Protecting the public? An analysis of professional regulation. Comparing outcomes in Fitness to Practice proceedings for social workers, nurses and doctors

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Abstract

The regulation of professional activity in the Health and Social Care sector in the UK is carried out by a number of statutory bodies that hold legal mandates to manage the risks of professional malpractice. The prime method used to perform this duty, and thereby protect the public, is the construction of a register of the suitability qualified - and creation of appropriate professional standards to establish a benchmark for practice. When registrant's performance or conduct is felt not to meet these standards they are placed within a Fitness to Practice process administered by the regulatory body. This article examines the publicly available data on Fitness to Practice cases from UK regulatory bodies relating to the professions of social workers, nurses, midwives and doctors. Examining nearly 1000 cases, the authors run a statistical analysis of the data to establish whether any differences are found amongst and between these professional groupings. We find there are several areas where significant differences arise, namely gender, attendance and representation. Most of these regulatory bodies are, in turn, regulated in the UK by the Professional Standards Authority and the article concludes by suggesting ways forward for the PSA in addressing or further examining apparent inequalities. The analysis is placed within a wide range of literature, with an emphasis on the international transferability of the approach to professional regulation.

Keywords: professional practice, risk, regulation

Introduction

One of the interesting features of the growth of modern professions is their relationship to - and reliance on - statutory regulation of their function as a necessary, if not sufficient, element of asserting professional status. The spheres of professional control that result from knowledge monopolies and gatekeeping activities have a direct link to state legitimatised function, protection of title and regulation. Seeking validation, professions trade independence for social governance and become more accountable (Brint, 1993; Friedson, 1994). Adams (2016) expands this thinking as she examines how, in turn, regulation becomes shaped by professional interest, legitimised social governance and broader benefits to society. In a parallel discourse, authors such as Beck (1992) and Harmon *et al.* (2013) have conceptualised the 'risk society' where the ubiquitous nature of risk of harm places individuals in a perpetual state of 'uncertainty' requiring risk mitigation responses from legal and other institutions. In areas of health and social care, the complexity of the statutory function, based within human, multifaceted, value based and essentially uncertain relationships, makes this a difficult task. How does one control the uncontrollable? The result tends to be complex, costly structures and processes - 'risk regulation regimes' (Hood *et al*., 2001), that appear to take on a life of their own as they simplify complexity in an effort to exert control over risk. The central tenet of many regulatory regimes, certainly those in the health and care sector, is the protection of the public through the management of professional risk. But in whose interest does regulation really operate: the profession, the public or the regulator themselves? (Horowitz, 1980).

One illustration of this process in the United Kingdom's health and social care sector, is the presence of large scale, regulatory bodies that directly manage professional risks to

the public around the roles of social worker, nurse, midwife and doctor. The Health and Care Professions Council, (HCPC) the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) have legally mandated functions to regulate their respective professions and form registers that govern the conduct and activity of over one million professionals in the UK. A new body named 'Social Work England' took over sole responsibility for social work in December 2019. The authors of this current paper have previously examined various elements of the regulation of the social work profession in England and globally (Worsley *et al*., 2019), along with the legal fairness of the Fitness to Practice (FTP) process (Kirkham *et al*., 2019). One of the questions raised by our research – and the aim of the current paper - was to assess the comparability of the registrant's experience within different regulatory regimes and to attempt to understand any differences that appear. Was, for example, the social worker's experience of regulation similar to that of the nurse? The authors have sought to answer that question by comparing one element of regulation through publicly available data – namely FTP proceedings, which refers to a model for investigating the behaviour of practitioners against professional standards. Regulatory bodies construct, typically, committee panels to consider evidence of misconduct and/or competence that might relate to behaviour such as failing to conduct appropriate relationships, fraud or keeping accurate records. Sanctions are available to these panels that rise from admonishments through to removal from the professional register – which therefore prevents the professional from working in that role under its protected title. This research has discovered considerable disparities between the professions, especially around gender equality. In turn, questions arise regarding the need for moderation within and amongst these regimes. This research, although exclusively concerned with data emanating from the UK, raises questions that can, and ought to be

asked in broader international contexts whilst also providing a methodology for the analysis of relevant data. We acknowledge that the very different histories of these professional groupings may affect direct comparability. We note the GMC was established in 1858 to regulate an already very 'mature' profession. The regulation of nursing (1919) and, much later, social work (2001) are arguably relatively 'modern' professions. Notwithstanding these differences, one of the main rationales for our selection of these professions was their shared relationship with the Professional Standards Authority (PSA). The PSA is the 'regulator's regulator' and was given a legal mandate for that role through the NHS Reform and Health Care Professions Act (2002). Their function is to, 'protect the public through work with organisations that register and regulate people working in health and social care', (Professional Standards Authority, 2019). This article will examine relevant literature before presenting a range of data illustrating differences between the professions and discussing some potential explanations for these differences. We then briefly examine the opportunities for the PSA to create greater fairness for registrants whilst also enhancing the protection of the public.

Literature Review

The twentieth-century saw an increase in occupations seeking to become recognised as professions with their own knowledge base and concomitant expertise. These developments ran parallel with increased attempts for some form of regulation to be put in place to ensure good practice and exert some form of control over professionals. Initially, this tended to be in the form of self-regulation by the professions themselves (Schon, 2001), but in recent years, there has been a growing trend for external regulation of many

professions. Furthermore, analysis of several established profession's journey to regulation across Europe, highlights how national differences in those themes have diminished over time (Malatesta, 2010) and internationally, one can identify a range of broadly similar regulatory processes in place, although, the degree of self-regulation or administration via professional boards can differ (Byrne, 2016; Beddoe, 2018; Worsley *et al*., 2019). Whilst an increase in external regulation of the professions has been broadly welcomed, some criticism has emerged (Furness, 2012; Leigh *et al*., 2017). Indeed, the very concept of external regulation has provoked much debate and disagreement amongst professional bodies themselves. Such contestation has mainly arisen from a fear of external regulations reducing professional autonomy (McLaughlin, 2007; Haney 2012). These objections have been countered with the argument that self-regulation could allow professional self-interest to override the public interest (Schön, 2001).

As social workers in England engage with a third regulatory body in seven years, their profession is at an interesting juncture and one that, perhaps, raises timely questions about comparisons between sister professions across health and social care. Each regulatory body publishes an Annual 'Fitness to Practice' report, albeit in slightly different formats that inhibit direct comparison, which suggest widely differing rates of referral for FTP proceedings. Considering the most recent of these we find that Social Work (in England) from a register of approximately 96,000 has a 'cases received' rate of 1.42% of the register (HCPC, 2019). In comparison, the GMC register of Doctors carries some 300,000 and has a 'referral' rate of 0.02% of the register (GMC, 2019). Finally, the NMC has a register of around 700,000 (650,000 of which are nurses) and deals with a 'referral' rate of 0.08% i.e. 8 in 1,000 (NMC 2019). Whilst available data cannot detect if there are different 'thresholds'

to proceedings at play, clearly, these figures suggest very different experiences and exposures to FTP regulation across the professional groupings that merits exploration.

Data Source

Data included in this research was gathered from the six professional bodies that regulate social workers, doctors, nurses and midwives in the UK, with each regulatory body having their own specific website. Within the UK, each of the four nations have their own professional social work body. The HCPC regulated social workers in England during our period of study, with Social Care Wales (SCW), Northern Ireland Social Care Council (NISCC), and Scottish Social Services Council (SSSC) preforming their respective regulatory functions for the profession. We acknowledged above the significant differences between the professional histories and, indeed, contexts of social work in the four countries – but offer the data to form a complete picture of the UK. As mentioned earlier, doctors in the UK must be registered with the GMC, whilst UK nurses and midwives must be registered with the NMC.

All six professional regulators have their own FTP process where practitioners, whose behaviour falls below professional standards, are at risk of being referred to their profession's relevant committee. All six professional bodies regularly publish such hearings online. For HCPC registrants, these concerns are heard by the Health and Care Professions Tribunal Service (HCPTS), with outcomes being documented on their website. Between 1st January 2018 and 1st January 2019 (our period), social workers were linked to 150 final hearing FTP cases, with the researchers downloading all cases. SCW has a dedicated FTP section on their website, with information relating to the hearing process, upcoming

hearings and the outcomes of past hearings being presented. For this research, hearings that occurred during our period and identified a registrant's role as either social worker or qualified social worker were manually selected, resulting in five hearing outcomes being identified and downloaded. Hearings and decisions relating to social workers, social care workers and social work students in Northern Ireland are stored on the NISCC website. The inclusion criteria for NISCC cases was that it involved a registrant on the social worker part of the register, with the case being active or occurred during our period. Based on this criterion, two hearings were found, with only one case available for download. For SSSC cases involving a social worker, with an effective outcome in the chosen time period, fifteen cases were identified, with all cases downloaded by the researchers.

GMC Fitness to Practice hearings are heard by the Medical Practitioners Tribunal Service (MPTS), with recent tribunal decisions and upcoming hearings being presented on their website. However, MPTS only publishes decisions that ended within the last 12 months. Data that relates to GMC registrants was obtained in January 2019, enabling the researchers to access all cases that occurred during our period during which 381 decisions were published by MPTS, with the researchers able to download 83% of these cases (n=317). Finally, FTP hearings and sanctions for nurses and midwives are accessible via the NMC website. Significantly, the NMC website only publishes outcomes and sanctions that have been made in the last three full months. Individual outcomes are listed indefinitely but need to be searched for using a registrant's name or pin. At the time of identifying NMC cases (mid-January 2019), data was only available for November and December 2018 yet 276 cases were accessible with researchers able to download 72% (n=200). The authors request to access the NMC data across our period was refused. We appreciate that this incomplete data set inhibits full comparison across the selected timeframe and therefore

are conscious throughout that our findings are best thought of as indicative and suggestive of further areas for research and analysis.

Based on the criteria that FTP hearings and or decisions had to occur between 1st January 2018 and 1st January 2019, a total of 830 cases were recorded by all six professional bodies or tribunals. Of these 830 cases, the researchers were able to download 83% of case files and outcomes (n=688). To ensure the final analysis was representative and manageable, the researchers decided to analyse 50% of all downloaded cases per professional body. If there was an odd number of cases, the number of cases analysed was rounded up, resulting in 348 cases being included in the final analysis.

Data Analysis.

Content analysis was used to analyse the information contained within the chosen cases. In its broadest sense, content analysis refers to the process of transforming raw qualitative data into a standardised form (Kohlbacher, 2006). Content analysis involves the subjective interpretation of data (Hsieh and Shannon, 2005), with researchers having to systematically code data, before identifying themes or patterns. For this study, a conceptual content analysis was chosen, enabling the existence and frequency of a concept to be quantified. To assist with the identification of concepts, a coding framework was developed, with codes being associated with pre-determined categories of interest.

Within the UK, the Professional Standards Authority (PSA) has a legal responsibility to regulate nine health and care regulators, with HCPC, GMC and NMC falling under the PSA remit. To reflect the role of the PSA and to capture regional variance, social work FTP cases

were split into two groups: PSA regulated Social Workers (HCPTS cases) and non-PSA regulated Social Workers (SCW, NISCC and SSSC). Doctors (MPTS cases) and Nurse/Midwife (NMC cases) formed two other distinctive groups. By analysing the data in this way, the fairness of processes between professional background could be explored, alongside identifying any differences between PSA and non-PSA regulated regulators – although the limited numbers of the latter limit strong conclusions. To determine the gender of the registrant (not recorded by the regulatory body), codes were based on the name of the registrant, alongside the pronouns used in the body of the case. Explicit terms were used to code the registrants professional background and professional body. Codes relating to the registrant attending their hearing were based upon a case clearly stating that the registrant attended or did not attend. A similar process was applied to the registrant being legally represented, with a *Yes* code being attributed to cases explicitly reporting the presence of legal representation, whilst a *No* code was applied to cases were the absence of legal representation was recorded.

The outcome of a hearing was generally explicitly recorded on a case, with the researchers using these outcomes to code the data. The rationale for an outcome was also captured within the content analysis. Within a case, multiple reasons for an outcome were typically reported, with the researchers grouping reasons into broad themes. Therefore, whilst cases only appear in one category, there was the potential for some cases to have identified additional reasons. A primary purpose of publishing FTP cases is to provide transparency between regulators, registrants and the public, not to assist with academic research. Therefore, whilst cases provided a wealth of information, the consistency and depth of information recorded often varied. Subsequently, not all cases clearly reported

information of interest, causing gaps in knowledge to emerge. In these instances, an *Unknown* variable was created, with this variable being omitted from the final analysis.

To assist with the content analysis, the coding framework was designed in Excel, with the same researcher reading and coding all 348 cases. To calculate inferential statistics, the completed coded Excel spreadsheet was transferred to SPSS, allowing the interaction between the various variables to be identified. Data was normally distributed, enabling parametric tests to be used. Chi-square tests were used to investigate categorical data, whilst one-way analysis of variance (ANOVA) tests were used to explore interval data that had three or more levels to the independent variable. Ethical approval to conduct this research was obtained from the University of Central Lancashire's ethics committee.

Findings

Overview of Fitness to Practice Cases.

Of the 348 FTP cases analysed, 46% related to Doctors (n=160), with Nurses /Midwives accounting for 29% of cases (n=100 with Nurses comprising 95% of those cases). PSA regulated Social Workers were linked to 21% of cases (n=74), whilst non-PSA regulated Social Workers represented 4% of the cases analysed (n=14) (Table 1). Over half of FTP registrants (henceforth 'registrants') were male (n=210, 60%), with a significant association between a registrant's gender and professional background being found, ($X^2 (3) = 96.081, p < .001$, *Cramer's V = .525*). PSA regulated Social Workers (n=41, 55%) and Nurse/Midwife (n=70, 70%) registrants were most likely to be female, whilst 88% of Doctors were male (n=140). When these figures were compared with the gender breakdown of the

professional registers, it was found that male registrants were overrepresented within the cases. On UK social work registers, men account for approximately 17% of all registrants (HCPC, 2019; NISCC, 2017; SCW, 2018), yet 45% of PSA regulated and 50% of non-PSA regulated Social Worker cases involved male registrants. Equally, on the GMC register, 54% of registrants are male (GMC, 2019a), with this study finding that 88% of FTP cases investigated identified a male registrant. This trend was also replicated for Nurses and Midwives. Around 11% of registrants are male (NMC, 2018), however, males accounted for 30% of cases analysed. Thus, it could be argued that in relation to the gender breakdown of professional registers, men are at an increased risk of being referred to a FTP process compared to their female counterparts.

Most cases explicitly stated whether the registrant attended their hearing (n=299, 86%), with Doctors (n=113, 71%) significantly more likely to attend their hearing compared to PSA regulated Social Workers (n=3, 7%) and Nurses/Midwives (n=45, 46%), (X^2 *(3) = 56.080, p< .001, Cramer's V = .433*). Equally, Doctors (n=93, 58%) were significantly more likely to be legally represented than PSA regulated Social Workers (n=1, 6%) and Nurses/Midwives (n=39, 41%), (X^2 *(3) = 21.714, p< .001, Cramer's V = .282*). These findings suggest that out of the three professional backgrounds, social workers are most likely to not attend their FTP hearing or be legally represented.

The main type of allegation, regardless of professional background was Misconduct (n=223, 72%), followed by a Caution/Conviction (n=55, 18%), implying that regardless of professional background, hearings are addressing behaviour of a similar nature. Although, the association between professional background and type of allegation was non-significant, (X^2 *(12) = 20.828, p> .05, Cramer's V = .150*).

Table 1: Summary of All FTP Cases by Professional Background.

Variable	Professional Background									
	PSA Regulated Social Workers		Non-PSA Regulated Social Workers		Doctors		Nurse/Midwife		All Professions	
Gender*	*N=74*		*N=14*		*N=160*		*N=100*		*N=348*	
Female	41	55%	7	50%	20	12%	70	70%	138	40%
Male	33	45%	7	50%	140	88%	30	30%	210	60%
Registrant Attended^*	*N=40*		*N=1*		*N=158*		*N=97*		*N=299*	
Yes	3	7%	1	100%	113	71%	45	46%	162	54%
No	37	93%	-	-	47	29%	53	54%	137	46%
Legally Represented^*	*N=17*		*N=1*		*N=160*		*N=96*		*N=274*	
Yes	1	6%	1	100%	93	58%	39	41%	134	51%
No	16	94%	-	-	67	42%	57	59%	140	49%
Mean Number of Allegations^	15 (SD=13.66)		21 (SD=22.38)		14 (SD=17.26)		10 (SD=8.54)		14 (SD=15.08)	
Type of Allegation^	*N=74*		*N=14*		*N=159*		*N=63*		*N=310*	
Misconduct	57	77%	12	86%	114	72%	40	63%	223	72%
Caution/Conviction	11	15%	-	-	33	21%	11	17%	55	18%
Lack of Competence	6	8%	2	14%	11	7%	9	14%	28	9%
Ill Health	-	-	-	-	-	-	3	5%	3	1%
Determination of Other Regulator	-	-	-	-	1	<1%	-	-	1	<1%

**p< .001, ^Unknown cases removed*

Outcome of Fitness to Practice Cases.

Nearly a third of all FTP cases (n=112, 32%) resulted in an outcome of Suspension or Interim Suspension (Table 2), with the relationship between professional body and outcome being significant, (X^2 *(27) = 170.355, p< .001, Cramer's V = .407*). Compared to the other professional backgrounds, PSA registered (n=23, 32%) and non-PSA registered (n=8, 57%) Social Workers were most likely to have been removed from their professional register. Conversely, Doctors (n=60, 38%) and Nurses/Midwives (n=34, 34%) predominantly received a suspension, implying that FTP hearings are more punitive towards social workers than doctors or nurses/midwives.

Of those cases that provided a rationale for an outcome (n=290, 83%), a significant relationship between professional background and rationale was found, (X^2 *(27) = 75.255, p< .001, Cramer's V = .294*). The dominant theme associated with PSA regulated (n=18, 32%) and non-PSA regulated (n=6, 46%) Social Workers outcomes was to reflect the 'seriousness of allegation'. For Doctors (n=51, 32%), the primary rationale for an outcome was related to the registrant evidencing remediation, insight or remorse, whilst in 20% of Nurse/Midwife cases (n=13), the reason for an outcome was linked to allowing the registrant 'time for remediation/insight to develop'. Based on the findings, it could be argued that social work decisions were more concerned with what had occurred, whereas GMC and NMC decisions tended to acknowledge a registrant's ability to learn from their mistakes and make amends. Across the three professions therefore, social work regulatory activity may place more emphasis upon public protection, whilst the GMC and NMC may be more willing to consider a registrant as a public asset, who can change their ways.

Table 2: Outcome of All FTP Cases by Professional Background.

Variable	Professional Background									
	PSA Regulated Social Workers		Non-PSA Regulated Social Workers		Doctors		Nurse/Midwife		All Professions	
Outcome^*	*N=72*		*N=14*		*N=157*		*N=100*		*N=343*	
Suspension	18	25%	-	-	60	38%	34	34%	112	33%
Erasure/Removal/ Struck Off	23	32%	8	57%	38	24%	29	29%	98	29%
Conditions	5	7%	2	14%	18	11%	33	33%	58	17%
Adjourned	15	21%	-	-	5	3%	-	-	20	6%
No Action	2	3%	-	-	14	9%	1	1%	17	5%
Condition/Suspension Revoked	-	-	-	-	13	8%	-	-	13	4%
Caution	9	13%	-	-	-	-	3	3%	12	4%
Warning	-	-	4	29%	4	3%	-	-	8	2%
Restoration not granted	-	-	-	-	4	3%	-	-	4	1%
Restoration	-	-	-	-	1	<1%	-	-	1	<1%
Rationale for Outcome^*	*N=56*		*N=13*		*N=157*		*N=64*		*N=290*	
Evidence of remediation/insight/remorse	9	16%	1	8%	51	32%	7	11%	68	23%
Failure to remediate/insight/remorse	8	14%	3	23%	27	17%	12	19%	50	17%
Time for remediation/insight	8	14%	-	-	26	17%	13	20%	47	16%
Seriousness of allegation	18	32%	6	46%	23	15%	11	17%	58	20%
Allegations not proven	1	2%	-	-	9	6%	1	2%	11	4%
Disregard for rules	-	-	1	8%	9	6%	9	14%	19	7%
Public Safety	10	18%	-	-	8	5%	6	9%	24	8%
Case not yet concluded	1	2%	-	-	4	3%	4	6%	9	3%
Voluntary removal agreed	1	2%	1	8%	-	-	-	-	2	<1%
Other	-	-	1	8%	-	-	1	2%	2	<1%

**p< .001, ^Unknown cases removed*

Removal Cases.

To explore the notion that Fitness to Practice processes may be more punitive towards social workers, the researchers conducted a separate analysis of those cases that resulted in a registrant being removed from their register. Of the 98 removal cases, Doctors accounted for 39% of registrants (n=38), with over a fifth of cases relating to Nurses/Midwives (n=29, 30%). PSA regulated Social Workers represented 23% of removal cases (n=23), whilst 8% of cases involved non-PSA regulated Social Workers (n=8).

PSA regulated Social Workers (n=15, 65%) and Nurses/Midwives (n=21, 72%) were significantly more likely to be female, whereas non-PSA regulated Social Workers (n=5, 63%) and Doctors (n=35, 92%) were predominantly male, (X^2 *(2) = 32.23, p< .001, Cramer's V = .574*). Male social workers and doctors were again overrepresented within removal cases. Over a third of PSA regulated (n=8, 35%) and 63% of non-PSA regulated (n=5, 63%) Social Workers, who were removed from their professional register, were male. This contrasts, as noted above, with approximately 17% of UK registered social workers being male (HCPC 2019a). On the GMC register, 54% of registrants are male (GMC 2019a), yet within this analysis it was found that 92% of Doctors (n=35) removed from the GMC register were male. Likewise, 11% of NMC registrants are male (NMC op. cit.) but accounted for 28% of Nurses/Midwives (n=8) removed from their register, reinforcing the notion that compared to females, male social workers, doctors and nurses/midwives may be at an increased risk of not only being referred to FTP processes, but removed from their professional register. The association between removal cases, average number of allegations and professional background was also found to be significant, (*F (3, 84) =5.727, p< .001*). PSA regulated Social Workers (M=8, SD=6.04) and Nurses/Midwives (M=9, SD=9.34) were more likely to be

removed from their professional register for fewer concerns, compared to non-PSA regulated Social Workers (M=26, SD=21.64) and Doctors (M=23, SD=25.04). This suggests that concern thresholds may be lower for PSA regulated Social Workers and NMC registrants, than GMC registrants and non-PSA regulated Social Workers.

Finally, the rationale for an outcome was identified on 97% of removal cases (n=95), with the relationship between professional background and rationale for an outcome being significant, ($X^2 (8) = 16.28, p< .05, Cramer's V = .038$). Cases relating to PSA regulated (n=11, 50%) and non-PSA regulated (n=3, 43%) Social Workers mainly stated that a registrant had been removed due to the 'seriousness of the allegation'. This contrasts with the rationale identified for Doctors (n=15, 39%) and Nurses/Midwives (n=10, 36%), with these cases typically implying that a registrant had been removed due to failing to 'evidence remediation, insight or remorse'. This suggests that the purpose of a FTP outcome differs across professional bodies, with social work regulators more likely to focus upon what has been done and public safety, whilst decisions relating to doctors and nurses/midwives are potentially more considerate of a registrant's ability to amend their behaviour and their value to the public.

Discussion

Fairness

Our analysis clearly demonstrates significant differences between and within the professions on several variables that appear to raise questions about the fairness and consistency of the FTP process. However, this discussion must first recall the indicative and

limited nature of much of the data. It is important that we avoid monocausal explanations and this discussion therefore simply aims to raise questions for further study that arise from our data and one of the more salient is around gender. We are aware that professions are gendered institutions and many male dominated professions have successfully deployed gendered strategies and ideologies to achieve professional dominance (Adams, 2003). Other authors have characterised female dominated professions as 'semi-professions' and examined how such roles can be subordinated or limited by male dominated professions (Etzioni, 1969; Coburn, 1994). Such professional strategies employ gendered actors who can use gender as a criterion to determine access to skills and credentials - and what those skills and credentials are (Witz, 1992). Our chosen professions are notably different, with one 'traditional' profession – medicine - being the only one where registered males form a majority (albeit one that diminishes year on year (NHS, 2018) joined, arguably, by two semi-professions that are substantially majority female. Yet why are men in all three professions apparently at significantly greater risk of being referred to FTP proceedings and removed from the register? Relevant research to consider includes Simpson (2004), who looked at males in female dominated professions and found that whilst men can benefit from a minority status, an 'assumed authority' could mean men were more likely to be expected to lead in challenging situations. Similarly, Lupton (2006) reports how masculinity can be 'exposed' when working alongside females and adopting 'female' roles. Tennhoff et al. (2015) examined the intersectionality of gender and professionalization around men working in the field of early childhood. In such a setting, they argue, the image of the 'ideal worker' becomes feminine and one where men can be constructed as the 'unwanted other'. Tennhoff (op cit.) found, albeit through a very limited sample, that strategic responses for male workers to become 'wanted' might include activity such as taking on the role of

'pioneer' or emphasising the agency and autonomy of their role. With a different emphasis, Furness (2012) looked specifically at the higher rates of male failure in social work qualifying training and noted the 'suspicion of unsuitability' which can result in men having to work harder to prove their competence. Clearly, the interaction of gender identity, profession and activity is hard to capture and, in any event, would unlikely be sufficient to fully explain such a complex phenomenon. Finally, of course, whilst that might all be applicable to Social Work, Nursing and Midwifery, it less obviously relates to Medicine, although that setting is also moving quite rapidly towards being a female dominated profession.

We have argued elsewhere that there are numerous problems located within the 'thin procedural fairness' of FTP proceedings in social work, noting especially the blanket transposition of court-like models on to complex work environments that focus entirely on the individual and never on issues such as organisational failure (Kirkham *et al*., 2019). Furthermore, inadequately addressing this issue, we argued, undermines the integrity of the process. Similar arguments may well accrue in our other selected professions. On this theme, one of the features of the data is that which presents significant differences between the professions in terms of attendance and representation (legal and related) at FTP events – with large numbers clearly voting with their feet. The differences are stark with 71% of doctors in attendance (where this is mentioned) compared to only 7% of social workers. Likewise, social workers are far more unlikely to be represented (6% compared to Nurses at 41%). What this means for the fairness of the processes is, again, complex but what the data suggests is that there are significant differences between professions regarding access to and engagement with a fair, just process. Why might social workers attend relatively less? Cost may well be a factor as earlier primary research with social workers going through FTP proceedings indicated costs may run from £5000 to £15000

(McLaughlin *et al*., 2016). Professional associations, related organisations and schemes offer varying forms of support for those going through FTP, but this is not a role the regulatory bodies adopt. We are aware that there are more mature organisational approaches to the provision of indemnity legal advice through professional association in the Royal College of Nursing and the British Medical Association than social work – perhaps with greater proportions of registered membership. One could argue, of course, that cost is more linked to representation than attendance. Ultimately, whatever the options for support, there are large numbers of professionals who simply are not attending their FTP process – with our data suggesting that in Social Work we are heading towards greater levels of disengagement. Whatever the reason behind this, the regulators must give serious consideration to what this says about the fairness and justice of their models.

Public interest and risk

This brings us to the question of the public interest and the protection of the public. We know that the public's level of trust in different professions varies – with nurses and doctors often rated most highly (Ipsos, 2019). Conversely, there is a wealth of research examining the continued (mis) representation of the social work profession in the media (see for example Jones, 2014). Our evidence suggests that different regulators operationalise different models of understanding how they protect the public. State legitimised professional, statutory and regulatory bodies (PSRBs) have the promotion of the public interest delegated to them through legislation (Veloso *et al*., 2015). Authors such as Hood (2011) refer to 'blame-prevention re-engineering' where risk management strategies develop to deflect blame. In this sense, for the government, PSRB's are arguably a risk

management strategy – offering a way of diverting the high-profile risk issues related to professions and avoiding central, political blame. Indeed, the presence of a 'scandal-reform cycle' – can also greatly influence the character of these risk management strategies (Stanley and Manthorpe, 2004). The role of PSRB's in navigating and interpreting the protection of the public is clearly complex and multi-faceted. Yet, it is interesting to reflect on how PSRB's construct an understanding of the 'public' they are seeking to protect. Is it based on the 'reality' of such risks, the media portrayal of those risks – or their interpretation of the government view of the seriousness of those risks? Nevertheless, our data suggests that the risks posed – or the perceptions of the risks posed - of breaches in standards by registrants from different professions vary significantly.

As can be seen, there are significant differences between professions on rates of removal from the register with social workers (32%) being more likely to be removed than the other professions such as doctors (24%). This is also reflected in far greater use of conditional disposals attached to nurses (32%) than social workers (7%). One element of this difference is the apparent willingness of different FTP processes to engage more fully with concepts of remediation and remorse as rationales for disposal (especially noticeable with doctors) whereas for social workers the rationale was frequently around the seriousness of the matters being considered – with seriousness being used as a rationale for them more than twice the incidence as that for doctors. This is especially interesting when compared with the power these professions hold over the public. Clearly social workers have significant, state legitimised, powers such as removal of liberty – which might suggest they present greater 'risks' to the public who therefore have greater need to be protected from their malpractice. But do those risks really exceed those of nurses and doctors who's access to the physical person of the public is unparalleled across the professions?

Data Transparency and Moderation

In accessing this range of publicly available data and, where appropriate, triangulating it against FTP Annual reports, we have been struck by what the data doesn't show. Whilst it is understandable that the regulatory bodies' desire to remain transparent is aimed primarily at the public it purports to protect, it is also self-evident that its recording of FTP hearings is designed more for its own purposes. Thus, there are no expectations that we are aware of regarding some basic data set requirements that might dictate, for example, note of key issues such as race, gender, age, representation and so on. FTP Annual Reports are typically quantitative analyses of the processing of cases through systems devoid of any content that amounts to learning from the individual cases (see for example HCPC, 2019). And they certainly do not allow the public (or registrant) eye to gaze on whether their processes are equally fair regardless of demographic details such as race, gender, age and so forth. How PSRB's address their legal obligations regarding the Public-Sector Equality Duty is not clear in relation to this query, specifically around how they minimise disadvantage to those with protected characteristics (Equality and Human Rights Commission, 2019). We also note the suggestion, from earlier research, that length of service and time on the register appears to be another relevant factor affecting outcomes that might usefully be the subject of further enquiry – where the more experienced staff are more likely to be involved in FTP processes (see Leigh, Worsley & McLaughlin, 2017).

It seems appropriate at this juncture to reflect on the role of the PSA and whether there is a need for some form of moderation across the professions. Our data suggests there are significant differences between regulatory bodies in their implementation of FTP

regimes which appear gendered and perhaps lacking some essential elements of fairness and justice, notably around attendance and representation. We hope the PSA considers these findings and deploys its legal authority to investigate the data more thoroughly than we are able. Yet, this is not simply a plea for registrants, there are genuine issues about prime purpose. The PSA considers at length, in several of its publications, the notion of 'upstreaming' whereby regulators are encouraged to use the data they gather to help avoid future risks – and reduce the incidence of non-compliance with standards – so as to prevent harm to the public (PSA, 2017). It could be argued that in failing to adequately upstream FTP data, the PSA are failing to protect the public, let alone the registrants. The apparent absence of this imperative suggests that it is the prosecution of the case that assumes far greater precedence (and commands far greater resource) than the protection of the public through learning from all these cases why something went wrong and preventing it from happening again.

Conclusion

This paper has analysed a year's worth of publicly available Fitness to Practice data from the professional regulatory bodies covering the roles of social worker, nurses, midwives and doctors. The function of the regulator in protecting the public and assessing the risks that registrants pose to them has been examined and questions have been raised specifically regarding significant differences between professions based on gender, attendance and representation. Taken as a whole, the data raises questions about fairness, consistency and equity across the professions regulated by the PSA, which may need to develop a moderative function to temper differences. Furthermore, we have argued that the PSA

needs to do more with regards to 'upstreaming', utilising its greater access to this kind of data to *prevent* incidents of malpractice – rather than focusing exclusively on the punishment of registrants. It is only through making this conceptual shift that the PSA will truly be protecting the public it serves. The questions raised in this study are, we feel, applicable to a range of international professional regulatory activity and can be used to examine its fairness and transparency for the benefit of professionals and public alike.

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