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Guest editorial

Does professional regulation for nursing protect patients or is it simply a way of gaining professional status?

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'Boot camp' nurse struck off

> 'A nurse accused of running a care home like a military 'boot camp' yesterday escaped being struck off the nursing register despite being found guilty of abusing mentally ill residents .... Yesterday, at a reopening of the Nursing and Midwifery Council (NMC) hearing, the committee decided that the nurse, who for 10 years had trained other nurses, had acted in a way that amounted to professional misconduct. The panel decided to issue a caution, which would remain on her records for five years.'[1]

From time to time the media shock us with headlines such as this. As professionals we believe that we have standards that guard against such professional misconduct. Such standards are enacted through our regulatory bodies, which have the power to remove unscrupulous practitioners from the professional register. However, by definition, professions have the power to regulate themselves. In his classic work on the profession of medicine in 1970, Friedson proposes that the right to professional autonomy is justified by three criteria.[2] Firstly, the profession has a unique body of knowledge and skills, so much so that outsiders are not equipped to regulate it or evaluate it; secondly, professionals are responsible and can be trusted to work conscientiously without supervision; and, thirdly, the profession itself may be trusted to undertake the proper regulatory action should one of its members breach accepted standards. It is this third criterion that some may question in the light of the above press cutting.

Nursing has long striven to be recognised as a profession in its own right, separate from medicine. To this end nursing achieved registration status in 1919 and in 1921 the General Nursing Council was instigated as the regulatory body for nursing, surviving until 1979 when it was replaced by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). This new body was made up of 40 nurses, midwives and health visitors, elected by the nursing workforce and 20 appointees selected by the Secretary of State for Health.[3] For the first time, a live register of nurses was maintained, with registrants paying a fee every three years to maintain their registration. The UKCC produced a series of professional guidelines for nurses, which were distributed through regular mailings to registrants, for example, *Code of Professional Conduct*, which set out clearly the professional issues relating to accountability and ethical practice.[4] Additional to such guidelines for practice, the council maintained a register and set criteria for admission to the different parts, however, almost half of its budget was spent on professional conduct matters.[3] Towards the end of the 1990s the government became uneasy about the autonomy of the council, fuelled by criticism in the nursing press that 'a series of decisions resulted in convicted rapists and abusers remaining on the professional register and, in some cases, continuing to practise as nurses or care assistants'.[5]

An independent inquiry into the UKCC was commissioned. The outcome of this inquiry, published by JM Consulting in 1997, called for the abolition of the UKCC.[6] Furthermore, the report called for a streamlining of nursing qualifications, reducing the 15 parts of the register to two: nursing and midwifery. The most controversial part of this proposal was that health visiting should be subsumed within nursing. Health visiting has a long history, originating from the sanitary reform movement of the 19th century and later turning its attention to the reduction of the high infant mortality rate of the early part of the 20th century. Health visitors lobbied to re-establish their public health role, claiming that their role was different from that of nursing, and suggesting that they should have a third part of the register allowing direct entry to the profession without the current prerequisite of a nursing registration. Eventually a compromise was reached, allowing for a third part of the register based on public health principles but maintained as a second registration following initial registration as a nurse or a midwife.

The NMC was established under the Nursing and Midwifery Order 2001, and came into being in April 2002. It is more streamlined than its forerunner the UKCC and has only 24 members. Thirteen of these members are from the professions of nursing, midwifery and health visiting and the remaining 11 are lay members, who have a very strong voice within the council. The prime function of the NMC is to protect the public, and to this end it maintains a register and sets standards and guidelines for professional behaviour and accountability for registrants.

The council has a statutory duty to inform and educate registrants and to keep the public fully informed. Before establishing any standards or guidance the Council must consult widely.[7]

The NMC will open a new register later this year when the current 15 parts will be replaced by three: nursing, midwifery, and specialist community public health nursing. The standards for nursing and midwifery will be transferred from the existing register. However, no standards currently exist for the third part and this is the area that has caused confusion and is also politically controversial.

The third part of the register, specialist community public health nursing, is for those practitioners who are already registered on the nursing or midwifery register and whose work *is substantially within the area of public health*. Health visitors registered on part II of the current register will automatically be placed on the third part. It is acknowledged, however, that other practitioners may have a substantial public health role and there is the facility for such individuals to gain access to the third part if they can satisfy the council that they meet the standards and competencies determined for this part. Early indications suggest that school nursing and occupational health nursing may achieve such competencies.

The third part of the register has been the subject of a long and controversial consultation by the NMC. The community nursing press has published numerous letters from irate health visitors insisting that their title be preserved. The other branches of community nursing that currently exist (district nursing, general practice nursing, community mental health nursing, community learning disability nursing and community children's nursing) have largely been ignored, although there is evidence to suggest that they all make a contribution to public health, albeit with differing emphases.[8] With the implementation of *Agenda for Change*, which aims to address the issue of equal pay for work of equal value, many community nurses believe that an additional registration will not only increase their professional status but also ensure that they achieve a higher band in the pay scale.[9]

The sad thing is that an exercise that set out to make the nursing profession more accountable and answerable to the public has degenerated into a battle for professional status and titles once more!

REFERENCES

1 Action for Elder Abuse. *Press Cuttings*, 2004. www.elderabuse.org.uk
2 Friedson E. *Profession of Medicine: a study of the sociology of applied knowledge*. New York: Dodd, Mead and Company, Inc., 1970.
3 Hart C. *Nurses and Politics: the impact of power and practice*. Basingstoke: Palgrave MacMillan, 2004.
4 UKCC. *Code of Professional Conduct*. London: UKCC, 1992.
5 Life bans take a lifetime. *Nursing Times* 1997;93(4): editorial.
6 JM Consulting. *Review of the Nursing, Midwifery and Health Visitors' Act*. Bristol: JM Consulting, 1997.
7 www.nmc-uk.org
8 Poulton B, Mason C, McKenna H *et al. The Contribution of Nurses, Midwives and Health Visitors to the Public Health Agenda*. Belfast: DHSSPS, 2000.
9 Royal College of Nursing. *What does Agenda for Change Mean for You?* London: Royal College of Nursing, 2004. www.rcn.org.uk/agendaforchange

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