Dookie to work in if she were issued with a suspension order, this is not the norm. Furthermore, a Suspension Order, even one as short as a month, can result in a registrant losing their job and suffering severe financial implications as a result. This is a clear example of how registrants can be placed in an almost impossible situation. They are expected to do everything possible to remediate their misconduct to mitigate the consequences/sanction from the panel, but in an almost Orwellian Twist, by doing so they end up with a harsher sanction.

7.14: Interim Orders and the Public Interest

A further issue concerning Conditions of Practice Orders and Suspension Orders is the way in which they are formulated and imposed when the registrant has already been under either an Interim Conditions of Practice Order or a Suspension Order, which, in some cases, can be for several years. In the criminal justice system, if a defendant has been held on remand pending their trial, the time that the defendant has already served will be automatically taken off of any custodial term that they are sentenced to upon conviction, as stated in Section 108 of the *Legal Aid, Sentencing and Punishment of Offenders Act 2012 (SI 2012/534).* Furthermore, under Section 109 of the *Legal Aid, Sentencing and Punishment of Offenders Act 2012*, if a defendant has been under certain curfew conditions for nine hours a day or more prior to their trial, such as not being allowed to leave their house between the hours of 9pm and 7am, each day of the curfew will count as half a day of custodial time already served. This, again, will be automatically taken off of any custodial term that the defendant receives upon conviction. However, in NMC FtP hearings, the panel do not automatically take off the time

served under an Interim Conditions of Practice Order or Suspension Order for the following reasons:

> "The fact that a nurse or midwife was previously under an interim order, and for how long, are relevant background factors in deciding on a proportionate length of sanction. However, it would not be appropriate simply to deduct or discount the length of time for which the nurse or midwife was previously restricted or suspended under an interim order from a proposed sanction. Interim orders have a separate and distinct role from sanctions, in that their focus is on addressing risk on an interim basis before any finding of impairment of fitness to practise. If a panel identifies a current risk to public protection as part of that impairment decision, a risk of patient harm may follow if the 'time served' under an interim order was reflected in a shortened period of sanction."
>
> (NMC, 2017a)

The above statement makes clear that, when deciding upon a sanction, the panel will take into consideration the time spent under an interim order when the registrant's conduct is found to impaired on grounds of *public protection*. However, it fails to make any mention of misconduct which results in the registrant's conduct being found to be impaired based solely on the public interest. Put simply, the argument that Interim Orders are issued on the grounds of *risk*, whereas a Sanction is issued on the grounds of *public interest*, thus allegedly justifying the decision not to simply deduct the time spent under an Interim order for the sanction, could be seen as highly punitive. Furthermore, male nurses are also far more likely to have Interim orders applied prior to a Substantive Hearing. As stated earlier, in 2017 male nurses accounted for 10.8% of the nursing population yet made up 23.8% of all new referrals/allegations to the NMC. Male nurses also account for 29.1% of all Interim Conditions of Practice Orders and 34.3% of the Interim Suspension Orders imposed prior to the Substantive Hearings (NMC, 2017b).

This potential lack of concern expressed by the NMC for the punitive nature of the public interest may be due to the existing case law governing professional regulation. In *Bolton v. Law Society [1994] 1 WLR 512*, a solicitor who had misused funds entrusted to him complained to the courts that the effects of a two year suspension order imposed by the Law Society would have a permanent and negative effect on his potential earnings and his family. The Court of Appeal ruled that although the effects of this sanction would indeed have a significant impact on the complainant and his family:

> "The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is a part of the price.

As can be seen in the above quote, the case law clearly states that an individual professional's 'fortunes' are trumped by the reputation of the profession as a whole. However, it is also important to point out that the above case law concerns an 'individual' rather than a significant group of individuals within a given profession, such as male nurses.

7.15: Conclusion

As can be seen throughout this chapter, the role that transparency and the public interest plays, particularly in relation to shame, can have a significant impact on all registrants, but in particular, male nurses. Although it could be argued that such transparency is necessary in order to comply with the current political pressure surrounding the regulation of healthcare professionals, it can also be seen as directly contributing to the loss of them from the profession. This loss of nurses from the profession can either be temporary, in the case of Suspension Orders, or permanently, via the imposition of a Striking-Off Order. As I will argue in the conclusion, at a time when the NHS is facing a chronic and severe shortage of nurses (NHS Improvement, 2018), questions need to be asked about whether such an approach to the regulation of healthcare professionals can continue.

Chapter 8: Conclusion

8.1: Introduction

This thesis has examined the reason why male nurses are more likely to be referred to the NMC over concerns about their conduct and struck off as a result. As we have seen, in 2017, despite male nurses only accounting for 10.8% of the nursing population, they accounted for 23.8% of all those referred to the NMC and 36.6% of all those struck-off as a result (NMC, 2017b). This is despite research demonstrating how male nurses are more likely to be promoted faster and paid more over the course of their career (Lorentzon and Bryant, 1997; Pudney and Shields, 2000). The aim of this research was therefore to conduct a sociological exploration of why male nurses are twice as likely to be referred to the NMC over concerns about their conduct and are more than three times more likely to be struck-off the register as a result. In order to achieve this, I utilized three broad research objectives, which were:

- To analyse the NMC hearing records with a particular focus on disproportionate rates of referrals and outcomes for male nurses;
- To analyse the NMC FtP process and how it is conducted in relation to both male and female nurses;
- To analyse what mechanisms may be influencing these disproportionate rates.

To address these three research objectives a qualitative, multiple methods approach was adopted, which was underpinned by a Critical Realist epistemology. Critical realism helped expose the three ontological domains, the *real*, the *actual* and the *empirical*. It also helped facilitate the use of a multiple methods approach as different methods can be used to address phenomena, events or mechanisms in the three ontological domains. The domain of the *real* is comprised of underlying mechanisms that are causal and may give rise to events and/or

phenomena. The domain of the *actual* consists of the events that are triggered by mechanisms in the domain of the *real*, which may or may not be visible within a social system. Finally, the domain of the *empirical* is comprised of the observable phenomena resulting from the mechanisms and events triggered in the two aforementioned domains (Steinmetz, 1998).

In the case of this research, the first research objective sought to analyse mechanisms in the domain of the *real* and the *empirical*, and the second research objective sought to analyse events in the domain of the *actual.* By exploring these domains, it was possible to meet the third objective and the aim of this study, which was to analyse what mechanisms (in the domain of the real) influence the disproportionate rates of referral and outcome for male nurses subject to NMC FtP hearings. The large and varied amount of qualitative data collected via both the observations and documentary analysis meant I was able to consider and assess a multitude of interlinked mechanisms present in the events and documentation that operate within the different ontological domains.

This chapter will therefore conclude this thesis by, firstly, discussing my findings in relation to critical realism. I will then outline the contributions that this thesis has made to our current knowledge concerning male nurses and professional nursing regulation, which will be followed by a discussion of the recent changes to the NMC FtP process since the inception of this research. Finally, I will summarise the strengths and limitations of my research and conclude by presenting possible opportunities for further research. With this in mind, I will therefore begin by discussing the results of this research and how they fit within a Critical Realist epistemology.

8.2: Research Findings and Critical Realism

The results discussed in Chapter 4 centre around the quasi-legal nature of NMC FtP hearings. NMC FtP hearings and the outcomes of these hearings exist within the domain of the empirical as they are both observable and influenced by events and mechanisms in the domains of

the actual and the real. Due to the quasi-legal nature of NMC FtP hearings, the outcomes of individual hearings are highly variable because of the high degree of flexibility granted to NMC FtP panels. This flexibility is a result of the way that the *NMC (Fitness-to-Practise) Rules (2004)* are constructed, which exist within the domain of the actual. Once an NMC Rule is triggered via an application from either the NMC case presenter or the registrant/the registrant's representative, it produces observable phenomena in the hearing (the domain of the empirical). A key example of an NMC Rule being triggered can be seen in the rules governing the admittance of hearsay evidence in NMC FtP hearings. Although the guidelines overseeing hearsay evidence in both civil and criminal court are highly prescriptive in nature, the opposite can be said for NMC FtP hearings. Rule 31 (1) of the *NMC (fitness-to-practise) Rules (2004)* makes clear that, so long as the panel receive advice from the Legal Assessor, and so long as the requirements of fairness and relevance are met, the panel may admit hearsay evidence that would be inadmissible in civil court. Once the panel agree to admit hearsay evidence, it produces observable phenomena such as an unsupported witness testimony being used by the NMC case presenter to prove a charge.

The high degree of autonomy granted to the panel can make it particularly difficult for registrants to defend their case even when represented by a legally qualified representative. However, the panel do appear to try and assist unrepresented registrants to reduce the disadvantage that they face by being unrepresented. Examples of such assistance include allowing unrepresented registrants additional time to formulate submissions and adjourning the hearing to allow the unrepresented registrant to the chance obtain evidence that would assist in their defence. This finding exists in the domain of the empirical as such assistance is both observable during the hearings and is triggered by the registrant being unrepresented (the domain of the actual). Although it was not possible to conclusively determine what mechanisms result in registrants being unrepresented, the RCN do state that a

common reason for self-representation in NMC FtP hearings is due to the high cost of legal fees (if they are not a member of a trade union who will pay for their representation) (RCN, 2018a).

From here, Chapter 5 sought to examine the role that misconduct and remediation play in NMC FtP hearings. Chapter 5 highlighted how male and female nurses in my documentary analysis sample were more likely to be found to have committed certain types of misconduct. For example, male nurses were more likely to commit criminal offences, particularly those of a violence and/or sexual nature. They were also more likely to be found to have committed care-related misconduct and conduct-related misconduct. An example of proficiency-related misconduct would be if a nurse were to make a drug administration error whereas an example of conduct-related misconduct would be if a nurse were to have engaged in an inappropriate relationship with a patient. Female nurses, on the other hand, were more likely to be found to be lacking in competence, with all competence-related cases in my documentary analysis sample concerning female nurses. They were also more likely to be found to have committed proficiency-related misconduct and in particular, failures in record keeping. These findings can be seen as existing in the domain of the empirical as they are observable phenomena which occur as a result of the registrant being deemed to have violated a specific section of the NMC Code (2004; 2008; 2015). The NMC Code exists in the domain of the actual because when a nurse commits a certain act, they trigger one of the different sections of the NMC Code (2004; 2008; 2015). This then results in observable phenomena, such as the panel announcing that the registrant's conduct is impaired (domain of the empirical). However, as I did not interview affected nurses due to ethical concerns, I was not able to ascertain exactly mechanisms caused the registrants behaviour.

Chapter 5 also established how remediation is actively performed before the panel as part of a 'remediatory portfolio', which can include live witness evidence and reflective statements. The *performance* of remediation takes place in the domain of the empirical as it is both

observable and governed by the requirements of the *NMC (Fitness-to-Practise) Rules (2004)*, which exist in the domain of the actual. Chapter 5 also found that in order for a registrant to be able to successfully remediate their misconduct, the registrant had to demonstrate 'genuine' emotion when relaying their insight and remorse to the panel. 'Genuine emotion' is therefore a possible mechanism which exists within the domain of the real as it can influence whether a registrant is found to have successfully remediated their conduct. A registrant's attitude also appears to be a potential mechanism which influences whether misconduct can or cannot be remediated (the domain of the real). The NMC state that there are certain types of misconduct which are irremediable such as a registrant receiving a criminal conviction that resulted in a custodial sentence or a registrant being violent and/or neglectful towards a patient (NMC, 2017q). Both of these examples (along with others listed in Chapter 5) are associated with attitudinal issues, thus a nurses' attitude also appears to be a potential mechanism that can influence whether the misconduct can be remediated. This in turn greatly affects the outcome of the hearing (domain of empirical).

Chapter 5 also highlighted how another potential mechanism (discussed in Chapter 5) which appears to influence whether a registrant is able to successfully remediate their misconduct is the panel's 'professional judgement' (the domain of the real). The reason why the panel's professional judgement has such influence over the events in the domain of the actual and the resultant phenomena in the domain of the empirical is because there is no burden or standard of proof during the Misconduct, Impairment and Sanction stages. This allows the panel a high degree of autonomy when deciding whether a registrant has remediated their misconduct which in turn dictates the outcome of the hearing.

Finally, Chapter 6 examines the role that transparency, shame and public interest play in male nurses being more than three times more likely to be struck-off due to concerns about their conduct compared to female nurses. The outcome and/or sanction received by the registrant, along with the display of shame performed as part of the registrants

‘remediatory portfolio’, exists in the domain of the empirical as it is both observable and triggered by events in the domain of the actual. The feeling of shame, however, can be seen as a potential mechanism existing within the domain of the real. This is because shame appears to play a significant role in remediation, which greatly influences the outcome of the hearing. By displaying shame for one’s misconduct, coupled with insight and remorse, registrants potentially received less severe sanctions for their misconduct. It became apparent that male nurses may potentially disengage from Substantive Hearings to avoid experiencing shame.

The shame felt by registrants is often triggered by NMC FtP hearings being held in public and the degree of transparency in the NMC FtP process. The public nature of the NMC FtP hearings exists in the domain of the actual because hearings can either be held in public or private. If the registrant is referred over concerns about their health the hearing will be held in private whereas if the registrant has been referred over concerns about their conduct the hearing will be held in public (NMC, 2018b). If the panel needs to hear medical evidence during a public hearing, the hearing will go into private once Rule 19 of the *NMC (Fitness-to-Practise) Rules (2004)* has been triggered by either the panel, the NMC case presenter or the registrant/the registrant’s representative.

The transparency present in the NMC FtP process is partially as a result of the public interest, which is another potential mechanism existing within the domain of the real. Public interest appears to be a key possible mechanism (domain of the real) which influences whether a registrant’s conduct is found to be impaired and the resultant sanction (the domain of the empirical). This is evidenced by the fact that there have been a number of cases in my documentary analysis sample where the panel have stated that, despite the registrant having remediated their misconduct, due to the public interest they have no choice but to find the registrant’s conduct impaired. Given that male nurses are more likely to commit conduct-related misconduct which engages the public interest (and is harder to remediate) public interest is therefore a possible

mechanism that contributes towards male nurses being more than three times more likely to be struck-off than female nurses.

With this in mind, I will now move on to discuss what contributions the findings of this thesis make to the current sociological knowledge concerning male nurses, professional nursing regulation and the sociology of health in this otherwise under-researched area.

8.3: Contributions to Current Knowledge

To date, there has been little research looking at the way in which NMC FtP hearings are conducted both in relation to misconduct and competence; one exception to this is Cowan et al. (2005) who looked at the role of competence in NMC FtP hearings. The hearings analysed within my research were held by the Conduct and Competence Committee, however, all but four cases in my documentary analysis sample were held on the grounds of misconduct. The results of this research therefore shed new light on the role that misconduct plays in NMC FtP hearings. In addition to this, there has been no research to date that has specifically looked at the role of sex and gender and the NMC. This thesis therefore sheds light on this otherwise unresearched area using a sociological analysis. Some US based literature has also found that male nurses are more likely to be referred and disciplined by a number of state nursing boards (Evangelista and Sims-Giddens, 2008; Kenward, 2008; Zhong and Kenward, 2009). In Evangelista and Sims-Giddens' study, which looked at the disproportionate rates of referral and outcome for male nurses subject to disciplinary proceedings in Missouri, they found that men were more likely to be disciplined for 'abusing a patient' (2008: 505). As discussed in Chapter 5, male nurses in my documentary analysis sample were also more likely to be found to have violated Paragraph 1 and Paragraph 3 of the 2008 Edition of the NMC Code (*see* Appendix F) which state:

> "1 Your must treat people as individuals and respect their dignity…

3 Your must treat people kindly and considerately."

(NMC, 2008)

This suggests that there may be similar possible mechanisms that influence the types of misconduct that male nurses are found to have committed in both the UK and Missouri. However, in Evangelista and Sims-Giddens' (2008) research, as well as Kenward (2008) and Zhong and Kenward's (2009) research, the single most common offence was substance abuse, which was not the case in my documentary analysis sample. Nevertheless, male nurses in my sample were still more likely to commit conduct-related misconduct compared to female nurses (*see* Chapter 5).

Furthermore, the fact that there are possible mechanisms which result in male nurses in my documentary analysis sample being more likely to be found to have committed care-related misconduct links with existing literature looking at the negative stereotypes held by society concerning male nurses. Authors such as Evans (2002) and Harding et al. (2008) have demonstrated how male nurses are often perceived to be less able to provide adequate care due to their gender. This is because male nurse's physical touch is both sexualised and problematised as a result of gendered stereotypes held by members of society. Although the results of my research have not addressed these issues directly, the fact that male nurses in my sample are more likely to have been found to have committed care-related misconduct does suggest that these stereotypes may still have a role to play in the regulation of male nurses.

However, authors such as Greenhalgh et al. (1998) have found (when surveying male and female nurses in general and psychiatric practice) that male nurses report placing less emphasis on caring practices compared to technical ability. This would offer an alternative lens to explain why male nurses were more likely to be found to have committed care-related misconduct. This is because male nurses may not provide the same level of 'caring' behaviour as their female counterparts, thus

potentially putting them at greater risk of referral to the NMC due to care-related misconduct.

There is also additional literature in this field which focuses on specific areas of clinical practice within nursing. Holyoake (2001) and Harding (2007) have suggested that one response to working in a feminized field is to seek to emphasize the perceived masculine aspects of it. For male mental health nurses specifically, this includes the use of physical and chemical restraint. Holyoake (2001) has argued that male mental health nurses are therefore stuck within a 'macho' discourse that valorises and encourages physical aggression in order to engage in a display of hegemonic masculinity. Within my sample, there were twenty-two nurses who were qualified mental health nurses, with ten of them being male nurses (out of a total of twenty-three male nurses in my sample). The preponderance of male mental health nurses in the cases I observed suggests that gender may be a significant factor here. However, it is impossible to tell from my research whether males in these settings were choosing to display overtly masculine behaviours. It is equally not possible to tell whether the fact that male nurses are caregivers in a female dominated profession that emphasizes a highly gendered form of care makes it more likely for their 'ordinary' masculinity to be viewed as problematic against the norm. If either or both of these are causal mechanisms, the end result will still be an overrepresentation of males in NMC referrals.

Nevertheless, by examining the panels interpretation of behaviour, it was possible to identify possible mechanisms which increase the risk of male nurses receiving more severe sanctions. In Chapter 6, shame was identified as a possible mechanism that affects the registrant's ability to be able to demonstrate that they have remediated their misconduct. By displaying shame for one's misconduct, coupled with insight and remorse, registrants potentially received less severe sanctions for their misconduct. It became apparent that male nurses may potentially disengage from Substantive Hearings to avoid shame, which is exacerbated by the public nature of NMC FtP hearings.

However, the findings of this research were not limited solely to gender. My findings regarding the prescriptive nature of remediation in NMC FtP hearings support existing research which has looked at the way in which remorse is performed in GMC FtP hearings. Case (2011) examined a year worth of GMC FtP hearing records and concluded that GMC FtP hearings required a doctor to engage in what he described as 'contrived remorse' due to the prescriptive way that it is expected to be performed. My analysis here also found that the NMC required nurses to perform insight and remorse in a very prescriptive manner (*see* Chapter 5). An example of this is that registrants are required to provide a reflective piece which addresses set criteria such as what effect their actions have had on the reputation of the nursing profession. There was also an expectation that certain emotions were performed before the panel, such as displays of shame (*see* Chapter 6). This all formed part of a 'remediatory portfolio' that was required in order to be seen to attempt to successfully remediate one's misconduct.

Furthermore, the public nature of NMC FtP hearings also appeared to cause considerable discomfort for both registrants and panel members, with some panels stating that registrants had learned a 'salutary lesson' by having to attend a public hearing (*see* Chapter 6). This discomfort associated with the public nature of NMC FtP hearings links with existing research conducted by McGivern and Fischer (2010) and what they refer to as 'spectacular transparency'. McGivern and Fischer (2010) have argued that the increasing levels of transparency involved in GMC FtP processes has led to doctors practicing 'defensively' out of fear of ramifications that could occur, which comes at the expense of the patients. Although my research was not designed to identify defensive practice, the negative effects experienced by nurses as a result of the high levels of transparency involved in NMC FtP hearings is evidence for the impact of this policy upon healthcare professionals.

My research also adds to the existing literature on professions in that it demonstrates that Freidson's (1983) concept of 'mandated bureaucratic regulation' is also present within the nursing profession and the NMC (as

well as the medical profession). Friedson (1983) argued that mandated bureaucratic regulation is where a profession possesses a valued body of knowledge, along with monopolizing its application. The profession therefore requires an elite group within the profession who can claim the professional authority to set the criteria for its bureaucratization. This bureaucratization includes the formal examination and evaluation of other professionals. Waring et al. (2010) have argued that due to a number of high-profile scandals in both the medical and nursing profession in the UK, the regulation of healthcare professionals has been transformed from 'state-sanctioned collegial self-regulation' to 'state-sanctioned bureaucratic regulation'. Although the NMC FtP process is quasi-legal in nature (as discussed in Chapter 3), it is nevertheless a legalised process governed not only by the *NMC (fitness-to-practise) Rules (2004)* but also by the relevant case law. This falls in line with what Freidson (1983) refers to as the *formal* evaluation and examination of professionals. Furthermore, the *evaluation* and *examination* of professionals also occurs during NMC FtP hearings via the panel, which includes at least one registrant panel member (as discussed in Chapter 3 and 4).

Finally, this thesis also contributes to the existing literature which has looked at the way in which nurses are managed within healthcare settings, particularly in relation to disciplinary practices. Cooke (2006a) has found that nurse managers use disciplinary processes to help nurses learn not to make 'silly mistakes'. The findings of this research suggest that a punitive rationale also underpins NMC FtP hearings, which is exacerbated by the public nature of NMC FtP hearings and their outcomes. This is evidenced by the way in which the public nature of NMC FtP hearings is seen to act as a 'salutary lesson', along with the use of sanctions to declare and uphold proper standards of conduct and behaviour (Chapter 6).

8.4: Recent Changes to the NMC FtP Process

Nevertheless, it is important to note that since conducting this research, there have been recent changes to the way in which the NMC conduct FtP hearings, particularly regarding the issue of transparency. Following the high-profile case of Pauline Cafferky, the NMC made significant changes to the way in which they advertise the upcoming NMC FtP hearings on their website. Pauline Cafferky was a female nurse who had contracted Ebola whilst doing aid work, and, whilst suffering from the disease, lied about her temperature during a screening process held in the airport. The NMC decided to put Pauline Cafferky through a full NMC FtP hearing, with the panel ultimately finding that Cafferky's practise was not impaired as the virus would have impaired her judgement and/or behaviour (NMC, 2016c). Nevertheless, the NMC received considerable criticism from the media for forcing Cafferky to go through a public hearing (Cramb, 2016). Shortly after Cafferky's case, the NMC made the decision not to publish the charges against a nurse on their website until the hearing had been concluded (and only then if the nurse's conduct has been found impaired). This is compared to previously when the charges against a nurse were typically advertised on the NMC's website 28 days before the Substantive Hearing. The NMC later stated that the reason why they no longer publish the charges against a nurse prior to the hearing is that they deem such action to be 'disproportionate' and potentially 'prejudicial'. This is because the charges may be subsequently amended and/or not ultimately proved by the NMC (NMC, 2017c: 3).

Furthermore, as a result of the NMC's 2018 consultation *Ensuring patient safety, enabling professionalism* (NMC, 2018f), the NMC have now made the decision to hold NMC FtP hearings in private when there is no dispute over the assessment of the case. The NMC justified this decision on the following grounds:

> "Where there is no disagreement about the issues in the case, we don't need to hold costly and time-consuming public hearings. We can resolve cases at an early stage in

> the process by using our existing powers for case examiners to agree undertakings, issue warnings, or give advice if the registrant accepts our concerns. We already have the power to ask the Fitness to Practise Committee to decide cases on paper at a private meeting without the parties attending at a private meeting. We want to extend this to every case where the registrant does not disagree with our assessment of the case. We can remain transparent and accountable by publishing the panel's reasons. This will allow the public to see the concerns raised and how they have been dealt with."
>
> (NMC, 2018f: 17)

This has led to all CPD cases being conducted in a private meeting (NMC 2018f). Based on the results of this research, given that only a small number of registrants attend CPD hearings (there was only one CPD case where the registrant attended out of the twenty CPD cases analysed in my documentary analysis sample), this appears to be a sensible approach. However, as Chapter 6 established, CPD cases did not appear to influence male nurses in my documentary analysis sample being more likely to be struck-off, thus such changes would appear to have limited effect on my results. Furthermore, in the aforementioned consultation (NMC, 2018f) the NMC do acknowledge that the NMC FtP process is adversarial. According to the NMC (2018f) this adversarial nature can lead to registrants disengaging with the process and have a negative impact upon those involved, including the referrer(s) of the nurse, the witnesses and the registrant(s).

This decision to grant anonymity to registrants who agree with the NMC's assessment of their case could potentially be seen as an inducement to agree with and/or submit to the judgement of the NMC. Moreover, this reduction in transparency does not address the underlying issue(s) surrounding which cases the NMC decide to refer for a Substantive Hearing and/or Substantive Meeting. In fact, it could be argued that, by

reducing the transparency of the NMC FtP process in such a way, the NMC are actively attempting to limit the degree of criticism that they receive from the media and the public when 'prosecuting' cases that are deemed to be unnecessary. This there is much less chance of them being attended by the media and the public. However, whilst this thesis argues that the public nature of NMC FtP hearings can result in feelings of shame and in turn cause male nurses to disengage from the NMC FtP process, it is the nature and form of the transparency which is problematic rather than transparency as a whole. Nevertheless, this interpretation of a motivation to avoid criticism is reinforced by the fact that the consultation document states that the NMC will no longer be seeking to prosecute cases where registrants have made errors that any other nurse would have made in the same circumstances. The following quote makes this clear:

> "Do you agree that we should always take the context in which a patient safety incident occurs into account when deciding what regulatory action is appropriate?
>
> > If the employer, having addressed the issue locally, still referred the matter to us, we'd look at the context in which the nurse operated. The nurse was working as the only registered adult nurse in a 20 bed care home. She was called away to care for another resident. We'd want to take into account the staffing levels at the home and the support the nurse was given. It won't be misconduct if we decide that the nurse was working in a system which might have caused any professional to make the same mistake. We wouldn't take the case any further. We may instead refer the home to a systems regulator."
> >
> > (NMC, 2018f: 23)

This approach certainly represents a step change from the NMC's previous approach to regulation. In my documentary analysis sample,

out of the seventy-one cases analysed, thirteen involved the panel's acknowledging that there were organizational issues present when the misconduct occurred. Examples of organizational issues included low staffing on the wards that registrants worked on. Therefore, in addition to limiting criticism, the decision not to prosecute such cases can also be seen as a step away from what Cooke (2012) described as the 'bad apple' approach previously used to regulate healthcare professionals. However, this new approach only applies to cases involving proficiency related misconduct, not cases involving conduct-related misconduct. According to the results of my research, male nurses are significantly more likely to commit conduct-related misconduct, which is typically seen to engage the public interest. There is therefore the potential that male nurses will continue to be more likely to be referred to the NMC, to undergo public hearings, and to be more likely to be struck-off the register as a result.

8.5: Strengths and Limitations of My Research

I will now discuss the strengths of my research, with one of them being the fact that it is based on a qualitative framework. As the NMC had already collected statistics highlighting the disproportionate rates of referral and outcome for male nurses subject to NMC FtP hearings (NMC, 2013; 2017b), the use of a qualitative framework allowed me to gain a greater understanding of what lay behind such a statistic. As Rubin and Babbie have pointed out:

> "Qualitative research is especially effective for studying subtle nuances in attitudes and behaviour, and for examining social processes over time. As such, the chief strength of this method lies in the depth of understanding it permits. Whereas some quantitative research methods may be challenged as "superficial", this charge is seldom lodged against qualitative research"
>
> (Rubin and Babbie, 2009: 230)

This is further complemented by the fact that a multiple methods approach was adopted, which utilized interviews, observations and documentary analysis. As Brewer and Hunter (2006) have argued, multiple methods approaches allow for the collection of a wide variety of data which allows the researcher to gain a greater understanding of a given phenomenon. This was indeed the case in my research as I was able to analyse an entire month worth of hearing records published on the NMC's website, along with observing twenty hearings over the course of sixty-eight days. Furthermore, by utilizing observations and documentary analysis in this research, I was able to analyse the potential mechanisms and events in both the domain of the *real* and the *actual*. This meant that I could assess what potential mechanisms contribute towards male nurses being twice as likely to be referred to the NMC and nearly three and a half times more likely to be struck off as a result. As Kessler and Bach have highlighted:

> "It is the use of multiple methods which has particular value to the critical realist… The use of complimentary data sources establishes a more assured basis for the identification of tendencies or demi-regularities."
>
> (Kessler and Bach, 2014: 171)

By combing non-participant observations with documentary analysis, I was also able to collect rich data and cross-check the results of my observations with the panels' own decision-making process which was detailed in the official hearing documents. The official hearing documents themselves are also public records which allows for other researchers or individuals to look at the individual cases and assess the accuracy of my findings. Furthermore, the data that the official hearing documents contain were not recorded or compiled by myself, thus reducing the risk of potential bias (Kendall, 2010).

Linking with this, a specific weakness concerned with my research is whether my data are representative of the social problem at hand. If not, it could mean that the interpretations that I have drawn from my data

would be skewed, which is a common weakness that has been associated with qualitative research (Rubin and Babbie, 2009). In terms of my documentary analysis sample, there is the potential that the one-month worth of cases that I analysed were not representative of the entire year, thus affecting the generalisability of my results. However, between April 2016 and April 2017, 36.6% of all Striking-Off orders were issued to male nurses and, for the month studied as part of this research during that period, 42.3% of all Striking-Off orders were issued to male nurses. As my documentary analysis sample was collected in 2016, the above statistic for April 2016 to April 2017 demonstrates that the over-representation of male nurses in the Striking-Off statistics was a consistent feature of the whole twelve-month period.

Furthermore, the above statistics for both the month studied as part of this research, and the period between April 2016 and April 2017, included the outcomes of Substantive Hearings, Substantive Meetings and Substantive Order Reviews. As previously mentioned, Substantive meetings are held in private where the panel are only provided with documentary evidence; there is no NMC case presenter and the registrant does not attend or give evidence (NMC, 2018d). Substantive Order Reviews, on the other hand, are hearings where an NMC FtP panel decide whether to revoke, extend or replace either a Conditions of Practice Order or a Suspension Order that a nurse has received following a Substantive Hearing (NMC, 2017u). The reason why the NMC review cases where these sanctions have been issued is to ensure that the registrant's conduct is no longer impaired as a Conditions of Practice Order restricts a registrant's practice and a Suspension Order prevents a registrant from practicing. The decision to either revoke, extend or replace an order depends on whether the registrant has engaged with the NMC and has sufficiently remediated their conduct (NMC, 2017u). If the nurse has not engaged with the NMC after having received a Conditions of Practice Order or a Suspension Order, the panel can either extend the order or, in the case of a Conditions of Practice Order, replace it with a Suspension Order. Once a registrant has been under a

Conditions of Practice Order and/or a Suspension Order for two years or more and has continued to not engage with the NMC, the NMC FtP panel can then issue a registrant with a Striking-Off order under Article 29 (6) of the *Nursing and Midwifery Order (2001)*. Returning to the aforementioned statistics, if the outcomes of Substantive Meetings and Substantive Order Reviews are excluded, male nurses account for fifty-five percent of all registrants who were issued Striking-Off Orders following Substantive Hearings in the month studied as part of this research. Unfortunately, however, it is not possible to ascertain whether this was the case for the whole period between April 2016 and April 2017 as the NMC do not break down this statistic in either their Annual FtP Reports (NMC, 2017a) or their Annual Equality, Diversity and Inclusion Reports (NMC, 2017b).

A further issue associated with my documentary analysis sample is that I was unable to analyse the official hearing documents where the registrant's conduct was not found to be impaired, as these are not published online. It is important to note, however, that out of the 1513 hearings held by the NMC between April 2016 to April 2017, only 309 of the hearings resulted in the facts not being proven or the registrant's conduct not being found impaired. This therefore suggests that I was still able to analyse the majority of cases from my chosen month.

Another potential weakness associated with my observational sample is that purposive sampling was used for selection. This involves the researcher deliberately selecting cases which are relevant and/or particularly informative to the research (Roberts, 2009: 221). This therefore creates a risk that any unconscious bias that I possess would influence the cases that I selected, which could potentially comprise the strength of my findings. However, as the official hearing documents are public and the real names of the participants are also reported in the results of my research, it is therefore possible for another researcher to inspect the documents and then compare them with other cases in another month. This means that my sample, and the population from which it is drawn, is in the public domain and can be scrutinised.

Furthermore, the cases selected for observation covered all categories of misconduct listed by the NMC (as discussed in Chapter 3) with the exception of 'health issues' and 'social media'. This therefore reduces the risk that my case selection was not representative.

8.6: Reflexivity and My Position as a Researcher

That is not to say, however, that this potential risk of unconscious bias was unaccounted for during my research, which I sought to address by engaging in a reflexive process throughout my research. When beginning this research, I was initially interested in looking at whether there were certain mechanisms that resulted in panel bias concerning male nurses. This initial interest came about after I digested the existing literature on male nurses, such as Evans (2002) and Harding et al. (2008) who have highlighted the negative stereotypes faced by male nurses. As my research progressed it became apparent that there may be certain acts that are deemed more egregious when committed by a male nurse, such as sexually inappropriate behaviour. However, there appeared to be a number of other mechanisms that may also result in male nurses being more likely to be referred to the NMC and struck off as a result (NMC, 2017b). This demonstrated to me how prior knowledge of existing research can narrow one's focus and will serve as a reminder for me to carefully examine my own thought process in a reflexive manner when conducting future research.

Another issue that I was acutely aware of from the start of my research was that I am not a nurse, which meant that there was a risk that I would misinterpret behaviour. That being said, the fact that I am not a nurse and that I have never been involved in an employment disciplinary hearing could also be a potential strength. This is because what may be 'taken for granted' by those involved in the NMC FtP process could be seen by me as being noteworthy and analysable. As Monaghan and Just have stated:

> "While the insider is capable of noticing subtle local variations, the outsider is far more likely to notice the tacit

> understandings that local people take for granted as ‘common sense’ or ‘natural’ categories of thought.”
>
> (Monaghan and Just, 2000: 30)

This was indeed the case during the observations as, over the course of the twelve-month data collection period, I did find that what was initially noteworthy and unusual became almost normal and expected. This was evidenced by the fact that, when I first began conducting observations, I would be furiously noting down the fine details of the way that the registrants would seek to demonstrate remediation. However, as the research progressed I began to realise that there was a pattern to the way that remorse and insight were demonstrated. At this point, it was only when certain areas were not addressed by the registrant and/or their legally qualified representative that I would find it unusual. I noticed this when observing the case of Peck when his legally qualified representative did *not* ask him what effect he thought his actions had on the public’s perception of the nursing profession.

Another area of consideration was how my own personal characteristics could also influence that way that I collected the data and analysed my results. I am a white, middle-class man who was analysing a female dominated profession where male nurses were more likely to be referred to the NMC and struck-off as a result (NMC, 2017b), all of which could and can result in unconscious bias. Interestingly, a common assumption made about my research was that it is in direct opposition to feminism. One response that I received on an evaluation form following a presentation at the University of Nottingham has always stayed with me:

> “Provocative topic. Be prepared for a feminist response.”

Yet, I would argue that my research is situated alongside feminism rather than existing in opposition to it. My research does demonstrates that gender may possibly influence the rates of referral and outcome for male nurses subject to NMC FtP hearings. However, it is not a one dimensional argument claiming that male nurses are discriminated

against in a female dominated profession. Rather, male nurses' over-representation in the NMC statistics appears to be influenced by a number of possible mechanisms that are present both prior and during the NMC FtP process. These possible mechanisms include the frequency and nature of criminal convictions committed by male nurses, male nurses' greater propensity to commit conduct-related misconduct and the way in which insight, remorse and shame are performed.

I was also acutely aware of my own emotions and the role these played during my research. Whilst researchers should try and remain as objective as possible, social life, which the researcher is also a part of, does not take place in a vacuum, thus making it impossible for any individual to remain purely objective (Finlay, 2002). The Positivistic belief that a researcher can remain purely objective when conducting research is also antithetical to my Critical Realist epistemology. This is because the researcher must utilize *judgemental rationality* or, in other words, make rational judgements about which theory is correct about a given phenomenon. Nevertheless, it would certainly be a fallacy to say that there were not points during my research where I found myself considering the merits of a given case and whether it should have been brought before an NMC FtP panel. However, by utilizing two field research diaries, one where I would record my own analytic thoughts regarding my research and another where I would record my own emotions, I was able to closely analyse my own emotions and feelings and the way that they were influencing my research. This was also greatly aided by my academic supervisors who oversaw my analysis and would point out when my own thoughts and feelings ran the risk of affecting the way that I was interpreting the data.

I also found myself experiencing feelings of discomfort during the observations when I was aware that my presence was causing discomfort to the registrants. This occurred in cases such as Gilmour and Smith, both who looked visibly nervous at my presence when entering and leaving the hearing room. However, as authors such as Jaggar (1989) have argued, emotions and subjectivity do not necessarily

weaken the research, as emotions also play an important part in social life. Thus, so long as they can be accounted for and analysed, they can allow a researcher to be able to gain a greater depth of understanding about a given phenomenon.

8.7: Opportunities for Further Research

Whilst my research has shed sociological light on an under researched area of healthcare, there are still other potential avenues for research that could be undertaken. Despite using a multiple method approach which combined both observations and documentary analysis, I did not interview affected nurses due to ethical reasons concerning the potential distress that such interviews could cause. If these ethical concerns could be addressed, it would be fruitful to elicit affected nurse's' accounts of the process, particularly in relation to shame and transparency. A further area of potential research could therefore be to look at the lived experiences of male and female nurses subject to NMC FtP hearings.

Another area of potential research would be to look at the criteria that employers and nurses use when referring a nurse to the NMC. This would also provide an opportunity to look at the effects of the NMC's recent changes in policy regarding employers who are deemed to refer nurses to the NMC without sufficient reason (NMC, 2018f). Furthermore, another opportunity for future research would be to look at what effects the recent changes to transparency (NMC, 2018f) in NMC FtP hearings have had on feelings of shame and discomfort. This could be done by comparing the experiences of nurses who were referred pre and post the change.

Finally, there are also other minority groups within the nursing profession who are disproportionately likely to be referred to the NMC and sanctioned as a result. Despite Afro-Caribbean nurses only accounting for 6.5% of the nursing population, they account for 13% of all new referrals to the NMC and account for 21.3% of Caution Orders and 16.5% of Suspension Orders (NMC, 2017b). Although the NMC have acknowledged that this is the case following their commissioning of

research to break down the aforementioned statistics, there has yet to be any research which has looked at the reasons why this occurs. Another minority group that is over-represented in the NMC FtP statistics are gay and lesbian nurses. As of 2017, despite gay and lesbian nurses accounting for just 1.4% of the nursing population, they accounted for 2.1% of all those referred to the NMC (NMC, 2017b). However, it is worth pointing out that for 14.7% of the nursing population their sexuality is unknown (distinct from 'prefer not to say'). This category also accounts for 18.1% of all those referred (NMC, 2017b). Nevertheless, in terms of outcome, gay and lesbian nurses still account for 2.4% of all Caution Orders imposed and 2.6% of all Conditions of Practice Orders imposed (NMC, 2017b). Yet, unlike the case of Afro-Caribbean nurses, the NMC have yet to acknowledge this and there has not been any research looking at the reasons for such a statistic, thus providing another area of potential future research.

8.8: Conclusion

This thesis sought to examine the reason why male nurses are twice as likely to be referred to the NMC over concerns about their conduct and more than three times more likely to be struck off as a result (NMC, 2017b). Although I began by focusing solely on gender, I quickly found that there were many aspects of the NMC FtP process that needed to be explored. Whilst I have been able to shine a light on this under researched area, my research is in no way a complete picture of the many possible mechanisms operating within NMC FtP hearings that could potentially influence the above statistic. This thesis therefore ends with a call for further research examining the way that nurses are regulated in the UK; I can only hope that my findings offer a resource for reflection upon the current processes of nursing regulation.

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Appendix A: Glossary

Evidence / Hearing Bundle – The bundle is a collection of documents pertaining to the NMC's case and the registrant's case (NMC, 2017p)

Case Investigation Officer – "The case examiners' role is to decide first whether there is a case to answer, and second, which of the outcomes available under our rules should apply…", for example, there is no case to answer for due to insufficient evidence or that there is a case to answer so should be referred to a fitness-to-practise committee (NMC, 2017q)

Caution – A caution order is the lightest of sanctions, "It does not restrict the nurse or midwife's ability to practise, but is recorded on the register and published on our website" (NMC, 2017l).

Chair – The chair can be either a lay member or a nurse who is on the register who "is an experienced panel member and is responsible for the proceedings" (NMC, 2017b).

Conditions of Practice Order (CoP) – A Conditions of Practice Order restricts the nurses practice in certain areas and "requires the nurse or midwife to comply with conditions for a period of up to three years" (NMC, 2017j). An example of a CoP would be where the nurse is unable to administer medication without being supervised by a senior nurse.

Conduct and Competence Committee (CCC) – The Conduct and Competence Committee is made up of a panel of three, made up of the chair, a lay panel member and a registrant member, as described above. The CCC is responsible for hearing cases that involve, amongst other things, "misconduct; lack of competence; a conviction or caution for a criminal offence; not having the necessary knowledge of English; …a finding by any other health or social care regulator or licensing body that fitness to practise is impaired" (NMC, 2017d).

Consensual Panel Determination (CPD) – A Consensual Panel Determination is where the nurse of midwife accepts the facts of the case and admits to the allegations and that their conduct is impaired. If the NMC and the nurse or midwife agree on the sanction, a document will be drawn up and will "set out the agreed facts, impairment and sanction. It is signed by us [NMC] and the nurse or midwife" (NMC, 2017h). Nonetheless, in order for the CPD to be put in place, an independent panel will need to hear the case and confirm that the nurse or midwife's conduct is impaired and that the sanction is proportionate / appropriate.

Fitness-to-Practice (FtP) – Fitness-to-Practice is the term used to refer to whether a nurse is able to function correctly in accordance to the Nursing Code developed by the Nursing and Midwifery Council. This means that nurses must "have the skills, knowledge, good health and good character to do their job safely and effectively" (NMC, 2017c).

Health Committee (HC) – The Health Committee hears cases where "the nurse or midwife has done things as a result of their health condition… [and there is] sound medical evidence that the incidents would not have happened if the nurse or midwife did not have the health condition" (NMC, 2017e). In the case of a HC hearing, it will be held in private due to the confidential nature of the nurses medical history; equally the document will not be published online for the same reason (NMC, 2017e).

Interim Order – There are two types of interim orders, the first type is an interim conditions of practice order and the second is an interim suspension order. Both types either "…temporarily suspend or restrict the nurse or midwifes practice while their case is being investigated" (NMC, 2017g).

Investigating Committee (IC) – The Investigating Committee deals with the following matters: "the application and review of interim suspension orders and interim conditions of practice orders; fraudulent

and incorrect entries to the register; whether there is a case to answer for in a fitness-to-practise allegation" (NMC, 2017f)

Lay Panel Member (LPM) – The lay panel is an individual who is not a nurse and "are from outside the profession and not on the register" (NMC, 2017b) but can be a member of another profession, however, this is not a perquisite to become a lay panel member. An example of this would be an Occupational Therapist presiding over Fitness-to-Practice case concerning a general nurse.

Legal Assessor (LA) – The legal assessor "is an independent and experienced barrister or solicitor. The legal assessor advises the panel on matters of law" (NMC, 2017a). During the course of the hearing the panel will invite the legal assessor to give advice at different points during the hearing.

NMC Case Presenter – The NMC case presenter is a barrister or solicitor who acts "…as prosecutor in the case, on behalf of the NMC…" (2017a).

No Further Action – The option of no further action can be applied by the panel when they feel that there is no need for a sanction. "However, by finding that the nurse or midwife's fitness to practice is currently impaired, it [the panel] will have decided that there is either a continuing risk to patients, or the nurse or midwife's failures bring the profession into disrepute, or they have breached one of the fundamental tenets of the profession" (NMC, 2017m).

Nursing and Midwifery Council (NMC) – The Nursing and Midwifery Council is the regulatory body that, amongst other things is responsible conducting Fitness-to-Practice hearings concerning nurses and midwives.

Panel Secretary – "The panel secretary assists the panel with the drafting of their decision, but is not involved in making the decision" (NMC, 2017a). They also are responsible for organising/collecting the various parties, including observers, and bringing them to the hearing

room after allocated breaks, as well as assisting the panel with other administrative tasks.

Public Gallery – This is a row of seats along one side of the hearing where observers sit during the proceedings (NMC, 2017a).

Registrant Panel Member (RPM) – The Registrant Panel member is a nurse who is on the register; if it is the registrant's final hearing, the Registered Panel Member will be on the same part of the register as the registrant who is under the investigation (NMC, 2017a). An example of this would be if a mental health nurse was due to have their final hearing, the Registrant Panel Member would also be a mental health nurse on Part 2 of the register.

Registrant's Representative – The registrant can have either a legally qualified representative, such as a barrister or solicitor, and non-legally qualified representatives. In terms of non-legally qualified representatives, they do not require any qualifications or experience within the realm of nursing / healthcare. An example of a non-legally qualified representative would be a Trade Union representative.

Shorthand Typewriter – The shorthand type writer can either be a sonographer who uses a stenotype machine (the hearing is also recorded via a Dictaphone in all instances) or another individual who takes notes down of the hearing on a laptop or piece of paper, however, the latter is extremely uncommon.

Substantive Hearing – "A hearing allows the nurse or midwife to attend in person, and/or be represented. We will have a case presenter to present our evidence to the panel.

Both the NMC case presenter and the nurse or midwife can call witnesses to attend and provide their evidence verbally to the panel. This also means that both parties can question witness evidence through cross examination, and make submissions to the panel at each stage of the process. The powers available to the panel are the same

whether the matter is considered at a hearing or a meeting." (NMC, 2017n)

Substantive Meeting – "At a meeting, the panel will consider the matter on the papers. This will be the documentary evidence such as witness statements and exhibits that we have obtained, along with any written responses by the nurse or midwife. As a meeting is private, the nurse or midwife, their representative and the witnesses do not attend. There is also no case presenter. This means that the witnesses cannot be questioned, and parties cannot make verbal submissions to the panel." (NMC, 2017o)

Striking-off order – "A striking-off order results in the removal of the nurse or midwife's name from the register, thus preventing them from working as a registered nurse or midwife. They may not apply for restoration until a period of five years has elapsed since the striking-off order was made." (NMC, 2017k).

Suspension Order – A Suspension Order is reserved for serious offences, including where the nurse is deemed to have attitudinal problems. Said order "…directs the Registrar to suspend the nurse or midwife's registration for a period of up to one year" (NMC, 2017i).

REFERENCE **Signed off by**
Referred to

Supervisor **REC**

School of Sociology & Social Policy
Research Ethics Checklist for Students and Staff

The University of Nottingham's Guidance on Ethical Review states: "Ethical review (and approval) is required for all projects where the research involves participation of human subjects, their data and/or their tissue (even where the applicant indicates that there is only minimal risk)."

This form must be therefore be completed for all research projects, research assignments or dissertations/theses which are conducted within the School and involve human participants or data that are sensitive or protected. **You must not begin data collection or approach potential research participants until you have completed this form and received ethical clearance including the required signatures.**

If the study is based only on a review of documentary sources already in the public domain and involves NO fieldwork of any sort, then this form does not need to be completed.
Completing the form includes providing a summary of the research in Section 2 and ticking boxes in Section 4. Ticking a shaded box in Section 4 indicates that the study is above minimal risk and requires further action by the researcher. Two things need to be stressed:

- Ticking one or more shaded boxes does not mean that you cannot conduct your research as currently anticipated; however, it does mean that further questions will need to be asked and addressed, further discussions will need to take place, and alternatives may need to be considered or additional actions undertaken.
- Avoiding the shaded boxes does not mean that ethical considerations can subsequently be 'forgotten'; on the contrary, research ethics need to be informed - for everyone and in every project – by an ongoing process of reflection and debate throughout the study.

The following checklist is a starting point for an ongoing process of reflection about the ethical issues concerning your study.

The checklist must be completed electronically and submitted on line to Alison.Haigh@Nottingham.ac.uk. For all undergraduate and postgraduate taught students the checklist must be accompanied, where appropriate, by a completed Participant Information Sheet and Consent Form (Guidance and templates are included in Annex A below – these should be tailored to the individual project in the form they will be used in the field). All Ethics Checklists must be accompanied by a completed Fieldwork Risk Assessment Form (Please see School's Ethics webpage: http://www.nottingham.ac.uk/sociology/research/research-ethics.aspx).

The School also has guidance on researcher safety, lone working, working abroad, the Mental Capacity Act 2005 and the archiving of research data.

For further information on these and other ethical issues, please consult the School's Ethics webpage:
http://www.nottingham.ac.uk/sociology/research/research-ethics.aspx

SECTION 1: THE RESEARCHER(S)

To be completed in all cases

Title of project: *The Boys in Blue: An Exploration into the Disproportionate Rates of Referral and Outcome for Male Nurses Subject to Fitness-to-Practice Hearings Conducted by the Nursing and Midwifery Council.*

Name of principal researcher:

Status:
- ☐ Undergraduate student
- ☐ Postgraduate taught student
- ☑ Postgraduate research student
- ☐ Staff

Email address: *lqxbjmat@nottingham.ac.uk*

Names of other project members: *N/A*

To be completed by students only:

NAME IN CAPITALS

BENJAMIN JACOB MATHERS

Student ID number: *4240545*

Degree programme: *PhD Sociology*

Module name/number: *Thesis*

Supervisor/module leader or tutor: *Alison Pilnick; Alison Edgley*

SECTION 2: RESEARCH WITHIN OR INVOLVING THE NHS OR SOCIAL CARE

Does this research involve the recruitment of patients, staff, records or other data through the NHS or involve NHS sites or other property?

- ☐ Yes
- ☑ No

If you have answered **YES** to the above question, ethical approval **MUST** be sought from the relevant NHS research ethics committee. Evidence of approval from such a committee **MUST** be lodged with the School office prior to the commencement of data collection.

Does this research involve the recruitment of users, staff, records or other data through social service authorities (children and adult services) or involve social service sites or other property?

- ☐ Yes
- ☑ No

If you have answered **YES** to the above question, then you must check whether or not the relevant social service authority has its own ethical scrutiny procedures. If appropriate, evidence of approval from such an authority **MUST** be lodged with the School office prior to the commencement of data collection.

Even where external ethical approval has been obtained from an NHS committee or social service authority, completion of this form is mandatory.

SECTION 3: THE RESEARCH

This research is aimed at investigating the reasons behind why male nurses are twice as likely to be referred to the Nursing and Midwifery Council and three times more likely to be struck of as a result. This will be achieved by utilizing a multiple method approach and will be comprised of the textual analysis of NMC pre-hearing and hearing reports; observation of NMC Fitness-Practice Hearings; interviews with Trade Union representatives and NMC Independent Panel Members.

1. Research question(s) or aim(s)

I. To analyse the Nursing and Midwifery Council hearing records with a particular focus on disproportionate rates of referrals and outcomes for male nurses.
II. To analyse the Nursing and Midwifery Conduct and Competence Fitness-to-Practice process and how it is conducted in relation to both male and female nurses.
III. To assess what factors may be influencing these disproportionate rates.

2. Method(s) of data collection

i. A Freedom of Information Request to the Nursing and Midwifery Council asking that they provide the researcher with the number of male and female nurses subject to Fitness-to-Practice hearings in England.

ii. Textual analysis or Nursing and Midwifery Council Fitness-to-Practice pre-hearing and hearing reports made available via the Nursing and Midwifery Council's website.

iii. Observations of Nursing and Midwifery Council Fitness-to-Practice hearings, which the public are allowed to attend.

iv. Interviews with Trade Union Representatives and NMC Independent Panel Members

3. Proposed site(s) of data collection

Observations: *- NMC, 2 Stratford Place, Montfichet Road, London, E20 1EJ - NMC, 61 Aldwych, London, WC2B 4AE*

Interviews: *- Participants place of work e.g. Royal College of Nursing, 9 Bond St, Leeds, West Yorkshire LS1 2JZ*

4. How will access to participants be gained?

Observations: The general public are allowed attend NMC Fitness-to-Practice hearings by booking a place on each hearing via the NMC's website.

Interviews: The researcher will contact the Royal College of Nursing (RCN) and the NMC to request interviews with RCN Trade Union Representatives and NMC Independent Panel Members. Following the first round of interviews, the researcher will try to source participants via snowball sampling facilitated by other participants.

The researcher also has connections within the nursing and healthcare community in the form of a consultant nurse, a hospital psychotherapist (and former nurse) who provides counselling for staff subject to disciplinary proceedings and a registrant panel member of the Healthcare Practitioners Council who has connections with the NMC. In the event that there is limited response to the initial contact described above, the researcher will attempt to source participants via aforementioned contacts.

SECTION 4: ETHICAL CONSIDERATIONS

Please answer each question by ticking the appropriate box. All questions in section 4 **must** be answered.

4.1 General issues

	Yes	No
Will this research involve any participants who are known to be vulnerable due to: Being aged under 18? Residing in institutional care (permanently or temporarily)? Having a learning disability? Having a mental health condition? Having physical or sensory impairments? Previous life experiences (e.g. victims of abuse)? Other (please specify)…		☑
Will this research expose participants to any significant risk of physical or emotional harm?		☑
Will this research involve any physically invasive procedures or the collection of bodily samples?		☑
Will this research address sensitive issues, for example, abuse, illegal activities, sex, sexuality, drug use, serious illness? (This list is not exhaustive)	☑	
Will this research involve deception of any kind?		☑
Will this research involve access to personal information about identifiable individuals without their knowledge or consent?	☑	
I will inform immediately the School's Ethics Officer if I change the method(s) of data collection, the proposed sites of data collection, the means by which participants are accessed, or make any other significant changes to my research inquiry	☑	

4.2 Before starting data collection

	Yes	No
I have read the *Research Code of Conduct* guidelines of the University of Nottingham, particularly section 4 on Data, and agree to abide by them. The *Research Code of Conduct* can be found on the School's Ethics webpage: http://www.nottingham.ac.uk/sociology/research/research-ethics.aspx.	☑	
For those intending to work with children and/or vulnerable adults: I have read the University's *Guidance on the Protection of Children and Vulnerable Adults* The Guidance can be found on the School's Ethics webpage: http://www.nottingham.ac.uk/sociology/research/research-ethics.aspx).	N/A	

My full identity will be revealed to all research participants	☑	
All participants will be given accurate information about the nature of the research and the purposes to which the data will be put	☑	
All participants will freely consent to take part, and this will be confirmed by use of a consent form. (An example of a consent form is available for you to amend and use.)	☑	
One signed copy of the consent form will be held by the researcher and another will be retained by the participant	☑	
It will be made clear that declining to participate will have no negative consequences for the individual	☑	
It will be made clear that participation is unlikely to be of direct personal benefit to the individual	☑	
Participants will be asked for permission for quotations (from data) to be used in research outputs where this is intended	☑	
Incentives (other than basic expenses) are offered to potential participants as an inducement to participate in the research. (Here any incentives include cash payments and non-cash items such as vouchers and book tokens.)		☑
For research conducted within, or concerning, organisations (e.g. universities, schools, hospitals, care homes, etc) I will gain authorisation in advance from an appropriate committee or individual. (This is in addition to any research ethics procedures required by those organisations, particularly health and social care agencies – see Section 2 above.)	☑	

4.3 During the process of data collection

	Yes	No
I will provide participants with my University contact details, and those of my supervisor, so that they may make get in touch about any aspect of the research if they wish to do so	☑	
Participants will be guaranteed anonymity only insofar as they do not disclose any illegal activities. This will be made clear before any data are collected	☑	
Anonymity will not be guaranteed where there is disclosure or evidence of significant harm, abuse, neglect or danger to participants or to others. This will be made clear before any data are collected	☑	
All participants will be free to withdraw from the study at any time, including withdrawing data following its collection	☑	
Data collection will take place only in public and/or professional spaces (e.g. in a work setting). If fieldwork takes place in the respondent's home please outline in	☑	

Section 6 what steps will be taken to ensure your safety. You must read the University's Lone Worker Policy and may wish to consult the SRA researcher safety guidelines (Please see School's Ethics webpage: http://www.nottingham.ac.uk/sociology/research/research-ethics.aspx)		
Research participants will be informed when observations and/or recording is taking place	☑	
Participants will be treated with dignity and respect at all times	☑	

4.4 After collection of data

	Yes	No
Where anonymity has been agreed with the participant, data will be anonymised as soon as possible after collection	☑	
All data collected will be stored in accordance with the requirements of the Data Protection Act 1998	☑	
Data will only be used for the purposes outlined within the participant information sheet and consent form	☑	
Details which could identify individual participants will not be disclosed to anyone other than the researcher, their supervisor and (if necessary) internal and/or external examiners without their explicit consent	☑	
I will inform my supervisor and/or the School's Research Ethics Officer and (if necessary) statutory services of any incidents of actual or suspected harm of children or vulnerable adults which are disclosed to me during the course of data collection	☑	

4.5 After completion of research

	Yes	No
Participants will be given the opportunity to know about the overall research findings	☑	
Data must be submitted to the School office and will be retained (in a secure location) for 7 years from the date of any publication based upon them, after which time it will be destroyed.	☑	
All hard copies of data collection tools and data which enable the identification of individual participants will be destroyed	☑	

SECTION 5: ETHICAL APPROVAL

Declaration of ethical research

1. ***If you did not tick any of the shaded boxes*** *in section 4 of this form*, please sign and date below **and** get the checklist countersigned (see below for who the checklist must be countersigned by).
   Keep one copy of this form for your personal records.
   Students who undertake research involving primary data collection on non-dissertation modules must submit the authorised checklist along with their assessed work to Alison Haigh in the School Office.
   Undergraduate dissertation students who intend to conduct fieldwork should include **two hard copies** of the checklist with their dissertation plans submitted to dissertation tutors in the autumn. Then assuming the checklist is signed and authorised by their dissertation supervisor, **students should confirm this authorisation in a section discussing ethics in the text of the dissertation**. Failure to do so may incur penalties when the dissertation is marked. Some undergraduate module convenors will also distribute a short 'ethical declaration' that you will have to sign.

   Principal investigators and other researchers, including postgraduate research students and postgraduate taught students, should keep a copy of the authorised checklist on file.
   By signing this form you are agreeing to work within the protocol which you have outlined and to abide by the University of Nottingham's Code of Research Ethics. If you make changes to your protocol which in turn would change your answers to any of the above questions then you **must** complete a new form and submit a copy to Alison Haigh or for undergraduates to your tutor/supervisor.

Signed …………………………………………………..…. Date ……………………………..

2. ***If you ticked any of the shaded boxes in section 4 of this form, then you must complete SECTION 6 (overleaf). You must then discuss all ethical issues arising, record the outcome, including the supervisor's or REO's response, and have this form counter-signed (see below)***

Authorisation

This section **must** be completed in **all** cases – by type of investigator the form must be countersigned by the following personnel:

Undergraduate student (no shaded boxes ticked) → module convenor or tutor/project supervisor
Undergraduate student (shaded boxes ticked) → module convenor or tutor/project supervisor → School Research Ethics Officer (REO)

Postgraduate taught student (no shaded boxes ticked) → dissertation supervisor
Postgraduate taught student (shaded boxes ticked) → dissertation supervisor → School Research Ethics Officer (REO)

Postgraduate research student → supervisor/upgrade panel → School Research Ethics Officer (REO)

Staff → School Research Ethics Officer (REO)

Having reviewed the ethical issues arising from the proposed research:

- ☐ I am happy for the research to go ahead as planned
- ☐ I have requested that changes be made to the research protocol. The principal researcher must complete and submit a revised form which integrates these changes
- ☑ This project must be referred on for more detailed ethical scrutiny by the REO/Research Ethics Committee
- ☐ This project is to be referred to Research Development Group for consideration (this option is for School REO only)

Signed ………………………………………………………………………… Date …………………………

Role

…….

School REO……………………………………………………………………… Date …………………………

Note: **any** research protocols lodged with the School Office may be subject to review by the School's Research Ethics Officer

SECTION 6: FURTHER INFORMATION & JUSTIFICATION OF METHODOLOGY

One box should be completed for **each** shaded box ticked in section 4 of this form.

Ethical issue:
Will this research involve access to personal information about identifiable individuals without their knowledge or consent?

Textual analysis: Data will be obtained concerning nurses that have been subject to Fitness-to-Practice hearings in the form of pre-hearing and hearing repots via the NMC's website and a Freedom of Information request without the nurses consent.
Observations: Fitness-to-Practice hearings will also be observed without the affected nurse's consent.

Rationale for chosen methodology and/or how ethical issue is to be addressed:
Whilst the Nursing and Midwifery Council do provide access via their website to the Fitness-to-Practice pre-hearing and hearing reports for all nurses who have been found guilty of misconduct, the NMC does not publish the reports for nurses who have been ultimately found to have *not* committed misconduct. The researcher will therefore seek to gain access to these reports via a Freedom of Information request. However, the researcher will request that all identifiable information regarding the affected parties be excluded, with the exception of the nurses' ethnicity and gender, in order to comply with both the Data Protection Act and also to help alleviate the issues of non-consent, as the researcher will be unaware of who the report(s) concern and is interested in general themes and patterns.

Furthermore, the Nursing and Midwifery Council allow the general public to attend Fitness-to-Practice hearings; in other words, the hearing itself is held in a public forum, thus potentially negating the issue of non-consent as the hearings themselves are held in a public forum.

Supervisor/REO's response (including whether ethical issue has been satisfactorily addressed):

Ethical issue:
Will this research address sensitive issues, for example, abuse, illegal activities, sex, sexuality, drug use, serious illness?

Rationale for chosen methodology and/or how ethical issue is to be addressed:
This research will address the contentious issue of employment disciplinaries and these may also cover areas concerning harm to patients, staff and the affected nurse, as well as other issues such as illegal activity during the course of employment. The rationale behind this topic is based upon the fact that male nurses currently account for 22% of all those referred to the Nursing and Midwifery Council for Fitness-to-Practice hearings, and 33% of all those struck off as a result. In order to begin to address this issue, research needs to be conducted with the aim of analyzing the root cause(s) of these disproportionate rates, which will involve investigating the circumstances that result in male nurses being struck off at such a striking rate.
However, in saying this, the researcher will not be speaking directly to anyone has been involved in committing harm or subject to that harm, this data will be obtained via observations of Nursing and Midwifery Council Fitness-to-Practice hearings that are in the public domain by virtue of them allowing the general public to attend and observe them.
Supervisor/REO's response (including whether ethical issue has been satisfactorily addressed):

Please continue on separate sheets if required

School Research Ethics Officer on behalf of
Research Development Group

September 2014

ANNEX A

This annex contains:

- A suggested format for a written consent form
- A suggested format for Participant Information Sheets

We hope you find these documents useful and that you will give us any comments for improvement.

All researchers

For all research the Ethics Checklist must be accompanied by a completed Fieldwork Risk and Assessment Plan (Please see School's Ethics webpage: http://www.nottingham.ac.uk/sociology/research/research-ethics.aspx)

Undergraduate and postgraduate taught students only

You must include drafts of your Consent Form and Participant Information Sheet when you submit your completed Research Ethics Checklist for scrutiny to your supervisor and to the REO/Research Ethics Committee. These should be tailored to the individual project in the form they will be used in the field.

CONSENT FORMS

Research that involves the collection of personal or other sensitive data cannot proceed until potential participants have formally given their consent. However, consent forms are not required where consent is implied, for example, the anonymous return of questionnaires by mail.

When seeking consent adults are assumed to be competent to do so unless the researcher judges that they are unable to assess the information provided to make a decision.

Where potential participants are aged *either* under 18 years *or* 18 years and over and are unable to make an informed decision about participation in the research, additional separate consent forms are required for a relevant third party, such as parents/guardians or partners/carers. In such cases the consent form will invite the third party to sign a statement that they have read and understood the Participant Information Sheet, and agree that the potential participant can take part in the research. In addition, children and young people should be asked to sign a consent form in their own right, even where parents have signed one.

Where potential participants are aged under18 years then you are required to undergo a **Disclosure and Barring Service** check. The responsibility

for completing this satisfactorily is yours (see https://www.gov.uk/government/organisations/disclosure-and-barring-service) Proof of successful completion must be made available at all times.

In certain circumstance the researcher may also require the consent of an independent party, such as a Headteacher when fieldwork is being conducted in a school.

When a potential respondent declines to give consent, the researcher is allowed to offer further information or explanation about the research but must not apply any moral or other pressure to get the individual to agree to take part.

The signed Consent Form is returned to the researcher and must be securely retained with any field notes and interview transcriptions. The participant (or third party) may retain a copy of the Participant Information Sheet.

Consent Form(s) for your research project
This guidance includes a template for writing a Consent Form for your research – variations to suit particular projects are allowed. Notes are given in *italics*.

Consent Forms may be produced on plain paper (rather than letterhead) since, unlike the Participant Information Sheet, they are collected and retained by the researcher.

School of Sociology and Social Policy - University of Nottingham

Participant Consent Form

The Boys in Blue: An Exploration in to the Differential Rates of Referral and Outcome for Male Nurses Subject to Fitness-to-Practice Hearings Conducted by the Nursing and Midwifery Council

In signing this consent form I confirm that:

I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me.	Yes ☐	No ☐
I have had the opportunity to ask questions.	Yes ☐	No ☐
I understand the purpose of the research project and my involvement in it.	Yes ☐	No ☐
I understand that my participation is voluntary and I may withdraw from the research project at any stage, without having to give any reason and withdrawing will not penalise or disadvantaged me in any way.	Yes ☐	No ☐
I understand that while information gained during the study may be published, any information I provide is confidential (with one exception – see below), and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published.	Yes ☐	No ☐
I understand that the researcher may be required to report to the authorities any significant harm to a child/young person (up to the age of 18 years) that he/she becomes aware of during the research. I agree that such harm may violate the principle of confidentiality.	Yes ☐	No ☐
I agree that extracts from the interview may be anonymously quoted in any report or publication arising from the research.	Yes ☐	No ☐
I understand that the interview will be recorded using audiotape	Yes ☐	No ☐
I understand that data will be securely stored	Yes ☐	No ☐

I understand that I may contact the researcher's supervisor if I require further information about the research, and that I may contact the Research Ethics Officer of the School of Sociology and Social Policy, University of Nottingham, if I wish to make a complaint. relating to my involvement in the research.	Yes	☐	No	☐
I agree to take part in the above research project.	Yes	☐	No	☐

____________________	____________________	____________
Participant's name (BLOCK CAPITAL)	Participant's signature	Date
____________________	____________________	____________
Researcher's name (BLOCK CAPITAL)	Researcher's signature	Date

GUIDANCE AND TEMPLATE FOR PARTICIPANT INFORMATION SHEET

The Participant Information Sheet is given to potential participants so that they can give informed consent to participate in the research.

The Participant Information Sheet should:

- Clearly identify the School and the University – this can normally be achieved by using letterhead paper.
- Be written in clear and accessible style.
- Include the title of the research project.
- Identify the name of the researcher and give contact details.
- A statement of the aim/purpose of the research.
- Outline what groups of people are being asked to take part in the research, and if relevant how they are being identified/selected.
- Outline what the individual is expected to do as a participant in the study. This will include a statement of the likely time commitment involved and any inconvenience/discomfort that might be incurred.
- A description of any financial or other incentives for taking part in the research.
- A description of the possible benefits for participants/society of participation.
- An assessment of any foreseeable risks that participation might entail.
- A statement that participation is voluntary and s/he can withdraw at anytime without giving any reasons.
- A statement of what will happen to the collected information, including where it will be stored and details of access and when it will be destroyed.
- A statement of what will happen if researcher becomes aware of significant harm to a child/young person up to the age of 18 years and what this implies for the confidentiality of the research.
- If relevant, a statement that the participant will be allowed to comment on the transcript and/or given a report of the (main) research findings.
- An outline of intended research outputs, and a statement of whether anonymity will be maintained and whether anonymous quotes will be used in reports/publications.
- If relevant, a statement that the data may be used (by others) in secondary analysis.
- Contacts for staff who can deal with (a) any queries about the research (this will normally be the principle investigator or the student's supervisor; and (b) formal complaints about the researcher or other aspects of the research.

As appropriate the information sheet (and associated consent form) should be made available in languages other than English and in other formats.

In certain circumstances the Participant Information Sheet may be accompanied by a covering letter or incorporated in an opt-in or opt-out letter. With an 'opt-in' potential participants are asked to contact the researcher if they want to take part in the study, whilst with an 'opt-out'

potential participants contact the researcher if they do not want to take part in the study.

This guidance includes a template for writing a Participant Information Sheet for your research – variations to suit particular projects are allowed. Notes are given in *italics*.

Participant Information Sheet may be produced on letterhead paper because they may be retained by participants as a record of the research.

School of Sociology and Social Policy
University of Nottingham

Information for Participants

The Boys in Blue: An Exploration into the Disproportionate Rates of Referral and Outcome for Male Nurses Subject to Fitness-to-Practice Hearings Conducted by the Nursing and Midwifery Council

Who is carrying out the study?

The study will be carried out by Benjamin Mathers, a current PhD student based in the School of Sociology and Social Policy at the University of Nottingham. This research is funded by the Economic and Social Research Council.

What the study is about?

This study aims to investigate the reasons for the disproportionate rates of referral and outcome for male nurses subject to Conduct and Competence Fitness-to-Practice hearings conducted by the Nursing and Midwifery Council. The three research questions that underpin this study are:

IV. To analyse the Nursing and Midwifery Council hearing records with a particular focus on disproportionate rates of referrals and outcomes for male nurses.
V. To analyse the Nursing and Midwifery Conduct and Competence Fitness-to-Practice process and how it is conducted in relation to both male and female nurses.
VI. To assess what factors may be influencing these disproportionate rates.

What will you have to do?

You will be asked to discuss topics surrounding Conduct and Competence Fitness-to-Practice hearings conducted by the Nursing and Midwifery Council. An example of this would be patterns in the rates of referrals for different social groups referred to the Nursing and Midwifery Council for Conduct and Competence Fitness-to-Practice hearings.

What are the benefits of participating in the study?

The benefit of participating in the research is that you will be helping to contribute to an under-researched area of healthcare practice, as well as assisting in the exploration of the potential effects that gender may have on the outcome of Nursing and Midwifery Fitness-to-Practice hearings.

Are there any foreseeable risks to the individual if you participate in the research?

There are no foreseeable risks in participating in the research. All names, locations and any other identifiable information will be anonymized and no specific information will be asked about individual cases or individuals working for the Nursing and Midwifery Council.

Are there any costs or inducements to taking part in the research?

There are no costs or inducements involved in taking part in the research. All participation is voluntary. You have the right to withdraw from the study for any reasons, both before and after the data has been collected, up until the point of publication. If you wish to do so, please contact the researcher via email on: lqxbjma@nottingham.ac.uk.

What happens to the collected information?

Once the data is collected, it will be transcribed with all identifiable information being anonymized in the transcription. The audio file will then be destroyed and the transcription will be stored on an encrypted external hard-drive until the analysis is finished. Once the analysis has finished, a copy of the transcription will be then be placed in secure storage at the University of Nottingham, and all remaining files containing the transcription will then be deleted from the external hard-drive.

What are the research outputs?

The research outputs will be a PhD project and other publications arising from it such as academic journal articles and presentations to academics and policy makers.

What other sorts of people are being asked to take part, and how are they being identified/selected?

The people selected for the interview process are individuals who have participated in Fitness-to-Practice hearings conducted by the Nursing and Midwifery council. They are being selected/identified through existing contacts and referrals.

Contact details

Researcher: *Benjamin Mathers; 07947 148038; lqxbjmat@nottingham.ac.uk or write to the above address.*

Supervisor: *Prof. Alison Pilnick; 0115 95 15232; alison.pilnick@nottingham.ac.uk or write to the above address*.

Complaint procedure

If you wish to complain about the way in which the research is being conducted or have any concerns about the research then in the first

instance please contact Prof. Alison Pilnick. If this does not resolve the matter to your satisfaction then please contact the School's Research Ethics Officer, Dr Simon Roberts; 0115 846 7767; simon.roberts@nottingham.ac.uk

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From: Roberts Simon <lqzsjr@exmail.nottingham.ac.uk>
Sent: 21 January 2016 16:21
To: Mathers Benjamin <lqxbjmat@exmail.nottingham.ac.uk>
Cc: Pilnick Alison <Lqzpi@exmail.nottingham.ac.uk>; Edgley Alison <ntzae1@exmail.nottingham.ac.uk>; Alison Haigh (Alison.Haigh@nottingham.ac.uk) <Alison.Haigh@nottingham.ac.uk>
Subject: RE: Ethical approval and change in circumstances

Hi Ben,

Thank you. That being the case you have ethical approval to recruit and interview your Nurse Manager respondents.

Good luck and best wishes

Simon

Dr Simon Roberts
Associate Professor of Public and Social Policy
Lead of International Centre for Public and Social Policy (IcPSP)
Chair of Research Ethics Committee
School of Sociology and Social Policy
University of Nottingham
B39, Law and Social Science Building, University Park
Nottingham, NG7 2RD
t: +44 (0) 115 846 7767
w: www.nottingham.ac.uk/sociology/people/simon.roberts

From: Mathers Benjamin
Sent: 21 January 2016 16:05
To: Roberts Simon
Subject: RE: Ethical approval and change in circumstances

Hi Simon,

Thanks for your email - I can confirm that the recruitment of nurse managers will not be through the NHS and that the interviews will not take place on NHS sites and/or property.

Many thanks for all your help.

Best wishes,
Ben

Sent from my Sony Xperia™ smartphone

---- Roberts Simon wrote ----

Hi Ben,

Following our telephone conversation of a few moments ago, as long as your recruitment of Nurse Managers is not through the NHS and the interviews do not take place on NHS sites or other NHS property, your existing ethics authorisation covers your proposed interviews of Nurse Managers. Can you confirm that this is the case please?

Best wishes

Simon

Dr Simon Roberts
Associate Professor of Public and Social Policy
Lead of International Centre for Public and Social Policy (IcPSP)
Chair of Research Ethics Committee
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t: +44 (0) 115 846 7767
w: www.nottingham.ac.uk/sociology/people/simon.roberts

From: Mathers Benjamin
Sent: 21 January 2016 15:38
To: Roberts Simon
Cc: Pilnick Alison; Edgley Alison
Subject: Ethical approval and change in circumstances

Dear Simon,

I am just emailing you to ask your advice regarding my ethical approval and a slight change in circumstances.

I stated on my ethics form that I am interviewing Trade Union Representatives from the Royal College of Nursing and Tribunal Adjudicators from the Nursing and Midwifery Council, which was approved. However, I now also want to interview Nurse Managers (many of whom are also Trade Union Representatives, although not in all cases) as well as the above individuals.

I was therefore wondering whether my existing ethical clearance would suffice for Nurse Managers or whether I would need to submit another ethics form?

Many thanks for all your help.

All the best,

Ben

Appendix C: Interview Schedule

Interview Questions for Nurse Managers / Trade Union Representatives

Thank you taking the time to let me interview you. My research is looking at the NMC FtP process and the role that gender plays in the outcome of these hearings. I am also looking to find out more about the process that nurses undergo prior to being referred to the NMC. You have the right to withdraw from the research at any point prior to the publication of my research and if there are any questions that you did not wish to answer, please let me know. Are you happy with me audio recording this interview?

- What is your role?
- How many male and female nurses do you have in your team?
- Do you think there is any differences in the way that male nurses practice in comparison to female nurses and vice versa?
  Can you give any specific examples?

- Do male nurses treat female nurses differently and vice versa?
- Is there a difference in the way that male and female nurses are managed on a day-to-day basis?
- From a trade union / management perspective, what role have you played in the disciplining of nurses?
- Have you noticed any differences in the type of offences/incidents between male and female nurses?
- Are there any differences between male and female nurses when being interviewed / investigated as a result of the incident(s) leading to disciplinary actions?
- In terms of your experience, do you perceive that there are certain offences / incidents that would attract more attention depending on whether the nurse is male or female?
- What type of cases are typically referred on to the NMC by the Trust, and are there any differences between the type of cases referred regarding male and female nurses?

Statistically male nurses are twice as likely to be referred to the NMC for misconduct and three times more likely to be struck off the register as a result:

- Do you perceive/think that there are any differences with regard to engagement with the disciplinary process between male and female nurses?

- In terms of your experience, do you think that there are any differences in admissions of guilt between male and female nurses?

Appendix D: Observational Sample Description

Name of Registrant	Gender	Background of Nurse	Description of case	Finding of Impairment	Sanction
Akinbote, Elizabeth	Female	Mental Health Nurse	Akinbote was accused of sexually assaulting a vulnerable male psychiatric outpatient on several occasions, who later reported her to the police, although the Crown Prosecution Service did not proceed with the case. The patient had recorded a telephone conversation between himself and Akinbote, which he later provided to the NMC, where it was alleged that Akinbote stated to the patient: "if you tell anyone [about the sexual assault] I will overdose you and you won't know it". Akinbote denied all ten of the charges against her, although she was not present at the hearing. She was however represented by a non-legally qualified representative who was present at the hearing. The panel found nine	Yes	Striking-off order

			out of the ten charges against Akinbote had been proven.		
Ansal, Ceylan	Female	Adult Nurse	Ansal was accused of not having participated in staff handover on two separate occasions, as well as not having recorded that she increased a patient oxygen saturation levels and failing to administer medication to another patient. All of the charges against Ansal were based on the testimony of one witness, which the NMC were not able to get into contact with on the day of the hearing. The two other witnesses were also unable to attend. The NMC therefore made an application for the hearing to be postponed, which was accepted by the panel. The case has not been re-filed and there are no restrictions on Ansal's registration history at present.	N/A	N/A
Badjie, Alagie	Male	Mental Health Nurse	Badjie was accused of mistreating several elderly residential patients on a number of occasions, which included pushing food into a male resident's closed mouth, lifting a female resident's legs up in a demeaning manner whilst she was lying on her back in order to change her incontinence pad and using an inappropriate	Yes	Suspension order – 6 months

			handling technique when moving another resident. Badjie denied the charges against him, but was not present or represented during the hearing. The panel found all but two charges against Badjie had been proven.		
Collier, Philip	Male	Mental Health Nurse	Collier was accused of not carrying out a risk assessment or ascertaining whether the Home Treatment team would be able to provide a psychiatric outpatient with support over a given weekend. Collier also admitted to advising another psychiatric outpatient to remain off his prescribed anti-depressant and did not consult the patient's psychiatrist or general practitioner about this nor did he ensure that the patient was regularly monitored for side effects and/or increased symptoms. Collier admitted all of the charges and formed a CPD agreement with the NMC, which the panel ratified.	Yes	Suspension order – 4 months
Fullerton, Katie	Female	Adult Nurse	Fullerton was accused of stealing codeine phosphate tablets on multiple occasions, which her employer tracked via an electronic pharmacy dispensing machine (Medi365 machine). Fullerton denied all of the charges	Yes	Striking-off order

			against her and was present and represented by a legally qualified representative. The panel found all three charges against her had been proven.		
Gilmour, Sarah	Female	Adult Nurse	Gilmour was accused of attending work whilst under the influence of alcohol, although she did not treat any patients and left shortly after arriving in order to drive to another site. During the drive to the other site, Gilmour was arrested, charged and later convicted of driving with excess alcohol and was given an eight-week prison sentence wholly suspended for twelve months. Gilmour admitted to the two charges pertaining to the above events. Gilmour was also accused of deliberately not informing her employer of her conviction in order to conceal it, despite her employment contract stating that she must disclose any criminal convictions. Gilmour denied that she had intentionally not disclosed her conviction to her employer in order to conceal it. The panel found that although she had not disclosed her conviction to her	Yes	Caution order – 18 months

			employer, she did not do so in order to intentionally conceal her conviction.		
Henry, Lois	Female	Adult nurse	Henry was accused of several acts of misconduct at two different care homes. In the first care home Henry was accused of putting laxatives in a male colleague's drink and later behaving in a sexually inappropriate manner towards the aforementioned male colleague, which included grabbing his legs and spreading them apart as well as making sexually inappropriate comments. Henry was also accused of making xenophobic and derogatory comments towards other members of staff on another occasion. In the second care home, Henry was accused of making sexually inappropriate comments and gestures towards a female member of staff. Henry denied all but one of the charges, admitting that she made the comment "Hello big tits" towards the female member of staff in the second care home. The panel found all of the charges against her proved.	Yes	Caution order – 3 years

Heslop, Pauline	Female	Adult nurse	Heslop had two charges against her, the first alleging misconduct and the second charge alleging that she lacked the necessary competencies to be a nurse. In terms of the misconduct, Heslop was accused of forcibly administering intravenous antibiotics to a post-operative patient despite the patient refusing treatment. The second charge concerning Heslop's competence alleged that she failed her clinical observation assessments held on four different occasions over a three-month period. Heslop denied all of the charges. Her representative made a successful application to have the misconduct charges dismissed due to insufficient evidence. The panel did, however, find the competence charges proved.	Yes	Conditions of practice order – 12 months
Holberry, Wayne	Male	Adult nurse	Holberry was accused of having instinctually "tapped" a patient's hand in response to her digging her nails into his skin, drawing blood as a result. Holberry admitted the charge and formed a CPD agreement with the NMC. Holberry was not present although his legally qualified representative was available via	Yes	Caution order – 1 year

			telephone in the event the panel needed to speak to him. The panel ratified the CPD agreement.		
McGill, James	Male	Adult	McGill was accused of not completing a controlled drugs check with another member of staff after which he forged her name on the controlled drug chart without her permission. McGill admitted all of the charges but did not form a CPD agreement with the NMC. McGill was neither present nor represented.	Yes	Suspension order – 6 months
O'Brien, Mary	Female	Mental Health	O'Brien was accused of having consumed alcohol either before or during two separate shifts at the care home that she was working at. On the first shift she was working as a Registered Nurse and on the second shift she was working as a Health Care Assistant (HCA). Although the panel found all of the charges proved, they decided that the NMC's authority did not extend to O'Brien's behaviour when working as a HCA.	Yes	Striking-off order
Ofili, Frank	Male	Mental Health	Ofili was accused of having plagiarised two essays on a Masters degree paid for by the NHS Trust (now CCG) that he was employed	Yes	Suspension order –

			by. One essay concerned nursing theory and the second essay was designed to assess clinical skills. Ofili was also accused of having concealed the fact he had been found to have committed plagiarism by the University disciplinary committee and expelled from the University as a result. Ofili denied all of the charges and was present and represented by a legally qualified representative. The panel found all of the charges pertaining to plagiarism proved and although the panel found that Ofili had failed to notify his employed, they decided that he had not done so with the intention of concealing this information from his employer.		6 months
Parker, John	Male	Adult nurse	Parker was accused of offering to refund money to a customer who had paid him for a cosmetic treatment in return for her withdrawing the complaint she made to the NMC about him. This arrangement was suggested and implemented by Trading Standards who the patient had also complained to. Parker admitted the charges but denied that he had committed misconduct. Parker was present and	Yes	Caution order – 3 years

			represented by a legally qualified representative. The panel found that he had committed misconduct.		
Peck, Kevin	Male	Adult nurse	Peck was accused of smacking the bottom of a female colleague and pled guilty in a criminal court to assault by beating. Peck was also accused of swearing and making aggressive comments to a second colleague, who he was formerly in a relationship with and then making sexually inappropriate comments to a third colleague and resting his head on her shoulder. Peck admitted to smacking the first colleague on the buttocks, swearing at the second colleague but denied making sexually inappropriate comments to the third colleague. The panel found that he had rested his head on the third colleague's shoulder but had not made the sexually inappropriate comments. During the hearing, it was discovered that the second and third witness had read each other's witness statement when travelling to the NMC hearing. Peck was present and represented by a legally qualified representative. The panel found that	No	Not impaired

			although Peck had committed misconduct, he had since sufficiently remediated his conduct.		
Pinto, Arun	Male	Adult nurse	Pinto was accused of accessing the medical records of over 100 friends, family members and work colleagues on multiple occasions. Pinto admitted to the charges but did not form a CPD agreement with the NMC. Pinto was present but not represented.	Yes	Suspension order – 12 months
Smith, Heather	Female	Adult nurse	Smith was accused of stealing prescription antiemetic medication from her work place for her own personal use. Smith admitted the charges and formed a CPD agreement with the NMC. Smith was presented and represented by a legally qualified representative. The panel ratified the CPD agreement.	Yes	Suspension order – 12 months
Stanton, Samantha	Female	Midwife	Stanton was accused of shouting and making inappropriate comments to a patient whilst she was in labour. Stanton was also accused of conducting a vaginal examination in a rough manner and performing a medically unnecessary episiotomy on the aforementioned patient without pain relief and without the patient's consent. Stanton was also accused of	Yes	Striking-off order

			having failed to administer an epidural to the aforementioned patient despite there being two opportunities for her to do so. Stanton was also accused of having failed to make adequate records of some of the procedures carried out. Stanton was present and represented by a legally qualified representative. Stanton's representative was able to make a successful application on the grounds that there was insufficient evidence in relation to the charge that episiotomy was medically unnecessary and that she had missed two opportunities to administer an epidural, amongst other things. Stanton admitted having failed to take adequate records regarding two of her actions but denied the rest of the charges. The panel found some, but not all of the charges proven.		
Tregay, Ian	Male	Mental Health	Tregay was accused of intentionally pushing an elderly patient with dementia to the floor, not calling for help following the incident and intentionally filling in an incorrect entry in two different systems used to report incidents and falls. Tregay was criminally prosecuted for the	N/A	N/A

			incident but was found not guilty. Tregay was present but unrepresented. The panel found none of the charges proven and the case therefore ended.		
Warren, John	Male	Mental Health	Warren was accused of having engaged in an inappropriate relationship, which culminated in him having sexual intercourse with a vulnerable patient he was treating in an outpatient addiction service. Warren denied all of the charges, although he admitted that the acts contained within the charges did occur. He was present and represented by a non-legally qualified representative. The panel found all charges against him proved.	Yes	Suspension order – 12 months
Zinyemba, Tendai	Female	Mental Health	Zinyemba was accused of having engaged in an inappropriate relationship with a nineteen-year-old prison inmate who had been referred to psychiatry after being moved from a juvenile prison to an adult prison. Although the NMC did not allege that Zinyemba had sexual contact with the inmate, it did allege that she wrote love letters and had unnecessary meetings with the inmate. Zinyemba denied the charges,	Yes	Suspension order – 12 months

			however, after the panel found all of them proved she did then admit to having had an inappropriate relationship with the inmate/the charges being true. Zinyemba was present and represented by a legally qualified representative.		

Appendix E:

NMC Code Conversion: 2004 to 2008 and 2015 to 2018

NMC 2015 code	NMC 2008 code
1.2 Make sure you deliver the fundamentals of care effectively	35 You must deliver care based on the best available evidence or best practice.
1.4 Make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay	Preamble
3.1 Pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages	36 You must ensure any advice you give is evidence-based if you are suggesting healthcare products or services.
3.4 Act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care.	4 You must act as an advocate for those in your care, helping them to access relevant health and social care, information and support.
7.5 Be able to communicate clearly and effectively in English.	*Not included in code*
8.2 Maintain effective communication with colleagues	26 You must consult and take advice from colleagues when appropriate.
8.3 Keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff	21 You must keep your colleagues informed when you are sharing the care of others.
8.6 Share information to identify and reduce risk	7 You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising.

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event	43 You must complete records as soon as possible after an event has occurred.
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need	42 You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.
13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment	28 You must make a referral to another practitioner when it is in the best interests of someone in your care.
15.2 Arrange, wherever possible, for emergency care to be accessed and provided promptly	17 You must be able to demonstrate that you have acted in someone's best interests if you have provided care in an emergency.
16.1 Raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other healthcare setting and use the channels available to you in line with our guidance and your local working practices	32 You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.
16.2 Raise your concerns immediately if you are being asked to practise beyond your role, experience and training	39 You must recognise and work within the limits of your competence.
17.1 Take all reasonable steps to protect people who are vulnerable	34 You must report your concerns in writing if problems in

or at risk from harm, neglect or abuse	the environment of care are putting people at risk.
20.1 Keep to and uphold the standards and values set out in the code	Preamble
20.2 Act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment	27 You must treat your colleagues fairly and without discrimination.
20.3 Be aware at all times of how your behaviour can affect and influence the behaviour of other people	48 You must demonstrate a personal and professional commitment to equality and diversity.
20.4 Keep to the laws of the country in which you are practising	49 You must adhere to the laws of the country in which you are practising
20.5 Treat people in a way that does not take advantage of their vulnerability or cause them upset or distress	57 You must not abuse your privileged position to your own ends
20.8 Act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to	23 You must facilitate students and others to develop their competence.
20.9 Maintain the level of health you need to carry out your professional role	33 You must inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards.

NMC 2004 Code	**NMC 2008 Code**
1.2 As a registered nurse, midwife or specialist community public health nurse, you must:	4 You must act as an advocate for those in your care, helping them to access relevant health

▪ Protect and support the health of individual patients and clients ▪ Protect and support the health of the wider community ▪ Act in such a way that justifies the trust and confidence the public have in you	and social care, information and support.
1.5 You must adhere to the laws of the country in which you are practising	49 You must adhere to the laws of the country in which you are practising
7.1 You must behave in a way that upholds the reputation of the professions. Behaviour that compromises this reputation may call your registration into question even if is not directly connected to your professional practice.	61 you must uphold the reputation of your profession at all times.

Appendix F:

Female and Male Nurses Code Violations in Documentary Analysis Sample

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Paragraphs of 2008 Code	Number of Female Nurses
Paragraph 1 - *You must treat people as individuals and respect their dignity.*	7 female nurses
Paragraph 2 - *You must not discriminate in any way against those in your care.*	1 female nurse
Paragraph 3 - *You must treat people kindly and considerately.*	5 female nurses
Paragraph 4 - *You must act as an advocate for those in your care, helping them to access relevant health and social care, information and support.*	7 female nurses
Paragraph 5 - *You must respect people's right to confidentiality.*	None
Paragraph 6 - *You must ensure people are informed about how and why information is shared by those who will be providing their care.*	1 female nurse
Paragraph 7 - *You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising.*	2 female nurses
Paragraph 8 - *You must listen to the people in your care and respond to their concerns and preferences.*	3 female nurses

Paragraph 9 - *You must support people in caring for themselves to improve and maintain their health.*	2 female nurses
Paragraph 10 - *You must recognise and respect the contribution that people make to their own care and wellbeing.*	1 female nurse
Paragraph 11 - *You must make arrangements to meet people's language and communication needs.*	2 female nurses
Paragraph 12 – *You must share with people, in a way they can understand, the information they want or need to know about their health.*	2 female nurses
Paragraph 13 - You must ensure that you gain consent before you begin any treatment or care.	3 female nurses
Paragraph 14 - *You must respect and support people's rights to accept or decline treatment and care.*	2 female nurses
Paragraph 15 - *You must uphold people's rights to be fully involved in decisions about their care.*	2 female nurses
Paragraph 16 - *You must be aware of the legislation regarding mental capacity, ensuring that people who lack capacity remain at the centre of decision making and are fully safeguarded.*	3 female nurses
Paragraph 17 - *You must be able to demonstrate that you have acted in someone's best interests if you have provided care in an emergency.*	2 female nurses

Paragraph 18 - *You must refuse any gifts, favours or hospitality that might be interpreted as an attempt to gain preferential treatment.*	1 female nurse
Paragraph 19 - *You must not ask for or accept loans from anyone in your care or anyone close to them.*	2 female nurses
Paragraph 20 - *You must establish and actively maintain clear sexual boundaries at all times with people in your care, their families and carers.*	3 female nurses
Paragraph 21 - *You must keep your colleagues informed when you are sharing the care of others.*	10 female nurses
Paragraph 22 - *You must work with colleagues to monitor the quality of your work and maintain the safety of those in your care.*	14 female nurses
Paragraph 23 - *You must facilitate students and others to develop their competence.*	4 female nurses
Paragraph 24 - *You must work cooperatively within teams and respect the skills, expertise and contributions of your colleagues.*	6 female nurses
Paragraph 25 - *You must be willing to share your skills and experience for the benefit of your colleagues.*	2 female nurses
Paragraph 26 - *You must consult and take advice from colleagues when appropriate.*	7 female nurses

Paragraph 27 - *You must treat your colleagues fairly and without discrimination.*	5 female nurses
Paragraph 28 - *You must make a referral to another practitioner when it is in the best interests of someone in your care.*	5 female nurses
Paragraph 29 - *You must establish that anyone you delegate to is able to carry out your instructions.*	2 female nurses
Paragraph 30 - *You must confirm that the outcome of any delegated task meets required standards.*	4 female nurses
Paragraph 31 - *You must make sure that everyone you are responsible for is supervised and supported.*	5 female nurses
Paragraph 32 - *You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.*	9 female nurses
Paragraph 33 - *You must inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards.*	6 female nurses
Paragraph 34 - *You must report your concerns in writing if problems in the environment of care are putting people at risk.*	2 female nurses
Paragraph 35 - *You must deliver care based on the best available evidence or best practice.*	15 female nurses
Paragraph 36 - *You must ensure any advice you give is evidence-based if*	2 female nurses

you are suggesting healthcare products or services.	
Paragraph 37 - *You must ensure that the use of complementary or alternative therapies is safe and in the best interests of those in your care.*	1 female nurse
Paragraph 38 - *You must have the knowledge and skills for safe and effective practice when working without direct supervision.*	5 female nurses
Paragraph 39 - *You must recognise and work within the limits of your competence.*	5 female nurses
Paragraph 40 - You must keep your knowledge and skills up to date throughout your working life.	3 female nurses
Paragraph 41 - *You must take part in appropriate learning and practice activities that maintain and develop your competence and performance.*	1 female nurse
Paragraph 42 - *You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.*	13 female nurses
Paragraph 43 - *You must complete records as soon as possible after an event has occurred.*	9 female nurses
Paragraph 44 - *You must not tamper with original records in any way.*	2 female nurses
Paragraph 45 - *You must ensure any entries you make in someone's paper*	2 female nurses

records are clearly and legibly signed, dated and timed.	
Paragraph 46 - *You must ensure any entries you make in someone's electronic records are clearly attributable to you.*	1 female nurse
Paragraph 47 - *You must ensure all records are kept securely.*	1 female nurse
Paragraph 48 - *You must demonstrate a personal and professional commitment to equality and diversity.*	3 female nurses
Paragraph 49 - *You must adhere to the laws of the country in which you are practising.*	9 female nurses
Paragraph 50 - *You must inform the NMC if you have been cautioned, charged or found guilty of a criminal offence.*	2 female nurses
Paragraph 51 - *You must inform any employers you work for if your fitness to practise is called into question.*	3 female nurses
Paragraph 52 - *You must give a constructive and honest response to anyone who complains about the care they have received.*	1 female nurse
Paragraph 53 - *You must not allow someone's complaint to prejudice the care you provide for them.*	1 female nurse
Paragraph 54 - *You must act immediately to put matters right if someone in your care has suffered harm for any reason.*	2 female nurses

Paragraph 55 - *You must explain fully and promptly to the person affected what has happened and the likely effects.*	1 female nurse
Paragraph 56 - *You must cooperate with internal and external investigations.*	None
Paragraph 57 - *You must not abuse your privileged position for your own ends.*	1 female nurse
Paragraph 58 - *You must ensure that your professional judgement is not influenced by any commercial considerations.*	3 female nurses
Paragraph 59 - *You must not use your professional status to promote causes that are not related to health.*	1 female nurse
Paragraph 60 - *You must cooperate with the media only when you can confidently protect the confidential information and dignity of those in your care.*	1 female nurse
Paragraph 61 - *You must uphold the reputation of your profession at all times.*	30 female nurses
Paragraph 62 - *You must have in force an indemnity arrangement which provides appropriate cover for any practice you undertake as a nurse or midwife in the United Kingdom.*	None

Paragraphs of 2008 Code	Number of Male Nurses
Paragraph 1 - *You must treat people as individuals and respect their dignity.*	4 male nurses
Paragraph 2 - *You must not discriminate in any way against those in your care.*	None
Paragraph 3 - *You must treat people kindly and considerately.*	4 male nurses
Paragraph 4 - *You must act as an advocate for those in your care, helping them to access relevant health and social care, information and support.*	None
Paragraph 5 - *You must respect people's right to confidentiality.*	1 male nurse
Paragraph 6 - *You must ensure people are informed about how and why information is shared by those who will be providing their care.*	None
Paragraph 7 - *You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising.*	None
Paragraph 8 - *You must listen to the people in your care and respond to their concerns and preferences.*	3 male nurses
Paragraph 9 - *You must support people in caring for themselves to improve and maintain their health.*	2 male nurses

Paragraph 10 - *You must recognise and respect the contribution that people make to their own care and wellbeing.*	1 male nurse
Paragraph 11 - *You must make arrangements to meet people's language and communication needs.*	None
Paragraph 12 – *You must share with people, in a way they can understand, the information they want or need to know about their health.*	None
Paragraph 13 - You must ensure that you gain consent before you begin any treatment or care.	1 male nurse
Paragraph 14 - *You must respect and support people's rights to accept or decline treatment and care.*	None
Paragraph 15 - *You must uphold people's rights to be fully involved in decisions about their care.*	1 male nurse
Paragraph 16 - *You must be aware of the legislation regarding mental capacity, ensuring that people who lack capacity remain at the centre of decision making and are fully safeguarded.*	3 male nurses
Paragraph 17 - *You must be able to demonstrate that you have acted in someone's best interests if you have provided care in an emergency.*	2 male nurses
Paragraph 18 - *You must refuse any gifts, favours or hospitality that might be interpreted as an attempt to gain preferential treatment.*	None

Paragraph 19 - *You must not ask for or accept loans from anyone in your care or anyone close to them.*	None
Paragraph 20 - *You must establish and actively maintain clear sexual boundaries at all times with people in your care, their families and carers.*	None
Paragraph 21 - *You must keep your colleagues informed when you are sharing the care of others.*	3 male nurses
Paragraph 22 - *You must work with colleagues to monitor the quality of your work and maintain the safety of those in your care.*	3 male nurses
Paragraph 23 - *You must facilitate students and others to develop their competence.*	1 male nurse
Paragraph 24 - *You must work cooperatively within teams and respect the skills, expertise and contributions of your colleagues.*	4 male nurses
Paragraph 25 - *You must be willing to share your skills and experience for the benefit of your colleagues.*	1 male nurse
Paragraph 26 - *You must consult and take advice from colleagues when appropriate.*	4 male nurses
Paragraph 27 - *You must treat your colleagues* *fairly and without discrimination.*	3 male nurses
Paragraph 28 - *You must make a referral to another practitioner when it is in the best interests of someone in your care.*	2 male nurses

Paragraph 29 - *You must establish that anyone you delegate to is able to carry out your instructions.*	1 male nurse
Paragraph 30 - *You must confirm that the outcome of any delegated task meets required standards.*	1 male nurse
Paragraph 31 - *You must make sure that everyone you are responsible for is supervised and supported.*	2 male nurses
Paragraph 32 - *You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.*	5 male nurses
Paragraph 33 - *You must inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards.*	2 male nurses
Paragraph 34 - *You must report your concerns in writing if problems in the environment of care are putting people at risk.*	1 male nurse
Paragraph 35 - *You must deliver care based on the best available evidence or best practice.*	5 male nurses
Paragraph 36 - *You must ensure any advice you give is evidence-based if you are suggesting healthcare products or services.*	None
Paragraph 37 - *You must ensure that the use of complementary or alternative therapies is safe and in the best interests of those in your care.*	None
Paragraph 38 - *You must have the knowledge and skills for safe and effective*	1 male nurse

practice when working without direct supervision.	
Paragraph 39 - *You must recognise and work within the limits of your competence.*	2 male nurses
Paragraph 40 - *You must keep your knowledge and skills up to date throughout your working life.*	2 male nurses
Paragraph 41 - *You must take part in appropriate learning and practice activities that maintain and develop your competence and performance.*	1 male nurse
Paragraph 42 - *You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.*	4 male nurses
Paragraph 43 - *You must complete records as soon as possible after an event has occurred.*	1 male nurse
Paragraph 44 - *You must not tamper with original records in any way.*	None
Paragraph 45 - *You must ensure any entries you make in someone's paper records are clearly and legibly signed, dated and timed.*	None
Paragraph 46 - *You must ensure any entries you make in someone's electronic records are clearly attributable to you.*	None
Paragraph 47 - *You must ensure all records are kept securely.*	1 male nurse
Paragraph 48 - *You must demonstrate a personal and professional commitment to equality and diversity.*	2 male nurses

Paragraph 49 - *You must adhere to the laws of the country in which you are practising.*	4 male nurses
Paragraph 50 - *You must inform the NMC if you have been cautioned, charged or found guilty of a criminal offence.*	1 male nurse
Paragraph 51 - *You must inform any employers you work for if your fitness to practise is called into question.*	None
Paragraph 52 - *You must give a constructive and honest response to anyone who complains about the care they have received.*	None
Paragraph 53 - *You must not allow someone's complaint to prejudice the care you provide for them.*	None
Paragraph 54 - *You must act immediately to put matters right if someone in your care has suffered harm for any reason.*	1 male nurse
Paragraph 55 - *You must explain fully and promptly to the person affected what has happened and the likely effects.*	None
Paragraph 56 - *You must cooperate with internal and external investigations.*	None
Paragraph 57 - *You must not abuse your privileged position for your own ends.*	2 male nurses
Paragraph 58 - *You must ensure that your professional judgement is not influenced by any commercial considerations.*	None

Paragraph 59 - *You must not use your professional status to promote causes that are not related to health.*	None
Paragraph 60 - *You must cooperate with the media only when you can confidently protect the confidential information and dignity of those in your care.*	None
Paragraph 61 - *You must uphold the reputation of your profession at all times.*	16 male nurses
Paragraph 62 - *You must have in force an indemnity arrangement which provides appropriate cover for any practice you undertake as a nurse or midwife in the United Kingdom.*	None

Side note: The cases where the only paragraph cited by the panel was 7.5 of the 2015 code or paragraph 50 of the 2008 code, I have added this in (check official hearing documents so you can list them) as they are related to conviction so would automatically break that section of the code. However, although the nurse may have broken other sections of the code, as the panel have not cited them, no further violations have been added.

Appendix G: Criminal Convictions in Documentary Analysis Sample

Case	Gender	Name	Description	Sanction
Case 11	Male	Chime	That you, a registered nurse: 1. Were convicted on [date] in the Crown Court sitting at [name of court] of: a. Obtain pecuniary advantage for self by deception. b. Person who is not a British citizen obtaining or seeking to obtain leave to enter or remain in the United Kingdom by deception.	Striking-off order
Case 16	Male	Crook	That you, a registered nurse: 1. On [date], received a police caution for theft by employee between [date] and [date], contrary to s.1 of the Theft Act 1968.	Suspension order – 9 months
Case 24	Female	Edet	That you, a registered nurse: 1. On [date] at [Crown Court], you were convicted of: i) Cruelty to a child under the age of 16 in that you failed to provide education and treated him as a servant; ii) Servitude; iii) Assisting illegal immigration into a member state.	Striking-off order
Case 26	Female	Fredericks	That you, a Registered Nurse were convicted at [Magistrates' Court] on [date]: 1. Dishonestly failing to promptly notify of a change of circumstances between [date] to [date], to [the Borough Council] in the prescribed manner which you knew would affect your entitlement to housing benefit and council	Striking-off order

			tax benefit, contrary to section 111A (1A) of the Social Security Administration Act 1992. 2. Dishonestly making a false statement or representation on or about [date], to [the Borough Council] with a view to obtaining for yourself, housing benefit and council tax benefit, contrary to section 111A(1)(a) and (3) of the Social Security Administration Act 1992.	
Case 28	Female	Greening	1) On [date] at Cornwall Magistrates Court were convicted of: a) Failing to report an accident on [date] contrary to the Road Traffic Act 1988 s. 170(4) 2) On [date] at Cornwall Magistrates Court were convicted of: a) Driving a motor vehicle with excess alcohol on [date] contrary to the Road Traffic Act 1988 s. 5 (1)(a) b) Driving a motor vehicle with excess alcohol on [date] contrary to the Road Traffic Act 1988 s. 5 (1)(a) 3) On [date] at Cornwall Magistrates Court were convicted of: a) Failing to give name and address after accident on [date] contrary to the Road Traffic Act 1988 s. 170 (4)	Conditions of prac-tice order – 18 months
Case 31	Female	Hart	That you, a registered nurse: 1. Were convicted on [date] by the [Magistrates Court] of driving a motor vehicle with excess alcohol on 13 January 2015 contrary to section 5 (1) (a) of the Road Traffic Act 1988 and Schedule 2 of the Road Traffic Offenders Act 1988.	Suspension order – 12 months

Case 39	Female	Kangethe	That you, a registered nurse, 1. On [date], were convicted of driving a motor vehicle with excess alcohol on [date2]; 2. On [date], were convicted of driving a motor vehicle with excess alcohol on [date3].	Caution order – 5 years
Case 47	Male	Nare	That you, a registered nurse: 1. On [date] were convicted at [Magistrates Court] of failing to keep adequate accounting records between [date] and [date] contrary to the Companies Act 2006 s.387.	Suspension order – 6 months
Case 48	Female	Ndoro	“That you, a registered nurse: 3. On the [date], received a caution for being in drunk while in charge of a child, contrary to section 2 of the Licensing Act 1902; 4. On the [date] at the [Magistrates Court], were convicted of one count of being drunk in a public place, in charge of a child under the age of 7 years, contrary to section 2 (1) of the Licensing Act 1902; 5. On the [date] at the [Magistrates Court], were convicted of one count of being drunk in a public place, in charge of a child under the age of 7 years, contrary to section 2 (1) of the Licensing Act 1902;	Striking-off order
Case 64	Female	Shanahan	“That you, a registered nurse, i. On [date] accepted a police caution for theft of medication.	Suspension order – 9 months
Case 69	Male	Ragoonath	That you, a Registered Nurse: 1. On [date] were convicted by [Magistrates Court] of intentionally touching a woman aged 16 or over when the touching was sexual and she did not consent, contrary to section 3 of the Sexual Offences Act 2003.	Striking-off order

Case 74	Male	Wingrove	That you, a registered nurse, 1. On [date] at [Crown Court] were tried and convicted of two counts of Sexual Assault on a male	Striking-off order

Appendix H:

Outline of Participants in Documentary Analysis Sample

Name of Registrant	Gender	Part of Register	Hearing Type	Attendance	Representation	Type of Charges(s)	Outcome
Adenusi	Female	General	Substantive Hearing	Present	Legally qualified	Misconduct only	Suspension
Allen	Female	Mental Health	CPD	Absent	Unrepresented	Misconduct only	Caution
Allsebrook	Male	Learning	CPD	Absent	Unrepresented	Misconduct only	Suspension
Asante	Female	General	Substantive Hearing	Present	Unrepresented	Competence only	CoPO
Bailey	Female	Mental Health	Substantive Hearing	Absent	Unrepresented	Misconduct only	Suspension
Banks	Male	Mental Health	Substantive Hearing	Absent	Unrepresented	Misconduct only	Striking-Off
Benyu	Female	Mental Health	Substantive Hearing	Present	Unrepresented	Other Trinbunal only	Striking-Off
Boodhoo	Male	General	Substantive Hearing	Present	Legally qualified	Misconduct only	Caution
Burnett	Female	General	Substantive Hearing	Absent	Unrepresented	Misconduct only	Suspension
Chikoto	Male	Mental Health	Substantive Hearing	Absent	Unrepresented	Misconduct only	Striking-Off
Chime	Male	Mental Health	Substantive Hearing	Absent	Unrepresented	Conviction only	Striking-off
Cimbacruz	Female	Mental Health	Substantive Hearing	Present	Legally qualified	Misconduct only	CoPO
Ciocan	Male	General	Substantive Hearing	Present	Unrepresented	Misconduct & English	CoPO
Cochlin	Male	General	Substantive Hearing	Partial	Unrepresented	Misconduct only	Suspension
Corser	Female	Mental Health	CPD	Absent	Legally qualified	Misconduct only	Caution
Crook	Male	General	CPD	Absent	Unrepresented	Conviction only	Suspension
Curtis	Female	General	Substantive Hearing	Present	Unrepresented	Misconduct only	CoPO

Day	Female	General	CPD	Absent	Unrepresented	Misconduct only	Caution
Dass	Male	General	CPD	Absent	Unrepresented	Misconduct only	Caution
Deane	Female	Midwife	N/A	N/A	N/A	N/A	N/A
Despard	Male	Mental Health	Substantive Hearing	Absent	Unrepresented	Misconduct only	Striking-Off
Diaconu	Female	General	Substantive Hearing	Absent	Unrepresented	Misconduct only	Suspension
Dookie	Female	General	Substantive Hearing	Present	Legally qualified	Misconduct only	Suspension
Edet	Female	General	Substantive Hearing	Absent	Unrepresented	Conviction only	Striking-Off
Franklin	Female	General	Substantive Hearing	Absent	Unrepresented	Misconduct only	Suspension
Fredericks	Female	General	Substantive Hearing	Absent	Unrepresented	Conviction only	Striking-Off
Fox-Cobham	Female	General	Substantive Hearing	Present	Legally qualified	Misconduct only	Caution
Greening	Female	General	Substantive Hearing	Present	Legally qualified	Conviction only	CoPO
Guy-Miller	Female	General	CPD	Absent	Unrepresented	Misconduct only	Suspension
Hamilton	Female	Mental Health	Substantive Hearing	Absent	Unrepresented	Misconduct & Competence	Suspension
Hart	Female	General	Substantive Hearing	Absent	Unrepresented	Conviction & Misconduct	Suspension
Hardy	Female	General	Substantive Hearing	Absent	Unrepresented	Misconduct only	Suspension
Harvey	Female	General	Substantive Hearing	Absent	Unrepresented	Misconduct only	Suspension
Horan	Female	General	Substantive Hearing	Present	Unrepresented	Misconduct only	Suspension
Hawson	Female	General	CPD	Absent	Unrepresented	Misconduct only	Caution
Haydon	Male	General	CPD	Absent	Unrepresented	Misconduct only	Striking-Off
Jenkins	Female	General	Substantive Hearing	Absent	Unrepresented	Competence only	Suspension
Jordan	Female	General	Substantive Hearing	Present	Legally qualified	Misconduct only	CoPO
Kangethe	Female	General	CPD	Absent	Legally qualified	Conviction & Misconduct	Caution

Kasumba	Female	Mental Health	CPD	Absent	Unrepresented	Misconduct only	CoPO
Kenny	Female	General	Substantive Hearing	Absent	Unrepresented	Misconduct only	Suspension
King	Female	General	Substantive Hearing	Present	Legally qualified	Misconduct only	Striking-Off
Labdon	Female	Mental Health	Substantive Hearing	Present	Unrepresented	Misconduct only	CoPO
Langford	Male	Mental Health	Substantive Hearing	Absent	Unrepresented	Misconduct only	Striking-Off
Maharaj	Male	General	Substantive Hearing	Present	Legally qualified	Misconduct only	Striking-Off
Nahoor	Male	Learning & Mental Health	Substantive Hearing	Present	Legally qualified	Misconduct only	Suspension
Nare	Male	General	Substantive Hearing	Absent	Unrepresented	Conviction & Misconduct	Suspension
Ndoro	Female	General	Substantive Hearing	Present	Unrepresented	Conviction & Misconduct	Striking-Off
Neaves	Female	General & Midwife	N/A	N/A	N/A	N/A	N/A
Nixon	Female	Mental Health	Substantive Hearing	Partial	Unrepresented	Misconduct only	Suspension
Nullatamby	Male	Mental Health & General	Substantive Hearing	Absent	Unrepresented	Misconduct only	Striking-Off
Nyahwema	Male	Mental Health	Substantive Hearing	Absent	Unrepresented	Misconduct only	CoPO
Obiri	Female	General & Midwife	N/A	N/A	N/A	N/A	N/A
Odgers	Female	Midwife	N/A	N/A	N/A	N/A	N/A
Oshikoya	Female	Mental Health	Substantive Hearing	Absent	Unrepresented	Misconduct only	Striking-Off
Panaikkal John	Female	General	Substantive Hearing	Present	Legally qualified	Misconduct only	Caution
Panaitu	Male	General	Substantive Hearing	Present	Unrepresented	English only	CoPO
Pepple	Female	Mental Health	Substantive Hearing	Present	Non-legally qualified	Misconduct only	CoPO

Priest	Female	General	Substantive Hearing	Present	Legally qualified	Misconduct only	Suspension
Revill	Female	Learning	Substantive Hearing	Absent	Unrepresented	Misconduct only	CoPO
Rodgers	Male	Learning & Mental Health	CPD	Absent	Unrepresented	Misconduct only	Caution
Roberts	Female	Mental Health	Substantive Hearing	Present	Unrepresented	Misconduct only	Striking-Off
Sandford	Female	General	CPD	Absent	Unrepresented	Misconduct only	Suspension
Shanahan	Female	General	CPD	Absent	Represented	Conviction only	Suspension
Sherwin	Female	General	Substantive Hearing	Absent	Unrepresented	Misconduct only	Suspension
Simpson	Female	General	CPD	Absent	Unrepresented	Misconduct only	Striking-Off
Smith (A)	Female	General & Paediatric	Substantive Hearing	Present	Legally qualified	Misconduct only	CoPO
Smith (C)	Male	Mental Health	CPD	Present	Unrepresented	Misconduct only	CoPO
Ragoonath	Male	General	CPD	Absent	Unrepresented	Conviction only	Striking-Off
Vanghese	Male	General	Substantive Hearing	Present	Legally qualified	Misconduct only	Striking-Off
Vasantha	Female	General	Substantive Hearing	Present	Unrepresented	Misconduct only	CoPO
Vitalis	Female	General	Substantive Hearing	Present	Legally qualified	Misconduct only	Striking-Off
Whyte	Female	General	Substantive Hearing	Present	Legally qualified	Other Trinbunal & Misconduct	Caution
Wingrove	Male	General	CPD	Absent	Unrepresented	Conviction only	Striking-Off
Wood	Female	General	Substantive Hearing	Present	Legally qualified	Misconduct only	Suspension