

Jacqueline S. Hutchison

Published in Nursing Inquiry

Abstract

Through an analysis of several high-profile scandals in health care in the UK, this article discusses the nature of scandal and its impact on policy reform. The nursing profession is compared to social work and medicine, which have also undergone considerable examination and change as a result of scandals. The author draws on reports from public inquiries from 1945-2013 to form the basis of the discussion about policy responses following scandals in health care. In each case, the nature of the scandal, the public and government discourses generated by events, and the policy response to those failings are explored. These scandals are compared to the recent scandal at Mid Staffordshire Hospital. Conclusions are drawn about the impact of these events on the future of the profession and on health policy directions. Recent events have raised public anxieties about caring practices in nursing. Health policy reform driven by scandal may obscure the effect of under resourcing in health services and poses a very real threat to the continued support for state run services. Understanding the socially constructed nature of scandal, enables the nurse to develop a greater critical awareness of policy contexts in order that they can influence health service reform. 200 words

Key words: scandal, health policy, nursing, public enquiries, Francis, patient experience, blame, social construction.

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Introduction

Scandals in healthcare transcend national borders and have significant local, national and international implications for nurses. Scandals in one context may have repercussions not only for national health reforms, but international agendas for health care delivery. Furthermore, narratives which construct nurses as uncaring have the potential to influence changes to the regulation and control of nursing practice. These concerns are not isolated to the UK. Throughout Europe and North America there has been increasing public and media disquiet about reports of the mistreatment, abuse or neglect of patients (Reader and Gillespie 2013). The recent UK scandals have provided an opportunity for North American critics of the new health bill to warn of the possible effects of what has been coined, 'Obamacare' (Gibberman 2013). Reports of scandal have been used by critics of the bill to paint an unflattering picture of national health services. European countries are facing problems with rising health care costs and experiencing quality and efficiency problems. Doetter and Gotze (2011) examine the timing of health reforms in both England and Italy. They conclude, that it is largely the perceived failings of care systems and political agendas that are drivers for change, however, economic crises offer the opportunities for change. The risk to health service provision, is that health scandals are used as political tools to influence moves toward further privatisation in health care.

Nursing practice also has the potential to be altered by reports of scandal. Cooke (2012) argues that changes to narratives around nursing and health care in the US have also affected nurses in the UK. She claims that nurses have become the victims in a growing blame culture and this has affected the regulation, control and disciplining of nurses

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internationally. Blaming health care professionals directs responsibility away from organisations, politicians and managers and makes nurses more vulnerable to being blamed for poor standards. By analysing previous scandals in health and social care and their effects on UK public policy, the constructed nature of scandals becomes apparent and their potential to drive health policy and professional practice on a global scale (Brown 1995).

Data source.

Reports from public inquiries in the UK from 1945-2013 form the greater part of the literature used to discuss the policy responses to scandalous events in health care. Search terms which include 'scandal/s' 'scandal/s and nursing' 'scandal/s and health and social care' and 'scandal/s in medicine' were used to identify relevant articles from nursing, policy, social work and medical journals that were within these dates, in English and peer reviewed. Literature was searched using CINAHL, MEDLINE, Springer LINK, SwetsWise, Wiley-Blackwell and Google. Literature was collected that considered the nature of scandals; subsequent public inquiries; the public response to scandals and the policy response following those events. Whilst there are many more scandals that could have been discussed, these discussions focus on episodes where clear changes to health policy preceded particular scandals. The specific names of these incidents and the individuals involved in these scandals were also used as search terms to broaden the search. Those specific names and events included; the deaths and reports of neglect which occurred at Mid Staffordshire National Health Service (NHS) Trust (2005-2009), the murders committed by Dr Harold Shipman (2000), and the surgical incompetence of Rodney Ledward (1996), the high death rate of babies at Bristol Royal Infirmary (1998), and the deaths of Maria Colwell (1973) and Denis O'Neil (1945) in foster care. Relevant

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newspaper articles and television programs have also been utilised in consideration of the public response to scandal.

What is scandal?

A scandal is commonly defined as ‘an action or event regarded as morally or legally wrong and causing general public outrage’ (Oxford English Dictionary 2013). The word scandal is in common usage and is used to describe the transgression of a moral code and is often associated with gossip and rumour. There is a body of literature which explores the growing phenomena of political scandals in Western democracies (Thompson 2000, Ekström and Johansson 2008). Thompson (2000) identifies four characteristics of scandal. These characteristics involve actions which involve a transgression; a degree of concealment or secrecy surrounding events; presuppose some public knowledge of events and lastly, illicit a public response or outrage. Scandals have clear political dimensions but are also cultural and social phenomena affecting modern institutions and healthcare organisations have become increasingly susceptible to the effects of scandal.

There have been debates in social work which explore how scandals have been influential in changing perceptions of welfare problems and influencing the solutions identified to deal with them (Butler and Drakeford 2005). Very little nursing literature has explored “healthcare scandal” even though these events have considerable import and consequences for patient outcomes, as they involve the welfare of sick and often vulnerable individuals.

The media has given increasing attention to reports of poor care, neglect or abuse in the

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health services. It is reports of malnutrition, dehydration, patients in poor states of cleanliness and in pain, which form the basis of complaints from patients and relatives in situations that have become scandalous (Francis 2013). It is publicity that gives events momentum and turns a series of actions and events into scandals. The development of investigative journalism has played an important role in making scandals a significant global phenomenon (Tumber and Waisbord 2004). An important feature of scandal is that it is the public response and outrage or damage to reputation that is significant in defining the phenomenon (Butler et al 2005).

Considering the nature of scandal from either a constructionist or objectivist position provides a useful analysis of the phenomena. An adverse event can be observed objectively and considered a problem or a danger to human life. Such events in health care are common. But when does an event become a scandal? Herbert Blumer (1969) stressed that we cannot truly know the actual meaning of events, but that they are given meaning according to our experiences and the interpretations of others. This constitutes a common social constructionist view of how reality is socially produced. The constructionist approach diverges from the positivist position which asserts that that social phenomena are fixed, can be objectively observed, and that the existence of a social problem defines how it is perceived. The existence of a hazard, or in this case, poor care, however, does not in itself constitute a social problem. Emerging from an interpretive paradigm, constructionists consider that a social problem is defined through collective action and is constituted by the reactions of a group.

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The constructionist position (Berger and Luckmann 1966) is a far more valuable position for exploring the nature of events which are considered scandalous, as it becomes apparent that a number of conditions need to exist for particular events to be seen as unacceptable and for those situations to come to the attention of the public and media. Whilst I am not arguing that poor care and neglect does not occur, I argue it would be naive to believe that the health problems and solutions reached by public inquiries are not shaped by the political and social discourses which help to regulate our ways of thinking.

A policy-as-discourse approach to policy analysis, harnesses an interpretive approach to understanding policy formation. Policy-as-discourse theorists argue that policy problems and solutions to those problems, are not simply based on rational, objective measurement of facts. This genre of policy analysis considers that policy problems do not exist independently of the social, cultural and political environment, but sees them as being created and shaped by that environment. Problems are identified and addressed through the activities of interests groups. The way problems are framed, results in the solutions offered in policy reform (Bacchi 2000, Fairclough 2000, Shaw 2010).

By considering a number of scandals in health over the last seventy years, the characteristics and nature of scandals in health can be analysed; the discourses created around the events analysed and subsequently the impact these events have on changes to health policy are identified. This discussion considers that scandals are more than problematic events; they are created and driven by particular political, social and economic circumstances. Economic crises, political agendas, organised campaigns, public awareness and media representations of an event, converge to influence public perceptions

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about standards of care delivery. The effect of scandals on local communities, national health services, international agendas and policy change, can be far reaching. The discussion that follows demonstrates how responses to scandals in social work, nursing, and medicine in the UK, have set in motion changes to health professions and health policy reform over the last 70 years.

Scandals in social care

Scandals in healthcare are nothing new. One of the earliest, prior to the inception of the NHS, dates back to 1945 following the death of Denis O'Neil, a child in foster care. Reports indicated that there were administrative inadequacies which led to a failure of supervision of care. The public disquiet about the case was profound (Heywood 1959/1965) and prompted the government to undertake the first public inquiry into events of this nature. The inquiry took seven weeks (Monckton 1945) and subsequent events led to the introduction of the Children Act of 1948 (Warren 2000) (figure 1). Between 1948 and 2003 seventy public enquiries were undertaken following child deaths (Select Committee Report 2003). Subsequently we saw social work as a profession under scrutiny because of perceived failures.

In some areas of social care scandals have a long established tradition of generating pressure for reform, and academics in the UK have begun to theorise about the role of scandals in policy formulation and policy delivery. In child protection social work, for example, policy in this area has almost uniquely been driven by responses to several high-profile deaths of young children since the case of Maria Colwell (Corby 2006). Maria

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Colwell's death in 1973 led to the public inquiry in 1974 which was chaired by T.G. Field-Fisher. In response to these numerous scandals we saw the transformation of child protection systems and a new professional governing body for social workers and social care workers (General Social Care Council 2002).

The reputation of social work has been gravely affected by public debates around child protection and the perceived failures which have been explored in numerous public inquiries (Rustin 2004). Regulation of social work practice and social care has almost entirely been driven by a culture of risk avoidance following these failures. Media interest in child abuse has created a clamour for the reform of social work as a profession. Statutory control of professionals is aimed at protecting the public but equally has been used as an exercise to improve public confidence and trust in social workers (McLaughlin 2007). Several costly and lengthy public inquiries have spent their efforts attempting to make professionals more accountable, and child protection systems less susceptible to failure (Manthorpe and Stanley 2004). The responses to these inquiries in academic circles have intensified and some intractable questions have been posed about the effectiveness of heavy handed government responses to the perceived crises in child protection. Health professionals and academics have asked themselves what, if anything, has been learned from these inquiries? (Manthorpe et al 2004).

Academics in the social work field have asked about the wisdom of extrapolating from cases where things go badly wrong (Rustin 2004). In child protection cases for example, the number of child abuse related deaths in the UK, compared internationally per head of

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population, relates favourably to many of their comparable welfare state neighbours. Furthermore, recent evidence suggests that the number of child abuse related deaths is falling considerably (Pritchard and Williams 2010). Extrapolating only from negatives obviously ignores much good practice.

It appears significant, that in a recent high profile review of the tragic death of the infant Peter Connolly, the expert invited to review the child protection practice, Lord Laming, and the academic invited to suggest reform of child protection organisation and training, Eileen Munro, both appeared to eschew another revolution of increased scrutiny and regulation of professionals. They called for enhanced autonomy of the professionals involved in child protection, supported by increased investment in continued professional development and renewed engagement with the problems of the child protection system (Munro 2011).

Hospital inquires

Allegations of the mistreatment of patients in Ely Hospital near Cardiff in 1967, prompted the first hospital inquiry into scandal, and was conducted in only 4 days in 1969 by Brian Abel-Smith. Butler et al (2005) discussed how this was a landmark case in terms of how it was viewed by the government and the general public. The social framing of the scandal was a key factor in getting events recognised nationally. Senior nurses and doctors involved in the accusations of poor care in the hospital in Cardiff were vilified by the public; moreover, events which occurred at a local level became national scandal. The

authors comment that this event was unique, in that interest groups found a vehicle through
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which they could mobilise wider public support for the purposes of establishing change in the way hospitals were scrutinised, inspected, and funds were allocated, and in how policy came to be formulated. The response to these events led to the 1971 White Paper *Better Services for the Mentally Handicapped* (DHSS) and the introduction of regular visiting and inspection of services. Ultimately the effect of these responses was to fundamentally affect the place of mental institutions in mental health provision, paving the way for a rationale for community care in mental health (Fig 1).

Scandals in medicine

Scandals have been generated by the most obvious and serious abuses of power by doctors, one of the most heavily regulated professions. The murders of patients by Harold Shipman, the surgical incompetence of Rodney Ledward, and the high death rate of children at Bristol Royal Infirmary, came to light in the late 1990s. Dixon-Woods, Yeung and Bosk (2011) discuss the nature of scandal regards to these events. They note that individual transgressions do not in themselves constitute scandal and can often go unnoticed. The inquiry, by Dame Janet Smith, examined the records of over five hundred patients cared for by Harold Shipman. She concluded that he may have murdered two hundred and fifteen of his patients (2005). Although concerns about the high numbers of deaths in Shipman's care had been raised by his colleagues (Smith 2003), Shipman's crimes only came to-light when Angela Woodruff, the daughter, of one of the victims, refused to believe the explanations given to her about the death of her mother. Dixon et al (2011) suggest that it was the high status of the individuals involved in the incidents which contributed to them being tolerated or ignored.

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The actions of Shipman live on in people's memories. The numerous and brutal nature of the killings, coupled with the perceived status of the perpetrator of the act, had particular resonance with the media and general public. The conduct and performance of doctors, and the system they worked in, was increasingly exposed. These incidents damaged the confidence of the public in professions that have traditionally enjoyed considerable public trust and support (Smith 1998). The effectiveness of agencies like the Commission for Health Improvement (CHI), whose prime responsibility it was to regulate and monitor health professionals, came under increased criticism and scrutiny.

These key events marked the end of self-governance for doctors and the introduction of the Health Care Commission with a new approach to regulation. Clinical governance procedures and arrangements for the monitoring and analysis of mortality data, and subsequently, the performance of doctors and hospitals were introduced as a direct result of the public response to these scandals. However, there was widespread acknowledgement that monitoring systems and the collection of statistics, may not in themselves flag up malpractice, and if they did, this would probably only be in hindsight (Bevan 2008). Events in the 1990s signalled the decline in dominance of doctors as a powerful professional group in the NHS and supported the Labour Party's planned modernisation of the NHS (fig 1). Dixon-Wood et al (2011) suggest that these scandals were not just simple determinants of reform, but they constituted part of a wider context within which change occurred.

Mid Staffordshire

The most recent high-profile scandal in health policy to dominate the discourse around healthcare, has been summarised by the production of Robert Francis QC's report into events at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. The public inquiry followed an independent report and was finally published in 2013, some four years later. Whilst in terms of policy reform the legacy of this scandal is still to be seen, lessons can be learned from previous scandals. The socially constructed nature of events can be analysed to reveal the public discourses which surround healthcare scandals and identify common phases evident in processes which constitute these events. The potential for scandal to influence changes to professions and future health policy can be examined.

Whilst mortality figures at Mid Staffordshire have been subject to academic controversy, an estimated 400-1,200 patients were reported to have died as a direct result of the poor care they received at the Mid Staffordshire Hospital (Francis 2010). Reports from relatives of patients who were mistreated, left un-feed, dehydrated and in pain, were numerous. The Health Care Commission (HCC)—then called the National Health Service Care Regulator—was initially alarmed by the apparently high death rates at the Staffordshire hospital. Julie Bailie, whose 86 year old mother died at the hospital in 2007 as a result of poor care, played an important role in raising the alarm at Mid Staffordshire. She was instrumental in coordinating a campaign group formed by relatives of patients who had died at the hospital. This campaign group, Cure the NHS (CURE), demanded a public inquiry in order that the hospital and key players could be held to account. A general

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inquiry published in 2010 was interested in the experience and concern of patients and relatives who were failed by the trust and subsequently a public inquiry was initiated to investigate the failings of regulatory and supervisory bodies.

The inquiry highlighted the systemic failures of the provider trust board:

It failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care (Francis 2013, 3).

Two hundred and ninety recommendations were made in the Mid Staffordshire Report. Some of these recommendations called for fundamental changes to cultural practices (fig 1). Criticism is made of NHS trust boards, systems, structures, institutions and management and leadership cultures. The ex-chief nurse, Janice Harry, was suspended from nursing for 2 years and subsequently struck off the nurse register. There were calls from interests groups like CURE for the resignation of Sir David Nicholson- the NHS chief executive, however, the report did not actually blame individuals. This is a situation which has been typical of public inquiries of this sort in the past, however, as a direct result of the “lessons learned” at Mid Staffordshire, new measures have been introduced which will allow for the criminal prosecution of individuals and institutions who are guilty of the wilful neglect of patients (DH 2015).

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The Francis report (2013) called for a focus on the culture of caring. Recommendations for nursing range from how student nurses are assessed at recruitment, to the training they receive on providing compassionate care, and the values that leaders in nursing exhibit. National training standards for nurses are also to be introduced and a common national exam to be developed. The recommendations for doctors, in contrast, focus on regulation, monitoring and standards. In the table of recommendations from the report, the word ‘compassion’ is used seven times with respect to those recommendations for nursing, but there are no comments about compassion or caring in the recommendations for doctors. Clearly these characteristics are constructed as nursing attributes, and the common perception that nursing is synonymous with ‘caring’ and is a feminine endeavour, is reflected in the response.

Many of the recommendations from the report pertaining to nurse education are already part of current codes and standards for nurses which form the basis of learning outcomes for training student nurses. *The Quality Assurance Agency (QAA) Benchmarks for Nursing* (2001), *NHS Knowledge and Skills Framework* (Department of Health 2004) and *The Health and Social Care Occupational standards* (2008) are used in conjunction with the Nursing and Midwifery Council’s *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives* (2015). These documents focus on professional values, dignity and respect in relation to patient care, patient safety and risk management. The existence of documents which highlight the need for care and compassion, clearly do not prevent abhorrent events from occurring or prevent health professionals from cutting corners or turning a blind eye to the transgressions of others.

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Discussion

The following discussion considers in what way events at Mid Staffordshire conform to the nature of the scandals discussed earlier, and analyses the public discourses surrounding scandal which have significant implications for nurses internationally. A comparative analysis of scandal demonstrates how committees of inquiry contribute to how events are constructed and are powerful mediators of ideas which become symbolic of the national interest. Emerging discourses around events at Mid-Staffordshire have been constructed around risk and patient safety, and a systemic culture which failed to heed warning signals and promote positive cultural environments in which staff could alert others of their concerns for patient safety (Francis 2010, 2013). Images of nurses as uncaring fuel public anxieties. Recommendations from inquiries shape the popular discourses about events, and I will argue, may even contribute to obscuring the context of care within which health professions practice. A focus on the need for professional change conceals the need to address political agendas which create the conditions within which health professionals practice. The events that Mid Staffordshire demonstrate how situations that are particular and local, become events for national and even international scrutiny and engage the attention of interest groups, the media and the general public.

Common phases in health care scandals are evident. Health scandals involve transgressions in the behaviour of health professionals or standards of care provided. These transgressions may have been previously accepted or ignored by staff and are suddenly constructed as problematic. Claims are subsequently made by individuals with personal interests who harness the media to construct narratives and disseminate their

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views. Motivated and empowered consumers of healthcare have created new dynamics in the relationships between service users and the health professionals delivering healthcare. As a consequence there have been several high profile scandals, precipitated by the actions of small groups of determined service users, bringing poor care to the attention of the media. It is in these very specific social, cultural and economic circumstances that scandals emerge. Public outrage precipitates subsequent inquiries and frames the context in which reform occurs.

Discourses about patient safety have raised concerns around nurses and caring cultures and formed the basis of a national debate about professional and particularly nursing values. Scandals therefore serve to reaffirm common values in communities. These values are reflected in how events are interpreted and will inevitably inform policy making. Policy responses will be shaped by how problems are defined and how events are interpreted. It is anxieties around patient safety, dignity and compassion in caring (Francis 2013, Keogh 2013) that have formed the basis for a ‘moral panic’ about standards of care delivered in the UK. Cohen wrote that ‘societies appear to be subject, every now and then to periods of moral panic. A condition, episode, person or group of persons emerge to be defined as a threat to societal values and interests’ (Cohen 1972, 9). Narratives around events are promoted by the media and other concerned members of society. Scandals appear to be constructed and sustained by discourses which promote anxiety and concern over health care. The stories of neglect at Mid Staffordshire have been so damaging to public confidence, that it was announced by the Health Secretary in 2014, that the Trust was to be dissolved and the Stafford and Cannock Chase Hospitals would be operated under other

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local providers (The Office of the Trust Special Administrators of Mid Staffordshire NHS foundation Trust 2013).

Whilst events at Mid Staffordshire Hospitals have caused public alarm nationally, there has also been growing international concern about changing public narratives which construct nurses as uncaring. Millar et al (2012) examine the portrayal of nursing homes by the media in the USA following numerous scandals in the sector. By analysing the content of 1,704 news articles, they chart the nature of the debates and their effect on the public's opinion regarding the care that is provided in nursing homes. Their study also supports the assertion, that predominately negative media reports have the potential to damage public confidence and pose a challenge to welfare and professional reform. The framing of nurses as uncaring is damaging to the trust the public place in nurse professionals and may result in the profession being singled out and blamed for the inadequacies of health services.

Obscuring the effects of under resourcing

Debates around caring cultures in nursing, provide the discourses which obscure the political dimensions of health care, which have had such a fundamental effect on care provision in the UK. The RN4CAST study, carried out in 300 hospitals in 9 European countries, demonstrated that an increase in nurses' workload increases the likelihood of inpatient hospital deaths. The authors acknowledge that this finding may be hard to accept in an era of health service reform designed to minimize hospital expenditures (Aiken et al. 2014). Research demonstrating the effects of nursing ratios on patient mortality rates has, to date, had little effect on policy reform in Europe. Neo-liberal policies which focus on

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constraint of health expenditure as an important policy objective in Europe, have inevitably resulted in cutbacks to nursing staff as a quick way of making savings. There has been little political will in Europe to acknowledge the evidence which has shown that an increase in the nurse's workload corresponds with a rise in inpatient mortality (Aiken et al 2014). Nurses and nursing have become the scapegoats for the moral panic created around health care provision. The danger is that the profession will become subject to the whim of public and media sentiment, and that any changes will be shaped by these moral panics around providing compassionate care and not on tackling the systemic failures in health care provision. Acknowledging the socially constructed nature of scandal offers a more informed and critical dimension to policy reform.

Implications for nursing

The consequences of scandal may have far reaching effects for health policy and for nursing as a profession. In the UK we may have seen a change in the attitude of the public to nurses as a result of the Mid Staffordshire scandal. Whilst poor nursing care has most certainly existed since nursing began, the degree of outcry from the press, the general public and political groups has been unprecedented. Popular discourses constructed in the media undermine the trust and public confidence in nurses and promote suspicion and fear of the care provided by health professionals.

Public images or stereotypes of nurses have been discussed by several authors. Generally nurses' work or "caring" is synonymous with being female (Graham 1983). Nurses see their work as being practical and altruistic and often base their ideas and images of nursing around the idea of vocation (Dahborg-Lyckhage and Pilhammer. 2008). This image of

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nurses as practical doers does not assist nurses in developing positive and empowering images of themselves to help them strive for autonomy in their work. Dahborg-Lyckhage et al. (2008) assert that nurses need to promote more positive images of themselves to strengthen the work of the profession. Poor images of nurses can have far reaching affects for resource allocation, staff recruitment, staff shortages and retention of nursing staff as well as for public confidence (Rezaei-Adaryani and Mohammadi 2012).

Roy Lilley argues that as nurses are at the frontline of caring environments, they are ultimately responsible for the failings of care systems. He argues that nursing has been irreparably damaged by these scandalous events and ‘the whole nursing brand is damaged’ (2010, 10). A plethora of recent media reports in the UK have also attacked the nursing brand and questioned the ability of nurses to provide compassionate care. News Headlines such as ‘You’re not too posh to wash a patient: Minister orders student nurses back to basics to improve compassion in NHS’ (Chapman and Martin 2013) and ‘Nurses need compassion not a degree’ (Odone 2012) as well as the headline on the ‘Tonight’ programme, Channel 4 on 21st March 2013, ‘has the NHS stopped caring?’ are examples of popular rhetoric in recent years. The focus of public concern has been on the nurse’s ability to provide ‘care’. Whilst this appears to be a common public narrative, Aiken et al (2014), found that nurses with bachelor degrees had better patient mortality rates than those without. Confronting the public perception that degree trained nurses are less compassionate and caring than those without a degree, is a major challenge for nurse education.

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The Francis Report has indicated that the failures at Mid Staffordshire were systemic and caused by a culture which was target driven and tolerant of poor practice which could be seen from the bedside through to management; a culture which ultimately has been formed from the policy initiatives in health over the last few decades. The press and public, however, have focused specifically on the many stories describing the poor nursing care and standards described by friends and relatives of patients affected by these scandalous events. It is these events which have constructed views of nurses and nursing as problematic.

Public inquiries seek to understand events and to learn from past failures and mistakes but they also seek to apportion blame. The dominant discourse surrounding these events in the UK is that nursing is in crisis. Public perceptions of nurses have inevitably been damaged by these events. As a result nursing as a profession is coming under increased scrutiny by both the public and state. Such scrutiny is bound to have an impact on the profession and promote change. In the same way as scandals in child protection have driven regulation in social work; and scandals involving Shipman, Ledward and children in Bristol precipitated the end to self-regulation of doctors, nursing will all most certainly be transformed as a result of these events.

At a time of crisis in health service provision in many parts of the world, nurses need to engage with, and tackle the policy agenda today or we may find changes to our profession driven by public and political reactions to such events. Failings in healthcare provide the opportunity for health professionals to rethink what values and roles are fundamental to

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them and how these values will be protected as services change in response to global public health needs in the future. Nurses need to learn to speak out against changes that endanger the ability of the nurse to practice compassionately. The profession also needs to ensure that it responds to the general public's concerns for caring cultures in nursing environments by embedding caring theories, principles and values in nurse education and giving these dimensions as much importance as the technical, research and critical thinking skills also necessary to practice as a nurse today. A report by Lord Willis (2012) into the future of pre-registration nurse education in the UK, highlights the importance of improving partnerships between users, carers, public organisations and representatives and nursing faculties. Sharing the experiences of patients and carers and developing a dialogue between nurse educators and the public, may help dispel damaging myths about nurses.

Conclusion

The events in the UK clearly demonstrate that scandals have an important role in shaping healthcare policy. Furthermore, by understanding the socially constructed nature of scandal a greater critical awareness of policy formation and its impact can be developed. Politically, the impact of scandal on health policy may be far reaching and a perceived crisis in health, promote an agenda for change. Whilst shared values and a commitment to delivering high quality health services can be reaffirmed, policy strategies may also be formulated to provide services which are perceived as value for money. Methods focusing on reduction of health expenditure can be attractive to Neoliberal supporters. Scandals may provide further rationale for free market principles in a bid to improve quality through competition. Whilst scandal, as a phenomenon in policy formulation, can be a powerful

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tool to promote change for the good, there are also dangers to political responses to scandals. Responses can be heavy handed, ill-informed and punitive resulting not only in excessive monitoring and regulation of professions, but they can obscure the conditions in which professionals have to work. Nurses need to engage with public and political discourses in health, and with the political agendas to policy reform, and resist changes to the profession which focus heavily on regulation and monitoring, which may come at the expense of finding time and space to provide compassionate care. 5543 words

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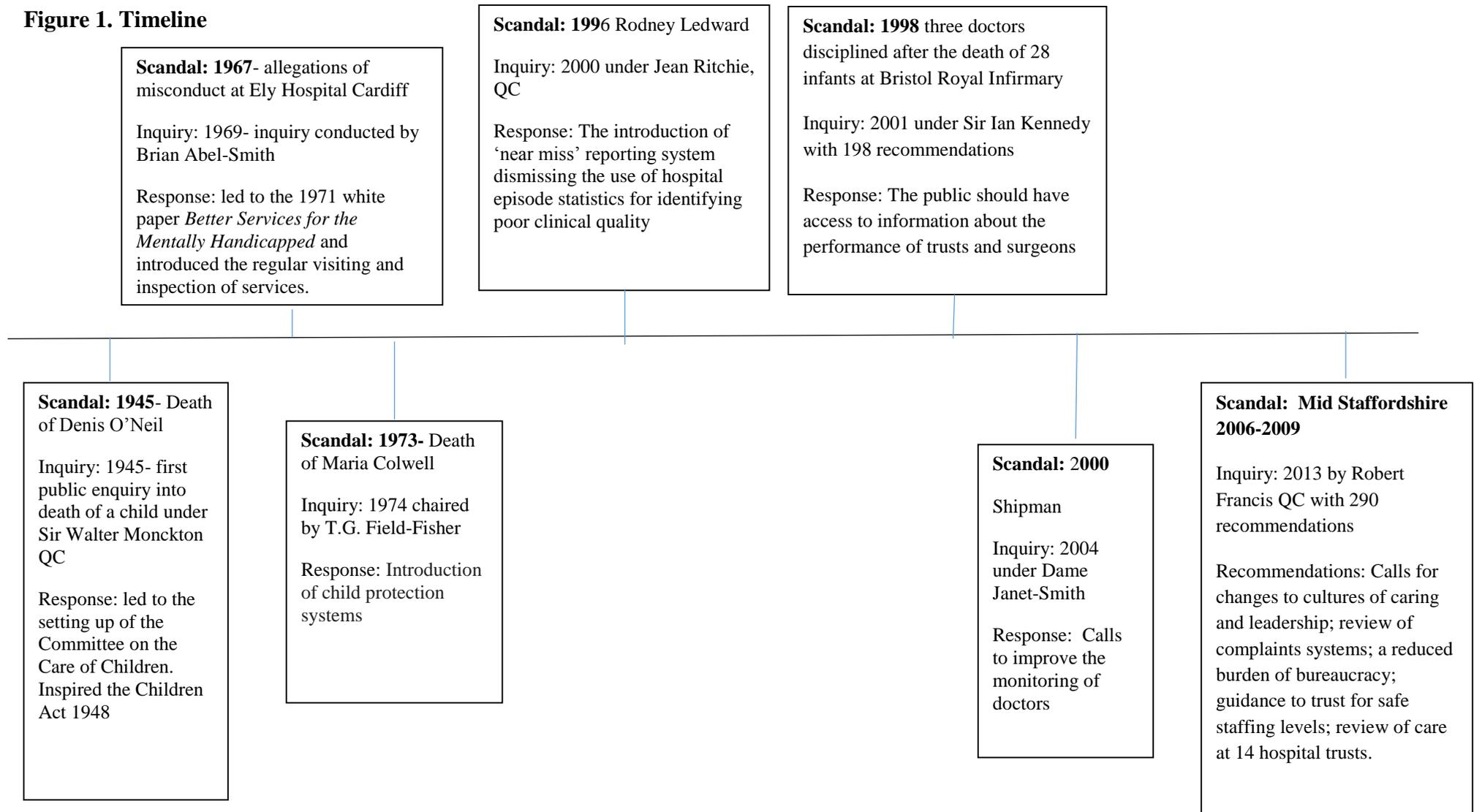
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Figure 1. Timeline



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