Professional Misconduct in Healthcare: Setting Out a Research Agenda for Work Sociology

Abstract:

In the light of its surprising absence in extant literature in the domain of the sociology of work, specifically within the journal *Work, Employment and Society*, this article represents a 'call to arms' for research focused upon professional misconduct in healthcare. Specifically, interrogation of four dimensions of professional misconduct in healthcare is called for: a broader definition of professional misconduct; antecedents of professional misconduct that recognise the effect of context; professional response to regulation of misconduct; and the hierarchical and affective challenge to frontline professionals blowing the whistle on professional misconduct.

Keywords: Healthcare, Professional Misconduct, Regulation, Whistleblowing, Work Sociology

Introduction:

Our research note focuses upon professional misconduct, specifically in healthcare. Our research note follows a large scale funded research programme examining service failures in healthcare that led to 'serious untoward incidents (SUIs)' (Currie et al., 2014), some of which resulted in death of a patient. The organizational response to failure was two-fold: a frontline professional was 'held out to dry' for their 'mistake' or the fault was ascribed to the system, commonly work pressures and resource constraints, such as staff shortages. The focus of the commissioned research was upon how doctors and nurses in managerial positions brokered knowledge to improve services so future similar failure was reduced. While the final report met the commissioned intention, nevertheless its principal author increasingly reflected upon whether and when failure represented misconduct, and if that could be ascribed to individual professionals or to the organizational context that produced it. The research note presented here is a product of reflections about a research agenda to examine professional misconduct in healthcare from a work sociology perspective.

Research into professional misconduct links into more generic concerns in work sociology, specifically sociology of professions. First, there exists contestation around definitions of professionalism, and by implication professional misconduct, amongst those studying sociology of professions. Second, work sociologists have traditionally exhibited concern about external control of employees by managers, and ensuing conflict across managers and the workforce. Third, those researching sociology of professions examine professional hierarchy and its effects. The influence of differential power between lower status actors and their higher status colleagues upon whistleblowing about professional misconduct reflects the traditional concerns of sociology of professions. Finally, affective organizational experience of employees has always been part of sociological theory, with which the affective response of healthcare professionals to misconduct aligns. In short, while advocating a specific research agenda focused upon professional misconduct, our 'call to arms' is proximate to traditional research agendas of work sociology and sociology of professions.

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. In recent years, there has been a proliferation of studies on misconduct carried out by and within corporate organizations (Ackroyd and Thompson, 1999; Karlson, 2012). Professional misconduct, however, differs from organizational misconduct in two important ways. First, while organizational misconduct normally occurs within the boundaries of a single organization, professional misconduct tends to be more systemic, collective in nature, involving a number of professionals at the same time. Second, the question of the societal worth and intrinsic moral good of professions per se has been debated extensively in the literature for many years (Carr-Saunders & Wilson, 1933; Parsons, 1954). This is especially true for healthcare professionals, who are responsible for the

well-being of individuals and society at large and whose misconduct may result in irreversible damages and even fatalities. Revelations about professional misconduct go to the heart of such functionalist viewpoints. Yet, other perspectives upon professional organization, suggest contested dynamics across professions as they pursue self-interest (Abbott, 1988; Freidson, 1970), and conflict between managerial control and professional autonomy (Raelin, 1985), from which professional misconduct is derived. Such matters are worthy of greater attention from work sociologists.

Empirically, recent cases of professional misconduct in healthcare have engendered public demand for accountability and action. These resulted in high level national inquiries, such as those in England, For example, there have been high level inquiries focused on Beverley Allitt, killing patients in a children's ward (Department of Health, 1994); GP, Harold Shipman, killing older patients (Smith, 2003); deaths of children following paediatric heart surgery at Bristol Royal Infirmary (Kennedy, 2001); poor care for older people at Mid-Staffordshire Hospital (Francis, 2013), and inappropriate storing of children's organs at Liverpool Alder Hey Hospital (Redfern, 2001). Such reporting of professional misconduct in healthcare has also gained pace in other countries. In the USA for example, national attention focused upon the death of Betsy Lehman in Boston from an overdose prescribed by a clinician (Crane, 2001) and death of Josie King, a young girl who died under expert care at John Hopkins Children's Hospital despite her parents telling clinicians their concern about her deteriorating condition (Niedowski, 2003).

The paucity of research on professional misconduct in healthcare, coupled with an increase in public interest in such matters, makes it an important domain for research from a work sociology perspective. It is therefore surprising that Cooke (2006) apart, it has never been subject to specific analytical investigation in *Work Employment & Society*. There thus appears

a need to set out a research agenda that work sociologists might pursue, focused upon professional misconduct in healthcare. In this Research Note, we set out four dimensions of what might constitute such a research agenda, which follows a literature review that searched ABI/INFORM Global and Business Source Complete (EBSCO) journal databases. First, we used the search term "professional misconduct", following this with more specific additional search terms, such as "health(care)". At the same time, we made a judgement about orientation of literature to align with concerns of work sociology rather than that of social and organizational psychology, which represented the other dominant episteme concerned with professional misconduct. We identified four prominent research dimensions from close reading and thematic coding of each peer-reviewed journal article by two of the authors, with the other three authors validating themes.

Research Dimension 1: Definition of Professional (Mis)conduct

One definition of professional misconduct relates to definitions of professionalism and emphasises a sense of internalised moral responsibility that transcends professional self-interest and shows itself in a sentiment of care for the client and society at large (Carr-Saunders & Wilson, 1933; Parsons, 1954). From this viewpoint, professions have a normative value that comes from the role they exercise for the benefit of society. As such, their members are duty-bound and constrained by occupational loyalty from engaging in unethical or illegal acts. Following this definition, professional misconduct encompasses actions that deviate from benefit for the client and society at large. Below we ground our understanding of a wider sense of professional misconduct in two serious untoward incidents observed in our large scale healthcare research programme that prompted our reflections upon professional misconduct:

Example 1: A frail older patient arrived at the hospital's emergency department. He was placed in the acute medical unit after some delay following his admission, because there were no beds available. He arrived with medical supplies, one prescription for which required injection through specialist kit. Attempts were made to contact the patient's GP beforehand about his injection, but because it was the weekend the GP was unavailable. Such unavailability was accepted by nurses as prevalent and "they worked around" it. A nurse then administered the injection and did not use the kit in the way it was intended. This resulted in the patient's death 4 hours later. In the formal inquiry, cause of death was attributed to the injection not being performed in the correct manner. Here we see a case where the failure could be ascribed, on the one hand, to the individual nurse and characterised as professional misconduct (e.g. not following the protocol for the injection). On the other hand, the death may be viewed as failure of the system (e.g. delayed admission, lack of coordination across hospital and primary care).

Example 2: A frail older patient arrived at the same hospital's emergency department and was admitted to a ward under the care of the urology team. The patient's blood result was phoned to the ward from the laboratory, a standard practice when results are abnormal, in this case an elevated potassium level. These results were received by a newly qualified nurse who was unaware they were abnormal, but followed standard practice to notify the patient's attending urologist anyway. The pathology department, when later questioned, were confident that "they had met their responsibilities". The nurse interrupted the urology doctor responsible for the patient's care to show him the patient's blood results, but the doctor asked the nurse not to disturb him as he was educating junior doctors. The nurse was newly qualified and admitted she was "cowed by doctor's power, and felt unable to challenge him". The patient was discharged later that day with an elevated potassium level. The following day, the patient arrived by ambulance at the same emergency department, this time in cardiac arrest, staff were

unable to resuscitate him, and he died. The nurse involved found the incident to be "soul destroying" and left the organization less than a year later.

Drawing upon the two examples above, a research agenda on professional misconduct in healthcare should recognise misconduct itself is a heterogeneous phenomenon, and its causes are multiple. Misconduct can be viewed as a continuum of instances that range from actions that are illegal (prohibited by criminal and civil laws) to actions that are unethical (contrary to societal norms and expectations) or unprofessional (against professional codes of conduct and protocols). This opens up the possibility of theorising the different factors at play in a range of examples of misconduct. In a healthcare context, cases such as those of Beverly Allitt or Harold Shipman, who deliberately killed some of their patients (Department of Health, 1994; Smith, 2003), would fall into the first category of professional misconduct. In contrast, the prescription of 'branded' rather than 'generic' medicines in exchange for financial rewards by pharmaceutical companies (Singh & Jayanti, 2013) while not violating the law, runs counter to the expectation that doctors should act in their patients' rather than in their own best interest. In a similar vein, professionals may operate within legal boundaries, but violate professional codes of conduct. Examples of this type of behaviours in a healthcare setting are poor care for patients, of the kind practiced at Mid-Staffordshire Hospital where some patients were left unwashed for up to a month, or pain relief was delivered late (Francis, 2013).

These diverse instances of professional misconduct deserve better analytical investigation by work sociologists as part of efforts to more effectively define professional misconduct in healthcare.

Research Dimension 2: Antecedents of Professional Misconduct

Antecedents to professional misconduct commonly derive from the production of 'bad apples' or 'bad barrels'. From a bad apple perspective, misconduct results from behaviour of rogue individuals acting against professional standards and norms (Dixon-Woods, Yeung & Bosk, 2011; Kish-Gephart, Harrison & Treviño, 2010). In a healthcare setting the obvious example of a bad apple is Harold Shipman, who administered lethal doses of morphine to older patients, signed their death certificates and simultaneously falsified their medical records to suggest they had been in poor health prior to their death.

Focusing on the individual, studies about antecedents of professional misconduct have investigated the relationship between professional misconduct and individual characteristics in specific settings, particularly accountancy. Individual antecedents identified for accountants that appear relevant to healthcare settings include moral reasoning that underpins locus of control (Douglas et al., 2001; Lord & DeZoort, 2001; Sweeney & Roberts, 1997; Tsui & Gul, 1996), and professional socialisation (Abdolmohammadi et al. 2003; Ponemon, 1992). Both antecedents may be derived from wider influences of the employing organization or professional group. In healthcare specifically, studies overwhelmingly emphasise underpinning organizational, rather than individual level, factors for professional misconduct (Ovretveit, 2009; Vincent, 2012). This focus is driven by the widespread adoption of investigative methods in healthcare, which aim to identify latent system factors rather than target individuals (Reason, 1993, 2000). In essence, it is hard to delineate individual level antecedents from those derived from the wider contextual influences that shape professional misconduct. This invokes the 'bad barrel' perspective, which provides a very different understanding of professional misconduct.

According to the ‘bad barrel’ perspective, professional misconduct occurs because of the context in which professionals operate. In particular, cultures, incentive systems, managerial practices and flawed organizational design have a dysfunctional effect. Again examination of professional misconduct in accountancy raises interesting issues. The prestige, wealth and size of professional organizations may shelter individual practitioners from broader professional norms and values. Professional organizations may refocus the attention of individual practitioners away from occupational priorities, such as public service and social trusteeship, towards organizational goals that may result in professional misconduct (Cooper & Robson 2006; Grey, 1998).

In assessing the ‘bad barrel’ perspective within healthcare, studies have highlighted how work pressures produced by organizational systems of resource allocation and performance management result in healthcare professionals ‘patching’ care, rather than addressing more fundamental problems of care delivery (Apesoa-Varano & Varano, 2014). Our first empirical case of the older person’s death in the hospital’s acute medical unit illustrates how frontline professionals did not address the larger problem of coordinating care across health sector boundaries and this led to failure that might be construed as professional misconduct.

Moving away from functionalist perspectives upon professionalism, sociology of professions literature highlights jurisdictional contestation amongst professionals as a ‘peculiar type of occupational control’ (Johnson, 1972: 45). This empowers producers vis-à-vis consumers by entrusting professionals with ‘occupational dominance’ over the performance of their own work, including its means, ends and the terms and conditions under which it is performed (Freidson 1970). This dominance enables professionals to translate “a scarce set of cultural and technical resources into a secure and institutionalised system of social and financial rewards”

(Larson 1977: xvii). From this perspective, professional organization is structured to prioritise professional interests over the public good, with professionals able to exploit their status to obtain personal benefit. Our second empirical case illustrates the ascendancy of doctors in this respect. Shaped by the professional hierarchy, nurses face considerable challenge in shaping doctors' priorities towards a greater patient orientation. In short, professional misconduct might be characterised as pursuit of self-interest by higher status actors.

As evident in the two earlier empirical examples, 'bad apple' and 'bad barrel' perspectives are interlinked and account for a very significant range of cases of professional misconduct. However, they overlook how misconduct may arise from the functioning of a broader ecological system. This is particularly important in today's increasingly globalised, multi-disciplinary and interconnected world, where professional work is enacted within complex networks of expertise (Seabrooke, 2014). To account for this, a third 'bad cellar' perspective has been advanced, whereby wrongdoing emerges from the relationship between different barrels (groups of professionals) in broader professional ecologies (Abbott, 1988; 2005). Three sets of boundaries are particularly important here: 'jurisdictional' (boundaries between different occupational domains); 'geo-political' (between different national realms); and 'ecological' (between stakeholders such as practitioners, clients and employers) (Muzio et al., 2016).

The 'bad cellar' perspective was originally developed in relation to corporate oriented professions of law and accounting. It is clearly relevant to understanding professional misconduct in healthcare, with institutionalised jurisdictional boundaries. Medical work is based upon the coordination of different occupational groups (nurses, technicians, occupations allied to health) in multi-disciplinary teams. Yet differences in epistemological orientations,

organizational status and political interest (Bucher & Strauss, 1961; Oborn & Dawson, 2010) mean collaborations do not always work and may propagate misconduct. In our second empirical case, segmentation of the clinical workforce around discrete medical and nursing jurisdictions poses a challenge for coordination of care.

In summary, work sociologists should examine the broader context within which professional misconduct is derived, not just with a focus upon managerial organization, but encompassing professional organization and the broader system ecology.

Research Dimension 3: Regulation of professional misconduct and professional response

High level inquiries lead to erosion of self-regulating systems of professional governance in healthcare, and signal a shift to implement policies and procedures, which enforce, control, and monitor standards relating to the performance of healthcare professionals. The end result has been a shift in power and control to the state, through their agents, organizational managers, over medical, and other professionals. As a third element of a research agenda around professional misconduct in healthcare, work sociologists should investigate pluralist professional responses to external regulation (Levay & Waks, 2009). Pluralist responses encompass overt resistance (Power, 1997; Raelin, 1985); 'reverse' colonisation where healthcare professionals attempt to retain their autonomy by monitoring their own activities (Authors, 2009; Levay & Waks, 2009); decoupling of professional practice from regulation so the former remained unaffected (McGivern & Ferlie, 2007; Nicolini et al., 2011). Each response reveals a particular strategy by which occupational professionals at the local level, seek to work with and adapt to management change, based upon their prevailing expectations around clinical autonomy and underlying apprehension about management. On the one hand, policymakers and organizational managers 'rightly' seek to draw in external models and

principles that have proved effective elsewhere, such as from high reliability industries. On the other hand, strong social and cultural boundaries around clinical professions mean interpretation, and implementation of more generic interventions best remain controlled within professional practice (Waring & Currie, 2009). The latent conflict between managers and professionals revealed in attempts at external regulation over the conduct of clinicians represents a core dimension of work sociologists' research around professions, which might be orientated towards analysis of professional misconduct and responses to this.

Extending the research agenda around professional response to regulation, work sociologists should examine enhancement of responsibility, and assess whether a regulatory response, which 'merely' ascribes accountability for professional misconduct, is adequate (Bovens, 1998). The national level inquiry into unnecessary deaths of children following heart surgery at Bristol Royal Infirmary (Kennedy, 2001) highlights professional and managerial defensiveness around admitting organizational failure (Weick & Sutcliffe, 2003). In a more recent example, while managers and professionals had satisfied external regulators about performance around quality of care, again failure was evident, reflected in neglect of frail older patients in Mid-Staffordshire Hospital (Francis, 2013). In both examples, professionals and managers were held accountable for organizational failure, but this was retrospective, with poor care delivered in real time. We might ask, 'how did this happen, when performance is rendered visible by a panoply of regulatory surveillance?' It seems that everyone held accountable for their professional conduct claimed to have 'done their bit' within their jurisdiction, therefore professional misconduct was not evident. However, a functionalist definition of professional conduct as one within which a proactive responsibility is exhibited, characterised by a sentiment of care (Carr-Saunders & Wilson, 1933; Parsons, 1951), suggests professional misconduct is evident in the cases of organizational failure at both Bristol Royal

Infirmary and Mid-Staffordshire Hospital. Again, we encourage a research agenda that widens consideration of professional misconduct related to organizational failure in healthcare in line with investigation of a broader definition of professional misconduct we set out as the first dimension of our research agenda.

Research Dimension 4: Responding to professional misconduct through whistleblowing

Professional misconduct may emanate from professional organization itself. The hierarchy of professional organization mean some professionals are silenced in their reporting of professional misconduct. This was particularly evident in our second empirical example presented in our introduction, where the nurse was silenced by a doctor. The inquiry into child deaths following paediatric heart surgery at Bristol Royal Infirmary (Weick & Sutcliffe, 2003) highlighted the 'hierarchical challenge', within which inter-professional barriers inhibit nurses from speaking up and alerting doctors to potential process errors (Senot, Chandrasekaran & Ward, 2016). Such an effect is exacerbated because lower status actors, such as nurses or junior doctors, generally perceive raising concerns as a high-risk, low-reward scenario (Attree, 2007).

Linked to the hierarchical challenge is the role of employee voice, a broader term encompassing all forms of employee speaking-up behaviour including whistleblowing. Employee voice describes pro-social constructive employee behaviour intended to help the organization or work unit perform more effectively, or to make a positive difference for the collective (Morrison, 2011). Within the construct of voice, whistleblowing has a narrower target and motive. It describes speaking-up about perceived organizational wrongdoing behaviour to external authorities, who can take action, and is driven by a motive to stop negative, often extreme activity (Near & Miceli, 1985). In the realm of healthcare professionals, common examples of voice include speaking-up about traditional patient safety threats, like inadequate

hand hygiene, and unprofessional behaviour, such as a lack of commitment to ethical principles, integrity or accountability towards patients or colleagues. The latter is less likely to be reported than traditional patient safety threats, mainly because of a fear of conflict with, or eliciting anger from colleagues, particularly those of higher status (Currie, Burgess & Hayton, 2015). Healthcare professionals remain hesitant to voice their concerns, and are either ignored, or do not speak up at all (Cosby & Croskerry, 2004; Pronovost, 2010), because they are afraid, want to avoid conveying unwelcome ideas, and by normative and social pressures that exist in their group (Okuyama, Wagner & Bijnen, 2014). Thus we encourage sociologists of work to explore the antecedents influencing decisions of healthcare professionals about whether to speak-up in situations of professional misconduct.

Work sociologists should consider the effects of the wider organizational context weighing upon a professional's decision to speak-up. A more generic literature highlights supervisors and team leaders can create opportunities for voice through informal and formal mechanisms that influence employees' thought process when deciding whether or not to speak up (Ashford et al., 2009). Supervisors are frequently the target of voice and often have power over the outcomes (Morrison, 2011). In healthcare specifically, surgeons who led cardiac surgery teams were found to have encouraged voice among team members (nurses and other doctors) by downplaying power differences and engaging in coaching behaviour (Edmondson, 2003).

Anger and guilt might predict whistleblowing, while fear and shame influence decisions to remain silent (Detert & Edmondson, 2011; Kish-Gephart et al., 2009). Such effects have been noted as significant in healthcare settings. Empirical research is encouraged to examine how affective experience may not only close down whistleblowing, but how it can have a positively valenced effect upon voice and whistleblowing (Sirriyeh et al., 2010). Affective reaction is

positively correlated with severity of error (Sirriyeh et al., 2010). Thus, we expect professionals involved in serious misconduct, the 'second victims' (Wu, 2000), to exert some influence over the conditions for voice and silence. However, not all 'second victims' 'survive' or 'thrive', some might 'drop out', exiting the organization, such as the nurse in our second empirical example, thus their voice may go unheard (Behtoui et al., 2017; Scott, et al., 2009).

In light of this final dimension of discussion, the research agenda should be widened to encompass developing a greater understanding of the antecedents and consequences of speaking-up. This includes affective experiences of healthcare professionals, and the impact for this upon professional misconduct and whistleblowing.

Conclusion: Moving Forward

Interrogation of professional misconduct is not alien to a sociology of work. Much of the theoretical resource that might underpin this is avowedly sociological, for example, literature about sociology of the professions. Building upon well-established literatures such as sociology of professions, work sociologists might encompass other literatures, such as organization studies, in response to our 'call to arms' for researching professional misconduct.

In setting out a research agenda, we identify specific interlinked strands of potential research around professional misconduct of interest and novelty to work sociologists that the empirical case of healthcare illuminates. First, the definition of professional misconduct should be broadened to recognise it is a heterogeneous phenomenon. Specifically, research might examine further whether professional misconduct derives from pursuit of self-interest at the collective level of the profession, and hence critique functionalist assumptions about the intrinsic good and societal worth of professions. Taking a multiple stakeholder perspective,

from regulators, managers, professionals and clients, our proposed research agenda will identify potential sites of conflict and contestation that derive from divergent perspectives upon 'professional misconduct'. Second, linked to this, external regulation and the related role of managers in controlling for professional misconduct appear ascendant. Work sociologists should be concerned about diminution of valuable modes of professional self-regulation that prevent misconduct. Our proposed research agenda will identify consequences of tighter external regulation around professional misconduct, specifically the professional response to managerial modes of regulation. Third, work sociologists should throw critical light upon professional organization itself, with respect to potential misconduct in pursuit of collective self-interest. In particular, work sociologists should examine the effect of differential power across professional groups, which prevent lower status professionals from speaking up about professional misconduct, and consider how this might be circumvented. Finally, our proposed research agenda will elucidate the affective experience and response of healthcare professionals to misconduct.

Our research note has focused upon the case of misconduct amongst healthcare professionals. We have made a case for particular attention to the phenomenon in healthcare. Given the distinctiveness of the healthcare setting we encourage others to reflect upon a research agenda for professional misconduct in other settings. Such a research agenda has methodological implications. Examination of the four research dimensions requires the type of in-depth study gleaned from ethnographic methods and longitudinal studies to understand antecedents and consequences of professional misconduct.

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