

**'The Lighthouse Invites the Storm' – Professional Regulation of Nursing in
England and Wales – Under Threat**

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Abstract

This paper explores current issues related to the professional regulation of nursing in England and Wales and considers whether self-regulation is currently under threat.

In modern times there have been a significant number of serious incidents and scandals in health and social care and these have attracted adverse publicity in the media and exercised the mind of Government in the direction of public protection.

Mental health practice has not escaped the critical gaze and recent homicide inquiries continue to cast a long shadow over the provision of mental health services. Recently, the Government has questioned the effectiveness of the nurses' professional body, the Nursing and Midwifery Council, and has spelt out the pressing need for tighter regulation of nursing practice. Recent policy documents aimed at 'modernising' nursing careers may actually circumscribe professional autonomy and subtly control the development of nursing practice and nurse education.

On 1st April 2009 a new regulatory body, the Care Quality Commission will come into being and its advent will herald significant changes for health and social care. Lost in the changes will be the Mental Health Act Commission, as a stand alone visiting body.

Key Words: Professional regulation, accountability, mental health policy, mental health practice, nursing roles.

Introduction

Increasingly nursing is recognised as a profession in its own right (Harrison and MacDonald, 2008 and Morrall 2009) but for the last 10 years the nursing profession in the UK has been engaged in a long war of attrition with Government and currently they seem to be losing (Karstadt 2008).

In their practice New Labour, first under Prime Minister Tony Blair and now under the leadership of Gordon Brown, have more or less consistently denied the existence of anything fundamentally good about self-regulation in the context of the nursing profession.

Arguably, we are now seeing, effectively, the de-skilling of the profession, and the power of the NMC is fast ebbing away. Certainly nursing is under attack and some think Government has it wrong (Fullbrook 2008) whilst others think that change is long overdue (JM Consulting 1998). But why should the public care?

Perhaps, they should be celebrating, as far more people are now able to make autonomous informed decisions regarding their healthcare (McHale and Tingle 2007). In the early part of the 21st century patient autonomy is increasingly

respected and may be realistically viewed as the single guiding principle of healthcare law and ethics. Not only is autonomy central to contemporary health and social care practice, it also accurately reflects the spirit of the modern age.

Certainly, in the context of mental health care in the last decade we have seen the rise and rise of the user movement and there is now a very clear expectation that everyone accessing mental health services will be given at least some choices and will be actively encouraged to involve themselves in the care/treatment process.

This positive trend has been further emphasised by the publication of The Darzi Report and The NHS Constitution (Department of Health 2008/2009).

Darzi has been described as a 'crucial enabling document' (Appleby 2008) that will likely shape the future of the NHS and the UK Government strategy for mental health in the next several years. Its primary focus is very much upon treatment choice and expressing that choice in regard to care delivery, care planning and performance. Published at the same time as the Darzi report was the draft NHS Constitution, which includes a new right to choice expressed as 'the right to choose a provider of healthcare'. The new Constitution, implemented in January 2009, reaffirms NHS principles and values, and gives power to all patients and the public. It also explains the responsibilities of patients, staff and the general public.

Although there are few specific references to mental health in either of these documents their central themes may well impact significantly on the development of mental health practice in the next few years. The following priorities for mental health services can be identified.

Firstly, Darzi identifies a pressing need to measure quality more effectively. Practitioners are urged to engage in an 'enhanced' dialogue with service users and carers, in order to further understand their perspective, their needs and their expectations. Practitioners must go beyond tokenistic user-carer 'involvement' and do more to tackle negative attitudes and discrimination. Throughout the report there is a strong emphasis upon treatment choice and expressing that choice, notably in regard to delivery, care planning and performance.

Secondly, there is a call for inclusive, 'wrap-around' services and it is proposed that in future there needs to be an increased emphasis upon local leadership rather than central Government departments. How allocated money is used locally is critical and service providers must be efficient, cost-effective and offer value for money. It is proposed that in future NHS practitioners will work more closely with partner organisations in the voluntary sector, the independent sector and in social care.

Thirdly, the report focuses squarely upon health inequality, the prevention of illness and the problem of under-prevention. Darzi identifies six priority services and these include mental health and alcohol and drug dependence. 'Upstream' interventions should be central to mental health service provision and providers must prize innovation and improve access to evidence-based psychological therapies. Public health generally (and mental health in the workplace specifically) are identified as key areas for change.

Overall, the report marks a noticeable shift of focus away from mental ill health, and towards mental well-being but in all likelihood the new guidelines will have to be implemented within existing budgets and resources. Appleby (2008) warns that

there will be no big increases in money (due to the 'credit crunch' and economic recession) in the short term. The clear message from Government is that there already have been large increases in investment in mental health, notably two million pounds extra per year since 1999 for the implementation of the National Service Framework for Mental Health (Department of Health 1999).

Yet without any additional funds it is very difficult to see how the 21st century vision of Darzi and the citizenship agenda can be implemented in full. Perhaps it is the intention of Government to save money in other areas, notably by re-configuring and streamlining the regulation of health and social care.

A New Framework for Regulation

As of 1 April 2009, regulation of health and adult social care in England will no longer be carried out by the Healthcare Commission and the Commission for Social Care Inspection. Similarly, operational monitoring of the Mental Health Act 1983 (as amended by the MHA 2007) will no longer be carried out by the Mental Health Act Commission (MHAC). The Health and Social Care Act 2008 has established a single, integrated regulator for health and adult social care, the Care Quality Commission (CQC), to replace these three bodies. The so called 'super regulator', will begin operating on 1 April 2009 as a non-departmental public body.

The Act sets out the new Commission's functions in assuring safety and quality, performance assessment of commissioners and providers, monitoring the operation of the Mental Health Act and ensuring that regulation and inspection activity across health and adult social care is co-ordinated and managed.

It is envisaged by Government that the new system 'will enable joined-up regulation' of health and social care, and help to ensure 'better outcomes for the people who use services'. However, reducing cost is also a significant driver for change and dissatisfaction with the existing system of professional regulation (Department of Health 2007).

Although there are already many positive examples of integrated health and social care delivery there have also been significant problems in relation to partnership working such as frequent breakdowns in inter-agency communication and widespread duplication of roles. The Government hopes that the creation of a single regulatory system will help to resolve some of these issues.

In theory at least the CQC will have wide-ranging powers and as a last resort will be able to shut down inadequate service providers, although it is hard to see how such 'toothy' powers might be wielded in practice without great inconvenience to consumers.

Registration of Service Providers

Under the new regulatory system health and social care providers, including, for the first time, NHS providers, will be required to register with the new regulator in order to provide services. The registration requirements that all providers must meet 'will be consistent across both health and adult social care' (Department of Health 2007) and was put out for consultation in July 2008.

All health and adult social care providers that come within the future scope of registration will be required to register with the Care Quality Commission. In order to be granted registration, care providers will need to demonstrate that they can

meet, or are already meeting, the registration requirements. To maintain their registration they will need to demonstrate an 'ongoing ability' to meet the requirements (The Health and Social Care Act 2008).

Although a registration system for social care and independent health providers already exists under the Care Standards Act 2000, there is no such system for the NHS. The new registration system will incorporate providers 'from all sectors' into a single system. For NHS trusts, the registration criteria will thus replace 'Standards for Better Health' (Department of Health 2007).

In developing the new registration system and its requirements both the Government and the Care Quality Commission will build on the experience of the current commissions and service providers in operating under the existing system and against the current standards.

It has been announced that the new registration system will come into force in April 2010, with the exception of regulation of 'healthcare associated' infections, which will come into force some time in 2009/2010.

Drivers for Change

The Government proposes that by 'focusing regulation on the levels of safety and quality' (Department of Health 2006), that those who use services care most about will help ensure that patients, users and vulnerable groups are protected. In other words, the Government is concerned with 'what is done' and 'how it is done' rather than 'who does it' and this should perhaps sound loud alarm-bells for all healthcare professionals who value their independence and professional integrity.

Furthermore, the Government proposes that for staff working in provider organisations, the new regulatory system will deliver an enhanced, 'clearer' system of exactly which requirements they must meet in order to provide services. Yet this pre-supposes that the current system is unclear (is it?) and that a new regulatory framework will necessarily improve the situation (will it?).

Certainly, to a greater or lesser extent the changes will allow Government increased opportunity to control key professional groups in health and social care. Some professionals will inevitably view the changes as undermining their authority to police themselves.

Also, whilst it is claimed that a 'risk-based approach' will mean that 'regulation activity is targeted where action is required' (Department of Health 2006) in mental health such a reductionist approach might lead to risk management being preferred over therapeutic risk-taking, possibly to the detriment of service users and their families.

The Government also suggests that bringing the functions of the Mental Health Act Commission into the remit of the Care Quality Commission 'will serve to strengthen the monitoring of the Mental Health Act', and offer 'increased oversight of the treatment of patients subject to compulsory detention' (Department of Health 2007). However, serious concerns have already been raised in relation to 'diluted regulation' and 'over-stretched' resources (Joint Committee 2005), which might potentially result in reduced visiting and less scrutiny than that previously provided by the Mental Health Act Commission (MHAC).

It must be remembered that despite a weak remit and a lack of resources, the MHAC has been demonstrably successful and has improved professional and institutional practice in the implementation of the Act and the care and treatment of detained patients. To date, CQC executives have been reluctant to provide details of how compulsory powers will be monitored in future and they have not given any specific assurances re the number of monitoring visits or who will facilitate these (Young 2008).

Finally, although the CQC is technically accountable to Parliament rather than Government, it will be interesting to see exactly how arm's-length it is in practice and whether or not the new regulator can distance itself from the Government's political agenda, which has traditionally prioritized risk over rights. It would certainly be concerning if the CQC focused upon risk management at the expense of protecting the legal, ethical and human rights of vulnerable groups.

The Public Interest

Nursing is one of the professions whose organisation has changed substantially in recent years and the change has generated bitter dispute over the safety of patients (Godin 2007). For example, in regard to recruiting qualified nursing staff, there have been reported cases where professional referees have been asked to give a clinical job reference but themselves have not been active in the nursing practice for many years (Department of Health 2005). Arguably, from a patient safety point of view, the general public would probably feel much more comfortable and reassured if they knew that all professional referees and clinical sponsors are themselves active practitioners and understand current problems in regard to the provision of health and social care.

Historically, all of the major professions, law, medicine, accountancy (and the rest) have enjoyed enormous independence. This has been partly based upon their specialist knowledge but also on a higher claim to moral status, based upon ethical behaviour. Traditionally, in order to be seen as professional, you had to be seen as being 'above the market place' (Friedson 1994).

However, it is also true that professional status can sometimes be extremely lucrative (even in health and social care) and our generation is not the first to criticise professionals (Jaques 1978). Nevertheless, most of the time, 'professional' remains a term of high praise. So why is the UK Government taking action now, not only to control entry to the healthcare professions, but also in relation to major changes in professional freedom to self-regulate and run their own disciplinary procedures?

Scandal and Concern

In their recent book *The Politics of Healthcare in Britain* (2008) Stephen Harrison and Ruth McDonald consider a number of critical perspectives in relation to health professionalism and self-regulation and propose a bargain theory of the professions where they enjoy autonomy in exchange for upholding strict ethical standards. Unfortunately though, there have been a number of scandals, which have hit the media headlines in recent years, and so exercised that mind of Government.

We have seen Bristol, Alderhey, the Shipman murders, and a number of homicide inquiries in the field of mental health (Maden 2007). Consequently, in some

quarters there is a strong belief that the health professions have failed to uphold their side of the bargain (Brazier and Cave 2007).

Recently (in March 2008) there was the horrific case of Colin Norris, a qualified (adult) nurse practising in Leeds who was found guilty of murdering four frail elderly patients in their hospital beds. Driven by a hatred of pensioners, the 32-year-old staff nurse injected his female victims with insulin. Police suspected that Norris had killed at least six more pensioners. All of the victims were in hospital for hip operations and Norris described them as a 'burden' to everyone who was working on the wards (Metro News Report 2008).

Such crimes are demonstrably abhorrent but are they directly linked to the current regulatory regime for healthcare professionals?

This is a very difficult question to answer. One point of view is that such scandals do not simply represent terrible mistakes or individual acts of malice and dishonesty, but also 'systemic' failures. And those failures are invariably rooted in a lack of independence, ineffective clinical supervision and also a culture that too often puts professional self-interest before public interest (Godin 2007).

Yet, this cannot be the whole story. As stated previously there have been some big medical scandals, Dr Harold Shipman murdering his patients, and Bristol's failure to respond to abnormally high death rates in patients receiving heart surgery. Certainly, there has been nothing as high profile involving the other professions (architects, lawyers, accountants etc). But despite this the public hasn't actually taken against the healthcare professionals. Time and time again in public surveys doctors, nurses and other clinicians are consistently rated as the most trusted groups, with politicians and journalists well down the popularity league tables (O'Neil 2002).

In the UK, Suzanne Fullbrook, Senior Lecturer in Nursing Law and Politics, has written widely about professional regulation and the political aspects of the duty of care for healthcare professionals. She proposes a very different explanation for what is happening, namely the ambitions of a modern, centralising state. This can be traced back to the middle of the 1980s with Mrs Thatcher's assault on independent institutions of many kinds, of which the professions were only one. That involved a process of deliberately neutering alternative sources of influence to the Government because the 'iron lady' instinctively felt that existing institutions were viscerally opposed to what she was trying to do (Fullbrook 2008).

However, the covert policy of professional 'emasculatation' has arguably been greatly accelerated under New Labour since 1997. One of the things that is quite extraordinary is the number of additional powers lodged in the Secretary of State by legislation (Department of Health 2007) and because the Government does not want to lose control, or be seen to lose control, as soon as they start to introduce reforms in health and social care, they seek to limit and control the reforms.

Consequently, it is now very difficult to view healthcare professionals as 'street level bureaucrats' because any discretion they have is largely illusory. Although Michael Lipsky's theory (1980) might still hold some currency in relation to certain groups, in certain contexts (Wells 2007) greater emphasis on top-down management, target setting and care pathways has 'liberated' healthcare professionals from many street level dilemmas.

Arguably, one reason that Government is so antagonistic towards healthcare professionals is a perception - often originating and fuelled in the tabloid press - that some practitioners think they '*know it all*' and arrogantly believe that their clinical decisions are always right and should never be challenged. Recently we have seen savage media criticism levelled at social care professionals in relation to the 'Baby P' case and the failings of Haringey Social Services Department (Metro 2008)

The Government has been so vocal about its desire to protect that public that sometimes it is as though senior ministers believe that only the Government can genuinely speak for the public.

Yet it is very true that the healthcare professions ignore the public at their peril and Baroness Young (chair of the Care Quality Commission) recently stated that the new regulator will primarily 'serve patients and carers' and that patients and carers will only trust practitioners who are 'open, transparent, reliable and evidence-based' (CQC 2008 - draft Manifesto).

Unfortunately this has not been the case in the past, and some practitioners have created a situation which is intolerable from the point of view of most users and carers. In the public domain there are numerous examples of patients or relatives lodging a formal complaint against a Trust or Health Authority but the grievance was never dealt with, or was not dealt with effectively within a reasonable timescale (MHAC 2003 – Tenth Biennial Report).

This tarnishes the health and social care professions as a whole and the nursing profession specifically has paid a tough price for not paying attention to the needs and complaints of consumers (Department of Health 2007). Presently, nurses face the prospect of not being free to decide on their own career progression and must suffer the ignominy of Government compelling them to undertake training and education in certain prescribed areas (Fullbrook 2008).

Other professions have been subject to Government criticism and had their professional accountability called into question, yet few have been so thoroughly named, shamed and controlled as nursing. Significantly other professions are not being 'modernised' by proxy.

Changing Attitudes to Self-Regulation

It is proposed that the new Nursing and Midwifery Council will be made up of 14 appointed members, with only half of this number being made up of registrants. Essentially this means that there will be only seven spaces for nurses and midwives. With no representative members and no reserved places for any interest group the primary function of the appointed members is unambiguous – 'it is to manage fitness for practice' (Karstadt 2008).

In days gone by, there was deference to authority and 'the laity knew their place, invariably deferring to kings, priests and professionals' (Dowie and Elstein 1988, Friedson 1994). However, today's mood is much more sceptical about experts' claims to authority (Godin 2007) and supporters of strict Government regulation would like to see regulatory and complaint-hearing bodies hold a majority of lay people (i.e. individuals who do not have specific professional expertise).

Superficially at least there appears to be a strong argument in favour of this, as a means of ensuring independent scrutiny. However, some practitioners might

question how you can have a lay majority on decision-making bodies and still arrive at an appropriate decision. Complex technical cases might be far too specialised for lay people to understand, let alone appropriate for them to rule on fairly.

Yet perhaps it is possible to over-claim on this point. One clinical view (Freedon 1999) proposes that review structures can have 'specialism built within them', but that does not mean to say that specialists must always have decision-making power and the final say. Ultimately, decisions about regulation are made in the public interest and not in professional self-interest.

Even some NHS managers are very sceptical about self-regulation in nursing and one radical view is that all disciplinary committees should be composed entirely of lay members but take advice from appropriate professionals. Technically, in theory, there is no reason why there could not be professional witnesses in very much the same way that there are in the courts (Godin 2007).

In reality the choice of model is rather less important than health professionals generally acknowledging the 'role' of the taxpayer and their 'ownership' of the NHS. Invariably the person in the street will have an opinion about who is to blame when something goes wrong. These days, it must be questioned whether the public are prepared to put up with healthcare professionals basically looking after themselves, i.e. other professionals - after all this is essentially an 18th century idea and hopefully we have moved on from that.

But the idea that simply because you are part of a profession, then you will have an interest in getting your colleagues off the 'disciplinary' hook is also fallacious. In actual fact the opposite is invariably true and it is difficult to find empirical evidence to support the claim that self-regulation does not work in practice.

However the current frame of mind of Government goes a long way beyond this and appears to be based on an assumption that the professions are incapable of being trusted to regulate their own affairs and, in particular, their own disciplinary affairs (Fullbrook 2008). Yet it is hard to find any historical experience that justifies such a paternalistic view. Quite the contrary in fact, the professions generally, and specifically the healthcare professions, have a proven track record of being particularly savage to their own straying members. Historically, they have actually done this job well, whereas Government has tended to do it rather badly (Freedon 1988). Also there are other significant checks and balances inherent within the healthcare system, namely the legal framework for practice and, to some extent at least, professional self-interest.

Currently, every regulatory and disciplinary scheme operates within an environment steeped in law and legal regulation and is subject at every stage to a variety of legal challenges, so much so that it is actually very difficult now for Trusts and Health Authorities to operate without the assistance of lawyers (Herring 2008). Although law generally does not tell us how to practice - that is the job of ethics - in many cases it does tell us what we cannot do and provides a welcome degree of clarity about what is 'not' permitted in various clinical situations.

Also, given the huge costs associated with modern healthcare, and the lucrative nature of private healthcare practice, some healthcare professionals have a strong interest in maintaining public confidence. Interestingly, Freedon (1988) points out that economists, 'have a particularly well-developed nose for self-interest', yet they

focus their criticisms not on disciplinary issues but on the ability of professional cartels to drive up prices.

The Economic Perspective

Economic self-interest has been central to the development of all professional groups and professions have been described as 'monopolies which claim to be something they are not' (Berlant 1975).

Consequently, some argue that they need to be seen for what they really are (Harrison and McDonald 2008). Whilst, qualifications can sometimes be a useful indication of clinical skill and expertise it should not automatically follow that only the people with 'the right qualifications' should be allowed, or licensed by Government, to offer a particular service. Yes, practitioners must have specialist knowledge but professions are also trade unions, in a sense. Consequently they are essentially there to advance the interests of their members and there is no harm in that so long as the public does not take them at face value.

Although the process for obtaining state licensure is protracted and mired in politics (licensing nurses and midwives, dentists and opticians all took rather a long time) some believe that we already have far too many licences to practise in this country (Donnison 1988).

The opposite view is to suggest that actually we ought to have more licences because it is a way of protecting the consumer and ordinary members of the public, but whilst there is at least some virtue in that argument, perhaps a more robust view is that if people are to be regarded as fully adult and autonomous then they should know that if somebody practises in healthcare and does not have some letters after their name, they approach that practitioner at their own risk. They might get better treatment, they might get worse – 'caveat emptor' - let the buyer beware.

Moreover, there has been a quite deliberate, self-conscious effort to shake up the world of the professions, not least the healthcare professions. The Labour Government (Blairite and Brownite) have purposefully set out to generate what they refer to as 'constructive discomfort' (Freedon 1999) and we are currently witnessing the general erosion of the professions within the health service. Much of what doctors used to do is now done by nurses. Much of what nurses used to do is now done by healthcare assistants. We are effectively seeing the deskilling of the healthcare professions, and their power is fast ebbing away. Arguably the tipping point came with the introduction of role substitution.

The Skills Escalator

Originally, the Department of Health conceived the notion of a skills escalator as part of The NHS Plan (Department of Health 2000) and Agenda for Change (Department of Health 2004) and the basic premise was that people could start from just about anywhere and accumulate bundles of relevant skills. It was proposed that it was quite possible to develop clear rules and procedures that anyone might follow. By following such protocols, the health service could employ all sorts of new health practitioners, substituting them for fully trained and expensive doctors and nurses.

But this begs the question - are the traditional skills of healthcare professionals really so irrelevant or so easy to replicate?

Some doctors have certainly been critical of the way in which the Department of Health has approached professional skills, and of its belief that they can be broken down into smaller, simpler activities (McCaughan 2005). They suggest that the skills escalator is naïve and that different professional roles require different educational foundations.

In other words if you pursue a medical practitioner type of role, then you need a profound foundation in science, and a deep education to enable you to undertake the clinical reasoning which is absolutely key to diagnosis, and finding out what is wrong with the patient. If the pattern does not fit, then practitioners need to be able to go back to basic (bio-psycho-social) principles and work things out from a knowledge of science and research (Craddock et al 2008).

Those who are opposed to the notion of the skills escalator point out that the results of role substitution are not particularly well publicised but when studies are conducted and disseminated they tend to reveal that the 'role substitutor' for the doctor or nurse is no more cost effective and indeed in some cases less cost effective than the professional doing that role (Hollinghurst 2006).

Also, whilst a role substitutor may be able to follow a protocol, unfortunately human beings and human disease and disorder do not conform very neatly to protocols, and that has been forgotten by policy makers.

Although these changes were, no doubt, partly motivated by objectivity, it is likely that the Government also viewed the skills escalator as potentially a cost cutting exercise.

Whilst many individuals might have benefited from the skills escalator it is suggested that it has had quite a damaging impact in relation to self-regulation and has possibly contributed to the alienation of the healthcare professions as a whole. In combination with a hierarchical control system and loss of clinical engagement on the ground, it is perhaps not surprising that doctors and nurses have felt somewhat de-professionalised and undervalued.

But is de-professionalising inherently bad? Sometimes there are technological changes which, quite simply, transform what we do, and who can do it. This is very true in the field of healthcare. The rise of the internet means that not only do patients visit doctors and nurses primed with masses of information - more or less well digested - they can also access a variety of documents and advice that were once available only to a few, for a price.

Wherever there are professionals in the NHS, they are under pressure, and technology and de-skilling is undermining them all. Yet, some still strongly believe that there is still something special about health professionals (Hurst 2003). Indeed it is quite remarkable how many people actually enter the health professions with a genuine view of public service and view it as a genuinely fulfilling thing. Allsop (2002) suggests that this is not necessarily altruism, rather it is just what makes some individuals 'tick'.

This important point is sometimes disregarded and underestimated because too often cynical attitudes prevail in the post-modern world and it is wrongly assumed

that money is 'the' prime motivator for everyone whether it is associated with a Capitalist ideology or a Marxist one (Young 2007).

Regardless, ethics must also be part of the bigger professional picture, and whether or not the present Government believes this to be true, they certainly do not act as if they believe it. To understand fully what is going on, it is necessary and quite instructive to separate what the Labour Government espouses in theory and what they do in practice. In their practice the Government since 1997 have consistently denied the existence of anything fundamentally good about self-regulation within the healthcare professions. Instead they have concentrated on negative aspects, which, although they cannot be denied, are not necessarily representative of the profession as a whole.

The Government has certainly not denied such accusations (Department of Health 2007). On the contrary, they are one of the major justifications for that growth industry, 'Government regulation'. All over the country, either directly or at arm's-length, Government is taking over functions it was once happy to leave to the professionals themselves. This may be the professionals' own fault or it may be a straightforward grab for power on the part of Government (Hurst 2003).

Yet, the idea that the Government should be responsible for ensuring that nothing *goes* wrong in life is fundamentally flawed and unrealistic. In the modern-day regulated world, there seems to be a general reluctance to accept personal responsibility. One of the most striking examples of this can be found in the healthcare professions. In taking very difficult moral and ethical decisions, there is an increasing tendency for clinicians to run off to the courts and ask for legal absolution for whatever it is that they are about to do when this is actually an inescapable part of their personal, moral and ethical responsibility (Herring 2008).

Herring argues that the nature of professional accountability means that the buck stops with the individual clinician, or rather it should do. Increasingly, though, it stops with the Department of Health, despite the fact that a Government minister is probably the person who is least able to do anything about it except introduce a raft of additional clauses, sub-clauses and regulations.

However, it is not hard to understand why there might have been a recent dip in professional confidence. Costly lawsuits are increasingly common in healthcare practice and patients (and their families) are more aware of their legal, ethical and human rights, than they once were.

Also, many senior nurses now occupy advanced/specialised roles traditionally associated with doctors and medical practice. For example, in psychiatry the Mental Health Act 2007 has paved the way for non-medics to take on key roles in relation to sectioning and the management of detained patients.

Whilst these changes are professionally liberating, inevitably with increased autonomy comes increased accountability and modernisation may bring unwelcome pressure for some senior nurses who find themselves in key development roles.

Conclusion

Some are happy enough with the way things are moving and believe the old model of healthcare professionalism in which there was complete self-autonomy from external control, essentially a closed shop, has had its day (Allsop 2004).

Yet, there is much value in the healthcare professions, not least within mental health nursing, and there is a lot to admire in terms of upholding ethical standards and developing advanced skills and practice.

Indeed, the new NMC Code (as revised in 2008) sets a worryingly high ethical standard for qualified practitioners. Each nurse now has a duty to understand the implications of the new Code, rather than merely know it (Peate 2008) and there are references to specific pieces of legislation, namely the Mental Capacity Act 2005. The revised accountability framework may well exceed the basic legal standard expected of all qualified nurses. This is a little concerning and raises an important question: what is the purpose of setting the professional standard so high that day-to-day compliance is beyond the reach of some nurses working in busy, competitive, cash poor services?

The answer to this question may be simple enough. Perhaps the revised Code is simply the NMC response to Government criticism levelled at it. Certainly in recent years there has been growing pressure on the UK regulator for nurses, midwives and specialist community public health nurses to *raise its game* (CHRE 2008) and one way of appeasing an anxious executive is to raise the bar for professional practice higher. Another is to strike more nurses off the professional register and, worryingly this seems to be already happening (Fullbrook 2008).

Clearly, there are some very real professional challenges here. Nursing needs urgently to refresh its needs to open up to increased lay input and scrutiny and ultimately must embrace the market. If it does so, in the years to come the nursing profession may well thrive. However, if the profession sticks its head in the sand and does not do these things, then others may well rise up and take the place of qualified nurses. The professional values and attitudes of nurses are bound up with their independence and responsibility for their own affairs. If the nursing profession ends up losing all its privileges, surely there is a risk that they will take their value system down with them.

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