A Substantive Theory to Explain How Nurses Deal with an Allegation of Unprofessional Conduct

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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Declaration

I declare that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; and, any editorial work, paid or unpaid, carried out by a third party is acknowledged.

Dale Michelle Pugh

November 14 2006
Abstract

As a social endeavour, the practice of nursing is expected to minimise risk of harm to patients. In reality, the risk of breaching or failing to meet a standard of practice, with resultant harm to patients is ever present. Such variations to the expected standard may result in harm to the patient and be viewed as unprofessional conduct within the legislative context. The phenomenon of unprofessional conduct can have significant and sometimes dire outcomes for patients and nurses and provides challenges to understand antecedents to its occurrence and the impact on the nurse. From this realisation, the significance of this study is twofold. Firstly, the literature revealed that an allegation of unprofessional conduct and the associated experience of being reported to a regulatory authority can have significant psycho-social and professional impact on the nurse. Secondly, the phenomenon has received little formal analysis.

The purpose of this grounded theory study was to explore the phenomenon of alleged unprofessional conduct, and to develop a theory that provided understanding of the phenomenon and a framework for action. Data was obtained from in-depth interviews of a specialised sample of 21 nurses in any state or territory of Australia who had been the subject of notification by a nursing regulatory authority of alleged unprofessional conduct. Data analysis occurred simultaneously using the constant comparative method. This resulted in the generation of a substantive theory, explaining how nurses dealt with an allegation of unprofessional conduct.

This study found that nurses experienced varying degrees and combinations of personal and professional vulnerability. This put them at risk of
either making an error, breaching a practice standard, and/or at risk of being reported to a nurse regulatory authority for an allegation of unprofessional conduct.

The core social process, a transformation of the personal and professional self is a process that the nurse both ‘engages in’ and ‘goes through’, in response to the social problem, being reported to a nurse regulatory authority for alleged unprofessional conduct, and its aftermath. The social process is made up of two categories: loss of the assumptive world: the experience of deconstruction and relearning the world. Loss of the assumptive world is comprised of being confronted, deconstruction of the personal self and deconstruction of the professional self. The category Relearning the world: the experience of reconstruction is constructed of the sub-categories, preserving the self: minimising the unravelling; reconstructing the personal self; reconstructing the professional self; and living within the world. Consequences of the category relearning the world are dynamic and influenced by a number of factors. The ability to transact the deconstructed self and move through the reconstructive processes and experience can be viewed in the following states, stymied, evolving or transacted. The personal and professional transformation of the individual nurse is influenced by the degree of deconstruction initially experienced, the interplay with the influencing factors internal and external support processes; resilience; time; and the constant of vulnerability.

The findings of this study have implications for clinical, management, education and research practices in nursing. It also exposes problems with the use of nurse regulatory authorities as a punitive strategy for nurses who err. The uncovering of this substantive theory articulates a process whereby nurses are
transformed personally and professionally in response to a traumatic or challenging life event. This substantive theory has value in providing a decision making framework for managing breaches of nursing standards, as a learning tool to identifying and managing risk in nursing and providing a framework for self and external support to nurses who may find themselves in this situation.
Acknowledgments

The impetus for this study and its completion has not been in isolation. I wish to acknowledge the influences and assistance of the following people and extend my thanks and gratitude.

My personal journey would have been more difficult if it not were for the support of my family. To Andrew, a special thank you for giving me the time and space to finish the writing.

To my supervisors Professor Megan-Jane Johnstone and Professor Olga Kanitsaki whose expertise made this journey all the much easier.

I would like to thank, the Australian Nurses Journal, The Lamp, and the Western Nurse for providing advertising free of charge.

My sincere gratitude is extended to those nurses who bravely put their hand up to be interviewed. The stories so generously entrusted to me have provided the most poignant of experiences. The stories themselves without analysis sit solidly as testimony of one of the most significantly traumatising life events any nurse might experience.
CONTENTS

TITLE PAGE i
DECLARATION ii
ABSTRACT iii
ACKNOWLEDGMENTS vi
CONTENTS vii
LIST OF FIGURES xviii
LIST OF TABLES xix
GLOSSARY OF TERMS xx

CHAPTER ONE: BROAD CONTEXT TO THE STUDY 1

Introduction 1
Context within which Allegation of Unprofessional Conduct Took Place 2
Nursing Practice and Undesirable Outcomes 2
The Legal and Professional Landscape of Nursing 6
Accountability: The Professional Imperative 6
The Law and Nursing 8
Nurse Regulatory Authorities 17
Professional Conduct 19
Code of Professional Conduct for Nurses in Australia (ANMC) 20
Code of Ethics for Nurses in Australia (ANMC) 21
Competence 22
Unprofessional Conduct 24
Defined 24
Summary: Safe to Practice 30
Justification of the Study 31
Purpose of the Study 32
Objectives of the Study 33
CHAPTER TWO: A REVIEW OF THE LITERATURE

Introduction 36
An Overview of the Literature 36
Error 38
Theories of Error 38
Error in Health Care 39
Nursing Error 40
Systems Issues 43
Illustrative Cases of Systems Issues 44
Bristol Hospital Inquiry 44
Melbourne Health Review and Improvement Plan 46
The Macarthur Investigation 47
Bundaberg Hospital Inquiry 47
Violations 49
Negligence 51
Deviant Behaviour 52
The Impaired Practitioner 53
Alcohol and Drug Dependence 53
Mental Health Issues 54
Anti-Social Behaviour 54
Criminal Behaviour 56
The Impact of an Allegation of Unprofessional Conduct on the Nurse 59
Gender Issues 64
Management of Alleged Unprofessional Conduct Matters 65
Conclusion 67
## CHAPTER THREE: METHODOLOGY

### Introduction

#### Methodology of Grounded Theory

- Philosophical Foundations for Grounded Theory
- Tenets of Grounded Theory
- Rationale for Using Grounded Theory

#### The Method

- Substantive Theory
- Sample Description
- Participant Profiles
- Setting
- Sampling Strategies
- Sample Access
  - Advertising
  - Snowballing Technique
- Interviewing Strategies for Grounded Theory Research
- Interviews as the Source of Data
- Note Taking During Interviews
- Transcribing
- Management of the Data

#### The Constant Comparative Method

- **Stage One**
- **Stage Two**
- **Stage Three**
- **Stage Four**
- **Theoretical Sensitivity**
- **Theoretical Sampling**
- **Coding**
  - Open Coding
  - Memoing
  - Diagramming
  - Theoretical Coding
# TABLE OF CONTENTS

**Theoretical Saturation** 106  
**The Core Category** 107  
Rigour 108  
  - Methodological Rigour 111  
  - Theoretical Rigour 113  
  - Interpretative Rigour 113  
Ethics Approval 114  
  - Approval from the Human Research Ethics Committee 115  
  - Consent 116  
  - Risk 116  
  - Benefits 118  
  - Privacy and Confidentiality 119  
  - Security of Data Storage 120  
Strengths and Weaknesses 120  
  - The Role of the Researcher 120  
  - The Participants 124  
  - Research as Therapy 124  
  - Use of Literature in Grounded Theory 126  
Conclusion 127  

## CHAPTER FOUR: SOCIAL PHENOMENON 130

Introduction 130  
Social Phenomenon 131  
Profile of the Participants 135  
  - Demographics 136  
  - Allegation, Registration and Practice Profiles 137  
  - Responses to the Opportunity to Participate and the Interview 140  
  - Experience 143  
Vulnerability Introduced 143  
Personal Vulnerability 145  
  - Individual Causal Attributes 147  

  *Physical and Mental Health Issues* 147
Issues of Cognition 148
Pre-Existing Mental Health Issues 150

Dissenting Behaviours 151
Tall Poppy Syndrome 152
Whistleblowing 154
Industrial/union involvement 156
Sub-Standard Performance 157
Communication Difficulties 158

Contextual Causal Attributes 158

Out Group Perception 159
‘Face Doesn’t Fit’ 159
Non-Conformance to Group Think 161
Non-Conformance to Individual Biases 164
Judas Phenomenon 165

Isolating Strategies 166
Scapegoating 167
Workplace Bullying and Mobbing 171
Performance Management Strategy 172
Interruption to Employment 174

Professional Vulnerability 177

Contextual Causal Attributes 180

Organisational Culture 180
Not Knowing the Rules 180
Just Accepting the Rules 183
Physician-Nurse Relationships 184

Systems Issues 186
Workload 186
Interruptions 190
Medication Practices 191

Practice Contexts 193
Specific Contexts 193
Not Knowing the Patient 195
The Patient Imperative 197

Individual Causal Attributes 198
Physical Deconstruction 252
  Physical Symptoms and Illness 253

Psychological Deconstruction 256
  Impact on Self Identity 256
  Stress Reactions 257
  Traumatic Stress 259
  Depression 261
  Suicidal Ideation and Attempts 262
  Surrendering 264

Social Deconstruction 266
  Consequences on Family and Relationships 266
  Financial Consequences 267
  Need to Relocate 269
  Isolation 269

Deconstruction of the Professional Self: Interruption and Disintegration 271
  Nurse Interrupted 271
    Losing the Role 272
    Losing the Passion 275
    Loss of Confidence 276
  Spoiled Identity 278
    Shame 278
    Stigma 280
    Criminalisation 282

Punishment 285
  Self Punishment 285
  External Punishment 285

Relearning the World: The Experience of Reconstruction 286

Preserving the Self: Minimising the Deconstruction 287
  Assuming a Stance 289
    Questioning the Allegation 290
    Truth Telling 290
    Anticipating Responses 292

Taking a Stance 293
Preparedness 293
Self Defence 296
External Defenders 299

The Search for Meaning 300
Framing the Situation 301
Making Sense 301
Meaning Found 304

Reconstructing the Personal Self 305

Rethreading the Personal Self 305
Getting Better 306
Reinventing the Self 308

Re-threading the Social Fabric 309
Being Challenged 310
Picking up the Pieces 311

Reconstructing the Professional Self 312

Getting Back on the Horse 313
The Need to Risk 313
Accepting the Risk 314
Able to Risk 315

Lessons Learnt 316
Identifying Vulnerability 317
Minimising Vulnerability 318
Relearning Accountability 321

Finding the Balance 324
Over the Top 325
Questioning and Affirming 325
Getting it Right 326

Living within the New World 327

Existing 327
Psychologically Stuck 328
Re-experiencing 331
Feelings of Being Let Down 333
The Need for Revenge 333
The Need for Vindication 334
CHAPTER SIX: A SUBSTANTIVE THEORY TO EXPLAIN HOW NURSES DEAL WITH AN ALLEGATION OF UNPROFESSIONAL CONDUCT

Introduction 344

The Phoenix Process: Transformation of the Personal and Professional Selves 345

The Social Phenomenon: An Allegation of Unprofessional Conduct 349

Personal Vulnerability 351
Professional Vulnerability 352
Fragmentation of Decision Making 356
Allegations of Unprofessional Conduct 358
Motivations to Allege and Report 360

Loss of the Assumptive World: The Experience of Deconstruction 361

Being Confronted 362
Deconstruction of the Personal Self 365
Deconstruction of the Professional Self 367

Relearning the World: The Experience of Reconstruction 372

Preserving the Self: Minimising the Deconstruction 373
Reconstructing the Personal Self 377
Reconstructing the Professional Self 380
Living within the New World 386
Consequences of Reconstruction 389

Influencing Factors 390

The Thread of Resilience 391
The Thread of Support 396
The Thread of Time 398
The Thread of Vulnerability 399
# Chapter Seven: A Discussion of the Literature in Relation to the Substantive Theory

## Introduction

The Phoenix Process: Transformation of the Personal and Professional Self

- Loss of the Assumptive World: The Experience of Deconstruction
  - Being Confronted
  - Deconstruction of the Personal Self
  - Deconstruction of the Professional Self
- Relearning the World: The Experience of Reconstruction
  - Preserving the Self: Minimising Deconstruction
  - Reconstructing the Personal Self
  - Reconstructing the Professional Self
- Living Within the New World
  - Existing
  - Moving On
- Consequences of Reconstruction
- The Thread of Resilience

## Conclusion

# Chapter Eight: Achievement of the Study Objectives and Recommendations

## Introduction

Achievement of the Study Objectives

- Toward a New Understanding of Unprofessional Conduct
- The Substantive Theory
- A Clinical Risk Management Model for Managing Vulnerability in Nursing Practice
- A Support Framework for Nurses Reported to a Nurse Regulatory Authority

## Conclusion
# List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1.1</td>
<td>Classification of the law.</td>
<td>9</td>
</tr>
<tr>
<td>Figure 1.2</td>
<td>Scope of professional governance.</td>
<td>20</td>
</tr>
<tr>
<td>Figure 1.3</td>
<td>Matrix of unprofessional conduct.</td>
<td>29</td>
</tr>
<tr>
<td>Figure 2.1</td>
<td>Solution continuum.</td>
<td>66</td>
</tr>
<tr>
<td>Figure 3.1</td>
<td>A schematic representation of the grounded theory method.</td>
<td>89</td>
</tr>
<tr>
<td>Figure 3.2</td>
<td>An overview of the substantive theory.</td>
<td>129</td>
</tr>
<tr>
<td>Figure 4.1</td>
<td>Motivation to allege and report unprofessional conduct: A matrix.</td>
<td>213</td>
</tr>
<tr>
<td>Figure 5.1</td>
<td>A schematic representation of the loss of the assumptive world.</td>
<td>228</td>
</tr>
<tr>
<td>Figure 5.2</td>
<td>Time taken by the NRAs to arrive at a decision.</td>
<td>250</td>
</tr>
<tr>
<td>Figure 6.1</td>
<td>A schematic representation of the substantive theory: Transformation of the personal and professional self</td>
<td>350</td>
</tr>
<tr>
<td>Figure 6.2</td>
<td>A schematic representation of the social phenomenon: An allegation of unprofessional conduct.</td>
<td>352</td>
</tr>
<tr>
<td>Figure 6.3</td>
<td>A schematic representation of fragmentation of decision making.</td>
<td>357</td>
</tr>
<tr>
<td>Figure 6.4</td>
<td>A schematic representation of losing the role.</td>
<td>370</td>
</tr>
<tr>
<td>Figure 6.5</td>
<td>Consequential dimensions of reconstruction.</td>
<td>391</td>
</tr>
<tr>
<td>Figure 6.6</td>
<td>The experience of deconstruction and reconstruction: A case study</td>
<td>402</td>
</tr>
<tr>
<td>Figure 8.1</td>
<td>A decision making framework for breaches of, and failures to meet a nursing practice standard (<em>Part A, B, C</em>).</td>
<td>450</td>
</tr>
<tr>
<td>Figure 8.2</td>
<td>A model for minimising vulnerability for the individual nurse.</td>
<td>458</td>
</tr>
<tr>
<td>Figure 8.3</td>
<td>A support framework for the nurse reported to a nurse regulatory authority.</td>
<td>462</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 1.1 A statistical profile of nurses reported for an allegation of unprofessional conduct in Western Australia. 4
Table 1.2 Guidelines for Nursing and Midwifery Practice – NBWA. 12
Table 1.3 Examples of legislation related to nursing practice. 13
Table 1.4 Nursing legislation in Australia. 14
Table 2.1 Error types. 39
Table 2.2 Categories of violations. 50
Table 2.3 Examples of cases referred to a NRA for impairment secondary to a mental health issue 54
Table 4.1 The social phenomenon: Matrix of sub-categories, properties, and dimensions. 133
Table 4.2 Age profile of the participants. 136
Table 4.3 Gender profile of the participants. 137
Table 4.4 Source of allegations. 137
Table 4.5 Source of reports to the NRA. 138
Table 4.6 Practice contexts at the time of the allegation. 138
Table 4.7 Registration and outcome of allegation profile. 139
Table 4.8 Sub-category: Personal vulnerability - properties and dimensions. 146
Table 4.9 Sub-category: Professional vulnerability - properties and dimensions. 178
Table 4.10 A taxonomy of allegations of unprofessional conduct. 210
Table 5.1 Loss of the Assumptive World: Sub-categories, properties and dimensions. 225
Table 5.2 Sub-category: Being confronted - properties and dimensions. 230
Table 5.3 Sub-category: Deconstruction of the personal self – properties and dimensions. 253
Table 5.4 Sub-category: Deconstruction of the professional self – properties and dimensions. 271
Table 5.5 Relearning the world: The experience of reconstruction 288
Table 5.6 Sub-category: Preserving the self - properties and dimensions. 289
Table 5.7 Sub-category: Reconstructing the personal self – properties and dimensions. 305
Table 5.8 Personal and professional supports. 307
Table 5.9 Sub-category: Reconstructing the professional self – Properties and dimensions. 313
Table 5.10 Sub-category: Living within the new world – properties and dimensions 328
Table 8.1 An overview of the QUEST Model. 467
GLOSSARY OF TERMS


**Breach of Standard:** Where an *act* by the nurse has resulted in the standard not being met.

**Clinical Nurse (CN):** A term to denote a promotional nurse position.

**Failure to Meet Standard:** Where an *omission* by the nurse has resulted in the standard not being met.

**Nurses Board:** See Nurse Regulatory Authority.

**Nursing Board:** See Nurse Regulatory Authority.

**Nurse Regulatory Authority:** A statutory authority composed of relevant members as stipulated by the respective legislation, with the purpose of regulating nursing practice and the practice of nursing.

**Nursing Registration Board:** See Nurse Regulatory Authority.

**Nursing Error:** The failure of a planned patient (nursing) care action (Kohn, Corrigin & Donaldson, 1999).

**Nursing Practice Standard:** An authoritative statement enunciated and promulgated by the profession by which the quality of practice, service or education can be judged (American Nurses Association). For the purpose of this thesis ‘nursing practice standard’ will denote any written standard by any nursing or related authority related to patient care and the practices expected of a professional nurse. Standards may include policy, procedures, competency standards or adjunct policy which provides a written expectation of behaviours and outcomes.

**Registered Nurse:** A nurse registered to practice in Division 1 of the register in a state or territory in Australia.

**Unprofessional Conduct:** Nursing unprofessional conduct is defined in the broadest sense as conduct which is divergent from the agreed upon and accepted standards of practice of the profession (Johnstone & Kanitsaki, 2001).
CHAPTER ONE

Broad Context to the Study

I could begin my mother’s story with Charlotte Fugett Bedford’s death, but that would mean I’d chosen to open her life with what was for her the beginning of the end. It would suggest that all that matters in her life was the crucible that made my family a part of one tragic little footnote to history. So I won’t (Bohhalian, 1988, p. 19).

INTRODUCTION

The purpose of this study was to generate a theory grounded in the experiences of nurses who were reported to a nursing regulatory authority for an allegation of unprofessional conduct. To serve this end, grounded theory (Glaser & Strauss, 1967) was used to examine in detail, the nurse’s experience of the allegation of unprofessional conduct and how they dealt with the allegation, including the behavioural and contextual risk factors that contributed to the event and the personal and professional impact on the nurse at this time and through its aftermath.

This chapter will provide background to this grounded theory study of allegations of unprofessional conduct by nurses in the Australian context. To introduce the study, and to situate and justify its purpose, a preliminary review of the literature is provided. The legal and professional background of nursing will be introduced with an overview of the law as it pertains to nursing, the notion of accountability and the role of nursing regulatory authorities. The concept of unprofessional conduct, including definitions and examples will be situated within a précis of professional conduct and subsequent social expectations. This chapter will also set down the purpose, objectives and justification for this study. Operational definitions and an overview of the thesis are provided.
CONTEXT WITHIN WHICH ALLEGATION OF UNPROFESSIONAL CONDUCT TOOK PLACE

Nursing Practices and Undesirable Outcomes

Nursing practice is not without risk (Robinson, cited in Milligan & Robinson, 2003). The nature of nursing work in its many contexts, interfaced with the complexity of disease processes and treatment modalities; dynamic technology; changing consumer expectations; constraints of a burdened health care system; and the potential for human error provides the challenge to identify, minimise and correct risks to patients.

These concepts are inherent in the philosophy of safe nursing care and demonstrated in nursing education; continuing education programs and requirements; standard setting; quality improvement frameworks; and the presence of nursing regulatory authorities. Despite such a collective aim, nurses continue to be involved in nursing errors and subsequent allegations of unprofessional conduct.

Nursing is a social endeavour and as such nurses are bound by and accountable to society by its norms, values and laws. The Australian Nursing and Midwifery Council (ANMC) explains in the Code of Professional Conduct that each nurse must accept the responsibility and trust vested in the profession, and adhere to standards of professional conduct. Nurses have a fundamental responsibility to ensure that safe and competent nursing care is delivered to the health care client. The social phenomenon emerges when the nurse fails to uphold the prescribed standards and is made to be socially accountable through the legislative powers of a nursing regulatory authority (NRA). As a beginning point it is of value to explore the extent of this social phenomenon.
A review of the literature has revealed the emergence of a concerning trend in professional conduct matters related to nursing practice. While the North American context is significantly different to that of Australia in that it is more litigious, the reasons for nurses being named in malpractice suits are of interest. Beckmann (1996, p 1) argues that nursing malpractice is “beginning to haunt the nursing profession”. Despite this predicament it is important to put the number of nurses who were disciplined by a nursing regulatory authority into perspective. In 2002 the approximate number of nurses reported to boards of nursing in the US was 0.2% - 0.3%.

The Risk Management Foundation of the Harvard Medical Institution in its 12 year study of malpractice found that incidences of nurses being named in lawsuits had increased 100% over previous years (McDonough & Rioux, 1989). Scott (2002) in an editorial for the British Journal of Nursing articulates the rise in the number of complaints against nurses for supposedly basic nursing care, or the lack there of it. The cases being reported include the perceived or actual lack of care regarding core aspects of clinical nursing practice, like inadequate assessment and management of falls, and a lack of communication with patients and their families. Castledine (2002) reports that the ‘poor’ standards of nursing practice are beginning to concern the public in the United Kingdom. Although the antecedents for this alleged poor nursing care are many, and may also reflect an increased public awareness of their right to report nursing practice which falls short of the prescribed standard, it does not remove the accountability of the individual nurse in the expectation of appropriate and safe nursing care.

Walker (2000) describes how the incidence of complaints received by a NRA in a province of Canada since 1998 had increased from an annual rate of
147 for the period 1995 until 1998, to 208 per year. A report from Florida, USA in 2000 revealed that the Florida Board of Nursing heard 964 disciplinary cases and nearly all nurses involved in these matters were sanctioned. A concerning statistic was that of this number, 15% of nurses were viewed as repeat offenders (Mikos, 2000).

While such headlines surrounding nurses are yet to be seen in the Australian context, incidences concerning negative outcomes in the popular media are present. Although the numbers of nurses reported to a NRA in Australia are small as compared to the total number of nurses on the register it is the nature of the reasons why they are reported and the experience of being reported that holds significance. Fletcher (1998) states that for the period 1995-1996 there were approximately 265 000 nurses registered in Australia. Of these approximately 600 – 625 were reported for an allegation of unprofessional conduct. The following table provides an illustration of the number of nurses reported to the Nurses Board of Western Australia (NBWA) for the period 1989 until 2004.

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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>110</td>
<td>62</td>
<td>39</td>
<td>49</td>
<td>63</td>
<td>72</td>
</tr>
</tbody>
</table>

Table 1.1: A statistical profile of nurses reported for an allegation of unprofessional conduct in WA.

The Register in Western Australia (WA) for the 2002 period was 28 945 nurses. The number of nurses reported to the NBWA in this year represents just 0.2% of the Register. Of the 63 reported, 18, i.e. 28% were to do with matters of competence (NBWA Annual Report, 2002-2003). While the numbers can be interpreted as rising and falling they do not provide any background for the reasons for either an increase or decrease. The other dimension to the statistical
profile of nurses reported to a NRA is that not all matters that could be reported are. Therefore such profiles have limited uses.

In response to statistics of nurses reported to the Nurses Board of South Australia (NBSA) in February 2004, the NBSA responded with the following. They responded to the record number of complaints for the period 2002-2003 by saying that it only represented a 1% increase from the previous year. A reason for this was partly attributed to the fact that the board had undertaken extensive educational campaigns for the public, consumers were contacting the board with more complaints because of this increased awareness (Anonymous, 2004).

The Nurses Board of Victoria for the period July 2004 – June 2005 have reported a 9% decrease in complaints related to professional conduct. For this period 130 complaints were received in contrast to 150 for the previous financial year (Nexus, 2005). These numbers reflect though, the full scope of matters that can be reported to the board. Of the 130 reported for the last financial year, 18 were identified as being related to a failure to provide competent/safe care; 6 detailed matters related to incompetent practice; 7 involved incompetent drug administration; and 4 detailed a failure to communication (Nexus, 2005).

The paucity of research into antecedents of unprofessional conduct by nurses and subsequent outcomes, including the impact on the nurse provided the logical impetus for this study. To address what is certainly viewed as an important aspect of nursing practice, a number of alleged unprofessional conduct events by nurses were examined using the grounded theory method. This chapter provides an overview of the study with background to the study context, the purpose and objectives which provided a foundation for the study’s direction and importantly, justification for this study.
The Legal and Professional Landscape of Nursing

Nursing practice in Australia is articulated, monitored and governed by a number of authorities and agencies, they are: the employer, which may be a specific agency or under the auspices of the respective state or territory Minister of Health; statutory nursing authorities; professional nursing organisations and bodies; the Coroner; the Police; other government bodies, for example in Western Australia there exists the Office of Health Review; colleagues, including those in other health professions and the health care consumer.

The following discussion will describe the legal and professional landscape of nursing practice, and attempt to illustrate the complex and sometimes conflicting framework of accountability that nurses must navigate. The professional framework is really a sub-set of the legal framework because legislation and judge made law is the ultimate end point of accountability.

_Accountability: The Professional Imperative_

It is useful at this point to examine the concept of accountability. Copp (1988) has contended the importance of accountability to nursing practice and described it as the fundamental attribute of the profession. Although there is no universally accepted definition of accountability (Tingle, 1990), some useful definitions are presented as starting points in examining this concept and how it brings together the domains of legal and professional standards and requirements, and the overriding expectations of all nursing behaviours. Tschudin (1992) describes accountability as:

Not only having to answer for an action when something goes wrong, but it is a continuous process of monitoring how a nurse performs professionally. The responsibility differs in different situations, but
there is a need to be aware that one is constantly responsible, and therefore constantly accountable.

Another definition more general and simple is ‘responsible to someone or for some action; answerable’ (Collins English Dictionary, 5th Australian Ed., 2004). Rumsey (1997) provides a more nurse to patient notion of accountability by explaining that accountability involves: (a) the assessment of the what is in the best interests of the patient; (b) using nursing knowledge and one’s own judgement to decide on nursing interventions; and (c) being able to provide a rationale for these nursing interventions and if necessary be able to defend the course of action.

Watson (1995) articulates a number of ‘levels’ of accountability, all relevant to nursing practice but not necessarily of equal importance, they are: patient accountability; employee accountability; nurse regulatory authority accountability; society accountability; self accountability; colleague accountability; professional accountability; and legal accountability. Walsh (2000) explains that accountability provides a quandary for the nurse in that there are a number of opposing forces of to whom or what the nurse is accountable to and it is in this opposition that conflict arises. Nurses are accountable to the respective NRA through the respective legislation and associated rules and codes of practice but then may find that this expected line of accountability is in conflict with the organisational requirements, through policy and other codes of expected behaviour and practice. A common dilemma that all nurses will be able to relate to and described by Tingle (1993) is where the ward is understaffed and patient safety is potentially compromised. The nurse is expected to obviously provide safe nursing practice but is also required to cooperate with their employer and to obey all lawful instructions. The nurse is obliged to communicate concerns where
the standards are not able to be met, the nurse does so, but the management of the hospital advises that nothing can be done about the staffing levels and the nurse should just do the ‘best that they can’ with the poor working conditions. The staffing levels remain the same and the situation then begs the question to whom is the nurse accountable and has this accountability been exercised to a satisfactory end point? This dilemma has not been introduced as a part of a larger ethical debate but as another point on the compass for professional practice. In any assessment of alleged unprofessional conduct, mitigating circumstances, such as unsafe staffing levels will be considered. While these circumstances may explain and justify an alleged unprofessional conduct event, nurses can still be seen to be accountable. It is these mitigating circumstances in terms of contextual and behavioural risk factors or antecedents which have been of particular interest in examining the unprofessional conduct events that the research participants of this study were involved in. It is the line of accountability through the nurse regulatory authority, the law and the profession that has the most relevance in the context of this study and as thus providing background to the research objectives.

While there is a trend away from apportioning blame to individuals involved in an error the fact remains that at law the individual nurse can be ultimately accountable. This accountability grounded in law will be explored in the next section, including a number of legal cases.

**The Law and Nursing**

As a beginning point in describing a complex phenomenon, the following definition of law is provided. Law is ‘that which is laid down, ordained, or
established, a body of rules of action or conduct prescribed by controlling authority and having a binding legal force’ (Black 1990, p. 884). The law is classified (Figure 1.1) as substantive and procedural. Substantive law describes ‘what we can do, must do, or what we must not do, as well as the interpretation of

![Diagram](image-url)

**Figure 1.1: Classification of the law.**

the law, setting out rights and obligations’ (Wallace, 2001, p.3). Although both branches have relevance to nursing legislation, the domain of substantive law has the most relevance to this thesis. Nursing legislation belongs to the domain of administrative law. Matters of negligence can be dealt with under the principles and precedent of tort law. Nursing practice could also be judged against criminal codes and statutes should the nurse be charged with a crime (Wallace, 2001).

Judge made law, or sometimes known as common law is that which has been derived from previous decisions of courts, i.e. precedent (Sharpe, 1999). Examples of the relevance of this law would be where the individual nurse was before a court, charged with a criminal or civil action. This sort of legal process is not common for nurses in a professional sense, for the majority of professional matters relating to alleged unprofessional conduct are dealt with by nurse
regulatory authorities under the respective nursing legislation. Nonetheless, it is important to review aspects of criminal law and health care. Criminal law is concerned with the actions against persons or property where an offence has occurred and for health care professional the following are of particular interest: murder; manslaughter; euthanasia; abortion; drug offences; dealing with victims and perpetrators of crime and offences relating to infectious diseases (Wallace, 2001).

While it is not within the scope of this current discussion to describe all the components of criminal law necessary to prove that a criminal offence has occurred, it is of interest to examine specific case law pertaining to nursing practice to illustrate the legal landscape for nursing practice. In *R v Jenkin (June 1993, SC Townsville* for example, a nurse was charged with the murder of a patient and the attempted murder of three patients at a hospital in a Queensland hospital. It was alleged that the nurse had administered un-prescribed drugs to all four patients who were diagnosed at the time with terminal cancer. While the jury returned a not guilty verdict, post mortem examination did indicate the presence of the un-prescribed medication in ‘at least some of them’ (Wallace, 2001, p. 476). Wallace (2001) explains that the return of the not guilty verdict probably lies in a lack of evidence to prove the charges rather than a misinterpretation of the law. This matter, although within the domain of criminal law, i.e. one which was managed by the police and the courts could also have been addressed by the nurse regulatory authority, demonstrating a link between the accountability to legislative and common law.

A common legal term with links to both common law and legislation is negligence, more commonly reported in the North American literature as
malpractice (Beckmann, 1996; Sharpe, 1991) though more specifically in relation to the conduct of a person in a professional capacity. Pennels (1997) provides a definition of negligence from the following case, *Blyth v Birmingham Waterworks Co (1986)*. Negligence is the omission to do something which the reasonable ‘man’ would do, or doing something that a prudent and reasonable ‘man’ would not do. The legal principle of negligence states that in order for negligence to be proved the following criteria must be demonstrated: (1) a duty of care must be owed by the nurse to the patient; (2) a breach of the standard of care delivered must have occurred and (3) this breach of duty must have caused harm to the patient which was reasonably foreseeable (Pennels, 1997).

By way of example the following case involving a nurse is presented. In the case of *Smith v Brighton and Lewes Hospital Management Committee* reported in the *Time Law Report May 1 1958*, the plaintiff sustained injuries when a course of streptomycin injections were administered after the course has ended. The nurse was found negligent in that she did not take basic precautions to prevent this occurring. Damages were awarded to the plaintiff. In determining the judgement of negligence it was found that the nurse did owe a duty of care to the patient, there was a breach of the required standard, the patient suffered harm and there was a reasonable foreseeability of this harm (Watson, Ed., 1995). At this point it is necessary to explore the concept of standard, as this will form the cornerstone of all determinations of unprofessional conduct.

A standard as defined by the American Nurses Association is ‘an authoritative statement, enunciated and promulgated by the profession by which the quality of practice, service or judgment can be judged’ (Schroeder, 1991). Standards are a reflection of professional practice, they can exist to reflect the
uniqueness of a patient group (Schroeder, 1991), specifically serving as a basis for setting patient care priorities, defining the role of the nurse in the practice setting, and monitoring and evaluating the patient care delivery practices (Beckmann, 1986). Standards can be more global reflecting broader expectations of practice. Each nurse regulatory authority provides a selection of documents to guide practice. The following table lists a suite of such documents provided by the Nurses Board of Western Australia.

<table>
<thead>
<tr>
<th>Document Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boundaries for Therapeutic Relationships</td>
</tr>
<tr>
<td>Ethical Dilemmas: A Framework for Decision Making</td>
</tr>
<tr>
<td>Guidelines for Demonstration of Continuing Professional Competence</td>
</tr>
<tr>
<td>Guidelines for Employers and Managers in Respect to Reporting Complaints about nurses to the Nurses Board of WA</td>
</tr>
<tr>
<td>Guidelines for Preceptors and Preceptorship in Western Australian Nursing/Midwifery</td>
</tr>
<tr>
<td>Guidelines for the Referral of a Complaint to the Nurses Board of WA</td>
</tr>
<tr>
<td>Guidelines for the Use of Complementary Therapies in Nursing Practice</td>
</tr>
<tr>
<td>Guidelines for the Use of Restraint in Western Australia</td>
</tr>
<tr>
<td>Management of Patient Information and Documentation Guidelines</td>
</tr>
<tr>
<td>Medication Administration Guidelines</td>
</tr>
<tr>
<td>Nurses Code of Practice 2000</td>
</tr>
</tbody>
</table>

Table 1.2: Guidelines for Nursing and Midwifery Practice – NBWA.

Other examples of professional nursing practice standards include those articulated by professional organizations. Some examples include: the College of Midwives, the Flight Nurses Association of Australia and the Critical Care Nurses Association of Australia.

Legislation is law that sets out obligations and rights, penalties and procedures for a range of issues and organisations throughout the states and territories of Australia (Wallace, 2001). Federal, and states and territories parliaments make these legal documents into law and they are produced and known as statutes or acts of parliament. There are a number of acts relevant to health care and therefore nursing practice. To provide an example of the scope of the legislation that nurses must be aware of and factor into their nursing practice.
the following list of generic Acts (Table 1.3) is extrapolated from the extensive list of legislation of Australian states and territories (Wallace, 2001).

<table>
<thead>
<tr>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births, Deaths and Marriages Registration Act</td>
</tr>
<tr>
<td>Coroners Act</td>
</tr>
<tr>
<td>Disability Services Act</td>
</tr>
<tr>
<td>Health Records (Privacy and Access) Act</td>
</tr>
<tr>
<td>Health Regulation (Maternal Health Information) Act</td>
</tr>
<tr>
<td>Poisons Act</td>
</tr>
<tr>
<td>Public Health Act</td>
</tr>
<tr>
<td>Transplantation and Anatomy Act</td>
</tr>
<tr>
<td>Anti-Discrimination Act</td>
</tr>
<tr>
<td>Community Services (Complaints, Appeals and Monitoring) Act</td>
</tr>
<tr>
<td>Health Care Complaints Act</td>
</tr>
<tr>
<td>Nursing Homes Act</td>
</tr>
<tr>
<td>Occupational Health and Safety Act</td>
</tr>
</tbody>
</table>

Table 1.3: Examples of legislation related to nursing practice.

The core legislation which both directs and allows for the monitoring of nursing practice is the Nurses Act or Nursing Act, depending on the State or Territory and falls under the domain of administrative law. Nursing legislation provides respective boards the authority to monitor, govern and inform the individual practice of nurses and global nursing practice. Specifically, the Act is administered by a regulatory authority comprising a Board of elected members. An overview of the nursing legislation of the states and territories of Australia is provided in Table 1.4. This table lists the legislation and jurisdiction and the respective purpose of the Act and functions and powers of the Board. A summary of how ‘unprofessional conduct’ is defined is also included.
| Jurisdiction                      | Purpose of the Act                                                                                                                                                                                                 | Functions of the Board                                                                                                                                                                                                 | ‘Unprofessional Conduct’ Defined                                                                                     |
|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| **Australian Capital Territory** | An Act to provide for the registration and enrolment of nurses, the supervision of nursing education and standards, and for related purposes.                                                                                                                                     | To promote and maintain professional standards of nursing and midwifery practice in NSW; To promote the education of nurses and midwives and related educational programs; To advise the Minister; To publish and distribute information concerning this Act; To impose requirements or conditions on practice. | Unfit to practice: Conduct, whether practising nursing or not, that adversely affects practising nursing by the profession.                                                                                           |
| Australian Capital Territory     | **Nurses Act (1988) Amended 2003**                                                                                                                                                                                                                                             |                                                                                                                                                                                                                      |                                                                                                                                                                                                                   |
| **New South Wales**              | To protect the health and safety of the public by providing mechanisms to ensure that nurses and midwives are fit to practice; To provide mechanisms to enable the public and employers to readily identify nurses and midwives who are registered or enrolled under this Act. | To promote and maintain professional standards of nursing and midwifery practice in NSW; To promote the education of nurses and midwives and related educational programs; To advise the Minister; To publish and distribute information concerning this Act; To impose requirements or conditions on practice. | Unsatisfactory professional conduct: Lack of skill, knowledge, care or judgement; Contravention of the Act; Any other improper or unethical conduct. Professional misconduct: Of a sufficiently serious nature to justify the removal of the nurse’s name from the Register or Roll. |
| **Nurses and Midwives Act**      | (1991) Amended                                                                                                                                                                                                       |                                                                                                                                                                                                                      |                                                                                                                                                                                                                   |
| **Northern Territory**           | To protect and promote the health and safety of people in the Territory; To promote the highest standard of professional health care practices in the Territory; and To determine the standards for registration and enrolment of health practitioners and for professional health care practice in the Territory. | To administer the schemes of registration; To monitor the standard and provision of health care services; To monitor the competence of health care practitioners; To provide guidance on clinical conduct and ethical matters; To initiate investigations of complaints made against health care practitioners; To prosecute offences under this Act; To accredit courses for entry into the category of health care practice; To advise the Minister on matters relating to this Act. | Professional Misconduct: Without limiting the matters that may constitute professional conduct, a health practitioner is guilty of professional misconduct if they: Contravene the Act; Contravenes a foreign health care practice law; Contravenes a code that applies to the domain of health care practice; Contravenes a condition of registration; Practices without being registered; Contravenes a condition of an authorisation; Is negligent or incompetent in the domain of health care practice; and Behaves in a fraudulent or dishonest manner. |
| Health Practitioners Act         |                                                                                                                                                                                                                      |                                                                                                                                                                                                                      |                                                                                                                                                                                                                   |
| Northern Territory (1999)        |                                                                                                                                                                                                                      |                                                                                                                                                                                                                      |                                                                                          |
| State                  | Nursing Act (Year) | Purpose                                                                 | Duties                                                                                          | Professional Conduct                                                                 |
|-----------------------|--------------------|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| Queensland            | Nursing Act (1992) | **An Act to provide for the registration and enrolment of nurses, the practice and the education of nurses, and related purposes.** | Advise and report to the Minister on developments in nurse education and practice, and in relation to the needs of the State; Determine the scope of nursing practice; Determine standards for accreditation of nursing courses, and accredit such courses; Determine minimal requirements for entry into such courses; Develop or adopt codes of practice in relation to nursing and midwifery. | Unsatisfactory Professional Conduct: Professional conduct that is of lesser standard than that which might reasonably be expected of the relevant person by the public or the relevant person’s peers; Professional conduct that demonstrates incompetence, or a lack of adequate knowledge, skill judgement or care, in nursing practice; Infamous conduct in a professional respect; Misconduct in a professional respect; Conduct discreditable to the nursing profession; Providing a person with health services of a kind that are excessive, unnecessary or not reasonably required for the person’s wellbeing; Influencing or attempting to influence, the conduct of another nurse or midwife in a way that may compromise patient care; Fraudulent or dishonest behaviour in nursing practice. |
| South Australia       | Nurses Act (1999)  | To regulate the practice of nursing in the public interest; To determine the scope of nursing practice; To approve nursing education courses; To determine requirements for registration; To investigate the fitness of persons to practice as a nurse in this State; To exchange information with other NRA; To provide advice to the Minister. |                                                                                                 | Unprofessional Conduct: Improper or unethical conduct; Incompetence or negligence; Contravention of the Act or condition on practice and/or the Code of Practice |
| Tasmania              | Nursing Act (1995) | Administer the scheme of registration and enrolment; Monitor the standard and provision of nursing services in the State; Determine the activities that constitute or are included in the scope of nursing practice; Examine complaints and, as necessary, refer |                                                                                                 | Professional misconduct: Without limiting the matters that may constitute professional misconduct, a nurse is guilty of such misconduct if the nurse contravenes: A provision of this Act; Foreign nursing laws; A provision of the Nursing Code; |

Table 1.4: Nursing legislation States and Territories of Australia.
<table>
<thead>
<tr>
<th>State</th>
<th>Act and Amendments</th>
<th>Objectives</th>
<th>Conducts</th>
<th>Unprofessional conduct:</th>
<th>Unethical conduct:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td>Nurses Act (1993)</td>
<td>To protect the public by providing for the regulation of nurses and the investigation into the professional conduct and fitness to practice of registered nurses; and To establish the Nurses Board of Vic; and to Provide for other related matters.</td>
<td>A condition subject to which the nurse is registered or enrolled; A condition of an authorisation; Fails to pay within the specified time for payment a fine imposed on the nurse under; Fails to comply with a requirement made of that nurse; Fails to honour an undertaking given to the Board or Tribunal; Is negligent or incompetent in nursing practice; Behaves in a fraudulent or dishonest manner in nursing practice.</td>
<td>Professional conduct which is of a lesser standard than which the public might reasonably expect of a registered nurse; Professional misconduct; A finding of guilt of an indictable offence, or other specified offences, or an offence which is likely to affect ability to practice.</td>
<td>Carelessness; Incompetence; Impropriety; Misconduct; A breach of the Act; Non compliance with any condition or restriction imposed under the Act.</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Nurses Act (1992)</td>
<td>An Act to provide for the regulation of the practice of nursing, the registration of persons as nurse.</td>
<td>To advise the Minister on matters to which this Act applies; To administer the scheme of registration; To carry out and promote public education and research in relation to nursing; To monitor nursing education, and provide advice on nursing education to the Minister; To perform the other functions that are vested in the Board by this Act.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Nurse Regulatory Authorities

Nurse regulatory authorities are statutory bodies which have been established and function in accordance with the respective nurse legislation. They exist to regulate nursing practice and the practice of individual nurses to ensure contemporary and safe nursing practice to the public (Wallace, 2001). The following lists the nurse regulatory authorities in Australia:

- Nurses Registration Board New South Wales (NSW);
- Health Professionals Licensing Authority Northern Territory (NT);
- Nurses Board of the Australian Capital Territory (ACT);
- Nursing Board of Tasmania (Tas);
- Nurses Board of Victoria (Vic);
- Nurses Board of Western Australia (WA); and
- Queensland Nursing Council.

In particular they have the power and are obliged to investigate all allegations of unprofessional conduct (Wallace, 2001). They then decide whether to exercise a protective jurisdiction. This jurisdiction forms part of the body of law known as administrative law (Stanton & Chiarella, 2003). In comparison to criminal law which serves to punish and deter offenders, administrative law, in particular legislation which governs health protection serves to protect the public (Staunton & Chiarella, 2003). They emphasise that the role of a NRA is not to punish a nurse but rather protect the public against unsafe nursing practice.

Nursing legislation in the form of a nurses’ or nursing act exists primarily to allow the election of relevant members to a Board who are then empowered and responsible for monitoring and governing the safe delivery of nursing care to the public. Their powers and functions cover registration of nurses, including imposing conditions on practice, reviewing and setting the standard for nursing education and research and examining alleged unprofessional conduct matters,
and restricting the practice of nurses who are not able to meet the standards of the Board and the nursing profession (Wallace, 2001). To provide a specific example of the objectives of nursing legislation and subsequently the scope of the function and powers of a nurses board. As an example, the Nurses Board of WA has at its core the following objectives, to: (a) promote suitable standards of knowledge and clinical skills among nurses for the purpose of protecting the health of the people of WA; (b) establish and maintain suitable standards of education among nurses; and (c) regulate the practice of nursing and ensure safe standards of nursing care. A recent development by the Western Australian government has seen the emergence of the State Administrative Tribunal (Onboard, Summer 2003). This tribunal is aimed at fulfilling some aspects of the Board’s role with respect to disciplinary matters. Those matters which meet the criteria for a formal hearing will be referred to this tribunal where a panel of three will hear and make a determination. It is hoped that matters will be dealt with more expeditiously with the advent of this new tribunal. However, there has been no guarantee that the panel will compromise a nurse with contemporary and contextual knowledge of the allegation.

Nurse regulatory authorities in Australia publish a number of publications relating to the expectations of professional conduct. For example, the Nurses Registration Board of New South Wales (NRBNSW, 1999) has developed a manuscript detailing the boundaries of professional practice. This document is aimed at assisting nurses to make decisions regarding the boundaries of their practice. Although the NRBNSW acknowledges that only a small number of complaints are received about nurses regarding professional boundaries, the implications are viewed as potentially significant. In response to this significance,
a 12 month research project was undertaken to develop these guidelines. The resultant manuscript provides principles of safe practice and address such things as planning care around meeting the therapeutic needs of the patient and being aware of one's own needs, values and attitudes in a professional relationship.

The Nurses Registration Board of NSW commissioned the writing of a casebook of disciplinary decisions of professional conduct matters (NRBNSW, 2001). This text provides, along with a description of the role of the Board, an analysis of a number of cases and reasons for determination. A significant number of the cases discussed are with the basis of causality in competency issues. Cases centre on the legislative scope of unprofessional conduct.

**Professional Conduct**

Nursing practice is expected to be in accordance with agreed upon standards and more recently, informed by the best available research evidence, and practiced by a competent individual. Therefore, professional conduct can be viewed as nursing practices and associated behaviour that is expressed as compliance with the written standards and can be demonstrated in the delivery of safe nursing practice.

To articulate the notion of professional conduct it is necessary to review the concept of competency and competency statements, and a number of codes of conduct. The most overriding of these have been promulgated by the Australian Nursing and Midwifery Council (ANMC). All nursing boards throughout Australia have their own code of conduct and primarily reflect that which is contained with the codes set down by the ANMC. The scope of professional governance for nurses in Australia is outlined in Figure 1.2.
The purpose of the Code of Professional Conduct for Nurses in Australia (ANMC) (Australian Nursing Midwifery Council, 2003) is threefold: (a) to establish a national standard of professional conduct; (b) to inform the community of these standards; and (c) provide to consumers, regulatory authorities, employers and professional organisations a foundation for decisions regarding standards of professional conduct. This code of professional conduct sets out the following specific requirements of professional behaviour:

1. Practice in a safe and competent manner;
2. Practice in accordance with the agreed standards of the profession;
3. Not bring discredit upon the reputation of the nursing profession;
4. Practice in accordance with the laws relevant to the nurse’s area of practice;
5. Respect the dignity, culture, values and beliefs of an individual and any significant other person;
6. Support the health, well being and informed decision making of an individual;
7. Promote and preserve the trust that is inherent in the privileged relationship between the nurse and an individual, and respect both the person and property of that individual;
8. Treat personal information obtained in a professional capacity as confidential; and
9. Refrain from engaging in exploitation, misinformation and misrepresentation in regard to health care products and nursing services.

**Code of Ethics for Nurses in Australia (ANMC)**

A further code, the *Code of Ethics for Nurses in Australia* developed in 1993 under the auspices of the Australian Nursing Midwifery Council (ANMC), the Australian Nursing Federation (ANF) and the Royal College of Nursing Australia (RCNA) and revised in 2002, was developed when it was realised that there was inadequate articulation of ethical standards for the context that is Australian nursing. The value statements are that nurses must:

1. Respect the individual’s needs, values, culture and vulnerability in the provision of nursing care;
2. Accept the rights of individuals to make informed choices regarding their care;
3. Promote and uphold the delivery of quality nursing care;
4. Hold in confidence any information obtained in a professional capacity, use professional judgement when information about the client is required to be shared for the therapeutic good of the person;
5. Fulfil the accountability and responsibility inherent in their role; and

6. Value environmental ethics and a social, economic and ecologically sustainable environment to promote health and well-being (Code of Ethics for Nurses in Australia, 2002).

The challenge for nurses, along with complete adherence to the Code of Professional Conduct is the difficulty the practice context and associated deficits brings to the everyday world of the nurse and the reality that to adhere completely to these codes is not always possible. A particular challenge of the code of ethics has been reported. Scully (1994) questions how ‘reasonable behaviour’ as stated in the code could be discerned, particularly at a disciplinary hearing because it is not clear what type or level of evidence the statements are based on.

It is expected that all nursing practice must be in accordance with agreed upon standards for the profession. This scope of professional governance (Figure 1.2) reveals the diversity of compliance standards and the inherent difficulty which that brings. The following discussion of unprofessional conduct and examples will reveal that in theory, any breach of this scope can mean for the nurse an allegation of unprofessional conduct, should the respective nursing regulatory authority accept to investigate the matter. This is not contended to instil fear in the nurse but rather as a beginning point to critically examine the current concept of unprofessional conduct and how it may be interpreted in the future.

**Competence**

Competence is defined as ‘the condition of being capable; ability’ and competent means having sufficient skill and knowledge’ (Collins Australian
Competency is defined within the context of the ANMC competency statements as ‘a combination of attributes enabling performance of a range of professional tasks to the appropriate standards’ (Gonczi, Hager & Oliver, 1990, p. 62). Competency encompasses more than the performance of a skill, knowledge, abilities, skills and attitudes are required domains of demonstration and accomplishment before a nurse can be viewed as competent to practice as a beginning practitioner (Gonczi, Hager & Oliver, 1990).

The domains of the ANMC competencies for the registered nurse are: (a) professional and ethical practice; (b) critical thinking and analysis; (c) management of care; and (d) enabling. The scope of professional and ethical practice includes those competencies specific to legal and ethical aspects of patient care, for example demonstrating an adequate knowledge base, accountability, and protecting individuals. To demonstrate competency in critical thinking and analysis the beginning nurse must be able to self appraise, engage in professional development and incorporate research into clinical practice. The third domain, management of care, includes those competencies which relate to the assessment, implementation and evaluation of care. Enabling addresses those competencies which allow for the continuation of an appropriate and therapeutic nurse/patient relationship, i.e. interpersonal and communication skills.

Competence underpins the concept and expectations of professional conduct. Despite this, statements qualifying the notion of competence fall short of the realities of day to day practice. However, herein lies the dilemma and challenge for nurses: there is always a potential risk of performing a skill incompetently or making an incompetent decision. This breach or failure to meet the expected standard, viewed as either an error or a violation may be
viewed under respective legislation as unprofessional conduct. This concept, central to the research objectives is now introduced.

**Unprofessional Conduct**

*Defined*

Nursing unprofessional conduct is defined in the broadest sense as conduct which is divergent from the agreed upon and accepted standards of practice of the profession (Johnstone & Kanitsaki, 2001) and can be representative of any breach of the respective legislation or accepted nursing practice standards, governing nursing practice. There exist a number of terms with differing meanings, interpretations and use within the literature which contribute to the concept analysis of ‘unprofessional conduct’. MacFarlane (2000) explains that jurisdictions in Australia are empowered to impose a range of penalties and sanctions if it is determined that the nurse in question fails to meet the required standards for nursing practice. He also explains that despite difference in legislation and terms such as ‘unethical conduct’, ‘professional misconduct’, ‘misconduct in a professional respect’, or ‘unprofessional conduct’, they primarily describe conduct which is viewed as unacceptable. It is important to examine those terms found in the literature and the Australian nursing legislation to provide a clear understanding of the social phenomenon in question.

Professional misconduct is defined in a common law sense as, “something done in the pursuit of professional activities which would be reasonably regarded as disgraceful or dishonourable by professional brethren of good repute and competency (Nygh, 1997, p. 319). In contrast, Johnstone and Kanitsaki, (2001, p. xiv) state that professional misconduct is “literally the wrong, bad or erroneous
conduct of a professional person outside of the domain of his or her practice; conduct not befitting a professional person of good repute”. Further distinction of professional misconduct from unprofessional conduct includes the following: (1) that the conduct of the nurse is of a lesser standard than would be expected of a professional person in a general sense; (2) at the time of the allegation there was no impact on nursing care; and (3) the conduct of the nurse is harmful to persons other than patients. (Johnstone & Kanitsaki, 2005).

Another definition, within the North American context describes professional misconduct as a ‘violation of state laws or regulations that govern nursing practice, as determined by the state board of registration’ (La Duke, 2001, p 375). In the Australian nursing context, Wallace (2001) uses the term unprofessional conduct rather than professional misconduct and explains that the nurse regulatory authorities have varying defining components, but they generally fall into similar domains, that is a deviation from the prescribed standards of contemporary nursing practice, a breach of the relevant Act and/or code, regulation or order, any conduct that indicates that the nurse in question is not fit to practice nursing or any behaviour that brings nursing into ill repute may be indicative of unprofessional conduct. The following list has been extrapolated from states and territory’s legislation, and illustrates the scope of unprofessional conduct:

1. Conduct that demonstrates a lack of knowledge, experience, skill, judgment and/or care, this may be determined to be carelessness, incompetence or negligence;
2. Practising nursing while not registered or in possession of conditional registration, where the conditions were not heeded;
3. Engaging in improper or unethical conduct which renders the nurse unfit to practice, including some criminal offences or brings the professional of nursing into ill repute;
4. A physical or mental disorder, including alcohol and drug addiction which renders the nurse unfit to practice; and
5. Any other breach of the respective Act or condition imposed by the nurse regulatory authority (Wallace, 2001, p 428 – 432).

It is acknowledged that some nurse regulatory authorities use different terms to unprofessional misconduct but the meaning and intent is the same (MacFarlane, 2000). For example, the Nurses Act 1991 (NSW) articulates ‘professional misconduct; and ‘unsatisfactory professional conduct’ as defining unacceptable conduct within the Act. Professional misconduct is the more serious of the two allegations in that it is representative of the more ‘extreme and unacceptable aspect’ (Nurses Registration Board of NSW, 2001, p. 16) of the scope of possible specific events that the nurse could be reported. Whereas unsatisfactory professional conduct while still considered significant can include incompetent practice, including knowledge and skill; a contravention of the Act; holding oneself out to be a nurse; and any other behaviour that may be considered unethical (Nurses Registration Board of NSW, 2001).

The Nurses Act 1992 for the state of WA articulates the concept of unprofessional conduct as ‘unethical conduct’. Section 61 (g) of this Act provides that the Board may take disciplinary action where a nurse is guilty of unethical conduct as a nurse (i.e. while the person was engaged in nursing practice) by reason of (a) carelessness, (b) incompetence, (c) impropriety, (d) misconduct; (e) a breach of the Act, or (f) non-compliance with any condition or restriction imposed under the Act. Carelessness in this context has the same meaning as negligence. Incompetence reflects ‘improper professional action or treatment by a
nurse resulting from reprehensible ignorance or neglect’ (Buchbinder, no date).

Incompetence is more serious than carelessness, demonstrating a degree of ignorance or neglect in the nurse’s behaviour. The third field of unethical conduct is impropriety and reflects behaviour that is ‘improper’, ‘inappropriate’ or ‘unseeming’. Impropriety is usually behaviour not directly related to nursing duties but rather behaviour while employed as a nurse, for example a nurse who engaged in a loud debate about personal matters in a ward setting. Misconduct, a more specifically professional misconduct includes a deliberate departure from accepted standards or serious negligence (Buchbinder, no date). The emphasis at this point is that each state’s or territories nursing legislation has within them differing defining titles and qualities to explain the concept of ‘unprofessional conduct’.

To further the comparative views of unprofessional conduct, the following has been taken from the Victorian Nurses Act (1993). The Nurses Board of Victoria views unprofessional conduct as any or all of the following:

1. Conduct which is of a lesser standard than would be expected of a registered nurse, as viewed by the public or peer;
2. Professional misconduct;
3. A finding of guilt where the nurse was indicted for an offence, or where the indictment influences their ability to nurse; or an offence against the Nurses Act;
4. The provision of nursing care which is extensive or unnecessary;
5. Influencing or attempting to influence the conduct of another nurses practice where patient care would be compromised;
6. Failing to act as a nurse when required to do so under this Act or regulations; and
7. Failure to comply with any condition, limitation or restriction as imposed under the Act.
To further confuse this matter it is noted that the Nurses Board of Victoria denote ‘professional misconduct’ as a sub-set of ‘unprofessional conduct’.

In Tasmania, the Nursing Act 1995 provides the following interpretation of ‘unprofessional conduct’. Professional misconduct can be any matter which is seen to be in contravention of the Act or a foreign nursing law. A nurse can also be seen to engage in professional misconduct if they practice without a practising certificate, is negligent or incompetent in the practice of nursing or behaves in a fraudulent or dishonest way (MacFarlane, 2000).

To summarise the concepts of unprofessional conduct and professional misconduct the following examples from the Alberta Association of Registered Nurses are reported (Alberta RN, 2002). Two cases are reported. The first describes a nurse who was found guilty of unskilled practice and unprofessional conduct. The nurse who was a nursing manager intervened in a clinical case where a patient had severe respiratory distress. The nurse failed to conduct an accurate assessment of the situation, and declared the patient dead, subsequently did not call the emergency services or commence cardiopulmonary resuscitation. In contrast the second case details a nurse who was found guilty of professional misconduct after stealing a drug from their workplace.

It is acknowledged that different terms will be found in the literature to mean unprofessional conduct. The term ‘unprofessional conduct’ will be used to reflect the social phenomenon central to this study and to mean conduct which does not meet the professional practice standards. In keeping with the primary concept of unprofessional conduct the following will provide an introductory synopsis of defining components, examples and issues. The literature has been reviewed to provide depth to the definition of unprofessional conduct espoused in
the legislation. This thesis will illustrate that the scope of unprofessional conduct in terms of examples is broad. In understanding this preliminary review of the literature it is necessary to bear in mind a number of important questions which will be discussed in detail in chapters five and six. If expected nursing behaviours, articulated in the legislation and adjunct codes, and professional codes of practice are reflective of ‘professional conduct’ does any contravention of these standards mean that the nurse has practiced ‘unprofessionally’? More specifically does making a breach of a nursing standard and/or a nursing error constitute unprofessional conduct? There must be a distinction between everyday diversions from expected standards either through error or ‘rule-bending’ (Hutchinson, 1990) and the definition of unprofessional conduct. A schematic representation of the relationship between nursing practice standards and nurse behaviours and the outcome of unprofessional conduct are presented in Figure 1.3

![Matrix of unprofessional conduct](image)

**Figure 1.3: Matrix of unprofessional conduct.**
This matrix has been developed to present diagrammatically resultant unprofessional conduct within a matrix of ‘standards’, ‘behaviours’ and ‘compliance’ and ‘competence’. Unprofessional conduct can result from, for example, non-compliance or incompetence behaviours in a context of required standards for professional practice.

**Summary: Safe to Practice**

There is a social and professional expectation that nurses are safe to practice. This primary notion is at the core of nursing education and the ongoing assessment and development of nurses. The challenge for nurses is that the complexity and difficulty found in clinical situations and deficits from individual nurses poses a challenge to always providing nursing care that is safe.

Standards of appropriate nursing care and behaviour are both inherent and explicit, with the notions being found in the following: law, professional nursing body directives and research based clinical protocols. Beckmann (1996) explains that a nursing standard is an established measure of quality. The monitoring of standards of nursing practice is apportioned to a number of parties, the nurse, the patient or significant other, the employer, the nurse registration authority, the coroner and in some cases health review bodies. The resultant action can vary depending on a number of factors: the type of breach of standard and either the implication or actual outcome; the policies of the employing agency; the interface with the relevant law; and nurse factors, such as first or second offence, admission of guilt and self reporting.

Nurses must be able to deliver safe nursing practice. Despite this aim nurses are involved in matters where standards of practice are breached or are not
met, with or without resultant harm to patients. The nature of an unprofessional conduct event is a complex matrix of factors and there exists a myriad of potential trajectories of outcomes and resultant actions. In an attempt to identify and situate these factors within a framework of legal and professional standards and the impact on the nurse a systematic study is required. This grounded theory study provides an opportunity for meeting this requirement.

**JUSTIFICATION FOR THE STUDY**

The inherent need to provide safe nursing care to fulfil the expectations of society is without question. The public expects that the care that is provided to them by nurses authorised to practice will be in accordance with what is ‘good and right’. They don’t need an appreciation of the term standards, or evidence based practice or even criteria for registration; what they do expect is that they will not be harmed either intentionally or ‘accidentally’ during the delivery of nursing care. The expectation that the right drug will be administered, or that their dressing will be changed without causing undue pain and distress or that they will simply be treated with dignity and respect are powerful reasons to examine nursing practice where both the customer’s and the professions expectations of practice have fallen short.

La Duke (2000) contends that there has been minimal research and discourse associated with the professional discipline of nurses and even less relating to the impact on the nurse. To illustrate this point, to date, only one qualitative research study at doctoral level has been undertaken to examine the phenomenon of being reported to a NRA for an allegation of unprofessional conduct (Hutchinson, 1992). LaDuke (2000, 2001) had conducted two studies
where the experience of nurses has been examined using questionnaires. It is suggested that further research is needed to better understand the working environment of the nurse at the time that they violated nursing legislation (Booth & Carruth, 1998). Further research is necessary to augment what is known about factors associated with professional misconduct, disciplinary action and the links to nursing error (Power, Maurer & Wey, 2002).

The notion to ‘do no harm’ is imperative within the foundations of nursing care and therefore, research to determine the causative and related factors associated with actions of harm to patients and the impact on the nurse must be viewed as essential and timely in the domain of professional practice and regulation. The need to augment already existing notions of clinical risk management to real world experiences is necessary if such models are to parallel the complexities and realities of everyday nursing practice.

**PURPOSE OF THE STUDY**

The purpose of this study was to explore and describe the nature of the alleged unprofessional conduct scenarios talked about by the participants, specifically, those behavioural and contextual risk factors that contribute to the event and the impact on the nurse involved. This exploration provided rich and extensive data, and through the use of the constant comparative method articulated by Glaser and Strauss (1967) a substantive theory of the experience and impact of unprofessional conduct and how the participants dealt with this, in a nursing context was developed.
OBJECTIVES OF THE STUDY

Objectives of a research study are important because they bridge the gap between the more abstract purpose to more detailed and tangible goals (Burns & Grove, 1993). The following objectives have originated from the purpose of the study.

1. To develop an operational definition of unprofessional conduct within the nursing context;
2. To generate a substantive theory to explain the nature, processes and outcomes of the phenomenon of being reported for an allegation of unprofessional conduct within nursing practice and its aftermath, with specific objectives being to develop the following:
   a. Model for risk management of unprofessional conduct events in nursing; and a
   b. Theory that provides understanding and operationalisation of a framework for support for nurses during and after the event.

CONCLUSION

This chapter has provided an introduction to this grounded theory study of alleged unprofessional conduct in nursing. A review of the literature has been provided to illuminate the legal and professional background of nursing practice. Unprofessional conduct is defined in relation to nursing legislation and examples from the literature have been incorporated to provide background to the scope and dimensions of unprofessional conduct in nursing. This background provides relevance to the stated purpose, objectives and therefore justification of the study. A number of definitions of key words and terms used in this study have been provided.
OVERVIEW OF THE THESIS

Chapter two provides a review of the literature related to the phenomenon being studied and the context of professional practice and standards. Chapter three details the research methodology, including the method for grounded theory and its application to this study. Ethical protection of human participants in research is detailed along with issues and demonstration of rigour. Chapter four provides an analysis of the social phenomenon which was identified as an allegation of unprofessional conduct and its antecedents. Included in this chapter is a profile of the participants in relation to the nature of the social phenomenon. Where pertinent, literature has been included to situate the findings within the nursing world.

Chapter five details the social process grounded in the experiences of nurses who were reported to a NRA for unprofessional conduct. The emergence of the core category provides for a substantive theory where nurses are transformed personally and professionally with the onset of the allegation of unprofessional conduct. This transformation is brought about by deconstructive and reconstructive social processes, situated within a transactional matrix of cause, context and consequences. The main influencing factors were identified as support frameworks, resilience, the thread of time, and the ongoing thread of vulnerability.

Chapter six brings the study together by laying out the substantive theory. The reviewed literature is weaved throughout the findings and associated discussion. Chapter seven provides a discussion of the literature as it relates to the substantive theory. Chapter eight provides a review of the study objectives.
and achievement. Recommendations in keeping with the study objectives are also presented in chapter eight.

The following coding system has been used throughout this thesis to identifying participant statements. For example the following invented code P22/PG10/L26 denotes the participant, i.e., ‘P22; the page number i.e., “PG10” and the line number, i.e., ‘L26’. Where details could identify an individual they have been modified but do not change the nature of the experience or meaning the experience had for the individual. Those individuals who participated in the study will be referred to as ‘participant’ throughout the thesis. I have used the first person in this thesis in keeping with the qualities of qualitative research and with the need to distinguish my thoughts and actions as opposed to those of the participant.

*****

*I am convinced that our stories began in the early spring of 1980, a full eighteen months before my mother would watch her life unravel in a crowded courtroom in northern Vermont (Bohjalian, 1988, p. 19).*
CHAPTER TWO

An Overview of the Literature

The morning the judge gave the jury its instructions and sent them away to decide my mother’s fate, I overheard the attorney explain to my parents what he said was one of the great myths in litigation: You can tell what a jury had decided the moment they re-enter the courtroom after their deliberations, by the way they look at the defendant. Or refuse to look at them. But I don’t believe it, he told them, It just a myth (Bohjalian, 1988, p. 4).

INTRODUCTION

This chapter will provide an overview of the literature related to this study. The purpose of conducting a literature review in qualitative studies is twofold. Firstly, by reviewing the literature, gaps can be identified which gives purpose to the study. Secondly, to support the emergent theory by comparing and contrasting the current body of knowledge to the study findings. Further literature will be incorporated into proceeding chapters.

AN OVERVIEW OF THE LITERATURE

A review of the literature has revealed diverse topics surrounding the tenet of quality in health care. A plethora of literature related to the concepts of human error and adverse events in the medical and nursing context are evident, particularly with an increased interest in strategies for error reduction.

The literature related to nursing errors can be viewed in two broad domains, actual errors and patient outcomes (Brennan 1991; Leape et al. 1991; Meurier, 2001; Yamagishi, Kanda, & Takemura, 2003) and the understanding and minimisation of errors (Wolff & Bourke, 2000; Meurier, 2000; Douglas & Larrabee, 2003; Dunn, 2003). Individual event analysis, including conditions that
led to the event and the penalty incurred (Beckmann, 1996; Langslow, 1998; Langslow, 1998; Castledine, 2001; Castledine, 2002) and those addressed through case law reports reflect a significant amount of the identified literature. The British Journal of Nursing, a fortnightly publication, regularly details case studies of nurses who have been reported to the Nursing and Midwifery Council (NMC) for unprofessional conduct. The United States monthly journal Nursing 2005, also provides case reviews on matters where nurses breached practice standards. A number of these articles propose strategies for minimising risk of these matters occurring (Laskowski-Jones, 1998; Smetzer, 1998) including the profiling of nurses who may be involved in an unprofessional conduct event (Tranbarger, 1997; Booth & Carruth, 1998).

A number of articles (Cole, 1993; Pennels, 1997a; Pennels 1997b; Walker, 2000) and texts investigate the scope of nursing negligence and malpractice, and the interface with the law (Beckmann, 1996; Sharpe, 1999; Wallace, 2001). Another domain of the literature includes publications from professional health bodies, including nurse registration authorities (UKCC, 1996; UKCC, 1998+) and the publication of specific events in the media forum (Berens, 2002; Gibson, 2002).

Importantly, the literature is revealing a move away from analysis of error which attributes the blame to who ‘enacted’ the error. Instead, there is an acknowledgement that making error is part of a longer chain of events, multifactorial and sometimes involving multiple persons (Cho, 2001, Conner, Ponte & Conway, 2002, Federwisch, 2004, Reason, 1990, Reason, 2000).

This overview of the literature review will focus on the broad context within which the social phenomenon of unprofessional conduct has emerged by
introducing a range of associated concepts and conditions that influenced the
events of allegations of unprofessional conduct. This précis will provide a
foundation for exploring the nature of unprofessional conduct, the research
objectives and findings of the study.

**Error**

**Theories of Error**

It is imperative to understand what constitutes error. The following will
provide a synopsis of some theories and specific nursing studies related to error
and outcomes. It is important to note that the study of human error is extensive
and complex. The following is provided as an introduction to the psychology of
error. Reason (1990, p 17) states that error is connected to the concept of ‘intent’,
that is, an ‘error can only be meaningfully applied to planned actions that fail to
achieve their desired consequences without the intervention of some chance or
unforeseeable agency’. This concept of error can be viewed as having two
sub-sets: (1) a ‘slip (or lapse) where actions are not in accordance with the plan;
and (2) a mistake which reflects an inadequacy with the plan, i.e. there exists a
mismatch between the initial intention and the intended consequences. Errors are
further categorised as falling into one or more of the following three categories:
(1) behavioural; (2) contextual; and (3) conceptual and reveal the type of an error.
It is important to note that most errors are associated with human behaviour
(Dunn, 2003). Table 2.1 provides examples of error types (Bennett & Dune,
2002).

Reason (1990) explains that errors can be further divided as (a) a failure of
expertise and (b) a lack of expertise. A failure of expertise relates to where a pre-
established plan or problem solving trajectory is applied inappropriately. In contrast, a lack of expertise the individual who is not able to choose from a repertoire of solutions has to work out a solution based on what knowledge they have. Importantly states Reason (1990) the ‘form’ of an error are extremely widespread that their occurrence is rarely linked to failure of anyone single cognitive entity.

<table>
<thead>
<tr>
<th>COGNITIVE STAGE</th>
<th>EXAMPLE</th>
<th>ERROR TYPE</th>
</tr>
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<tbody>
<tr>
<td>Conceptual/planning</td>
<td>Administering all of the following medications, an analgesic, a sleeping tablet and an anti-anxiety tablet without realising that this combination could cause the patient to be over sedated.</td>
<td>Mistake: A failure of expertise or lack of expertise</td>
</tr>
<tr>
<td>Storage</td>
<td>Administration of insulin to a patient scheduled for surgery who is also fasting</td>
<td>Lapse: A gap in memory, the information is not retrievable</td>
</tr>
<tr>
<td>Execution</td>
<td>Documentation on the wrong chart; not inserting the new IV tubing into the IV pump</td>
<td>Slip: Not a planned action</td>
</tr>
</tbody>
</table>

Table 2.1: Error types.

Error in Health Care

The North American report ‘To Err is Human: Building a Better Health Care System’ released in 1999 (Kohn, Ed.) brought the statistics of error in health care to the forefront and with it, a call for action. It was estimated that between 44 000 and 98 000 deaths occur annually as a result of error (Federwisch, 2000). In the Australian context it is estimated that there are approximately 230 000 preventable adverse events each year (Wilson et al, 1995). The Quality in Australian Health Care Study further revealed that of this number, 14 000 resulted
in preventable deaths and 36 000 in preventable permanent disability (Wilson et al, 1995).

**Nursing Errors**

It is contended that although some nursing errors are prevented from occurring and some cause serious harm, most result in insignificant patient outcomes (Kelly, 2002). Error has been defined by nurses as ‘any wrongful decision, omission, or action for which the nurse feels responsible and that had adverse or potentially adverse consequences for the patient and that would have been judged wrong by knowledgeable peers at the time it occurred (Meurier, Vincent & Parmar, 1997). Tingle (2003) provides examples of nursing [practice] errors. A nursing error, or failing, can include poor documentation, care planning and nursing care; not communicating important information, failing to adequately supervise a student nurse, and poor infection control practices.

Benner et al (2002) undertook an analysis of 21 disciplinary cases from nursing regulatory authorities in the North American context. Eight categories of nursing error were identified. The categories or taxonomy of nursing errors are:

1. Lack of attentiveness to the clinical condition of the patient;
2. Lack of ethical agency or fiduciary concern;
3. Inappropriate nursing judgement;
4. Medication errors;
5. Lack of intervention;
6. Lack of prevention;
7. Missed or mistaken orders; and
8. Documentation errors.

Some other issues related to nursing errors include the following. Nurse staffing, specifically inadequate nurse-patient ratios, has been shown to affect the
mortality of hospital patients and contribute to adverse patient outcomes (Flood & Diers, 1988; Aiken, Smith & Lake, 1994). This theme was identified by Meurier, Vincent and Parmar (1997) who found that nurses identified work overload as a factor in making errors. This overload contributed to them being distracted.

Medication administration is a common area in nursing practice where mistakes are made and consequently, are well represented in the literature. From the study by Benner et al (2002) medication errors were further categorised:

1. Missed doses;
2. Wrong administration time (specifically 60 minutes before or after documented time);
3. Intravenous infusion rate too fast or too slow;
4. Wrong concentration of dosage administered intravenously;
5. Wrong administration route;
6. Wrong medication administration due to misidentification of the patient; and
7. Wrong medications administered.

In an Australian study it was found that nurses were more likely to report an error if they perceived that there was a threat to patient safety (Walker & Lowe, 1998). They were less likely to report an error where only documentation and minor variations from the order. This finding is supported by Hackel, Butt and Gaudria (1996) who contend that nurses are only likely to report an error if there is harm to the patient. Nurses in this reported study stated that the main reason for not reporting errors was a matter of self preservation. Walker and Lowe (1998) state that there is a genuine fear by nurses that they will get into trouble for having made an error and receiving punishment.

Understanding why errors occur and in particular why nursing errors occur is an important step to implementing preventative and minimisation
strategies. Two early studies provide insight into factors which contributed to a medication error. Fuqua and Stevens (1988) identified four factors which contributed to errors in medication administration:

1. Inadequate knowledge or medication administration skill;
2. Failure to comply with policy and procedure;
3. Failure in communication; and
4. Disruptive personal experiences.

Wolf (1989) in another study identified a number of situations that preceded an error, including:

1. Transcribing errors;
2. Environmental distractions;
3. Failure to read and apply information on drug labels;
4. Confusion with drugs which are similarly packaged;
5. Use of defective equipment;
6. Selecting the wrong drug container;
7. Poor handwriting;
8. Choosing (and giving) medications based on memory without looking at the medication order each time;
9. Recording medication given before actually administering it;
10. Leaving medication at the bedside; and
11. Scheduling administration times during shift change times.

More recent studies show that these contributing factors have not changed. A study conducted by Osborne, Blais and Hayes (1999) revealed nurses’ views of why medication errors occurred. Contributing nurse factors included: being ‘tired and exhausted’; miscalculating the dose; failing to check for the correct patient; and confusing medications with similar names. In contrast, system issues included: illegible handwritten medical orders; poor or confusing packaging of medications; environmental distractions; and wrong orders. The study conducted by Benner et al (2002) also found similar attributes. The preceding discussion
reveals the influence of systems issues in relation to nursing errors. Importantly one study showed that system issues were present in the majority of medication errors (Leape, Bates, Cullen et al, 1995) and furthermore, that errors directly related to knowledge deficit by the administering nurse were far less, and caused less harm.

**Systems Issues**

A system is defined as ‘a group or combination of interrelated, interdependent, or interacting elements forming a collective entity (Collins Australian Dictionary, 2003, p. 1637). An example of a system relevant to nursing and one in which many errors occur is the medication administration. Medication administration involves many steps: obtaining and interpreting the order; ordering the medication; obtaining the medication from the pharmacy; choosing the right medication, right dose, right route, right time and the right patient. In relation to understanding contributing and causative factors in error, the system and system components can be at fault (Reason, 1990).

Research into the domain of systems issues contends that in an interrelated system of human and nonhuman factors, should any one element go wrong, particularly when new system elements are introduced there is an increased risk of error (Page, 2001). It is further contended that errors typically occur as a result of problems within and of the system, rather than from individual worker performance (Page, 2001). This is based in part by the work of Reason (2000, p. 768) who asserts that ‘errors are to be expected even in the best of organisations’.
Reason (2000, p. 769) describes what he calls ‘the Swiss Cheese Model’ illustrate how system accidents occur. This model is visually represented by a number of slices of Swiss cheese, positioned, one in front of the other. The cheese represents ‘defences, barriers and safeguards’ in place to minimise or prevent the occurrence of an error. Reason (2000, p. 769) states that ‘in an ideal world each defensive layer would be intact’. In reality, the holes in the cheese are dynamic and move, thus creating the potential for an alignment of holes and as such the opportunity for an ‘accident trajectory’ to get through the holes and cause an error (Reason, 2000).

To better understand the interplay of systems and errors the following cases are offered. Although individuals contribute to errors by the commission of active failures and/or the creation of latent conditions (Reason, 1999) the system and its elements contribute significantly to error.

**Illustrative Cases**

**Bristol Hospital Inquiry**

The Bristol Hospital Inquiry (BRI) was in response to a number of poor outcomes of children undergoing cardiac surgery at the Bristol Royal Infirmary over an extended period of time (Merry & Smith, 2003). The BRI was conducted between October 1998 and July 2001. The terms of reference allowed the panel of experts to inquire into the management of the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995.

This inquiry revealed an extensive interplay of system issues, when combined with human factors, provided for the following undesirable outcomes.
Of the 53 children with congenital heart problems who underwent surgery, 29 died. The following selected findings from the inquiry are provided to illustrate the system and cultural issues that were identified as contributing factors in these deaths. What is identified in these findings is a deficit of shared and clinical governance, including adequate audit and monitoring systems. The BRI concluded:

- It is an account of people who cared greatly about human suffering, and were dedicated and well motivated… [though] some lacked insight and their behaviour was flawed. Many failed to communicate with each other, and to work together effectively for the interests of their patients. There was a lack of leadership, and of teamwork;
- It is an account of a service offering paediatric open heart surgery…split between two sites. There was no dedicated paediatric intensive care beds, no full-time paediatric cardiac surgeon and not enough nurses who were educated in paediatrics;
- There was no agreed means of assessing the quality of care. There were no standards for evaluating performance…confusion existed as to who was responsible for monitoring quality; and
- There was a ‘club culture’ at this hospital… an imbalance of power and too much control by a few persons (Bristol Royal Infirmary, Final Report).

The BRI made a number of recommendations in an attempt to remedy the identified system and cultural issues. A few of these are provided as examples of the theme of recommendations:

- All healthcare professionals will undergo appraisal, continuing professional development and revalidation to ensure competence;
- There must be agreed and published standards of clinical care…so that patients and the public know what to expect;
- There must be effective systems within the hospital to ensure that clinical performance is monitored; and
Children in hospital must be cared for in a child centred environment, by staff educated in paediatrics and in facilities appropriate to their needs (Bristol Royal Infirmary, Final Report).

This case provides an example of a number of systems issues, despite a number of other doctors and administrators trying to ‘raise the alarm’. This sort incident, where systems issues ‘collide with human behaviour’ and result in unfavourable, and in some cases dire outcomes, is not an isolated case.

Melbourne Health Review and Improvement Plan

In 2002 an investigation into alleged unprofessional conduct by a small number of nursing staff at the Royal Melbourne Hospital in Victoria, Australia was completed. The primary allegations were that the nurses concerned did not treat their patients with dignity or respect, administered medications inappropriately, used inappropriate and unprofessional language, took drugs that were Hospital property and worked while affected by drugs. What stemmed from these allegations was a larger investigation into not only the specific allegations but also the underlying organisational culture issues thought to have provided a context for less than satisfactory practices and reporting mechanisms. A number of major themes were identified and provide to some degree an explanation for why such allegations were possible. The first theme, culture and behaviour revealed a culture of blame which meant staff were reluctant to identify (and probably report) problems and a lack of consistent patient focus. A number of issues relevant to the second theme of accountability and responsibility included: (a) a lack of clarity surrounding accountabilities; (b) a lack of effective performance management systems; and (c) a lack of adequate training in management for clinical managers. The third theme, clinical practice, exposed inadequate support of novice staff and a failure to ensure knowledge of and
compliance with standards of practice. The fourth theme indicated a general unsatisfactory quality improvement system. The findings of this in-depth investigation promulgated a significant number of recommendations arising out of alleged unprofessional conduct by a small number of nurses. The relevance of this investigation for this research study provides support to the notion of contextual risk factors. This is not to negate the individual accountability of individual nurses but clearly demonstrates that any one unprofessional event, upheld or dismissed through a formal disciplinary investigation does not occur in isolation and both the organisational culture of the employing agency has a role to play in the behaviour of nurses (Melbourne Health, 2002).

**The Macarthur Investigation**

In 2003, the Director-General of New South Wales (NSW) referred a complaint to the Health Care Complaints Commission (HCCC) about allegations of sub-standard practice in two hospitals in the Macarthur Area Health Service, Campbelltown and Camden Hospitals. This case was brought to the attention of the Director-General by a number of nurses who worked at the hospitals.

After the initial report, the HCCC established a Special Commission of Inquiry to look at allegations of inadequate care. The HCCC team investigated 48 incidents of patient care which were listed in the initial report. The final report was issued on July 30, 2004 (HCCC, Annual Report, 2003-2004). It was found that from 1999 to 2003 there was evidence of mismanagement and neglect at these two hospitals, with the resultant death of 19 patients.

**Bundaberg Hospital Inquiry**

The inquiry into allegations of misconduct by one medical practitioner at the Bundaberg Hospital in Queensland, Australia has drawn much media
attention. A successful Supreme Court appeal has meant that the inquiry has been stopped in its current form, therefore, there are no conclusions or recommendations to report here. From the terms of reference, some insight into the allegations can be gleamed. A selection of points from the terms of reference for the inquiry into the practice of Dr Patel and patient outcomes, including alleged deaths of 90 patients relating to sub-standard practice are presented here:

- The role and conduct of the Queensland Medical Board in relation to the assessment, registration and monitoring of overseas trained medical practitioner, with particular reference to Dr Jayant Patel;
- Any substantive allegations, complaints or concerns and procedures conducted by Dr Patel at the Bundaberg Base Hospital, specifically;
- The adequacy of the response by Queensland Health to any complaints received concerning Dr Patel;
- Whether or not there were any reprisals or threatened reprisals by officials of Queensland Health against any person who made the complaint; and
- The appropriateness, adequacy and timeliness of action taken to any of the allegations, complaints or concerns within and outside the Bundaberg Hospital (Queensland Public Hospitals Commission, QLD Government, 2005).

The above cases have common characteristics which resulted compromised patient outcomes: undetected sentinel events; sub-standard clinical governance; and reporting of the issues by health care workers to politicians whose concerns had ‘fallen on deaf ears’ for too long (Van Der Weyden, 2005). Van Der Weyden (2005) expresses concern that it was not a system of clinical governance that unearthed the problems but rather, the concerns of medical practitioners and nurses.

An article in the Bulletin magazine (Davies, 2005) provides further insight into this growing phenomenon where individuals, because of a lack of clinical
governance, are ‘permitted’ to practice at their own standard and within their own worldview of how things should be done. For example, explains Davis (2005) Patel was allowed to conduct his own surgical audits. The challenge for other practitioners in these sort of situations is to work out how to ‘work around these people’ or deciding how and when to speak out. Davies (2005, p. 20) reports the comments of one physician from Bundaberg: he described Patel as ‘a man who was deeply narcissistic, a braggard, a sycophant and a bully’. Individual medical practitioners worked around Patel by not referring patients to him. Nurses reportedly ‘hid’ patients from Patel so that he could not intervene surgically (Davies, 2003).

**Violations**

Violations are different from error because they involve an element of ‘choice’ (Merry & Smith, 2003). A discussion of violations is included at this point to provide a comparative view to breaches of, or failure to meet standards through error making. An individual may breach, or fail to meet a standard by committing a violation. Reason (1990) defines a violation as:

> A deliberate, but not necessarily reprehensible deviation from those practices appreciated by the individual as being required by regulation, or necessary or advisable to achieve an appropriate objective while maintaining the safety of people and equipment and the ongoing operation of a device or system (Reason, 1990, p. 195).

Merry and Smith (2003) make a further distinction between violation and error by explaining that unlike an error where there is viewed a degree of inevitability, and as such, unavoidability, violations are in contrast, avoidable. Importantly therefore, there is a degree of culpability. Violations have been categorised and are presented in table 2.2 (Merry & Smith, 2003, p. 106-111).
<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine violations</td>
<td>Typically involve a ‘cutting of corners’ in everyday tasks.</td>
<td>Not providing the patient with all the information known about a procedure.</td>
</tr>
<tr>
<td>Appropriate violations</td>
<td>Where an individual makes a justifiable decision in good faith, but in doing so breaks a rule.</td>
<td>Administering an analgesic earlier than ordered because the patient is in pain and the order cannot be changed.</td>
</tr>
<tr>
<td>Exceptional violations</td>
<td>Occur in situations which are themselves exceptional and which mean some rule which is seen as normally appropriate cannot be followed.</td>
<td>Likely to occur in an emergency, e.g. limited hand washing in an emergency surgical situation.</td>
</tr>
<tr>
<td>Necessary violations</td>
<td>Created by unexpected and unpredicted situations, or what may be called system double-binds.</td>
<td>Combination of existing fatigue and having to work another extremely long shift.</td>
</tr>
<tr>
<td>Optimising violations</td>
<td>A violation for the thrill of it.</td>
<td>Actions deliberately aimed at causing harm, e.g. sabotage or fraud.</td>
</tr>
</tbody>
</table>

Table 2.2: Categories of violation.

A reported study of relevance to the concept of both routine and appropriate violations follows. Hutchinson (1990, p. 3) provides insight into why nurses ‘bend the rules for the sake of the patient’. From a larger qualitative study which examined unprofessional conduct by nurses, there were descriptions of ‘rule bending’, or as coined by Hutchinson (1990, p. 3) ‘responsible subversion’.

The participants in this reported study described the following strategies when bending the rules. ‘Pretending’ was a strategy that helped them to not notice something. For example one nurse in the reported study stated: ‘these visitors came from two hours away and walked right into the patient’s room. The patient wanted to see them. I just pretended not to notice’ (Hutchinson, 1990, p. 11). A further example follows. Nurses used ‘stalling’ tactics to avoid having to follow through with a medical practitioner’s order. Nurses slowed down their
actions so as not to interfere with processes they saw as ‘normal’, for example, labour and dying.

**Negligence**

Introducing negligence at this point is important because breaches of, or failures to meet a prescribed standard can be pursued in a civil proceeding by an individual who believes they have been harmed in the course of a health care experience. The link between error, violation and alleged negligence will be made.

Importantly, negligence is viewed as an isolated act where an error may have been made: incompetence is viewed as that which goes beyond a single act and falls under the jurisdiction of the NRA (Wallace, 2001). The definition of negligence and the forces of law were introduced in Chapter One, but are revisited to provide a foundation for discussing a number of cases where a nurse was found to be negligent.

Negligence, or professional negligence, is probably the domain of greatest legal importance for health care workers (Wallace, 2001). In fact, every nursing action has the potential for a charge of negligence (Tingle, 1990, p. 60). In law, negligence is considered a tort, and is way that individuals can seek compensation. A number of criteria have to be proved before a determination of negligence is made (Wallace, 2001). For negligence to be proved there must be an ‘owed’ duty of care by person A to person B; evidence that the duty of care has been breached; and that this act or omission has caused either physical or financial harm (Wallace, 2001). A number of cases demonstrate that nurses have been found to have been negligent. One case: Laidlaw et al v. Lions Gate Hospital et
al (1969) 70. W. W. R. 727, describes a case where two nurses were found to be
negligent in relation to inadequate assessment of at risk patients post anaesthesia
(O’Sullivan, 1983). A further case reveals the practice of nurse who administered
the wrong dose of a medication, resulted in the death of a child, Norton v
Argonaut Insurance Company (Staunton & Chiarella, 2003). Although there was
an understanding of the circumstances the nurse found herself in, including,
unfamiliarity with the drug, the fact that she had been out of clinical nursing for
some time, and that her attempts to determine the correct dose and administration
method, the judge determined that her practice fell short of what a reasonable
nurse should do: that is to contact the ordering medical practitioner (Staunton &
Chiarella, 2003).

Deviant Behaviours

This chapter, so far, has provided an introduction to the concepts of error
and violation. The next section will examine the concept of deviant behaviours in
the work context. The word deviant, although defined as ‘deviating from what is
considered acceptable behaviour’ (Collins Australian Dictionary, 2003, p. 454)
can be used to represent anyone who acts in a non-conforming way, and will be
used to mean in this context, a sustained deviant behaviour which comes to the
attention of others because of sub-standard work practices and attitudes. This
deviant behaviour can be seen in the following groups: the impaired practitioner;
persons displaying anti-social behaviours; and persons displaying behaviours of a
forensic nature.
The Impaired Practitioner

Alcohol and Drug Dependency

Healthcare professionals, including nurses are not immune to alcohol and drug dependency (Lillibridge, Cox & Cross, 2002; Lowell & Massey, 1997; Sullivan, Bissll & Leffler, 1990). Sullivan et al (1990) surveyed 300 nurses recovering from a dependency on alcohol and/or other drugs. Findings with employment consequences are reported. The study participants reported that their ability to practice effectively was impacted by the following: mood swings; irritability; poor co-workers relationships; memory loss; depression; anxiety; inappropriate behaviours and secretiveness (Sullivan, et al, 1990, p. 384). Participants were noted to make ‘numerous mistakes’, be involved in ‘frequent incidents’ and were responsible for ‘illegible charting’ (Sullivan, et al, 1990, p. 384).

Practicing nursing whilst impaired through an alcohol or drug dependency is viewed in some jurisdictions as unprofessional conduct (Fiesta, 1993; Nurses Act [1992] WA, amended). Fiesta (1993) states that while registering authorities can take disciplinary action, a number of them choose, in the first instance, to provide an opportunity for the nurse to recover from the dependency. As public safety is a key issue determining any action, nurses may have their registration suspended until they are fit to practice.

In Queensland, Australia, the Queensland Nursing Council (QNC), the state NRA, provide an opportunity for the nurse or midwife with a health concern to have the matter referred to the Health Assessment Advisory Panel for assessment (Queensland Nursing Forum, 2005, May). This panel has a two fold purpose: (1) to discuss with the nurse/midwife options for rehabilitation and the
processes for regaining and/or demonstrating fitness; and (2) to determine whether the nurse/midwife is prepared to provide an undertaking to the Council to meet this process. The QLC views this as a fairer and more expedient approach (Queensland Nursing Forum, 2005, May).

**Mental Health Issues**

Nurses may also be determined to be impaired because of a mental health issue. Similar to the pattern of nurses with an alcohol or drug dependency, it is not until an incident happens at work because of the addiction or illness that the matter is brought to the attention of the employer and then the NRA. Nurse registration authorities are able to inquire into the mental fitness of a nurse in relation to their ability to practice (Wallace, 2001). The following statistics (Table 2.3) provide insight into the issue of impairment to practice secondary to a mental health issue.

<table>
<thead>
<tr>
<th>State or Territory</th>
<th>Year</th>
<th>Number of complaints related to impairment secondary to a mental health issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td>2000</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>2001</td>
<td>3</td>
</tr>
<tr>
<td>New South Wales</td>
<td>2000</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>2001</td>
<td>22</td>
</tr>
<tr>
<td>South Australia</td>
<td>2000</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>2001</td>
<td>13</td>
</tr>
</tbody>
</table>

*Table 2.3: Examples of cases referred to a NRA for impairment secondary to a mental health issue.*

**Anti-Social Behaviour**

Anti-social is defined as ‘contrary or injurious to the interests of society in general’ (Collins Australian Dictionary, 2003, p. 72). The term anti-social is usually applied to people, though more specifically, to their behaviours. Labelling behaviours as anti-social for the purpose of this thesis means those behaviours that
would normally be seen as different to those of the group, ‘chosen’ by the individual and importantly, which result in negative impact or outcomes for others.

Clarke (2005) in his text ‘Working with Monsters’, provides a comprehensive overview of what he terms the ‘workplace psychopath’. Clarke (2005, p. 24) define psychopathy as ‘personality disorder, or a persistent and repetitive maladaptive way of coping with life’. He goes on to state that the workplace psychopath can be classified into four types: (1) the organisational psychopath; (2) the corporate criminal psychopath; (3) the violent criminal psychopath; and (4) the occupational psychopath. It is important to note each type is not discrete: individuals can display an overlapping of behaviours representative of each type. The organisational and occupational psychopath will be discussed in more detail.

The organisational psychopath in manipulating their way ‘up the career ladder’, have two motivating objectives. Firstly, they want to get to the ‘top’ because of the financial benefits and associated power, and secondly, they ‘revel in the suffering and misery’ they cause others in the workplace (Clarke, 2005, p. 56-57). Some characteristics and behaviours of the organisational psychopath are listed:

- Unethical;
- Undependable;
- Bullying;
- Intimidating;
- Deceitful;
- Superficially charming;
- Lacking a conscience;
- Egocentric or narcissistic; and
- Pathological lying (Clarke, 2005).

The occupational psychopath uses their occupation and associated work contexts to ‘satisfy their psychopathic needs’ (Clarke, 2005, p. 71). An example of an occupational psychopath is the firefighter who lights fires so they can be involved in the putting out of the fire and the associated excitement they feel (Clarke, 2005).

Such behaviours are not without implication for workplaces and individual colleagues. Individuals who are targeted by workplace psychopaths may experience and exhibit the following: panic attacks; depression; guilt; trust issues; powerless; and shame. Workplaces can experience a loss of productive hours due to stressed individuals not attending work and consequential financial implications (Clarke, 2005).

It is important to consider that the workplace psychopath can also be a criminal, nonetheless the preceding section has been included to acknowledge that individuals exist or through their egocentric needs and wants can make a colleagues life a living hell. This notion will be seen in case number 5 of this study and discussed in later chapters. Behaviours in the context of nursing, where a crime has been alleged and proven will now be introduced.

**Criminal Behaviour**

A darker theme within the literature addresses those nurses who have killed patients intentionally (Yorker, 1998; Martin, 1993; Stark, 1997) and nurses whose actions in the course of their duties have caused the death of a patient. The issue of whether charges of manslaughter or murder should be brought against the nurse are debated in a number of articles (Mellar, Cronin & Merry, 1995; Curtin, 1997; Mongeau, 1998). Tranbarger (1997) talks about the rogue nurse,
specifically the nurse who holds themselves out to be more qualified than is the truth, nurses who are ‘sexual predators’ (p 34), the nurse who is chemically dependent, and relevant to this section, nurses who kill their patients.

A media report (NurseWeek, August 2002) profiled allegations of unprofessional misconduct against an ex-nurse who has been charged with the killing of ten patients in Missouri, USA. The District Attorney will be seeking the death penalty. It is alleged that he injected these patients with the drug succinylcholine, a paralysing agent that without appropriate manual respiratory support can cause death.

This theme is continued with the allegation put to a Texas court over the actions of a licensed practising nurse who was found guilty of the murder of a child after administering to them the same drug. This much publicised case, the subject of two books and a television movie articulates not only the allegation that was tried, but a number of other allegations where this nurse administered to children in a paediatric intensive care unit drugs to induce a cardiac arrest in the child (Moore & Reed, 1988). In a foundational text on crime profiling, such behaviour is classified as ‘hero homicide’. In analysing the previously mentioned case the authors describe this as a situation where the nurse in question seemed to ‘crave and relish the pinnacles of emotion…working in a place where the stakes were so high’ (Douglas, Burgess, Burgess & Ressler, 1992, p. 117). It is posited that such nurses inject themselves into scenarios of ‘high drama’ and engineer clinical situations where they are able to respond to save the patients life and become the hero in the situation.

In a study of 34 female serial murderers in the USA, six were nurses (Stark, 1997). In an intensive care unit in Los Angeles, one nurse was convicted
of killing 12 patients in an intensive care unit. A nurse in Florida, pleaded guilty to murdering five patients in a nursing home. In the state of Georgia, USA, a nurse was found guilty of murdering one patient, although it is thought that this nurse may have been involved in the death of five other patients (Stark, 1997).

Nurses who murder their patients are not isolated to the US context. In 1993, Beverley Allitt was found guilty of murdering four children and injuring another nine (Lunn, 1994). Allitt was found to be suffering from Munchausen by Proxy (MBP) (Lunn, 1994): a psychiatric disorder where an adult individual claims or induces illness in children (Feldman & Ford, 1994). In contrast, Munchausen’s disease, is diagnosed when the individual claim or induce illness in themselves (Feldman & Ford, 1994). While making such diagnosis is not without question or risk if the diagnosis is wrong (McGill, 2002) there remains a great potential for harm, particularly to children who are invariably in a dependent relationship with the individual with MBP. These individuals are more often than note, female, a parent, or from the medical profession (including nurses, and those who commenced some training in the medical or allied professions but did not complete] (Meadows, 1977).

Whether a nurse is involved in a breach of, or failure to meet a standard by way of an error, and/or violation, whether the matter is dealt with by a NRA or through the civil courts with an action of negligence there are clear consequences for the nurse involved. This next section describes the impact on the nurse where an allegation of unprofessional conduct has been made.
The Impact of an Allegation of Unprofessional Conduct on the Nurse

Simpson (2000) quoting from a media report (Chicago Tribune, September 10, 2000) reports that in the preceding five year period 9 584 patients were ‘injured’ as a result of nursing actions or inactions. The article further stated that according to disciplinary records at state and national levels, ‘nurses have long been responsible for more patient deaths and injuries each year than any other health care professional because they spend more time with patients (Simpson, 2000 p. 21). The focus on nurses’ involvement in allegations is questionable in view of what is known about systems issues and the fact the majority of interventions patients receive in a hospital setting involve a nurse. Conner and Ponte (2002) state that although the systems issues contribute to errors, this does not mean that individuals cannot be held accountable errors but places emphasis on considering all issues to make a sound determination of culpability.

Importantly, systems issues, the behaviour of the individual nurse and the interplay or these two domains must be central to evaluating and considering any alleged breach of a nursing practice standard.

Although there is a concerted effort to minimise the apportioning of blame to nurses involved in errors, particularly where an error has occurred and where there have been system issues (Federwisch, 2000; Johnstone & Kanitsaki, 2005; Ramsey, 2005; Stewart, 2003; Wolf, 2004) the fact remains that nurses can, and are reported to nurse regulatory authorities for alleged unprofessional conduct.

A review of the literature related to the experiences of these nurses is provided. There are a small number of published accounts, both anecdotally (Mongeau, 1998; Porter, 1998; LaDuke, 2001) and research based (Hutchinson, 1992; Booth & Carruth, 1998; LaDuke, 2002) with respect to the nurses
involvement in an allegation of unprofessional conduct, the consequences of this experience and associated NRA actions.

Hutchinson (1992) explored and described the experiences of a volunteer purposive sample of 30 nurses who had been accused of violating the Nurse Practice Act in Florida, USA. Data from interviews and participant observation at disciplinary hearings was analysed using the constant comparative method of grounded theory. The study participants were found to experience a transformation of professional identity. Specifically, their way of viewing themselves, their work and the profession of nursing were altered over time. Five phases of this transformation process were identified: being confronted; assuming a stance; going through it; living the consequences and revisioning.

The sub-theme ‘being confronted’ details the nurse being advised that they have been reported to and are being investigated by the respective authority through receipt of a letter. This is the official beginning of this journey. The nurse then has to assume a stance over the allegation, including reliving the event in their minds, evaluating the nature of the violation, specifically the context, cause and the interface of themselves within the event. The nurse progresses to assume a stance which has effective and behavioural components, including feelings of guilt, low self esteem, anger and suicidal thoughts. Behavioural components including admission of guilt and assuming a passive approach to both the allegations and processes or a stance that involves an engineered assertive approach to facing the allegations. Nurses made comments like, ‘It’s the worst thing that ever happened to me’, ‘I was treated like a criminal’, ‘I’ve never been so scared in all my life’ and ‘the uncertainty was horrible’ (Hutchinson, 1996, p. 137). Not surprisingly this uncertainty and living in limbo was the most
problematic for the nurse as some cases took anything up to two years to fully process.

Living the consequences unfolded with each stage of the process from the point of confrontation. Some of the stages include: receipt of letters indicating the procedures of the regulatory authority; explaining the matter to friends, family and colleagues; and the experience and outcomes of the disciplinary hearing. The nurse used introspection to make decisions during this phase, for example, one nurse, upon realising that her nursing practice would be monitored for the duration of the investigation, decided to resign and work in a non-nursing context. Professional consequences included monitoring of practice, including changing employment so that they could be monitored and the need to leave nursing, either temporarily or permanently. The final sub-theme is re-visioning. Through the passage of time, and the use of reflection and integration of the experience into the lives nurses transcend their ‘own personal horror’ and revision (Hutchinson, 1996). All nurses experienced a transformation of their professional identity. Significantly these nurses now see the ‘power and dangerousness of nursing, the energy, determination, assertiveness and self control’ required to practice as a nurse (Hutchinson, 1996, p. 138).

A study to examine violations of the Nurse Practice Act in the state of Louisiana, USA, and the nurses’ experiences of the associated disciplinary action was undertaken by Booth and Carruth (1998) with the objective of profiling disciplined nurses and qualitatively examine the nurses’ experience. A demographic survey and a Nurse Incident Inventory (NIV) was sent to 249 nurses and although a low response rate did not surprise the investigators a number of key findings emerged from the completion of the NIV which sought a description
of the life events surrounding the behaviour that required disciplinary action.

From a total of 22 respondents, these comments were made by the nurses in relation to the actual alleged event. In two instance, nurses were vague about the events surrounding them being reported to the Board, one nurse accused her co-workers of not helping her during a period of ‘illness’ and another denied the charges and was angry that her name was publicly published. Those nurses who denied fault demonstrated less insight into the event or how they would avoid the error if given another chance. Some of the study participants, in particular those with a chemical dependence recognised that the disciplinary matter was a wake up call and actually forced them to address the matter of their addiction which in some cases had been longstanding. On average it took five years before their addiction was discovered by others in the work setting.

An extensively documented case highlights the jurisdiction of the law and not only the nurse regulatory authority when a medication error results in the death of a patient (Mongeau, 1998). For example, in 1996 three nurses in Denver Colorado, USA, were charged with criminally negligent homicide after they were involved in the administration of an overdose of *penicillin G procaine* to an infant. The matter was brought to the attention of the District Attorney who pursued the charges. Two of the nurses accepted plea bargains, admitting guilt, the other nurse was acquitted at trial. As part of the plea bargain, the two nurses were offered a deferred judgment, which means that two years after the event they could return to court and ask to have their cases dismissed, along with performing 24 hours of community service including educating nursing students about their mistakes. Despite their admission of guilt it was evident that the pharmacist involved in the making up of the antibiotic miscalculated the dose and filled the
syringe with ten times the ordered dose. The pharmacist distributed this amount into a number of syringes. Because of this larger number of syringes the nurses decided that they could not administer them intramuscularly, but decided to use the intravascular route, contrary to the medical practitioner’s order. The District Attorney alleged that this action was a ‘gross deviation from the standard of care that unjustifiably caused a risk to human health and safety’ (Mongeau, 1998, p. 49). Along with criminal proceedings two of the nurses had their license to practice suspended for 12 months. One nurse commented that ‘no amount of punishment that (the District Attorney) could ever have given me that I haven’t already done to myself and will for the rest of my life’ (Mongeau, 1998, p. 49).

LaDuke (2000) examined the perceptions and experiences of 33 nurses in New York State, USA who were disciplined for professional misconduct. A Likhert scale for a variety of questions was completed by the participants, including the provision to make comments. As with similar studies a low response rate was present. The investigator poses that this may be due to feelings of shame, anger and ongoing distrust. Some key findings from this reported study included: feelings of shame, negative impact on physical and mental health; and a negative effect on their personal relationships. These feelings commenced as soon as they found out about the allegations. Significantly, nurses had experienced a loss of income or job opportunity and financial hardship. Half of the respondents had either not returned to nursing electively, or because they could not secure a position. Importantly, LaDuke contends that further research is required to fully understand the response of nurses to alleged unprofessional misconduct, the events that can lead to allegations and the consequences.
LaDuke (2001) continues the theme of nurses’ experience of allegations of professional misconduct and the disciplinary proceedings. In this article the accounts of six nurses in the US accused of and disciplined for professional misconduct are detailed. Common themes of these six nurses include: a lack of information related to the allegations and disciplinary proceedings; a lack of knowledge regarding the governing nurse legislation; and a lack of personal and professional support. One nurse stated that she had no idea how this matter could have impacted so much on herself and her family. She suggested that a nurse in the same situation should mobilise their support systems sooner than later.

Some reported findings related to the gender of nurses reported to a NRA are included at this point. While there is no assumption made regarding these statistics, the findings are interesting in view of the fact that men comprise the smallest proportion of the nursing workforce in many countries.

**Gender Issues**

Information contained within the annual reports for Australian nurse regulatory authorities do not provide detail on the incidence of unprofessional conduct events according to gender. Cole, (1993) states that there was a higher incidence of reported unprofessional conduct to the UKCC of men compared to the number of women registered, and reported for an allegation of unprofessional conduct. Statistics provided reveal that of 124 nurses who appeared before a disciplinary committee, 48% of them were men, but even more importantly men at this time represented only approximately 10% of nurses registered in the United Kingdom. A great number of the allegations involving men, involved physical, verbal or sexual abuse of patients. In a study conducted by the Texas Board of
Examiners (1994) for the period 1991 – 1992 it was found that men were three times more to be reported to a NRA.

A review of gender representation of nurses in cases which proceeded to formal hearing at the Nurses Board of Victoria is provided (Johnstone & Kanitsaki, 2001). For the year ending June 1992, 92 cases went to formal hearing, men represented 33% of this number. In 1996, 1997 and 1998, men represented approximately 66% of the total number of cases which went to a formal hearing. In 2000, the NBV provided a percentage of men on the register: 8.1%. This year saw 16 cases going to formal inquiry, and 25% of these were men.

These statistics are significant because for the most part men represent a small proportion of the total nursing population. For example, for the period 1999-2000, men comprised only 8.9% of the register in South Australia (NBSA, Annual Report, 1999-2000). In 2000-2001 this percentage had changed little (NBSA Annual Report, 2000-2001).

The management of, and reporting of alleged unprofessional conduct are receiving some timely attention. In keeping with the trend of analysis and correction of system issues related to error as opposed to blaming the individual the following is presented.

**Management of Alleged Unprofessional Conduct Matters**

Smith (1998) contends that there are a variety of ways to deal with impropriety by health care professionals. These can be seen on the following continuum. Smith (1998) acknowledges criminal sanctions, disciplinary sanctions by a regulatory authority, and an ‘unofficial’ quiet word by a colleague,
I have included here ‘disciplinary sanctions by the employer’, and probably should include ‘turning of a blind eye’. ¹

How decisions are made to report a matter of alleged unprofessional conduct to a NRA are not clear. The literature reveals some possible reasons for deciding to report. These can be seen in the following reasons to sanction the individual for a matter of unprofessional conduct:

- Retribution, that is punishment;
- Deterrence, for the individual and in general;
- Protection of the community; and
- Rehabilitation (Smith, 1998, p. 31).

A further theme from the literature and one which will be discussed in greater detail as a finding of this study is the questioning of how allegations of unprofessional conduct are managed, and importantly the challenge to do things differently. Central to this theme is the impact of blaming the individual nurse and pursuing an almost criminal trial to address the allegation. Stewart (2003) states that in a culture of blame, the responsibility for the error is laid upon the nurse, and importantly contends that it is time to move away from such strategies as they do little to change the risk (and potential negative outcome) inherent in hospital practices.

¹ To disregard deliberately or pretend not to notice something, especially an action one disapproves of (Collins Australian Dictionary, 2003, p. 176).
Johnstone and Kanitsaki (2005) contend that nurse regulatory authorities may in fact be doing a ‘disservice’ to the nurse when they discipline a nurse who may have only made an honest error. What may occur in taking such a punitive course is that important information regarding the occurrence and antecedents to error making may never be fully known and as such important data will be lost. They provide another reason for challenging NRA involvement in nursing errors: rarely is an error the result of a single action, but because the nurse is often at the point of care delivery the blames will lay with them.

The assigning of blame to an individual, fails to acknowledge that in fact ‘to err is human’ (Page, Ed., 2004). The chasm between the nursing practice event and all that has transpired to its endpoint requires further emphasis in health care, although a change is occurring to attitudes of ‘naming, blaming and shaming’. The incongruence between how unprofessional conduct may be defined and the reality of nursing errors will become evident in later chapters.

**CONCLUSION**

This chapter has presented an overview of the literature related to the social problem: an allegation of unprofessional conduct. There exists a significant array of literature related to errors in health care including the imperative need and associated strategies to minimise this error. In contrast, limited literature was identified which specifically addressed the experiences of nurses who had been involved in an allegation of unprofessional conduct which had then been reported to a nurse regulatory authority and how they dealt with the allegation. This gap analysis provides support to the purpose of this study.
Further literature will be included in proceeding chapters. The next chapter will address the methodology of grounded theory along with specifics of the method.

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And while I am not proud of whatever hysteria I succumbed to that day in the courtroom, I am not ashamed of it either. If anyone should feel shame for whatever occurred that moment in a small courtroom in northeastern Vermont, in my mind it is the jury: Amidst my sobs and wails, people have said that I pleaded aloud, ‘Look at us! Oh, God, please, look at us! and still not one of the jurors would even glance in my mother’s or my direction (Bohjalian, 1988, p. 5).
CHAPTER THREE

Methodology

When an airplane crashes, usually far more than one thing has gone wrong. The safety systems on passenger planes overlap, and most of the time it demands a string of blunders and bad luck for a plane to plow into a forest outside of Pittsburgh, or skid off a La Guardia runway into Flushing Bay. It would take the same sort of string of misfortune and malfeasance for one of my mother’s patients to die in childbirth as it did for an airplane crash (Bohjalian, 1988, p. 55-56).

INTRODUCTION

The purpose of this study was to generate a theory grounded in the experiences of nurses who were reported to a nurse regulatory authority for allegations of unprofessional conduct, and the personal and professional impact on them at this time and through its aftermath. To serve this end, grounded theory (Glaser & Strauss, 1967) was used to examine, in detail, nurses’ experience of the allegations of unprofessional conduct including the behavioural and contextual risk factors that contributed to the event and the personal and professional impact on them. This chapter will provide a discussion of grounded theory with respect to the methodology, and the method to achieve the objectives of this study. Grounded theory will also be discussed in relation to issues of traditionalism described by a number of authors (Wilson & Hutchinson, 1996; Cutliffe, 2000). Strategies for addressing and ensuring theoretical, methodological and interpretive rigour are detailed. Ethical considerations including protection of the identity of participants and confidentiality of information are specified. Strengths and weaknesses of the study and method used are considered.
METHODOLOGY OF GROUNDED THEORY

Grounded theory is a qualitative research method, interpretative in nature and derived from the theoretical framework of symbolic interactionism (Glaser & Strauss, 1967). A systematic set of procedures is used to develop an inductively derived theory about a phenomenon which is grounded in the data pertaining to the experience of the study cohort. The intent is to develop an account of the phenomenon being studied that identifies the major constructs, their relationships and related processes.

Grounded theory was developed in 1967 by two North American sociologists, Glaser and Strauss. Their foundational text, *The Discovery of Grounded Theory: Strategies for Qualitative Research* details their own social research and subsequent development of grounded theory. They explain that generating grounded theory is a way to arrive at a theory suited to its supposed use. Importantly, they emphasize that the theory is one of process and is viewed as evolving, rather than set in stone at that moment in time.

Much has been written about grounded theory. In particular, by traditionalists, i.e., those who ascribe to the Glaser (1978) version of the original method, non-traditionalists, including Strauss and Corbin (1990) and nurse researchers who have used the methodology. A number of authors (Stern, 1994; Wilson & Hutchinson, 1996) explain that because of the debate on the correct interpretation of grounded theory method, it is important to specify which approach is to be employed in a grounded theory study.

The literature provides discussion of an ongoing debate initiated by the original researchers and augmented by differing schools of thought on the ‘correct’ method and interpretation of grounded theory. The method of grounded
theory as originally proposed by Glaser and Strauss (1967) has more recently been presented in densely codified and structured format (Strauss & Corbin, 1990). However, this later version has been criticised by Glaser (1992) on the grounds that it deviates from the original method in that it is orientated towards ‘forcing’ the data into a codified frame rather than allowing the theory or concepts to emerge from the data. This debate is further elaborated on by Kendall (1999) who states that Strauss and Corbin (1990) perceived the need to address what they viewed as the limitation caused by a lack of detail in the literature surrounding the processes involved in generating meaningful theories grounded in qualitative data. The main criticism of their approach is the apparent contradiction to the original assumptions, in particular the emphasis on conceptual description rather than emergent theory. Kendall (1999) proposes that the crux of the issue in differences between the two approaches is the use of axial coding. There is no argument regarding the importance of coding (Glaser, 1978; 1992; Strauss & Corbin, 1990) in that it is essential to transform the raw data into theoretical constructions of social processes. Glaser and Strauss (1967) and Glaser (1978) describes two types of coding, substantive or open and theoretical coding, whereas Strauss and Corbin (1990) articulate three types, open, axial and selective coding.

While the versions of open coding are espoused to be similar (Kendall, 1999) there are nonetheless, differences. The controversy was created when Strauss and Corbin (1990) added ‘axial’ coding to the coding process, which they define as a set of procedures whereby data is put back together in new ways after open coding has occurred, by making connections between the categories. Specifically, conditions, contexts, action and interactional strategies and consequences are articulated. Glaser (1978) emphasises the need to allow codes
and theoretical underpinnings to ‘freely’ emerge. It would appear that Glaser’s (1978) main concern with axial coding is the act of placing labels on the codes which should be guided by conceptual interests emergent from the data, and not interpreted as belonging to, or being representative of particular scheme as proposed in Strauss and Corbin’s (1990) paradigm model. Glaser (1978) identifies 18 coding elements which could be used to guide the researcher to connect categories. These elements are not exclusive and therefore, because there is no pre-set framework, there is an increased guarantee of a unique emergence of the data, rather than fitting it to a framework (Kendall, 1999). In a counterclaim, Strauss and Corbin (1990) argue that their process allows the researcher to be guided by a more complex, systematic and accurate method.

The key difference in the two approaches was formalised when Strauss co-published a text on grounded theory (Strauss & Corbin, 1990). Glaser went public with allegations that the method espoused in this text was not true to the original notion of grounded theory and he articulated two major reasons for this: (1) researchers are required to ask questions of the data which varies from the original purpose to ask ‘what is the main concern or problem and what accounts for most of the variation in processing the problem? and, (2) a preconceived framework for asking questions of the data is used rather than allowing the categories to emerge from the data itself.

Dimensional analysis, another approach to the grounded theory method is an abstract concept which refers to the process of examining a phenomenon by dimensionalising it into attributes, context, processes and meaning (Kools, et al, 1996). The key organising schema is dimensionalising or designation,
differentiation and integration or reintegration until a critical mass of dimensions is identified and analysed.

Eaves (2001) in response to what she viewed as a lack of clarity and inconsistency surrounding approaches to analysis in grounded theory studies synthesised analytical approaches articulated by Charmaz; Chesler; and Corbin and Strauss. The study undertaken by Eaves (2001) demonstrated that the resultant product of combined analytical steps was an appropriate approach for data analysis.

Kendall (1999) states that no one grounded theory approach is superior to another. Using the coding approach espoused by Strauss and Corbin (1992) does not diminish the integrity of the theory being generated (Personal communication, Irurita, 2003; Annells, as cited in Schneider, et al, 2003) but rather, provides an opportunity for a level of creativity and one which suits the ‘philosophical, cognitive and mean-making processes’ (Annells, 1997; Charmaz, 2000, & Eaves, 2001). A review of theses conducted through the School of Nursing and Midwifery at Curtin University reveal a strong trend toward the grounded theory method as described by Strauss and Corbin (1990). One PhD study which was reviewed and contended as using the [emphasis added] method described by Glaser and Strauss (1967) appeared to undertake axial coding but did not call it that. Dey (1999) suggests that Glaser (1978) in stipulating 18 coding criteria is guilty of what he accuses Strauss and Corbin off, and that is forcing the data to pre-set criteria. Annells (1996) states that the diversification in the methods should be interpreted as maturing and branching of the grounded theory method.
Philosophical Foundations of Grounded Theory

Grounded theory explains Annells (1996) is dependent to a degree on an awareness of the method’s ontological, epistemological and methodological perspectives and the theoretical underpinning of symbolic interactionism. Annells (1996) and Norton (1999) emphasises the importance of recognising and evaluating the philosophical basis of grounded theory.

Patton (2002) explains that a qualitative framework can be defined by the following questions: (a) what is believed about the nature of reality, or the ontological perspective; (b) how do we know what we know, or the epistemological perspective; (c) how should the world be studied, or the methodological perspective; (d) what is worth knowing, or the philosophical perspective, or the axiological view (Rothe, 2000); (e) what questions should be asked; and (f) how is the self engaged in the inquiry?

Epistemology, how knowledge is known, is important to articulate with respect to its relationship with ontology, and methodology when generating a grounded theory (Norton, 1999). More specifically, epistemology considers the nature and forms of knowledge, it reveals the relationship between the knower and what may be known and how it is judged to be true (Norton, 1999). Norton goes on to emphasise that the perspective of the researcher with regards to the nature of knowledge, that is ‘hard’ versus ‘soft’ will subsequently influence the choice of research method. To explain further, a researcher who views knowledge as subjective, inter-subjective, more personal or unique will be more likely to choose a qualitative method, in comparison to more tangible and objective knowledge which can be aligned to a quantitative approach.

Symbolic interactionism described by sociologists George Mead (1934)
and later by Herbert Blumer (1969), focuses on the manner in which people make sense of social interactions and the interpretations they attach to social symbols. Social interactionism provides the philosophical basis for grounded theory (Hutchinson, as cited in Munhall & Oiler, 2000) and the underlying epistemological assumption (Denzin & Lincoln, 2003).

A central tenet of interpretivism is that humans are viewed as thinking, feeling and responsive beings and as such are not just an ‘object of research’ but rather have a subjective side, this subjective side is what is important in the data collection phase (Norton, 1999). The notion of constructivism is that ‘social reality is produced and reproduced by social actors’ and consequently there are many constructions of social reality (Norton, 1999, p. 34). Importantly both the constructivist and interpretivist approach views the inseparability of the researcher and the social realities, that is the researcher in qualitative research cannot not help become involved in the complexities of the interplay between participant-data-researcher and subsequent data findings. Norton (1999, p. 34) therefore prescribes that:

In constructivism and interpretivism, ontology and epistemology merge…the knower (the researcher) is inseparable from whatever can be known within the overall construction of a particular reality.

This notion is articulated further in the section on the strengths and weaknesses which includes a discussion on the role of the researcher.

A difficulty, states Denzin and Lincoln (2003) in articulating symbolic interactionism is that its foundation is formed by a number of theoretical positions. One particular position with relevance to grounded theory (Blumer, 1969) draws on the work of Mead (1934), a North American social interactionist
theorist. Blumer (1969) articulated three main premises of symbolic interactionism:

1. Humans act toward the physical objects and others in the environment on the basis of the meanings these have for them;
2. These meanings derive from social interaction (communication) between and among individuals; and
3. These meanings are established and modified through an interpretative process.

Blumer (1969, p. 3) emphasises that meaning is central to symbolic interactionism and argues that to ignore the ‘meaning of things toward which people act is seen as falsifying the behaviour under study’. Using the perspective of symbolic interactionism, grounded theory therefore provides a means of studying human behaviour and interaction, creating a new perspective and understanding of common behaviour at both an interactional and symbolic level (Chentiz & Swanson, 1986).

Stern (et al 1982) describes how grounded theory has at its core, the objective of understanding how a group of people define and respond to, via social interactions, their reality. Specifically, symbolic interactionism is the notion that individuals interpret human interactions, social and cultural symbols and then construct meaning. It is this meaning that provides the impetus for actions and interaction. (Rothe, 2000).

There is an emphasis on the belief that a distinctive character of human relationships is having the ability to construct and share meaning (Bowers, 1988). The individual perceives that something has meaning and then organises and makes sense of that meaning in order to determine what actions will be taken. Hence, when individuals associate with one another, they are involved in interpretive interaction (Blumer, 1969).
Patton (2002) states the following questions are asked: ‘what common set of symbols and understanding have emerged to give meaning to people’s interactions?’ Persons who share, for whatever reason, common circumstances, tend to share common meanings and subsequent inter-subjective behaviours and activities. The sharing of these experiences constitutes ‘the substance of grounded theory’ (Hutchinson, 2000). The emphasis within symbolic interactionism is the importance of symbols and the interpretative processes which underscore human behaviour and in relation to actual research understanding these behaviours (Patton, 2002). In summary Schreiber (2001, p. 78) states:

The goal of good grounded theory research is the construction of a parsimonious theory with concepts linked together in explanatory relationships that, in accounting for the variation in the data, explain how participants resolve their basic social problem.

The tenets of grounded theory are now presented. The rationale for using grounded theory will also be discussed before the method is described.

**Tenets of Grounded Theory**

Although Glaser and Strauss (1967) did not specifically articulate the basic tenets of grounded theory, subsequent theorists have articulated such tenets as follows:

1. The theory must be generated from praxis;
2. The theory must be interesting and useful, or have what is called ‘grab’;
3. The resultant theory must fit, that is, demonstrate relevance and be able to explain, predict and be modified by the social phenomenon under study;
4. Data collection and analysis are undertaken simultaneously, that is both processes are interwoven, concepts and propositions which emerge guide the subsequent data collection;
5. The substantive theory should be able to transcend a particular setting and extend to a wider scope of circumstances;
6. The emergent theory must be able to both incorporate other theories, rather than existing in opposition; and
7. The approach of grounded theory presumes the possibility of discovering fundamental patterns in all social life, specifically the emergence of variability of the core category of basic social processes (Wilson, 1989).

The development of grounded theory takes time and the ability to think conceptually about the data. This time must be engineered to allow for both a component of creativity and comprehensive analysis (Wilson, 1989). In addressing all of these tenets what results is a theoretical explanation of the phenomenon which:

1. Fits the substantive area under study;
2. Is appropriately dense and thereby provides an adequate variational account;
3. Abstract enough to allow generalisation; and
4. Allows for a degree of control over structures and processes seen in the every day account of the phenomenon (Wilson, 1989).

To serve these underlying tenets a number of specific research strategies are relevant to grounded theory and were subsequently employed to arrive at a substantive theory. They include: purposeful and theoretical sampling; the use of the constant comparative method, including the coding of data and identification of categories and associated properties; and the identification of a core category (Glaser & Strauss, 1967).
Rationale for Using Grounded Theory

Grounded theory is a method that has been used extensively across a variety of social science disciplines and importantly the nursing discipline. Chenitz and Swanson (1986) state that grounded theory offers a systematic method for the collection, organisation and analysis of data from the empirical world of nursing practice. Thorne (1991) argues that grounded theory because of the premise to discover the underlying social forces which shape human action, is well positioned to assist nurses to understand and explain phenomena within the clinical context. This proposition is supported by Miller and Fredricks (1999) who state that grounded theory has become a paradigm of choice for qualitative nursing research.

The grounded theory method was appropriate for this research study on a number of fronts. It is a useful methodology where little is known about the phenomenon (Stern, 1980) and where the nature and meaning of the phenomenon is sought (Strauss & Corbin, 1998). The method allows for data to be drawn from a number of sources (Strauss & Corbin, 1998) and importantly allows for the capture of intricate details about the phenomenon, for example, feelings, emotions and thought processes.

More specifically, grounded theory seeks to derive a substantive theory situated in the socio-psychological dimensions of the human interactive experiences. This has particular relevance for the study of the phenomenon of alleged unprofessional conduct events and the experience of being reported to a nursing regulatory authority. Nursing is a social endeavour with ethical and legal accountability, the later being determined by the respective legislation and rules of the nurse regulatory authority. The experience of being reported to a nurse
regulatory authority for alleged unprofessional conduct is undoubtedly a profound life altering event where significant socio-psychological impact is possible. Therefore, a theory to explain the social phenomenon of alleged unprofessional conduct and related processes and the impact on the nurse was possible using symbolic interactionism which is an approach to exploring human behaviour (Annells, 1996).

**THE METHOD**

The grounded theory method as originally described by Glaser and Strauss (1967) was used to address the objectives of this research study. The method used to address the study objectives is now detailed.

**Substantive Theory**

In their original text, Glaser and Strauss (1967, p. 32) provide the following to distinguish between a substantive and formal (grounded) theory as follows:

By substantive theory we mean that developed for a substantive or empirical area of sociological inquiry, such as patient care, race relations, professional education, delinquency, or research organisations. By formal theory, we mean that developed for a formal, or conceptual area of sociological inquiry such as stigma, deviant behaviour, formal organisations, socialisation or status congruency.

To summarise, a substantive theory concerns a specialised population and context whereas a grounded theory represents a broader context, for example stigma which could be relevant to a number of populations, like divorced people, victims of sexual assault and persons wrongly accused of a crime (McCann & Baker, 2001). Therefore, this study has provided the data and subsequent analysis for the emergence of a substantive theory.
Sample Description

In keeping with the notion of purposeful sampling the following criteria were developed to ensure that the pool of participants allowed for the provision of rich descriptions of the phenomenon of interest. The criteria for the initial pool of potential participants were:

1. A nurse, either registered, deregistered, suspended from registration, or having conditional registration in any state or territory in Australia;
2. The nurse may be from any Division of the Register as detailed in the respective nurse registration act in any state or territory of Australia;
3. The alleged unprofessional conduct event must have been reported to the respective nurse regulatory authority and the matter dealt with by a disciplinary panel, and the allegation was either upheld or not upheld;
4. The time period for which the alleged unprofessional conduct event occurred is not relevant to determining the participant’s suitability; and
5. There is no age limit or gender bias for acceptance as a participant.

Participant Profiles

As part of the preliminary selection process participants were asked to complete a demographic and alleged unprofessional conduct event data form. Further data extrapolated from the narratives which provide depth to the profile of the nurse at risk of being both involved in alleged unprofessional conduct and being reported for it is reported in detail in Chapter Four which discuss the social phenomenon.

Setting

The setting of this study was situated within the context of the phenomenon and not in any particular nursing practice setting. Context is defined
by Strauss and Corbin (1990) as the properties of a phenomenon. The idea of context can be viewed as the associated conditions within the physical setting or ‘ambience’ of the setting. The phenomenon of interest, an allegation of unprofessional conduct had already occurred therefore the context is reflected in the experience of all participants and was expressed in their narratives. Interviews were conducted face to face, in Western Australia (WA) and Victoria (VIC) and where it was not possible to, others were conducted via the telephone.

**Sampling Strategies**

Two sampling strategies were employed for this research study, purposive and theoretical sampling. It is important to recognise the need to seek participants who had been involved in an alleged unprofessional conduct event to serve the objectives of the study. Purposeful sampling was used to identify an initial pool of participants, and then theoretical sampling was employed to collect additional data to further examine emerging categories and relationships to ensure representativeness and adequacy in each category. A review of the literature related to sampling in grounded theory revealed an affiliation to both purposive and theoretical sampling strategies. The following provides explanation of these strategies and the debate as to whether they are one in the same strategy.

It is important to note that the initial pool of potential participants was extremely small. The nature of the phenomenon being studied and the associated personal and professional trauma meant that few nurses were prepared to come forward, and even less were prepared to provide their consent to participate. Therefore while theoretical sampling is an acknowledged strategy for grounded
theory it was enacted using strategies for questioning rather than for choosing participants. A discussion of sampling is provided.

The nature of theoretical sampling is one of non-probability sampling that is, sampling of specific data sources occurs until each emerging category is saturated (Glaser & Strauss, 1967). The gathering of data is manoeuvred by concepts identified from the previous interviews and emerging theory, specifically this is driven by purposeful questioning of specific persons so that opportunities to discover variations in concepts and depth to the categories can be maximised (Strauss & Corbin, 1998). For this purpose there are no limits set at the beginning of the study in terms of participant numbers, but rather participants are selected until theoretical saturation occurs. Specifically, individuals who have experienced the phenomenon being studied are sought (Creswell, 1998).

The alternate theory of sample selection is presented by Lincoln and Guba (1985), Patton (2002) and Morse (1991) who argue that purposive sampling is the same as theoretical sampling. The confusion is addressed by Hutchinson (1993) who suggests that in the first instance a purposive technique is used, then once a direction emerges from the data and analysis then theoretical sampling is employed. This strategy is supported by Morse (1991) who contends that it is imperative to identify participants who have experienced the phenomenon to be studied and in fact, should be viewed as ‘expert’ in terms of their level of experience. This concept is supported by Popay, Rogers and Williams (1998, p. 356) who state that ‘randomness and representativeness are of less concern than relevance’. The critical point is, does the sample provide the opportunity to produce the type of knowledge necessary to understand the phenomenon at hand?
Sandelowski (1995) states that the sample size in a qualitative study is relative and dependent to a degree on the chosen methodology, and more specifically, by its appropriateness and adequacy (Morse & Field, 1996). Although the nature of grounded theory dictates an open sample number, a number of authors propose that it is reasonable to aim for a pre-determined size. Morse (1995) suggests a sample of 30 to 50 participants for grounded theory, whereas Strauss and Corbin (1998) and Creswell (1998) state that 20 to 30 persons is an appropriate size. The final number of participants in this study was 21. This number was guided by two issues. Firstly, the participant population emerged as a specialised one. Furthermore, the nature of the experience and the associated shame for the nurses who were eligible, meant that few nurses felt comfortable and safe to contact me. Therefore, the pool to choose from was small. Despite this limitation, theoretical sampling was used to develop the line of questioning for the next participant.

**Sample Access**

Participants were sought using two methods, advertising in the nursing literature and snowball technique. The two approaches to obtaining a purposive sample are now presented under separate sub-headings below.

**Advertising**

Advertisements, using a formal advertisement format included in Appendix A of the thesis, letters to the editor and articles seeking participants were submitted to the following nursing publications:
Australian Nursing Journal, the journal of the Australian Nursing Federation (ANF);
Western Nurse, the journal of the ANF in Western Australia;
The Lamp, the journal of the New South Wales Nurses Association;
Nursing Review, the monthly publication of the Royal College of Nurses – Australia;
OnBoard, the bi-annual journal of the Nurses Board of Western Australia;
Above and Beyond, the newsletter of the Flight Nurses Association of Australia;
NBV, the bi-annual journal of the Nurses Board of Victoria; and the Outback Flyer; the journal of the Council of Remote Area Nurses (CRANA).

Participant response was initially slow, but this was anticipated. I thought that nurses who had been involved in an alleged unprofessional conduct event may be hesitant in contacting me to discuss what understandably would be an extremely traumatic and harrowing event. Cognizant of this, I approached the Editor of the Australian Nurses Journal who agreed to interview me regarding this study and subsequently published a short article (Appendix B) detailing the research with emphasis on my ability to respect their confidentiality and also acknowledging that contacting me might be difficult. This attempt at a ‘softer’ approach to recruiting proved successful with approximately nine nurses responding after reading the article. One potential participant said that after he read the article, ‘he felt that he could relate to what I was saying’, and that ‘he felt comfortable in contacting me because of what was written and how I had approached the subject’.

Chiang, Keating and Williams (2001) outline some challenges of recruiting a vulnerable population in a grounded theory study and detail issues
congruent to my own experience in obtaining ethics approval in relation to the potential sample of participants who were viewed as particularly vulnerable because of the legal nature of the phenomenon. This issue will be discussed more in the section detailing the process for obtaining ethics approval.

**Snowball Technique**

A further sampling technique employed and appropriate in qualitative research is snowball or chain sampling\(^2\). Snowball technique (Patton, 2002) is a recruiting technique where someone who meets the criteria for inclusion in a study is identified and contacted by another person or participant who knew about the study. This technique was viewed as an important strategy in identifying participants who may have ‘gone underground’ because of the nature of the phenomenon. Also, the potential consequences of the NRA investigation may have meant that not all nurses were currently in the nursing workforce and therefore not consumers of the particular manuscript containing the advertisement. Therefore it was necessary to allow participants to be identified through ‘word of mouth’ or for nurses who were aware of other nurses with similar experiences to come forward.

Israel (2005) asserts that snowballing as a recruitment strategy is imperative when seeking participants who live on the edge of acceptable societal practices. His qualitative work in the disciplines of sociology and criminology mean that he is mostly reliant on this technique.

In one instance two nurses involved in the same event were interviewed. Because one participant had advised their colleague of this study and

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\(^2\) Snowballing is accepted by the NHMRC as an appropriate recruiting strategy.
communicated to each other, they were aware that they had both participated in the study. These participants are friends and were supportive of each other when they were reported to the NRA which had jurisdiction over their practice.

**Interviewing Strategies for Grounded Theory Research**

The collection of data in a grounded theory study can be primarily undertaken by engaging in an unstructured interview, ‘a conversation with a purpose’ with each participant (Chenitz, 1986). The interview is viewed as a reproduction of the participant’s reality (Hall & Callery, 2001). Unstructured interviews are an appropriate technique when little is known and equally where nothing is assumed about the phenomenon being examined. While it was particularly relevant to the first interview, subsequent interviews were guided by theoretical sampling and as such purposeful questioning which guides data collection based on emergent hypotheses and concepts from the previous interview.

Data analysis in grounded theory is ‘like a discussion between the actual data, the created theory, the memos, and the researcher’ (Backman & Kyngas, 1999). The method of grounded theory allows for the emergence of a theory grounded in a detailed and in-depth analysis of the data. The procedural steps of data collection and analysis occur simultaneously along with constructing the emerging theory which is driven by the mechanics of the constant comparative method (Glaser & Strauss, 1967). The following section will provide details on the scope and process of data collection and analysis, along with adjunct procedures for ensuing rigour. Figure 3.1 provides a schematic representation of the research methodology and the procedural components. This diagram reflects
the concurrent data collection and analysis and use of adjunct processes central to
the GT method.

A specific strategy used during these interviews included allowing the
participant to tell their story with minimal interruption. This was important for a
number of reasons. Morse and Field (1996) contend that the research participant
often knows better than the researcher as to what is relevant or not relevant to the
research topic, that is, it is important to allow the participant to tell their story.
Also, participants invariably tell their story sequentially, that is from beginning to
end, this is particularly useful in grounded theory research where understanding
the sequence of events is important to allow for delineation of the process.

**Interviews as the Source of Data**

Interviews were undertaken face to face, or via the telephone for those
nurses not living in the researcher’s home state and all were audio-taped. While
a telephone interview is recognised as not being the most preferred method it was
realised that travelling to many places throughout Australia would be too difficult
and expensive. This issue was discussed with my supervisors who agreed to this.
The interview commenced with a revision of the study purpose and an invitation
to the participant to discuss their experience of the alleged unprofessional conduct
event that they were involved in, specifically, (a) the actual event, (b) events,
including actions and thinking leading up to, and (c) what occurred immediately
after the event and later. The participant was also asked to speak about the impact
Figure 3.1: A schematic overview of the grounded theory method.
that the event has had on them at all stages, including personally and professionally.

The participants provided what I regarded as deep and personal insights into what were obviously incredibly traumatic times in their personal and professional lives. Despite this, the participants were able to continue through the interview providing detail and completeness to their stories. I believe that this was possible because the participants in most cases had expressed either a need to talk in terms of a commitment to be able to help other nurses who might find themselves in a similar situation and what also was seen to be an imperative need to tell their stories. Even though some potential participants did not return a consent form, they shared part or all of their stories to me during preliminary telephone conversations. For example, in a number of cases, after I had obtained the potential participants contact details, they would then say ‘don’t you want to know what it is about?’ and then proceed to tell me. In one specific case a nurse spoke to me for an hour reliving her experience, she did not end up agreeing to be interviewed and of course the information she shared with me was not recorded or used. The notion of interviewing participants regarding sensitive topics has received minimal attention except for the detailing of ethical topics strategies (Cowles, 1988). The ability of the researcher to establish a sense of trust, and the ability to demonstrate a balance between the objectiveness and empathy is imperative (Cowles 1988). Some participants asked if I was a nurse, this appeared to be reassuring to them. In terms of empathy, there were times during the pre interview chat or afterwards that I was able to share a connection with the participant in verbalising an understanding of nursing contexts that they were talking about. Data were collected and analysed over a period of 13 months,
commencing with the first interview in April 2004 and continued until theoretical saturation was achieved.

**Note Taking During the Interviews**

Using a template proposed by Morse and Field (1996) (Appendix C) minimal notes were taken during the interview and immediately after. Appendix D provides an example of one these completed forms. Key points were documented to prompt me to ask questions or follow up on a sub-category, property or dimensions that had emerged. My experience has confirmed that taking notes during an interview is difficult in that it distracts both parties from the interview and removes the ability of the researcher to listen more closely to the ongoing dialogue. Note taking was easier during the telephone interviews and it did not distract from the participants dialogue nor impede the interview.

**Transcribing**

Transcribing interviews is a common approach to assist the researcher in the recall of information provided in the interview (Wellard & McKenna, 2001). Limitations of this approach are noted. The ‘misplacement’ of a comma, for example, can change the true meaning of what had been said (Bourdieu, 1996). Therefore, there has to be an acknowledgement that transcribing will mean a degree of rewriting of ‘the story’, that is, transcription is both interpretative and constructive (Lapadat & Lindsay, 1999, p 72).

The fact remains that conducting 21 interviews means an enormous amount of data, either verbal or eventually written. Therefore, the interviews
were recorded to allow for subsequent transcription of the narratives to ensure a high level of accuracy and comprehensiveness of what was said.

**Management of the Data**

An enormous amount of data was obtained. This is not unusual in qualitative research and can pose its own problems (O’Connell & Irurita, 2000). All transcripts were kept in separate files and identified using the participant code. Analysis was undertaken by hand, and therefore a software program was not used to provide organised structure to the emerging categories. Instead, categories were listed alphabetically in a spreadsheet, allowing for ongoing updating and inclusion of other findings. This list was updated after each round of coding for each transcript. Memos were written on a card system and filed alphabetically under each category. They were also cross referenced to similar findings and categories. When a memo was made in relation to a category, mention of this was made in a corresponding column. The next section will discuss the constant comparative method including an explanation of theoretical sensitivity and theoretical sampling and the mechanics of coding, memoing and diagramming.

**The Constant Comparative Method**

The research process in grounded theory is a iterative methodological cycle, in which the collection, coding and analysis phases are interwoven continually from the beginning of an investigation to the end (Glaser & Strauss, 1967; Chicchi, 2000). Data analysis in grounded theory is a complex process where the constant comparative method prescribes the procedural and content analysis of all material produced during the interview. This method has its origins
in the disciplines of sociology and anthropology where it is suitable for examining and evaluating data from a broad range of sociological samples and sizes and serves to generate a substantive theory (Glaser & Strauss, 1967). The comparative analysis method has four purposes:

1. To determine accuracy of evidence;
2. Establish the generality of a fact;
3. Specify a concept; and

In the constant comparative method each piece of data is continually compared with every other piece of data so as to generate theoretical concepts that encompass as much behavioural variation as possible (Glaser & Strauss, 1967). Concepts identified in the data are then compared with subsequent and prior data to generate their interrelationships and theoretical suppositions. This involves comparing various cases, events, phenomena, and behaviours which emerge from each interview through purposeful questioning in order to establish the following: commonality and difference the delineation of interrelationships, and the development and refinement of themes. Concepts are also compared in order to facilitate their integration into the emergent theory (Glaser & Strauss, 1967).

There are four stages in the constant comparative method, they are: (1) comparison of incidents within categories; (2) the integration of categories; (3) delimitation of the theory; and (4) the writing of the theory (Glaser & Strauss, 1967). The analytical steps of the constant comparative method are fluid, that is, there exists a constant and purposeful interplay with the data and the subsequent emerging concepts and categories and resultant theory. The essential feature of the constant comparative method is that the process is a concurrent and cyclical, or as Annells, (1996) describes, a ‘back and forth’ process, where already
analysed data is reanalysed in light of later analysis. The researcher commences data analysis as soon as the data is collected. The stages are now described in more detail.

**Stage One**

The first stage involves the identification of categories and their properties. The process of identification involves coding which Glaser and Strauss (1967) defined as a method of explicit conceptualisation and has at its core the aim of generating theory. Glaser and Strauss (1967, p 106) state that ‘coding only need consist of noting categories…it should keep track of the comparison group in which the incident occurs’. Coding is an analytical process where data are broken down (or divided into abstract pieces), conceptualised (the abstract pieces are grouped) and integrated or linked. Coding occurs initially to identify categories.

A category is defined as an element of the theory which can ‘stand by itself” (Glaser & Strauss, 1967, p. 36). Thus the process of coding is to identify within the data those words, ideas, themes and examples which are representative of a category relevant to the phenomenon being examined. Coding not only involves identifying, but requires that what has been identified requires labelling. These labels are used to designate categories within the phenomenon, for example things like ‘social difficulties’, ‘relationships’, and ‘work activities’.

Glaser and Strauss (1967, p. 37-38) emphasise that a category is not just about the label but rather what the label tells us about the concept, thus a category does not represent the data but rather, is indicated by it. A further aspect of a category is that it should be able to provide a ‘meaningful picture’. This picture
will enable the reader to ‘see and hear vividly’ the people and their experiences (Glaser & Strauss, 1967, p. 37-38).

The next step in stage one involves the identification of properties. A property is defined as a conceptual element of a category (Glaser & Strauss, 1967). Properties and categories are similar but vary in degree of abstraction. That is, properties emerge from the data where there is a lower level of abstraction.

**Stage Two**

The second stage of the constant comparative method is the integration of categories and their properties. This stage involves the recognition of how the codes are connected, to reveal significant similarities and differences (Glaser & Strauss, 1967). The caution here is the potential to ‘force’ the codes into pre-perceived or prematurely defined categories and properties and thus inadequately determining relationships. Glaser and Strauss (1967) assert that the integration of the theory is best when it [is allowed] to emerge, like the concepts.

The process of integration involves a continuation of constant comparison and analysis of the relationships of the categories and properties, specifically the differences and similarities with the aim of allowing a framework to emerge which provides a ‘position’ for each concept. This positioning in turn allows for a defining of the relationships.

**Stage Three**

The third stage involves a delimiting of the categories and associated properties. Glaser and Strauss (1967) offer two strategies for delimiting the theory, reduction and focus. They explain that the need to obtain the ‘fullest possible diversity of categories and properties’ is found in the richness of
conceptual diversity as opposed to richness in empirical detail (Glaser & Strauss, 1967, p 41). Therefore, to address this they suggest the need to delimit the theory. They provide this description of reduction.

By reduction we mean that the analyst may discover underlying uniformities in the original set of categories or their properties, and can then formulate the theory with a smaller set of higher level concepts. This delimits its terminology and text (Glaser & Strauss, 1967, p. 110).

This strategy is not without some question (Dey, 1999). Glaser and Strauss (1967) provide the following example of reduction. They state that the concept of ‘loss rationales’ as identified by nurses when considering the loss experienced by patients, can be generalised to other professionals in their services to clients. Reduction is achieved by substituting ‘professionals’ for ‘nurses’ and ‘service to clients’ for ‘dying patients. Dey (1990) states that such a strategy ‘goes well beyond the available data’ and as such is in opposition to what Glaser and Strauss (1967) described as grounding the theory in the data.

Glaser and Strauss (1967, p. 111) describe the second level of delimiting the theory, when the original list of categories is reduced. They explain:

As the theory grows, becomes reduced, and increasingly works better for ordering a mass of qualitative data, the analyst becomes committed to it. His commitment now allows him to cut down the original list of categories for collecting and coding, according to the present boundaries of his theory. In turn, his consideration, coding and analysing of incidents can become more select and focused. He can devote more time to the constant comparison of incidents clearly applicable to this smaller set of categories. (Glaser & Strauss, 1967, p. 111).

This reduction therefore, allows for the elimination of ‘superfluous specificity, and therefore, the researcher can set some boundaries to the analysis and allow for a focus on the core category and relevant and defining variables (Dey, 1999, p. 43).
Stage Four

The final stage involves the writing of the theory (Glaser & Strauss, 1967). This is done once the analysis of data has been completed and can be viewed as bringing together the findings into a scholarly narrative. Glaser and Strauss (1967) state that the writing of the theory involves the bringing together of memos which have been collated on each category. Further analysis is possible if gaps are identified in the theory.

The constant comparative method, and the four stages have been explained. The next section provides a discussion of the actual processes and associated concepts used to collect and analyse the data using the constant comparative method. The processes and concepts relevant to the constant comparative method are now presented, namely: theoretical sensitivity; theoretical sampling; coding, both open and theoretical; memoing; diagramming; theoretical saturation; and the consequence of these by arriving at a core category.

Theoretical Sensitivity

In grounded theory, the processes of generating theory are based on the ability of the researcher to identify important features of the collected data including the perceived variables of the components of the theory and their interrelationships and the meaning afforded to them. Glaser and Strauss (1967) termed this theoretical sensitivity. Theoretical sensitivity means that the researcher can move beyond pure description to see theoretical possibilities in the data (Glaser, 1978) and it guides the researcher to conceptualise a theory as it emerges, thus ensuring it is faithfully reflects the true nature of the studied phenomenon (Glaser & Strauss, 1967).
Glaser and Strauss (1967) explain that a lack of openness to the data and emerging theory and premature decision making can limit the full and appropriate end point of a substantive theory. They contend that theoretical sensitivity has two features: the researcher’s personal and temperamental bent, and the ability to have and use insight. Glaser and Strauss (1967) warn that theoretical sensitivity may be lost if researchers commit themselves to a preconceived theory and therefore are not open to the possibility of other theories. Understanding this point, Corbin and Strauss (1990, p. 42) further explain that theoretical sensitivity is ‘having insight, the ability to give meaning to the data, the capacity to understand, and capability to separate the pertinent from that which isn’t’.

In keeping with the tradition of theoretical sensitivity it was important to enter the data collection and analytical events with an awareness of the subtleties of the data (Glaser, 1978) and is an important step to sensitise the researcher. Theoretical sensitivity dictates that the researcher must have insight, understand and give meaning to the data, and importantly detach the relevant from the irrelevant (Strauss & Corbin 1990, 1998). Carpenter (1999) states that theoretical sensitivity can be gained from a preliminary review of the literature and from professional experience. Strauss and Corbin (1990, 1998) suggest that a preliminary review of the literature would enhance theoretical sensitivity.

The researcher’s personal inclinations, assumptions, experience and knowledge are helpful in developing an astuteness and sensitivity to the research data (Glaser & Strauss, 1967; Glaser, 1992). The following provides insight to my interest in the phenomenon of interest. The phenomenon of interest was based on my readings and experience working at a nurse regulatory authority. I believed that having a preliminary interest and understanding of the phenomenon allowed
me to engage in the interviews and analysis with an adequate sense of the phenomenon to guide theoretical sampling, and to be equally ‘sensitive’ to the need to allow the emergence of the stories without premature closure of analysis.

**Theoretical Sampling**

Sampling as it pertains to grounded theory has been introduced in this chapter. Sampling in grounded theory is the process of data collection for generating theory whereby the researcher concurrently obtains the data and analyses it, to determine what data to collect next so as to develop the emerging theory. This process of data collection, theoretical sampling, is controlled by the emerging theory, specifically the emerging concepts and categories (Glaser & Strauss, 1967).

Broadly speaking, I used two questioning strategies to elicit more information from the participant, either in response to something they said, that is, a probing question, which was used to elicit clarification or elaboration of something that was said so as to better understand it. The second type of questioning, which was guided by the concept of theoretical sampling, contributed to the analysis of the emerging sub-categories, properties and dimensions, and allowed for refinement of thinking and understanding around these concepts. This questioning responded to the need to identify ongoing data collection and analysis. An example of this follows. One participant stated that she had and still continues to feel vulnerable as a nurse. This prompted me to question other participants whether they too felt vulnerable, and if so, how and why they felt vulnerable. Many ‘lines of questioning’ emerged from each interview in keeping with the concept of theoretical sampling, which in turn provided for a constant comparison of emerging concepts.
Theoretical sampling was further guided by ‘asking’ if what I was ‘hearing’ was in fact what the participant was ‘saying’ included asking clarifying questions, for example ‘do you mean this by what you just said’, or what if you had of done this do you think?’. I concluded the interview by asking the question ‘is there any thing else you would like to tell me?’ and in some instances allowed the participant to change tack; and asking them ‘if you could share one important message with other nurses from your experience, what would it be’, this allowed then some time to think more ‘creatively’ about their experience and allow for a summation.

**Coding**

Coding is the fundamental analytic process in the constant comparative method (Corbin & Strauss, 1990). Glaser and Strauss (1967, p. 101) describe coding as the conversion of data into a ‘crudely quantifiable form’. Coding is concerned with opening up of the text to expose thoughts, ideas, meanings, similarities and differences contained within the events, actions and interactions by doing a word, line or sentence analysis (Wilson, 1989) and comparing it to each incident retrospectively and prospectively (Glaser & Strauss, 1967). Open and theoretical coding was undertaken. The following provides a description of the coding techniques used in analysing the data to arrive at a core category.

**Open Coding**

Coding began with a tentative exploration of all the different facets of the narrative that I perceived as important or interesting. This meant re-reading the transcript many times. In undertaking open coding, that is, identifying, naming, categorising and describing phenomena, I repeatedly asked ‘what is this all about’, ‘what is being talked about here’. Two examples of open coding are
provided. Open coding meant that I conducted a ‘line by line’ and ‘word by
word’ analysis to identify key words, phrases and themes that have relevance to
the phenomenon and the participant’s story. It was important to break down the
story so that important ideas were not missed.

As I coded I asked questions about what the word, or phrase might mean
or indicate. This was done to not only obtain a deeper insight into what was being
said, but was done to identify commonality with key words and phrases. This was
the commencement of developing sub-categories, properties and dimensions.
Naming of these occurred concurrently with discovery.

In-vivo coding reflects the use of the word or phrase ‘as it is’ – rather than
re-labelling. The first example represents in-vivo coding and also identifies words
and phrases which either support the in-vivo word or phrase.

Yes, I felt really ostracised [in-vivo], I felt like I was an absolute
cockroach [example of feeling ostracised] amongst nurses. I felt as if I
was a totally different nurse [example of feeling ostracised] to everyone
else and I couldn’t understand why I was so. I felt as if I was singled out
[example of feeling ostracised].

A second example follows which demonstrates identification of a concept
from the narrative, rather than the participant using a specific word or phrase.

This example reveals how a participant ‘assumed a stance’ against the allegation:

I actually went to my nurse manager and got her to get me a copy of the
nurses board competencies. I did them all by myself, going through them
and signing them off. I thought if they think I am so incompetent how
come I can achieve all the competencies as set down by the nurses board.

This statement reveals the participant identifying the need to respond to the
allegation. The participant assumed a stance by having her practice assessed
against the competency standards required for registration as a registered nurse.

The codes provided the central point to the ongoing data collection and
analysis. Coding continued with each interview. I continually asked ‘where does
The coding and analytical process meant placing ‘codes’ into sub-categories, identifying them as properties or dimensions, and identifying patterns of connection. Coding was continued until there was a sense that no new concepts were being identified. At this point theoretical coding occurred which will be discussed later in this section to maintain a sense of order to the processes for the constant comparative method. The coding process and development of the emerging categories were facilitated by memoing and diagramming. These are now discussed.

**Memoing**

Glaser and Strauss (1967) explain that memoing is an integral component of the constant comparative method in that it allows the researcher to give shape to their thinking regarding the analysis of the data and can assist in the development of theory in a number of ways. Although the purpose of the memo is to assist in the formulation of the grounded theory, there is a degree of individuality to the process. Strauss (1987) contends that the researcher is engaged in a continual internal dialogue. I found this statement congruent with my own experience, reflecting the notion of living with the data and processing it nearly every waking moment.

Memos require that data be thought about at a conceptual level. They also serve to summarise the properties of each category which in turn provides for the beginning of the construction of operational definitions. Propositions about relationships between the categories and their properties can be summarised and categories can begin to be combined with clusters of other categories. Individual memos allow for the reconstruction of the story and writing up of the theory. The
memos become the story line of the theory and when refashioned, provided illustration of each sub-category and their properties and relationships.

Elliot and Lazenbatt (2004, p. 51) state that the ‘use of memoing controls distortion during analysis by sensitising the researcher to her or his personal biases’. The researcher is able to check if the memos fit the emerging theory. Those memos that do not fit are set aside. Thus, in grounded theory the memo as a dual role: they assist with data analysis and provide a way of countering subjectivity and bias from the perspective of the researcher. The use of memos ultimately enhances the likelihood of producing a theory which is accurate and reflective of the raw data (Elliot and Lazenbatt, 2004, p. 52).

My use of memos was extensive. They were written after interviews, during data analysis and at times when I was thinking about the study. The content of the memos was driven by analysis of the data, my responses to what I thought was happening; and at other times I wrote memos related to random thoughts that came to mind. Some examples of memos follow:

Example 1
The hospital lawyer was taking a statement from the hospital’s perspective…they were getting it from their perspective.

Memo:
This statement has a two-fold implication – blame/scapegoating and putting the nurse in a vulnerable position with respect to the unfolding legal and professional landscape.

Her rights have not been respected; almost ‘trampled’ on – also in view of the psychological trauma obtaining an accurate or coherent account would not have been possible and could further contribute to the trauma that this nurse was experiencing.

Example 2
I had actually signed and checked it out of the book and obviously again that was accountability…I knew the consequences of my actions.
Memo:
This nurse had a strong sense of the notion of accountability as relevant to nursing practice/actions. There was an immediate realisation of the significance of her actions and the probable trajectory of all of it. There was no shying away from the responsibility of her actions.

Example 3
This memo was in relation to considering the concept of vulnerability. The question that came to mind was ‘is vulnerability a continuum?’ This prompted the diagramming of this concept as occurring as in the pre-event stage, to post event critical moment and the post event secondary phase. At this point risk factors from the perspective of the nurse and the context, as per the emerging concepts were identified.

Writing the memos helped to identify and situate my thinking as opposed to the participant’s story, and as such allowed the emergent theory to be grounded in the data. Memoing allowed an objective analysis of the data as a constant attention to what was occurring in the data was needed to write about it. Specifically when analysing data I made notes of what I was thinking about in terms of the concepts being identified and the context that they had emerged. This proved constructive in that the story line was not infiltrated or influenced by my subjective views and it allowed me to consider how the codes and their properties related to each other. In summary, memoing provided a ‘track record of the analysis’ and eventually were used as the analytical building blocks from which the theory was developed (Elliot & Lazenbatt, 2004, p. 5).

Taking notes during the interviews, although minimally, (see Appendix D) provided a further opportunity to capture key points and responses during data collection. This contributed to the ability to undertake theoretical sampling and identifying my responses to the data to maintain theoretical sensitivity.

Diagramming
Diagrams and schematic representation of the emergent categories and relationships allows for a visual representation of the analysis of the data (Strauss
& Corbin, 1998). I found diagramming very useful in terms of giving direction to my thoughts and the emergence of processes and relationships. Two schemas eventually emerged, one giving illustration to the social phenomenon and other to the social process including consequences. An interesting comment provided by Orona (as cited in Strauss and Corbin, 1997) contends that unless the researcher is able to graphically depict the entirety of what is going on then they probably do not fully comprehend what is going on. I continually was driven by ‘getting the schema right’ as a measure of being on track with my analysis.

**Theoretical Coding**

Theoretical coding involves the identification of the emergent core category and occurs when theoretical saturation has been achieved. These two concepts will be discussed in this section.

Theoretical coding commences once open coding has finished. During this stage I finalised the development of the sub-categories, properties and dimensions which emerged to ‘form’ the core category and as such the substantive theory, which explains how nurses dealt with an allegation of unprofessional conduct. Undertaking theoretical coding gave shape to the identified concepts in terms of their types, properties, consequences and relationships. Conceptualising the ‘theoretical order’ of the emergent components led to the identification and visualisation of the core category.

**Theoretical Saturation**

Theoretical saturation which is guided by theoretical sampling, occurs when completeness of all levels of coding occurs and when no new conceptual information can be identified (Glaser & Strauss, 1967). Interestingly, Charmaz (2000) questions the veracity of being able to assert that the theory can even be
saturate and states that some grounded theorists avoid this assertion. Despite this contrasting view, in grounded theory studies the researcher continues collecting data until theoretical saturation is reached (Schreiber, 2001). The generation of theory is deemed completed when no new information about the core processes is forthcoming from ongoing data collection. Theoretical saturation occurs at the point where continued data collection yields only repetitive theoretical material. (Glaser & Strauss, 1967; Glaser, 1978).

Dey (1999) states that some researchers misunderstand the term theoretical saturation to imply that data sources have been systematically exhausted. Rather, theoretical saturation in grounded theory refers to the state at which categories cope adequately with new data without requiring continual extensions and modifications. It implies that the capacity of the data to generate new ideas is exhausted, and not the accumulation of evidence to support those ideas.

Wilson and Hutchinson (1999) warn against premature closure of the data analysis phase. Premature closure is the under analysis of the data. They explain that the grounded theory researcher must move the analysis of data through each of the coding types, specifically representing the deeper aspects of the emergent conceptual and theoretical codes, not just the descriptors but the categories. Once theoretical saturation has been reached then it is possible to fully discover the overriding analytical scheme. That is, having used the constant comparative method and the specifics of coding and memoing a core category is identified (Wilson, 1989). Glaser (1978) suggests some criteria for ensuring that the ‘chosen’ core category is appropriate and in turn provides guidance in realising that theoretical saturation has been obtained. The core category, as the name suggests must be central, that is the other categories and variational aspects must
be able to ‘fit around’ the core category. It must have occurred frequently within
the data and it must make sense to those in the study setting. The core category
must be sufficiently dense to allow for sufficient variation and it can be anyone of
the types of theoretical codes. The core category is now discussed.

**The Core Category**

The end product of developing theory is the core category (Glaser &
Strauss, 1967). Glaser and Strauss (1967) describe the emergence of a ‘core
category’ as follows:

> As categories and properties emerge, develop in abstraction, and become
related, their accumulating interrelations form an integrated central
theoretical framework – the core of the emerging theory.

This ‘core of the emerging theory’, is therefore, the substantive theory, but
also is more commonly known as the ‘core category’. The emergence of a core
category occurred after extensive analysis of the data using the constant
comparative method. The purpose of a core category is to conceptualise the basic
social psychological process; or the basic social problem which is addressed by
the theory. Glaser (1978, p. 93) states that the core category must account for
most of the variation in a pattern of behaviour. Glaser (1978) explains that for a
core category to be effective it must be central, stable, complex, integrative,
incisive, powerful and highly variable.

Eventually in this study, there was an identification of a core category,
*transformation of the personal and professional self*. This core category is central
to the overriding experience of this cohort of nurses in this study, and importantly
provides a comprehensive array of sub-categories, properties and dimensions
which account for the shared, individual and variations in of the experience of the
social phenomenon, an allegation of unprofessional conduct.
As already described stage four of the constant comparative method involves the writing up of the theory. This was done by bringing together the memos and the diagrams and developing a narrative describing and explaining the core category. This involved an elaboration of the sub-categories, properties and dimensions to explicate what emerged as the substantive theory to explain how nurses dealt with an allegation of unprofessional conduct.

**Rigour**

The concept of rigour in qualitative studies has received much commentary and criticism (Bailey, 1997; Burns & Grove, 1993; Emden & Sandelowski, 1998; Rose, Beeby & Parker, 1995; Walters, 1994) and one would hope after years of significant qualitative research that the debate could be put to rest. Nonetheless, it has been the view of some authors that the transfer of validity and reliability of criteria from a quantitative to a qualitative paradigm is inadequate (Bailey, 1997; Guba & Lincoln, 1981; Sandelowski, 1986; Yonge & Stewin, 1988). As such a number of criteria to evaluate rigour in qualitative studies have been proposed. These, and issues related to the rigour in a grounded theory study will now be presented.

Guba and Lincoln (1981) proposed four criteria for the assessment of rigour in qualitative research: credibility which assesses truth value; fittingness which assesses applicability; auditability for the assessment of consistency; and confirmability to assess for neutrality. Sandelowski (1993) although an early supporter of the framework articulated by Guba and Lincoln has more recently cautioned that creativity which is expected in a qualitative study, and particularly in a grounded theory study, is potentially stymied if such rigid criteria to establish
rigour are followed. In an even more recent co-authored article, Sandelowski, affirms a further move away from the criteria that qualitative researchers are used to.

Emden and Sandowloski (1998, p. 209) argue that the significant overriding notion in this debate is that qualitative research is ‘distinguished by complexities and nuances far beyond those capable of being captured by traditional usages of reliability and validity’ and that a number of views and practices are relevant to ensuring and evaluating rigour. They argue that a ‘leap of faith’ is required in making an overall opinion about the goodness and correctness of a qualitative research study. They use the example espoused by Hershusius who said that ‘if something is good, you [just] know it’, a bit like ‘the proof is in the pudding’, rather than an analysis of every ingredient, how long it was stirred and what water temperature was used to boil it.

Although a number of frameworks for criteria of rigour in qualitative inquiry have been proposed (Burns 1989; Guba & Lincoln, 1981; Patton, 2002; Popay, Rogers, & Williams, 1998; Meleis, 1996; Leninger, 1994 (as cited in Morse, Ed. 1994); Sandelowski, 1986) and although there is no one agreed upon framework, Koch (1996) argues that the qualitative researcher should choose a method that suits the nuances of the study at hand. Rigour specific to grounded theory is now discussed.

The mandate of grounded theory is to strive for the verification of its resulting hypothesis which is attained as part of the research method. Grounded theory aims to be a rigorous method through the provision of detailed and systematic procedures for data collection, analysis and theorising, along with the quality of the emerging theory (Strauss & Corbin, 1994). More specifically, the
most important criteria for maintaining and determining rigour in a grounded theory study is following the systematic grounded theory process and procedures. These include those that comprise the constant comparative method: concurrent collection of data and analysis; theoretical sampling; theoretical sensitivity; and memoing and diagramming (Glaser & Strauss, 1967; Strauss & Corbin, 1990).

Four central criteria for a good grounded theory are that it should: (1) reflect the phenomenon being studied; (2) be easily understood by both the researcher and those involved in the phenomenon; (3) provide generality and applicability to a diverse range of contexts; and (4) provide control by stating the condition which the theory applies (Glaser & Strauss, 1967).

Strauss and Corbin (1990) provide their own interpretation of criteria for rigour in response to their re-worked version of grounded theory which was primarily to allow for a more structured way to undertake grounded theory. These criteria include: plausibility; generalisability; concept generation; systematic conceptual relationships; density; variation; and the presence of process and broader conceptions. Hall and Callery (2001) argue that the criteria set out by Strauss and Corbin (1990) is problematic in that it continues to interfere with the notion of the ‘natural world’ as suggested by Blumer (1969). Rather, data are obtained from interviews which can be influenced by the researcher and therefore the data has not been obtained ‘untainted’. Therefore the quality of data will be influenced by the nature of the relationship of the researcher and participant, the quality of the interview, and the style and quality of data analysis (Hall & Callery, 2001).

The following framework has been used to address criteria for ensuring rigour both within the research process and the writing of this grounded theory as
outlined by Rice & Ezzy (1999). The framework addresses the relevant scope of criteria that would be expected in a grounded theory. It is acknowledged that rigour is fulfilled by not only addressing a number of specific areas, but emerges in an end product that while can be analysed in parts, too can be viewed as a gestalt with an overriding sense of ‘goodness and correctness’.

**Methodological Rigour**

Methodological rigour is demonstrated through the documentation of the actual research processes (Rice & Ezzy, 1999), including: (1) how the participants were chosen; (2) engagement of access to the sample and individual participants; (3) the development of trust and rapport with participants; (4) data collection and recording processes; and (5) data analysis methods. Guba and Lincoln (1981) use the term ‘auditability’ to explain the premise of methodological rigour. The research processes must be adequately documented to allow another researcher to follow the procedural and decision trail. The text provides a detailed account of the methodological procedures used, including:

1. Tape recording the interviews;
2. Accurate transcribing of the dialogue;
3. Providing an in-depth description of the data collection and analysis strategies, including contexts;
4. Descriptions of the informants;
5. Definitions of the categories, including their theoretical antecedents;
6. Review of the emergent theory to ensure interpretative truth; and
7. Maintenance of an audit trail detailing decision making (Rice & Ezzy, 1999).

The audit trail in this study was explicated with the recording decisions and related trajectories of actions and outcomes. Details of preparation before
engaging with the participants, thoughts, feelings and required actions post
interviews, actions to address researcher questions before the next interview and
the emergence of ideas with resultant action in response to the collective research
experience. Perceived influences on obtaining and interpreting the data have been
included. For example, the literature, my value positions and experiences of
unprofessional conduct events in nursing contexts, media reports and data being
memoed through the data collection phase were included.

Easton, McComish and Greenberg (2000) articulate three common pitfalls
that may occur during data collection and transcription and subsequently impact
on the methodological rigour of the qualitative study. In taping the interview it is
imperative to ensure that all equipment was in working order and this included the
use of a second tape-recorder should the first fail. They go to say that to minimise
error in the transcription the transcriber should be the researcher. This will allow
for a more accurate interpretation of words used and context. I was able to
transcribe a number of the interviews but a commercial transcriber conducted
some. To ensure accuracy of the heard and written word, intonation and use of
silence by the participant all tapes were listened to by me, a number of times and
compared to what had been transcribed. Corrections were made (Wellard &
McKenna, 2001).

Theoretical Rigour

Theoretical rigour can be demonstrated if both the theory and concepts
have been appropriately chosen to ensure that the strategies are consistent with the
objectives of the research study. As well, arguments and analysis should be
soundly constructed and written to demonstrate relatedness and a contextual fit with the literature available on the phenomenon (Rice & Ezzy, 1999).

Hall and Callery (2001) explain that a lack of detail to the social construction of knowledge and relationships with the research participants may influence, negatively, the structure of the emergent theory. To illustrate this contention, the authors provide an example of a grounded theory study (Rogan, Schmied, Barclay, Everitt & Wyllie, 1997) where there is minimal information regarding how data were collected. This potential conundrum is enforced by Silverman (1998) who states that qualitative researchers cannot assume that reliability is inferred but must be specific in documenting the procedure of research. To this end, the research study articulates the procedural ‘story line’ and nuances experienced.

**Interpretative Rigour**

The resultant theory which accurately reflects the understanding of events and processes within the framework and the world view of those engaged in the phenomenon demonstrate the achievement of interpretative rigour (Rice & Ezzy, 1999). Although some researchers do not believe in an end point of accuracy within such qualitative research it is possible to demonstrate how the interpretation was obtained. This area of rigour is linked to methodological rigour but goes a step further by providing if necessary the primary text to other researchers so that they can make their own determination of the adequacy of interpretation of the data (Rice & Ezzy, 1999). Guba and Lincoln (1981), and Strauss and Corbin (1990) describe fittingness as the ability of the study to be generalised to other populations, that is to say how well the working hypothesis or
propositions fit into a context other than the one from which they were generated. This is important to a grounded theory study.

A number of authors have criticised the interpretative ability of researchers using the grounded theory method. Melia (1996) argues that some researchers’ attempts to systematically analyse the data provide a resultant ‘artificially neat and tidy’ account of the phenomenon which is descriptive rather than interpretive. There is a potential for what Melia describes as a ‘slight of hand’ which reveals a list of themes which the reader must accept with a leap of faith rather than truly being convinced that they comprise the emergent substantive theory.

In a recent article qualities for determining a quality grounded theory study are offered. Elliott and Lazenbett (2005) state that the method of a grounded theory study also serves the objective of interpretative rigour. In grounded theory the checking process is a critical component of the constant comparative method and theoretical sampling. These strategies ensure a dynamic relationship between sampling and analysis which allows the researcher to ensure that the emergent findings are constant as further data is collected and analysed. This strategy is important because it is not a tenet of grounded theory to return to the subjects for validation of findings.

ETHICS APPROVAL

The pivotal notion of protecting human participants in a research study is to do no harm to them. The nature of potential ethical issues in a qualitative research study may be subtle and inherently different to the problems that may be experienced in a quantitative study (Orb, Eisenhauer & Wynaden, 2001). The specifics to ensure non-maleficence and beneficence of participants are listed, past and ongoing strategies discussed.
Approval from the Human Research Ethics Committee

The study proposal was scrutinised by the Human Research Ethic Committee (HREC) RMIT University and conformed to their policies and requirements. The HREC determined that research participants were potentially at risk with respect to the nature of the subject matter being discussed and how they may respond to that. Morse (2001) in an editorial discusses the types of risk potentially inherent in qualitative research and in doing so questions the differences of perception of this risk. For example Morse (2001) states that ethical review boards differ in their requirements from acknowledging that the risk of participants is no more than they would experience in every day life to an acknowledged risk, albeit it small if the principles of anonymity and confidentiality are adhered to. Morse (2001) proposes that there is risk in undertaking qualitative research for the novice, where they may even find themselves providing instruction to committees on the principles of qualitative inquiry and may even be made to compromise the inherent principles of the chosen methodology, like sampling, because of the lack of understanding by these groups.

The HREC also believed that there was potential that matters discussed and recorded could be the subject of further legal inquiry. For these reasons I was required to demonstrate that the nature of my inquiry would not put the nurse at any further risk of legal inquiry and equally that the risk to the individual in talking about the allegation against them would not pose any more distress than they had already encountered. After a number of submissions, over a five month period, the concerns of the Committee were finally addressed and permission was
granted to pursue data collection. The following provides further detail with respect to the minimisation of potential harm to the participant and clearly articulates that the benefit to nurses and nursing practice outweigh what the participant may experience in talking about this matter.

**Consent**

Consent can only be obtained once the participant has been advised of the full risks and benefits (Byrne, 2001). For this purpose the following is provided as background and formed part of the plain language statement [Appendix E] provided to participants to guide their decision to participate in this research study. A completed consent form (Appendix F) was received from all participants.

**Risk**

The scope of this risk was detailed and assurance was provided to each participant with regards to minimising identified risks at all stages of their involvement in the study. The nature of the research context has its basis in nursing events where the nurse allegedly participated in an unprofessional conduct event that was reported to the nurse regulatory authority (NRA). Because the matter had already been reported to the NRA and the matter heard by a disciplinary committee, and hence their conduct had already come to the attention of the NRA, there was no obligation to report the alleged unprofessional conduct event being examined.

Although only allegations of unprofessional conduct that had been dealt with in full by the respective NRA would be used in this research study, the RMIT
HREC required that participants be advised that there was a risk that should they provide new information on matters that could be viewed as having breached civil or criminal law then this information could be subpoenaed or obtained through the execution of a search warrant. Therefore, the participants were advised that they were potentially at risk of incriminating themselves (No author, 1995). For this reason, participants were advised to speak only about the alleged unprofessional conduct event that was reported to the NRA and to not talk about any new information relating to the event in question, or other alleged unprofessional conduct events where they were involved or another person was involved. The participants were also advised that should they not heed this caution, then they did so at their own risk.

The benefits of undertaking research that may contain some hypothetical legal risk in the case of disclosures being made concerning illegal behaviour have been articulated at a Legal Forum at Melbourne University (No author, 1995):

If the capacity to conduct research into illegal behaviours is diminished, it also diminishes the ability to develop fully informed public strategies to reduce the harm associated with illegal behaviours. The benefits from public health initiatives derived from Australian research into the spread of HIV for example have been recognised internationally. The knowledge about illegal behaviours that are obtained through research is fundamental to the creation of public initiatives to alleviate harm associated with illegal behaviours.

Reflecting on this legal opinion emerges the message that looking beyond the risk, there is almost an obligation to pursue research into areas that sit on the legal fringe. Volker (2004) also questions the risk to society associated with not conducting research into illegal activities. Evaluating the risk-benefit continuum is a dual participant researcher responsibility based on the provision of facts, and the value of the research objective.
Participants are vulnerable of experiencing upsetting emotions through remembering past traumatic events. While talking about the alleged event and the subsequent experience may cause the participant to become upset, the degree of emotions experienced during the interview were not expected to be beyond that normally expected by an individual who has experienced the phenomenon being studied. Importantly, the participants have already experienced the emotions and effect of the experience, having the matter already dealt with by the NRA. This is not stated to lessen or negate ongoing feelings and thoughts for the participant, but the risk of any reaction to the experience was not expected to be greater than what has already been experienced. The participant was advised of this risk in the letter they received. Potential risk to the participant was further minimised because there were no pre-existing relationships, including dependent ones with the participants and myself.

**Benefits**

In keeping with the principles of ethical participation in research, the participants were advised that they would not receive any material benefit to participating. Nonetheless, non material benefits could be recognised by individuals and in some cases may be central to choosing to participate in the first place, eg wanting to talk about their situation or the belief that they may be helping someone else. The benefits of participating in qualitative research have received little attention in the literature but interestingly are emerging in a lateral way (Hart & Crawford-Wright, 1999). The therapeutic value of research has been identified in the literature and provides an important argument when considering the ethics of a research study. Smith (1999) has identified the potential
therapeutic benefits of participants reliving and talking about unpleasant events. The benefits of being involved in a qualitative interview such as, catharsis, self acknowledgement, self awareness, empowerment, healing and providing a voice for the disenfranchised were identified by Hutchinson, Wilson and Wilson (1994).

The potential benefits of this study outweighed the hypothetical risk to the participants. There was determined to be no alternative for examining the actual experience of the phenomenon requiring study because it is the nature of the experience and the impact on the nurse as an individual that required examination.

**Privacy and Confidentiality**

In accordance with HREC policies the following strategies were employed. All data were coded using a number system so that the identity of the participants was only known to me. The code list was maintained as one hard copy and securely stored in accordance with RMIT policy.

Pseudonyms were used in the writing up of the data findings to disassociate the participant’s identify to the findings. Names of other persons inadvertently mentioned were not transcribed from the audiotapes and thus not mentioned in the writing up of the data findings.

Participants were sought using snowballing technique. Importantly persons were able to contact a third party allegedly involved in an unprofessional conduct event. In accordance with the tenets of this technique, participants were able to contact a nurse who they knew and who were allegedly involved in unprofessional conduct event proceedings. The participant before they were able to contact the nurse was advised that the principles of confidentiality were to be upheld.
Security of Data Storage

All written data will be kept for a period of five years and then destroyed in accordance with RMIT University requirements. The audio-tapes were erased upon completion of transcription. The only persons who had access to coded data were my research supervisors and commercial transcriber who signed a confidentiality agreement.

STRENGTHS AND WEAKNESSES

Strengths and weaknesses of the method are discussed. The role of the researcher in qualitative research as a potential weakness is introduced, along with an overview of the participants. Also included in this section is an introduction of the concept of ‘research as therapy’ and the role of literature in grounded theory.

The Role of the Researcher

Norton (1999) explains that as an interpretative research method, grounded theory does not pursue or guarantee ‘truth’ but rather the experience of the phenomenon is presented for what it is. Therefore, there is no instrument to assess reliability or validity. Instead, the issues of validity and truth rely on the interpersonal skills of the researcher to obtain the perspective of the participant, as the researcher is the instrument, or conduit for, receiving and interpreting the narrative. Importantly, therefore, the researcher in a qualitative study should utilise the following stratagems: acknowledgment of involvement and subsequent ‘inseparability’ from the research; use of the first person; use of reflexive accounts about the research process and decisions made.
Moreover, the qualitative researcher has both a privileged and responsible role to play in the collection and interpretation of data. The interplay of the researcher and the emerging data has received considerable commentary with respect to the potential for corrupting the data in that the researcher is in a position to lead the witness so to speak and to interpret the meaning of the participants experience erroneously. It is not possible to separate oneself from the data during an interview and in fact data analysis in the qualitative setting commences with listening and not with either transcribing or reading the transcripts.

Strauss (1978) alerts the researcher to the fact that they can shape the interview by the way they probe for detail, clarity or explanation, and non-verbal gestures and associated responses. I would argue that while this might be the case with each interview being quite different in terms of not only individual experiences, but the tack they might take may mean that some questions asked in some interviews may not be relevant. The researcher can have a list of previously emergent questions ready but the need to ask them may not emerge. Put simply, no two interviews will be alike. It is reasonable for qualitative researchers to use their initiative and insight, along with questions guided by the need for theoretical sampling to ‘propel’ the interview. The grounded theory researcher has to consider specific strategies when interviewing to suit the GT methods. Specifically, how to ask questions and what to ask based on: (a) what is being said in the interview; (b) questions predetermined as dictated by theoretical sampling; and (c) the development of hypotheses or relational statements (Glaser & Strauss, 1967; Strauss & Corbin, 1990). The grounded theory researcher ‘conducts’ the interview in a highly alert state – the interview although tape recorded and transcribed is a one off opportunity to engage with the source of data and
participate in the collection of data which could be missed without an in-depth awareness of what is being said, the nuances of the narrative and an understanding of what questions to ask.

The phenomenon of interest based on my readings and experience working at a nursing regulatory authority made it imperative to advertise the study to the benefit of participants, the slightest notion of blame or further reprisal for coming forward had to be avoided. The advertisement in the *Australian Nursing Journal* was seen as a ‘softer’ approach at recruitment and placed me in a collegial role rather than a power role. Some nurses who responded to the advertisement shared with me the fact that the reason they had responded was that they could see I cared about the topic and that is was non-threatening. This approach was imperative in recruiting a potentially vulnerable population. Retrospectively this strategy proved important because the reality is that the participants develop trust on ‘face value’, i.e., they really didn’t know me from the ‘proverbial bar of soap’. However, including in this article some important personal facts, e.g. my long standing interest in the phenomenon, the desire to help nurses and affiliation with a renowned university and expert nurse researchers, no doubt provided weight to my approach. Strategies to gain some comfort and ease during the interview included ‘small chat’ prior to and at times during the interview, providing moments of light heartedness to the situation, confirmation of what they were telling me as relevant and important, reaffirming issues of confidentiality and how I would write up the findings so as not to identify them, sharing with them some experiences of my own and empathising.

The majority of interviews were conducted over the telephone. This did not however, appear to pose any issues where there was a reduction in the
connectedness of the interviewer and interview. In fact, after posing the question to a number of participants they expressed that the telephone interview was very comfortable and provided an almost ‘confessional’ aspect to the interview in that they couldn’t see me. Qualitative telephone interviews are becoming increasingly popular (Burnard, 1994; Chapple, 1999; Grbich, 1999). Telephone interviews are useful when constraints of distance and associated travel cost may be an issue (Worth & Tierney, 1993). Swift (2002) provides a description of some of the advantages of telephone interviews. An advantage that I was experienced was being able to write notes without causing a ‘visual distraction’ (Swift, 2000, p. 60) and therefore not disrupting the interview process. A stated disadvantage is not being able to view the body language to appropriately interpret silences and as such opportunities to appropriately respond or interject with questions (Swift, 2002). While I acknowledge this in reality it did not prove a problem. Silences were interpreted as either the participant thinking about a question or what they were going to say next, or that they had come to the end of that particular train of thought. Equally, there were verbal cues, (e.g. crying and lowering of the voice) that provided invaluable information to guide my interaction. Not being able to assess their body language did not, I believe, diminish the quality of the interview experience.

The Participants

Demonstrating my genuineness in this study to the participants was not difficult. I was able to engage quickly and firmly with the participants allowing them to provide honest and detailed accounts of their experience. I didn’t feel that
anyone of them held back on details pertinent to their part in the alleged unprofessional conduct event.

Although this study was aimed at identifying and interpreting detailed accounts of their experience of the alleged unprofessional conduct event, limitations exist by the nature of the methodology and findings. A significant limitation is that the recounting of the experience being studied is dependent on the remembered past and can be influenced by the passage of time and the accumulative effects of the experience and other related experiences.

**Research as Therapy**

As already mentioned there was some initial difficulty in obtaining ethics approval from the university committee. The main reason for this was the committee’s belief that the participants were at significant risk of harm through the recounting of the story, and to a degree through potentially revealing evidence of other wrong doings which could be called to account. It is relevant at this point to address the notion of ‘research as therapy’, or more specifically the use of narrative as therapy. It is imperative to denounce the intention of any research as therapy in terms of a stated objective, but importantly the participation in the research using the qualitative approach of narrative does have therapeutic value and is not dissimilar, indirectly at least, to the purpose of ‘narrative therapy’ (Romanoff, as cited in Neimeyer, 2002). Narrative as a process in research serves to illuminate the experience, rather than identify issues needed to be further addressed or changed.

Romanoff (as cited in Neimeyer, 2002) explains that the mere fact that the participant agrees to engage in the research process reveals a therapeutic change,
specifically, the participant has agreed to a ‘painful line of questioning because they want to help others who are going through it, or because they see it as time to give something back (Romanoff, as cited in Neimeyer, 2002, p 249-252).

Participants in this research study expressed similar views during preliminary arrangements and during the interview. The following comment from Participant 6 at the beginning of the interview succinctly situates the value of the opportunity of participating in this study:

    I really appreciate this opportunity to offset an extremely negative impact into something positive instead of it living in my mind negatively and nothing good coming of it. [P06/PG01/L4-8]

A number of other participants expressed similar views. I was particularly struck however by one participant [P20] when she disclosed that the impact of being reported to the NRA was ‘so devastating to her’ that she had been, and is still too ashamed to speak to a counsellor about her situation and yet she had entrusted her story to me. She asserted that she had been eager to talk to me because it ‘felt that it might do her some good’. She also emphasised that talking to a nurse had made it ‘easier’.

**Use of Literature in Grounded Theory**

The use of literature in qualitative studies remains the subject of debate. In particular, when it should be conducted, and the extent of the review. Some authors state, and in doing so, maintain the assertion by Glaser and Strauss (1967) that the researcher should avoid conducting a literature review prior to collecting data (Hickey, 1997; Lincoln & Guba, 1985; Stern, 1980; Stern et al, 1982; Stern & Allen, 1984; Stern, 1994, as cited in Morse, 1994; Strauss & Corbin, 1994). It
is believed that this approach will more likely result in a theory more purely grounded in the data.

In contrast, other authors believe that a review of the literature before and during the data collection has value. Undertaking a literature review concurrently with data collection and analysis can assist in identifying knowledge gaps (Hutchinson, 1993). An example of this is provided. Glaser and Strauss (1967) confirm that literature can be used to provide data to assist with the delimiting of the emergent categories in that it can assist to formulate the theory with a smaller set of higher level concepts and as already discussed assist with maintaining theoretical sensitivity.

A preliminary review of the literature can provide a focus for and within the study, and identify the gaps within the body of knowledge with the purpose of proving the need and significance of the study (Patton, 2002; Hutchinson, 1993). Strauss and Corbin (1998) state that being able to have before you another set of field notes (through the literature) can provide links to the current research project.

The technical literature may stimulate questions during the analysis phase, for example, if a difference in the emerging data existed against the literature, the researcher would be prompted to ask why and examine such discrepancies further. The literature may also provide direction for theoretical sampling, in that sources of participants, situation, events and places, may be identified in the literature. Once data collection and analysis were completed, then the literature provided a backdrop for validation of the findings and as an impetus to refute, challenge or contribute to the literature.
Cutliffe (2000, p. 148) states that no researcher is an ‘empty vessel’ and it is common for a researcher to pursue a theme that they already have a background knowledge of. For this study, I had already accumulated a large array of literature because of my long standing interest in the phenomenon. It was probably because of this that I was able to recognise a significant paucity in comprehensive examinations of unprofessional conduct and the impact on the nurse, which in turn provided the impetus for this study. Once data collection and analysis commenced, the literature I had was examined within a more specific context and in relation to emerging categories, and further literature identified and incorporated into the analytical processes, the prologue and the narrative of findings.

**CONCLUSION**

The nature of grounded theory paralleled the intent of this research study. The ability to undertake unstructured interviews with an initial purposive sample of nurses who had been involved in an alleged unprofessional conduct event then provided evidence of the emergent categories. Theoretical sampling guided the selection of situations, events, conditions, consequences related to the phenomenon investigated. The nature of the phenomenon being studied meant a limited participant pool. It was recognised that the traumatic impact of being involved in an allegation of unprofessional conduct and reported to a NRA could mean that nurses would be very hesitant in coming forward.

The methods as described in this chapter provided instruction for data collection and analysis using the constant comparative method. The length of the interviews was guided by how much the participant wished to divulge in
accordance with their own stream of thinking and questioning. All of the participants were eager to participate and there were no unexpected reactions during the interview.

An overview of the substantive theory is now provided. Major components of the theory are illustrated which will form the narrative of the subsequent chapters. The first category of this substantive theory, the social phenomenon – the allegation of unprofessional conduct will be discussed in the next chapter.

*****

And it certainly seemed so, at least initially, in the death of Charlotte Fugett Bedford. She died in the middle of March, after a nightmarishly long labour. The black ice that fell and fell during the night had trapped my mother and her assistance alone with Asa and Charlotte: Even the sand trucks and plows were sliding like plastic sled off the roads. The phones weren’t down for particularly long on March 14, but they were down for just about four crucial hours between twelve twenty five and four fifteen in the morning (Bohjalian, 1988, p. 55-56).
Figure 3.2: An Overview of the Substantive Theory.
CHAPTER FOUR

Social Phenomenon

When things go wrong in obstetrics, they go wrong fast. They fall off a cliff. One minute mum and foetus are happily savouring the view from the top, and the next thing they’re tumbling over the edge and free-falling onto the rocks and trees far below (Bohjalian, 1988, p. 17).

INTRODUCTION

This chapter will provide a discussion of the social phenomenon identified at the conception of this study and from analysis of the data. The social phenomenon, defining sub-categories, properties and dimensions will be identified and examined in relation to the extrapolated findings and relevant literature. This chapter will also provide a profile of the study participants. This profile will include information surrounding demographics, registration status and the allegation.

Analysis of the narratives revealed that the allegations, a breach (an act) of, or failure to meet (an omission) a nursing practice standard did not arise in isolation. Rather, the social phenomenon of an allegation of unprofessional conduct was a juncture in the trajectories of, and interplays of personal and professional vulnerability. Within each of these sub-categories, personal vulnerability and professional vulnerability, there exist a number of properties, individual causal attributes and contextual causal attributes which either singularly or in combination provided a foundation for an allegation of unprofessional conduct. These vulnerabilities exist as singular concepts and on a causally linked. In those cases where there was an identified breach of, or failure to meet a nursing practice standard it emerged that there was fragmentation of decision making, which proved to be a juncture in the trajectories of vulnerability.
with a resultant nursing error. Whether the allegation was then upheld or not upheld as unprofessional conduct does not negate the fact that in some cases an error occurred in the course of nursing practice. These concepts will be fully discussed in this chapter.

Allegations of unprofessional conduct as already stated in the introduction are an end point of the interplay between personal and professional vulnerability. In the course of data analysis, a ‘continuum of motivation’ was identified which identified why an allegation was alleged and reported to a NRA. At one point of the continuum of motivation is ‘beneficence’, and at the other end is ‘maleficence’. Beneficence as a reason to allege and report has at its core evidence that a practice issue which could or did impact on patient safety. At the other end of the continuum was maleficence as the reason to allege and report. Where this existed, the reason to allege and report was primarily linked to reasons other than a concern with the nurse’s practice. The practice issue in this case was used to support the motivations of the reporting person. In all of the described cases there was some element of this identified maleficence to allege unprofessional conduct, although the beneficence in making the allegation or reporting was not always evident to the participant. The social phenomenon is now explained.

**SOCIAL PHENOMENON**

Nursing is a social endeavour, governed by social expectations and laws. There are therefore, legal and social expectations that patients will receive safe nursing care. The literature is replete with examples of failed health care events, including the involvement of nurses with negative patient outcomes (Anonymous,
The social phenomenon central to this study was identified from my experiences working as a professional officer at the Nurses Board of WA and being involved in allegations of unprofessional conduct; and through my acquisition of literature and media reports on the nurse who has erred. What have been identified from the data analysis are the antecedents, causative and resultant trajectories, and outcomes encasing the event of alleged unprofessional conduct.

The social phenomenon experienced by all of the participants was an *allegation of unprofessional conduct*. Unprofessional conduct as already defined and central to this discussion is revisited: (nursing) unprofessional conduct is defined in the broadest sense as behaviours which are divergent from the agreed upon and accepted standards of practice of the respective profession (Johnstone & Kanitsaki, 2001) and may be representative of any breach of, or failure to meet the respective legislation and or accepted nursing practice standards which aim to direct and govern nursing practice.

A matrix of the social phenomenon depicting the causal attributes and consequences is provided in Table 4.1. The social phenomenon as a category, the sub-categories of personal and professional vulnerability, associated properties and dimensions and defining dimensions are listed.
<table>
<thead>
<tr>
<th>Individual Causal Attributes</th>
<th>Contextual Causal Attributes</th>
<th>Contextual Causal Attributes</th>
<th>Individual Causal Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical &amp; Mental Health</td>
<td>Dissenting Behaviours</td>
<td>Out Group Perception</td>
<td>Isolating Strategies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Organisational Culture</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Systems Issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Practice Contexts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinical Knowledge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Working Around Standards</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Issues of Cognition</td>
<td>Face doesn’t fit</td>
<td>Scapegoating</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not knowing the rules</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Workload</td>
</tr>
<tr>
<td></td>
<td>Pre-existing health issues</td>
<td>Non-conformance to group think</td>
<td>Workplace bullying and mobbing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Just accepting the rules</td>
</tr>
<tr>
<td></td>
<td>Whistleblowing</td>
<td>Non-conformance to individual biases</td>
<td>Medication practices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Performance management strategy</td>
<td>The patient imperative</td>
</tr>
<tr>
<td></td>
<td>Industrial union involvement</td>
<td>Non-conformance to individual biases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substandard performance</td>
<td>Judas phenomenon</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communication difficulties</td>
<td>Interruption to employment</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.1: The social phenomenon: Sub-categories, properties and dimensions.
It emerged that nurses who were alleged to have been involved in a breach of, or failure to meet a nursing practice standard (also referred to as a nursing error or error throughout the document), with or without harm occurring to the patient revealed elements of personal vulnerability. This personal vulnerability comprised of individual and contextual causal attributes meant that, in some cases, there was an increased risk of the error occurring and/or an increased risk of being reported to a NRA. The other identified risk was that in some instances the nurse may have not been involved in a breach of, or failure to allege, but because of the identified causal attributes of this sub-category the allegation was used as a way of addressing what emerged as ‘out group perception’ by colleagues, the employer and health care consumers to ‘get at’, or ‘get back at’ the nurse.

The emergent concepts of personal and professional vulnerability and the inability to make sound decisions because of failed attempts to navigate and negotiate this vulnerability provided impetus for ‘fragmentation of decision making’. This fragmentation was seen as a juncture on the trajectories of vulnerability and associated decision making moved from being ‘sound’ to ‘fragmented’ and represented the ‘moment’ when the nursing error occurred. This fragmentation of decision making was identified with the recognition that the components that allow a nurse to make sound clinical decisions and enact them become ‘fragmented’, or broken, thus an error, actual or perceived occurred and was subsequently alleged.

Not all participants at the allegation of unprofessional conduct upheld but the construct of personal vulnerability positioned them at greater risk of an allegation where a motivation to allege was identified by the participant. This identified personal vulnerability, specifically the interplay between individual
casual attributes and the contextual casual attributes meant in some cases that the focus as perceived by the participant was a reason not necessarily related to nursing practice and requirements for safe patient outcomes.

To further set the scene for examination of the social phenomenon a profile of the study participants is provided. A demographic profile is provided along with an outline of the registration status of the participant at the time of interview. The outcome of the investigative process is provided including whether the allegation was upheld or not and where relevant, the penalty incurred. A number of participant responses to participating in the study are provided.

Profile of the Participants

The profiles of the participant as an individual and as a cohort are important to consider in the context of the social phenomenon. Situating these profiles in this chapter allows a ‘human disposition’ to the social phenomenon and a beginning point for considering whether there are patterns to the characteristics of the participants in relation to the allegation or consequences of the social phenomenon and process.

As identified in chapter two there was an initial difficulty in recruiting participants. I believe this was because of the nature of the phenomenon being studied. From analysis of the shared narratives it is clear that these events were in some cases devastating to the individuals and therefore a reluctance to come forward is easily understood. Notwithstanding this I received 30 completed consent forms. Of this 31, 21 met the criteria for inclusion in the study and were subsequently interviewed. I have chosen not to provide too many details regarding the personal and professional profiles of the study participants. This
strategy was used to minimise the possibility of identifying the individual. For reasons of confidentiality, I have not made a correlation between gender, age and or registration details because some of these details may have been made public during the NRA investigations.

**Demographics**

All participants were asked to complete a demographic data form as represented in Appendix F. While the nature of grounded theory does not rely on such strategies, this information is provided as background to the nurses and contexts they were working in. The profiles are provided to set the scene for reading the findings and discussion. The following tables and discussion profile the age and gender of the participants.

<table>
<thead>
<tr>
<th>AGE</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>26-30</td>
<td>1</td>
</tr>
<tr>
<td>31-35</td>
<td>0</td>
</tr>
<tr>
<td>36-40</td>
<td>1</td>
</tr>
<tr>
<td>41-45</td>
<td>7</td>
</tr>
<tr>
<td>46-50</td>
<td>4</td>
</tr>
<tr>
<td>51-55</td>
<td>2</td>
</tr>
<tr>
<td>56-60</td>
<td>5</td>
</tr>
<tr>
<td>61-65</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 4.2: Age profile of the participants

Twenty one nurses were interviewed. Of this 21, 14 were female, representing 66% of the population and seven were male, representing 34%.

It is of interest to note that of the seven males, 6 are registered psychiatric/mental health nurses and were working in the area of mental health
nursing when the allegation was made. This area of nursing is disproportionately represented in this study. This number represents 28% of the participant sample. 

<table>
<thead>
<tr>
<th>GENDER</th>
<th>PARTICIPANT NUMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>07</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
</tr>
</tbody>
</table>

Table 4.3: Gender profile of the participants.

**Allegation, Registration and Practice Profiles**

The following Tables (4.4 & 4.5) detail who made the allegation and who reported the matter to the NRA. The contexts that the participants were working in at the time of the allegation are detailed in Table 4.6. Table 4.7 details the registration profile and status of the participants at the time they submitted their demographic form and after the NRA inquiry. Also detailed is whether the allegation was upheld or not, and where relevant, the penalties imposed.

<table>
<thead>
<tr>
<th>ALLEGED BY</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Nursing</td>
<td>4</td>
</tr>
<tr>
<td>Colleagues</td>
<td>5</td>
</tr>
<tr>
<td>Management (non-clinical)</td>
<td>1</td>
</tr>
<tr>
<td>Supervisor</td>
<td>6</td>
</tr>
<tr>
<td>Patient</td>
<td>2</td>
</tr>
<tr>
<td>Relative</td>
<td>2</td>
</tr>
<tr>
<td>Coroner</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 4.4: Source of allegations.

As the following table will show the person who alleged unprofessional conduct, or made the initial complaint was not necessarily the one who reported the matter to the NRA. For the majority of cases the complaint was forwarded to the respective director of nursing who then reported the matter to the NRA.

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3 In 2001 in WA there were 26 678 registered nurses, of which 1627 were held mental health registration. This represents 6% of the register.
Study participants were not recruited with a particular context in mind. What eventuated was a predominance of nurses working in a medical area, mental health and aged care.

The Nurses Board of Victoria recently provided a profile of the number of complaints received by practice area (Nexus, 2005A). For the period 2003 – 2004 and 2004 – 2005 the majority of complaints were in the domains of aged care, acute care and psychiatric care, respectively. Complaints were received from the domains of community and rehabilitation, intellectual disability, midwifery, palliative care and others, but of far less numbers. For example, over 60 complaints were received in the area of aged care for the year ending 2004 while approximately 5 were received from the domain of midwifery (Nexus, 2005).
<table>
<thead>
<tr>
<th>PARTICIPANT INTERVIEW NUMBER (PIN)</th>
<th>REGISTRATION STATUS</th>
<th>OUTCOME OF ALLEGATION</th>
<th>DISCIPLINARY ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Registered General</td>
<td>Upheld</td>
<td>Fine $3000</td>
<td></td>
</tr>
<tr>
<td>2 Registered General</td>
<td>Partially upheld</td>
<td>Conditions on practice to be supervised by a registered nurse for a 12 month period – not able to obtain</td>
<td></td>
</tr>
<tr>
<td>3 Registered General Midwife</td>
<td>Not upheld but acknowledged that error occurred but not deemed unprofessional conduct</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>4 Registered General</td>
<td>Not upheld</td>
<td>Employment terminated 4</td>
<td></td>
</tr>
<tr>
<td>5 Registered General</td>
<td>Upheld</td>
<td>Reprimand</td>
<td></td>
</tr>
<tr>
<td>6 Registered General</td>
<td>Not upheld</td>
<td>Recommended to undertake a course in nursing management</td>
<td></td>
</tr>
<tr>
<td>7 Registered General</td>
<td>Partially upheld</td>
<td>Limited registration</td>
<td></td>
</tr>
<tr>
<td>8 Registered General Midwife</td>
<td>Not upheld but acknowledged that error occurred but not deemed unprofessional conduct</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>9 Registered General Mental Health</td>
<td>Not upheld</td>
<td>Costs $250</td>
<td></td>
</tr>
<tr>
<td>10 Registered General Mental Health</td>
<td>Upheld</td>
<td>Conditions on registration 12 month good behaviour bond with monthly supervision to discuss ongoing professional issues</td>
<td></td>
</tr>
<tr>
<td>11 Registered General Mental Health</td>
<td>Not upheld</td>
<td>Placed on professional review for a 3 month period, subsequently resigned.</td>
<td></td>
</tr>
<tr>
<td>12 Registered Comprehensive</td>
<td>Upheld</td>
<td>Counselling</td>
<td></td>
</tr>
<tr>
<td>13 Registered General Maternal</td>
<td>Upheld</td>
<td>Reprimand</td>
<td></td>
</tr>
<tr>
<td>14 Registered General Mental Health</td>
<td>Upheld</td>
<td>3 month supervisory period</td>
<td></td>
</tr>
<tr>
<td>15 Registered General</td>
<td>Not upheld</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>16 Registered General Mental Health</td>
<td>Upheld</td>
<td>Practice only with a NRA approved employer, practice under supervision of an experienced nurse, provision of report to the NRA regarding interaction with patients and Costs $30 000</td>
<td></td>
</tr>
<tr>
<td>17 Registered General Midwifery</td>
<td>Not upheld</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>18 Not registered General Midwifery</td>
<td>Upheld</td>
<td>12 months treatment by a counsellor, satisfactory report to obtain re-registration, has not practiced since incident</td>
<td></td>
</tr>
<tr>
<td>19 Registered General</td>
<td>Upheld</td>
<td>Suspended for 2 months Education course</td>
<td></td>
</tr>
<tr>
<td>20 Registered General Midwifery</td>
<td>Upheld</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>21 Registered General Midwifery</td>
<td>Upheld</td>
<td>Not upheld on appeal</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.7: Registration and allegation outcome profile.

4 This employee had his employment terminated based on the same allegations that were reported to the NRA. The participant did seek redress in the industrial court system and received a ruling that he was unfairly dismissed but did not seek to have his employment reinstated.
Responses to the Opportunity to Participate and the Interview Experience

As introduced in chapter two there was some difficulty in obtaining ethics permission to conduct this study. At this point it is important to include quotations from the participant narratives where they spontaneously expressed the value being able to participate had for them. The concern expressed by the Human Research Ethics Committee (HREC) was that there was potential for harm to come to the participants through the distressing nature of the remembered past and the legal risk should they provide any new information that could be dealt with by a legal and or professional authority. The very nature of the experience was indicative that recall would prove to some degree, distressing.

A number of themes relevant to the perceived risk to these participants emerged from the interviews and provide the message to pursue imperative research even if it sits on the ‘legal fringe’. All participants were eager to talk about their experiences and in some instances contended that being able to participate had a therapeutic value because someone was listening to them. For many participants this was the first time that they had told the whole story. Some participants also expressed a hope that by sharing their story that someone else could be prevented from going through such a traumatic experience. A number of participants demonstrated that contacting me and agreeing to talk was timely, specifically, that the time was now ‘right’ for them to talk about the experience. It can be inferred that if the time was not right then the individual would not have agreed to talk about their experience, thus revealing an inherent ‘self imposed safety mechanism’.

It is contended that these participants were able to identify their own capability of reliving the experience. The following quotations support these
contentions. None of what is reported here was prompted; the participants in the course of telling their story chose to divulge their feelings on participating. As an example, Participant 13 provides the following:

When I read that you were doing this research I called you as soon as I saw it because I thought that is was wonderful that someone was studying this because I am sure that the Board has absolutely no idea what sort of impact that they have on people, what a devastating effect their actions have had. I am glad that you are doing this research, I wanted to be involved and I have been looking forward to talking to you. [P13/PG14/L18-22]

And from another:

I just saw your advertisement in the Nursing Review and thought I’ve never even had a chance to talk about it to anyone. [P05/PG66/L26-27]

Participant 13 reiterated the value of participating and the realisation that she was not the only one to have gone through this:

When you phoned me a couple of weeks ago and I asked how long it would take and you replied that one nurse has spoken for four hours, that was like ‘oh fantastic’ there are other people out there who need to talk about it too. I got off the phone and said to my husband, somebody else has gone through this. [P13/PG19/L9-12]

An altruistic view to participating is provided here:

The reason I decided to speak with you was because of the amount of pain I was over this whole thing and how unresolved it is. If I can make it better for someone else, if whatever you write at the end of the day makes it better for someone else then I knew I had to do it. I think this is a very worthwhile topic. There are a lot of nurses out there in a great deal of pain, as I have been. [P20/PG11/L22-26]

And from another nurse who saw this study as another message of challenge to redress what had happened to her:

A friend rang me after he saw something on television about bullying in the workplace and the implications of it. He challenged me to do something about it. I said, ‘as far as I’m concerned I’m finished with the whole thing. I’m not putting myself through anything else’. The friend replied ‘look there is a lot of people out there who are getting hurt, who are being bullied, and who are being blamed for things’. And here you are doing a PhD, and if anyone can say anything on behalf of these people who cannot articulate how they, feel you can. And saying to herself ‘now get off your backside and do something about it’. [P07/PG27/L11-22]
The following provides a sense that the participant knows when the right time is to talk about such matters:

The timing of this interview is brilliant. If you had of interviewed me at the time that we first talked I wouldn’t have been able to do it objectively, I was still very angry at that point. [P15/PG09/L3-6]

This from another participant:

The timing of this interview has been a bit serendipitous, talking now is the right time, I wouldn’t have been able to do it 12 months ago, so the timing is good. [P13/PG18/L29-30]

The other benefit to participating in qualitative research which is not widely accepted is ‘research as therapy’ (Romanoff, 2002, p. 245). While it is not my intention to enter into this debate this concept could be further considered using the positive words the participants have provided. The following from one participant touches on this theme:

Thank you. I really appreciate this opportunity to offset an extremely negative impact into something positive, instead of it living in my mind negatively and nothing good coming of it. [P06/PG01/L2-9]

Another participant shares the positive response she experienced to participating:

I’ve really appreciated this opportunity. I don’t know why I’ve appreciated the opportunity. I guess because you are a nurse, that makes the difference, whereas talking to an unbiased counsellor who doesn’t know anything about the nursing profession and what we deal with is a bit lacking. [P20/PG18/10-14]

And this:

I am glad that I can talk about it, any other time I’ve talked about it I’ve come away feeling absolutely drained, but I don’t this time. [P15/PG24/L40-41]

The most poignant of these comments came from Participant 19 who in response to me asking her what she thinks it would take to move on from the experience replies: ‘actually I think talking to you will. I think this is one of the reasons that I rang you because I thought it might help to resolve it’ [P19/PG05/L3-5].
These are important findings for other researchers who may be asked to identify participant risk if conducting similar studies where the phenomenon being examined was traumatic. The comments also support the notion that potential research participants can identify the risks to participating and contribute to the decision to determine if the benefits to themselves and the broader discipline outweigh the risks. The concepts of personal and professional vulnerability which led to a ‘fragmentation of decision making related to these vulnerabilities, will now be discussed. The concept of vulnerability is introduced.

**Vulnerability Introduced**

Vulnerable\(^2\) is defined as ‘capable of being physically or emotionally wounded or hurt; open to temptation, persuasion or censure, etc; liable or exposed to disease or disaster, etc’ (Collins Australian Dictionary, 2003, p 1803). Vulnerability is a broad concept with relevance to a number of situations and disciplines. A significant paucity of literature related to the concept of professional vulnerability in nursing practice was identified. What literature was identified centred on vulnerability and the patient (Iruita, 1994) and the themes of vulnerability and resilience in psychology circles (Luthar, Ed., 2003).

One unpublished study which examined flight nurses’ understanding of legislation directing their nursing practice, in particular medication administration, provides a definition of professional vulnerability. Nicholls (2000) identified that there was no literature which centred on medication administration and professional vulnerability but for the purpose of her study, defined professional vulnerability as professional exposure or openness to persuasion. This reported
study will be discussed again in relation to findings of what contexts nurses may find themselves vulnerable.

Malone (2000) states that two views of vulnerability are evident in the nursing literature. That which describes the risk of harm associated with public health and the second model is that which states that there is a degree of vulnerability in all sentient beings. The sense of vulnerability that emerges from this model and from the discussion by Malone is the emotional vulnerability which nurses experience because of caring for certain patient populations, for example ‘bearing witness to suffering’. Another dimension of vulnerability, as opposed to what is described by Malone (2000) and Irurita (1996) is that which has been identified in this study.

This concept of vulnerability can be viewed as those risks which are associated with the individual causal attributes and contextual causal attributes and the interplay of these two properties. This vulnerability and the inability to navigate it can cause a fragmentation of decision making and exposure to professional harm. The identification of this concept and its constructs in relation to nursing practice is long over due in the literature. The first sub-category of personal vulnerability will now be discussed. It is important to interpret the concepts of personal vulnerability and professional vulnerability as interconnected and not in isolation. Situating and considering these vulnerabilities in a ‘cause and effect’ model will provide a more accurate picture of what is occurring in the world of these participants. The concept of vulnerability has to be viewed as a complex and dynamic matrix of the causal attributes.

5 C17: from Late Latin vulnerābilis, from Latin vulnerāre to wound, from vulnus a wound (Collins Australian Dictionary, 2003, p. 1803).


Personal Vulnerability

The sub-category personal vulnerability was identified within the experiences of all participants but with varying dimensions with respect to significance, or impact of the causative properties in relation to the allegation of the breach of, or failure to meet the nursing practice standard. Within this sub-category there are two properties, individual causal attributes and contextual causal attributes a number of dimensions and dimensions (Table 4.8).

The property, individual causal attributes revealed two dimensions: physical and mental well-being; and dissenting behaviours. There are well defined relationships demonstrated in the experiences of some participants, between the individual and contextual causal attributes, and in some cases to the sub-category professional vulnerability.

The idea that some nurses are reported to a NRA for reasons other than primarily an alleged breach of, or failure to meet a nursing practice standard has been introduced. The motivations of the individual reporting the nurse to the NRA was ‘served’ by the presence of a practice error, alleged or bona fide. This finding was completely unexpected but becoming less surprising as the interviews progressed.

The emergence of this finding also posed a number of questions. Firstly, what is it about the individual nurse that they are viewed as being more vulnerable to being reported, and secondly, why is it that the NRA has agreed to investigate these matters and not attempted to identify the true reason for the nurse being reported? It is hoped through a number of recommendations that such matters can be identified at an employer level, a nurse advocate level and by the respective NRA to ensure effective management and unnecessary reporting. It is important
146
are situated in the ‘truth’ that was presented at the time of the interview and does not include the ‘what ifs’ and the ‘maybes’, or the views of another person.

**Individual Causal Attributes**

Individual causal attributes contributing to the dimension personal vulnerability were identified as the following: (a) **physical and mental health issues**; and (b) **dissenting behaviours**. These attributes were identified as belonging to the category of personal vulnerability because the behaviours are predominantly seen as belonging and or originating with the individual.

**Physical and Mental Health Issues**

It is contended that the purpose of this research was not to evaluate the physical and mental well being of the participants, nor was this ever asked within the context of the interview. At no time do I make the contention that a nurse was physically or mentally unwell and as such not fit to practice as a nurse. The reason for choosing this label is twofold. Firstly, there exists implications from the narratives that physical and mental well-being may have been an issue for some nurses in that strategies were requested to determine wellbeing, and the participant themselves make reference to them. Secondly, it is a requirement for registration as a nurse that the individual is not physically or mentally impaired to a degree that the ability to practice as a nurse is compromised. Thus, what emerged for some participants and poses important questions for employers and nursing regulatory authorities is the concept of physical and mental impairment and the impact on the nurse to fulfil the required competencies of a registered
nurse and role for which they are employed, and how best to manage these matters.

Issues of Cognition

One theme to emerge from the data is the perceived problem of cognition. One participant, in telling her story, introduced the idea that the respective NRA that chose to investigate an allegation of unprofessional conduct were responding to a question posed by her employer about her cognitive ability. By suggesting that this nurse was having cognitive difficulties at work, the NRA required her to be assessed by a psychologist. Her story illustrates that the motivation to report was based in maleficence rather than beneficence. As well, this story provides an opportunity to analyse how matters of cognition and therefore competency to practice should be managed. Her working context in my view contributed to her inability to effectively practice as a nurse. This concept will be discussed in the sub-categories ‘workload’ and ‘systems issues’ identified as a contextual causal attributes for professional vulnerability. This participant was devastated by what transpired and how this sensitive matter was dealt with.

In telling her story, Participant 2 kept coming back to a sense of being discriminated against. In giving what she described as a lot of thought ‘I arrived at a two fold conclusion’ promulgated from her words with respect to one, why she was reported to the NRA and two, her sense of being discriminated against. She viewed the reasons as being connected. This nurse believed that her co-workers though that she was experiencing, memory problems because of her age. She was instructed to visit a psychologist to be assessed as she was told ‘her memory was bad’. The allegations centred on episodes where she had forgotten
to sign administered medications and an incident where the wrong dosage of a
dangerous drug had been given by her.

The issue of age and related cognition is provided by another participant.
She describes what was being said about her in relation to her nursing practices
and perceived memory issues. The NRA was concerned that this nurse had a
cognitive problem because she couldn’t remember the incident that was central to
the allegations:

The nurses’ board responded to the hospital saying that they thought I was
losing my memory and made me have an assessment done by a
psychologist. There were all these insinuations and accusations that I was
too old for the job and that I was cognitively impaired. [P07/PG13/L2-5]

It is interesting to note that at the time of the allegations for Participant 7
she was in the early stages of undertaking a Doctor of Philosophy degree. That
fact that this participant was undertaking higher education will be again
introduced in the findings of tall poppy syndrome.

The following case provides yet another example of suspected cognitive
problem. From the outset I contend that this information emerged from the words
of the participant as part of the explanation of what may have contributed to the
alleged nursing error he was involved in. This is included not only because it
was an identified finding but to provide a point for future reference with respect to
addressing cognitive abilities of the nurse as part of the greater notion of
‘competent to practice’ and the need for an individualised approach to clinical
development. He tells of the reason why he was sent to a neuro-psychologist:

They sent me to a neuro-psychologist to talk to someone about the whole
learning issue because they were convinced that I had a real problem with
knowledge and about my ability to learn. [P12/PG07/L17-20]

Central to a nurse being allowed to practice is the belief that she/he is
competent to do so. Nurse regulatory authorities in all states and territories of
Australia require that nurses are ‘fit to practice’. For example, the *Nurses Act 1991 (NSW)* states in section 44 (1) (b) that ‘a complaint may be made that an accredited nurse suffers from an impairment’ and where a nurse s 44 (1) (e) ‘does not have sufficient physical or mental capacity to practice nursing’. The Nurses Board of WA under the *Nurses Act 1992 (WA)* are obligated to investigate reported matters where the nurse is considered unfit to practice nursing. Specifically, Section 61 (f) of the *Act* articulates those matters the Board can investigate and act where a person suffers from any mental or physical disorder to a degree that renders the person unfit to practice as a nurse. The legislation in both the above examples supports the removal of the nurse’s name from the Register if they are assessed as lacking sufficient physical and/or mental capacity to effect the requirements of registration requirements and role.

**Pre-existing Mental Health Issues**

From the outset, it is important to state that I did not attempt to seek information from the participants regarding their mental health wellbeing or any specific diagnosis. From listening to the participants there were in a few cases there appeared to be indication that a pre-existing mental health issue may have meant that the participant was more vulnerable to other vulnerabilities identified in their stories, and inhibited having insight into what was happening to them and their coping abilities. Of the 21 participants, I believe that three may have had some mental health issue which impacted on their practice and the aftermath of the allegation being made. For example, one participant spoke at length about their life history, the reasons for coming into nursing, the problems they had experienced in previous employment positions, their issue with anger management and the fact that they had had previous counselling. The counselling
relationship had not been sustained. The second case revealed hints that the participant had been suffering long term stress and anxiety which had never been professionally managed. The experience of being reported to the NRA had contributed to this stress which continued to go unchecked. This participant had been experiencing, in my view, long term stress, compounded by the experience of being reported to a NRA. In the third case, the participant indicated that she had experienced depression in the past. Having an allegation of unprofessional conduct made against her and being reported to the NRA for it proved extremely stressful. This participant required hospitalisation for depression and suicidal ideation.

**Dissenting Behaviours**

The dimension dissenting behaviours was established with the identification of the following: (a) Tall Poppy Syndrome; (b) whistleblowing; (c) industrial/union involvement; (d) sub-standard performance (actual or alleged); and (e) communication difficulties. Dissent⁶ is defined as ‘[1] to have a disagreement or withhold assent or [2] a difference of opinion (Collins Australian Dictionary, 2003, p. 478). In using the term ‘dissenting’ I am not contending a sense of wrong doing by the nurse in anyway, but rather, their behaviour was different to the ‘group think’ or contrary to the practices and philosophies of management and being different to that of the organisational culture. In some cases their behaviour was assessed as different to that expected of a professional nurse.

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⁶ Dissent: C16: from Latin dissentire to disagree, from DIS + sentire to perceive, feel (Collins Australian Dictionary, 2003, p. 478).
For the dissenting behaviour to become an issue or problem, it has to be viewed as such by an individual or the group, thus the property *out-group perception* was identified and resulted in a reciprocal behaviour, *isolating strategies*. These will be discussed as components of the property contextual casual attributes for the sub-category of personal vulnerability. When reviewing the dimensions in relation to the concept out-group perception it can be seen that for the most part, they mirror the dissenting behaviours.

It is important to discuss these individual causal attributes not only because they demonstrate the personal vulnerability for this cohort of nurses but potentially they may be a problem for any nurse. Should the ‘conditions’ become right then any nurse could find their behaviour being viewed as dissenting. The dimensions of the property dissenting behaviours are now presented.

**Tall Poppy Syndrome**

Tall Poppy Syndrome\(^7\) was identified as a dimension of the property dissenting behaviours. Participant 6 provides insight to what was viewed as a less than professional management of an allegation of drug use while she was employed in an aged care setting in response to her addressing a number of clinical and management practices. The allegations by three nursing supervisors were eventually founded to be without basis. This participant believed that because of her professional achievements she was viewed as a target for a degree of victimisation. This experience questions the risk of being a patient advocate and having to step outside the culture of the organisation and the implications of this for the individual nurse. A link is made between being perceived as a tall poppy, being a whistleblower and then being targeted for these. She explains:
At the time of the allegations I had two degrees and I was definitely viewed as the tall poppy of the nursing home and I was targeted as such. The supervisory nurse struck me off the roster for being ‘greedy’ quote, unquote and then she documented in the resident’s record that I was rude. It was alleged that I was using non prescribed medications and dependent on them. I think that this bully deliberately accused me to try and discredit my academic qualifications, she was jealous of me during my whole time there, she continually targeted me and continually drew people to target me. [P06/PG02-03/L17-21/15-17]

The allegations of drug dependence as stated were unfounded and subsequently dismissed by the NRA but not before a very traumatic, and importantly unnecessary experience for this participant. The allegations were based on this nurse being targeted because of other nurses’ perception that she was a ‘tall poppy’. This participant explained that she believed that she was a tall poppy because of her success in managing in the aged care facility, and the fact that the person who instigated the campaign against her wanted her job.

A further example of Tall Poppy Syndrome is provided by Participant 5. She acknowledges that it was a possible reason for being reported to the NRA for allegations of unprofessional conduct surrounding allegations of breaching aged care standards. These allegations were also unfounded. She shares a harrowing experience but here makes specific mention of the Tall Poppy Syndrome identified as a reason for the event: ‘That’s what I got told, it was Tall Poppy Syndrome’. [P5/PG59/L10-11]

Participant 7 in relation to being asked if she felt that one of the reasons she had been reported to the NRA was possibly a ‘tall poppy’ situation replied with the following and in doing so identifies, and maybe more accurately, the reason for being reported was that she was viewed as a whistleblower: ‘I certainly do think it’s the case’ [P7/PG34/L11]. This nurse also articulates how she felt that she

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7 A tendency to disparage any person who has achieved great prominence or wealth. (Collins Australian Dictionary, 2003, p. 1644). Perhaps from the Tarquin’s decapitation of the tallest
was in turn reported to a NRA because she had reported a nurse to the DON for unprofessional conduct, she states ‘I was just paying the price for being a whistleblower.’ [P7PG34/L11]

Participant 7 was enrolled to do a Doctor of Philosophy degree, which she acknowledged was probably a reason for being viewed as a tall poppy’. [P07/PG/L11]

The connection between doing higher studies and being seen as a tall poppy is demonstrated in the words of Participant 13: ‘as a nurse I had pursued further studies, which meant I was in the minority. I was the only nurse employed who was doing a masters degree. [P13/PG06/L24-26]

**Whistleblowing**

Participant 6 provides insight into her experience of being seen as a whistleblower. In response to being compelled to report a number of matters to the Australian Nursing Federation (ANF) and the Equal Opportunity Office (EEO) she reveals the effect of this:

I found a sexually offensive calendar and was continually harassed by staff about it…I ended up having to contact the EEO and there was a debacle about it and the nurse continued to target me. [P06/PG03/L22-26]

She goes on to explain the situation:

The union had to be brought in because my wages were cut without authorisation by over $8000 in a year…the biggest problem was that the management were confronted with were the union jumping up and down particularly about my salary cut…I was continually harassed right up to that time. [P6/PG04/L23-26/PG04/19-23]

Participant 11 provides the following interpretation of what initiated allegations of unprofessional conduct and subsequently having the matter reported to a NRA and in doing so reveals the concept of whistleblowing:

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8 A person who informs on someone or puts a stop to something (Collins Australian Dictionary, 2003, p. 1831).
As acting manager on night duty I had written a letter of concern about a particular nurse’s practice and that she had falsified her timesheets. As a consequence of this I got back to work the next night and stuck on the window in the nursing office was a great big yellow envelope with my name on it, which consisted of a series of complaints about my behaviour from patients.

Two issues emerge here, firstly the use of making an allegation as a method of retaliation, a ‘tit for tat’ practice, and the use of positioning the envelope in a public place which had obvious meaning within the culture of the unit. While this may not have been meant as a purposeful attempt at ‘naming, blaming and shaming’ this was for this participant a recognised symbol by putting the named envelope on the window.

These examples of whistleblowing are representative of dissenting behaviours. Whistleblowing (Boatright, 1993, p. 133, cited in Johnstone, 2004, p. 354) is defined as:

The voluntary release of non-public information, as a ethical protest, by a member or former member of an organisation outside the normal channels of communication to an appropriate audience about illegal and/or unethical conduct in the organisation or conduct in the organisation that is opposed in some significant way to the public interest.

Another participant was involved in whistleblowing activity. In response to some issues that were alleged to have occurred in a mental health setting, and which were reported in the media, including a suicide and risk to patients, this participant believed that he had a mandate to make some changes. This change included making known the issues. He explains what happened in response to this:

They wanted to silence me. They said that I had no credibility, so I thought I am going to be a whistleblower on this.

There is a clear responsibility as a professional nurse contended by key nursing organisations and articulated in respective codes of ethics and conduct
that nurses must ensure through reporting mechanisms and relevant actions that
individuals are safeguarded against unsafe practices (Johnstone, 2004). There is a
difficulty in, and therefore an understandable reluctance in speaking up when
standards are not being met, be it by a colleague or by someone else in another
health discipline. The consequences for whistleblowing are clear.

The experience of Participant 4 demonstrates this. His employment was
terminated after expressing concerns to the owners of an aged care facility when a
number of industrial policies and standards for safe practice were being
compromised. While his whistleblowing actions were to the owners the reasons
for and consequences are similar to ‘going public’ with such knowledge. Some
examples include:

I was going through the rosters and I noticed that the total number of hours
was reducing each fortnight and I challenged them about it and they got
very angry and told me not to mention it to anyone else. I also had to
challenge them about the way they were treating one of the staff members.
[P04/PG01/L9-18]

Industrial/Union Involvement

Another example of dissenting behaviours was involvement with industrial
and union matters. Nurses in union positions and activities may have these
behaviours seen as dissenting to those of management and individual nurse
philosophies. This was true for Participant 11 and provides explanation from his
perspective of why he was seen as ‘outside the group’. In his words he makes a
direct connection to vulnerability because of this:

Certainly involvement in the union and questioning things had made me
vulnerable. I had been a worksite representative for the hospital and I had
been involved in enterprise bargaining committees. I was a political beast
for a long time. [P11/PG06/L7-9]

Another example of union involvement and self perception of this as a
dissenting behaviour is expressed by Participant 14:
I was involved in union matters for a long time. At the time of the allegations I was the President. I think it was my union involvement that prompted these allegations. 

It was the actions of Participant 6 in having to contact the ANF and obtain advice from the respective equal opportunity authority in relation to a number of industrial matters that caused a retaliatory response from the employer.

Sub-Standard Performance

The expectation that nursing practice is in accordance with prescribed and necessary standards for the best possible outcome is clear. While there was an allegation of ‘sub-standard performance against all of the participants by the nature of having an allegation of unprofessional conduct made against them, a number of cases stand out. The ultimate allegation of sub-standard performance is when a nurse is accused of being involved in the death of a patient either through a breach of, or omission of a nursing practice standard.

The first case to be discussed involves a nurse who was working in a prison setting. A patient presented in cardiac arrest. Despite extensive resuscitation efforts by the nursing staff on duty the patient died. This case was investigated by the Coroner. The respective NRA was aware that it was a coronial matter. The allegations contended by the NRA (which were not upheld), were that this participant was negligent in her duty, which contributed to the death of the patient. There was noted to be conflicting views by the medical officer [expressed at the coronial inquiry] regarding the care of this patient which was seen as a red flag by the NRA.

A further example of sub-standard performance revealed in the allegation set down by the NRA is illustrated in the case of Participant 19. It was alleged that this participant failed to make a timely and accurate assessment of a patient
who had sustained a fall. The patient whose clinical condition had deteriorated later died after being transferred. This participant was not the direct care giver but was the senior nurse on at the time. [P19/PG02/L15-25]

Communication Difficulties

Communication difficulties are illustrated in the following examples and reveal a dissenting behaviour which contributes to the personal vulnerability of the individual: This participant also demonstrates insight into these communication difficulties but the focus I believe has to do with the impact these difficulties have rather than in recognising the overall problem.

It has been made clear to me since that incident that I have an attitude, which is that I say what I think too much. This obviously upsets managers and I certainly try not to do it in a confronting way but I don’t put up with people being rude to me. If people are rude to me I can ruder, I can be louder. [P04/PG10/L2-7]

A number of other examples are provided and in doing so reveal a pattern of communication difficulties:

I just blew the shit out of them, I just ranted and raved and shouted and got it off my chest and told them to go f*** themselves. [P04/PG28/L9-10], and I ended up having a shouting match. [P04/PG23/L17-18]

Not withstanding the difficulties this participant was experiencing he also demonstrates a considerable amount of insight into them, albeit, it is contended that he is not able to address the cause of these difficulties.

Contextual Causal Attributes

A number of contextual causal attributes were identified which formed the sub-category of personal vulnerability, they are: (a) out-group perception; and (b) isolating strategies. The following also provides illumination of the experience that the participant has gone through leading up to the allegation, the matter being
reported to a NRA and subsequent deconstructive processes of the personal and professional self.

**Out Group Perception**

The term ‘out group perception’ has been borrowed in part from the field of social psychology (Moghaddam, 1998). What emerged in the narratives was evidence that some participants were perceived as ‘outside of the group’, that is, having qualities and behaviours that were seen as presumably either non-conforming, or in conflict to the in-house rules of the group. This was particularly so in the case of where the team leader was central to the allegation being made. Out group perception may be demonstrated in the following ways:

(a) ‘face doesn’t fit’; (b) non-conformance to group think; (c) non-conformance to individual biases; and (d) Judas phenomenon. The following discussion provides examples of this out-group perception. It is important to recognise that this perception by the participant is in response to the identification and interpretation of dissenting behaviours by those within the group.

**Face Doesn’t Fit**

I have always had a sense that some nurses are more prone, more at risk of being ‘noticed’ and subsequently brought into question because they just ‘don’t quite conform’. I was coming to the end of the interview with Participant 10 when I put the following question to him: ‘do you feel that because of your need to care for and voice your concerns, these make you particularly personally and professionally vulnerable to what occurred?’ He replies:

Too bloody right I do. I’ve had this vision, this image in my mind for years, and particularly since I read this cartoon by Larson. There’s a bear in one of his drawings and he’s got a target on him, and in the story line, his mate says to him ‘bummer birthmark Ralph’, and guess what? I reckon
I’ve had a target on me for years because I am a very pragmatic sort of person, very practical and I actually do think of the clients and when I get sanctimonious gits telling me they’re caring for the clients and then they do the exact opposite I don’t like that stuff.  

While not making a judgement on this nurse’s communication style it can be seen that his style probably made him more vulnerable to being labelled as problematic because of the way he communicated. This concept of increased vulnerability must be acknowledged by managers and educators so that the individual nurse will not be judged in such a negative light.

Participant 10 was viewed as ‘dissenting’ by one particular supervisor. He provides this explanation through the eyes of some of his peers:

I had this feeling that I wasn’t liked and it also became obvious to my fellow colleagues. They would come to me and say ‘you’re a real threat to him because people see you as the service down here [and not him].’

He explains further:

This guy felt very threatened by me. Almost from the beginning I felt these vibes that I was on the outer. He very quickly brought down a lot of people that he had worked with and developed what I call the ‘purple circle’9. Those belonging to the purple circle were his favourites.

His inadvertent dissent also emerged in him voicing concerns, questioning the status quo and really, just getting on with an extensive workload. It is notable that an individual can be labelled as dissenting by just standing out from the crowd and not necessarily by behaving in a negative way. He provides examples including expressing concern for non clinicians, that is occupational therapist and social workers working with acute psychiatric patients, specifically their inability to manage the acute patient including administration of medication. He saw this public questioning as one reason why ‘he was on the outer’  

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9 This participant made reference to the ‘purple circle’ as a group within the work place who were favoured and protected. Purple is a colour that signifies nobility or royalty (Collins Australian Dictionary, 2003, p. 1316) and may have some bearing on this term.
acknowledges that he was targeted rather than his nursing colleagues because they were more politically astute, translated as they kept their mouths shut.

Participant 11 mirrors the experience of Participant 10. He contends that his ‘face didn’t fit’ [P11/PG02/L46] and goes on to say that he was basically bullied out of his position because of this.

**Non-Conformance to Group Think**

An example of ‘non-conformance to group think’ is provided. While the experiences of the participant conveys other out-group perceptions like his ‘face not fitting’, his behaviours in relation to the management of this clinical situation reveal non-conformance with the required standards for this group. There is an acknowledged challenge with the making of clinical decisions at an expert practice when nursing practice standards fail to incorporate this expertise and therefore the less tangible aspects of the situation. He sets the scene:

One of the things I was charged with after the investigation was prescribing medication to this particular patient, but it wasn’t prescribing medication. What happened was that this patient presented in a manic episode. I went and assessed her and suggested she re-commence her medication that had previously been agreed to by her general practitioner (GP) and ordered. It being an acute situation and knowing that that would be what the GP ordered I re-commenced the medication. [P10/PG08-10]

I always telephone the GP and liase with them - they’d always take my call even if they are with a client, because of that trust thing we had. I would say so and so is doing such and such I’ve just told her to take such and such and I’m going to get her to come in to see you as soon as possible. - yes good on you thanks. yeah, OK, all right, we would arrive at a plan which included an agreement on the medication and dose to be given. She was one of the people that the charge was levelled against me that I prescribed medication. The GP actually wrote a letter saying that I had his full authorisation to do that, but I was still found guilty of it because I’d prescribed the medication, because I’d actually recommended taking the medication before consulting with the GP. [P10/PG10/L6-13]

There was never a denial from this participant with respect to the allegations. He acknowledges that he did ‘prescribe’ the medication. In the
narrative the notion of professional jealousy is hinted at when I asked him if he felt that there was an element of Tall Poppy Syndrome to any of this:

I had this sneaking suspicion that I was not liked because of the respect I had from other people, and here was this guy who wanted the glory for everything, he was very narcissistic, egocentric, whatever term you like, and the GPs still wanted to refer to me and deal with me even with non-clinical issues and I don’t think he liked that. Four of my colleagues at different times came to me and said he’s so threatened by you because you know your stuff so well and you’re so established here and so respected. And that’s what my colleagues were telling me. So if that’s what you mean by tall poppy, then yes. [P10/PG26/L19-25/PG27L1-5]

An example of non-conformance to group think, and subsequently out-group perception was experienced by Participant 15 after she was employed with the intention of the employer to sort out some conflict issues in this particular unit. The manager had spoken to the nursing staff informing them that this nurse had been employed to ‘sort things out’. This was obviously seen as a ‘red flag to a bull’ to those nurses who had some dominance in this unit. The participant talks about this out-group perception and resultant behaviours from the group:

Right from the start some of the nurses in the unit made it clear that they didn’t like me and they didn’t want me there. These antagonistic nurses worked relentlessly over the next fifteen months to try and push me out. It is hard for me to give a clear description of the magnitude and the consistency of what I call oppression, harassment, cruelty and their relentless push to get rid of me. [P15/PG01/L21-40]

Participant 4 was working as a registered nurse in an aged care context. After he made a number of complaints with respect to clinical standards and management decisions this nurse had his employment terminated. After he pursued the matter through the respective industrial commission, the ex-employer made allegations of unprofessional conduct to the NRA. A number of examples are provided:

I had to challenge them [nursing home owners] about the way they were treating one of the staff members and that resulted in an abusive encounter with them. [P04/PG01/L12-18], and I was getting a hard time about various
things, nothing to do with my nursing work. I had reason to complain to them about reduction in staffing hours which was a continual issue.

Participant 5 provides an account of examples of isolating strategies directed in her in her role as a nursing director of an aged care facility. From the outset it was clear that the allegations against this nurse were without substance. After an extensive investigation, the allegations were eventually not upheld by the NRA. What transpired in this narrative was an almost incredulous story of a witch-hunt. Aspects of this will be addressed at the end of this chapter and in chapter four but I wish to provide some background to the risk factors evident in this case. The case is complex and the allegations stemmed from what can only be viewed without knowing more details, as malicious actions on the part of one nurse and what I can only call a reactive hysteria by other staff members who for whatever reason shared the motive to discredit this nurse. After giving this case much thought there does not appear to be any behaviours or contextual risk factors which the nurse could have avoided or better managed, but rather the risk lies within the purposeful behaviour of the nurse who instigated the allegations. It is difficult to know the true reasons for the reporting of this nurse, except to surmise that she represented an obstacle to one nurse’s ‘ambition’ of becoming the nursing director of this particular aged care facility. The following details the orchestration of positing this participant so that she was seen as ‘non-conforming to the group think’.

She presents the allegations and the response by the facilities governing board:

On the Tuesday night a facsimile arrived. It listed about 20 complaints to a Commonwealth department including such things as: allowing non-clinical staff to hold the keys; putting clients in nappies prior to an audit review; not washing bed pans properly; unsafe medication practices; and providing food that no-one was happy with.
Participant 5 explains further in terms of the motivations of the nurse who made the allegations:

She told me how she had had another nurse deregistered, saying ‘I got her’. She reported another nurse at the facility to the nurses’ board and I was the third. [P05/PG20/L4-22]

Participant 14 provides this interesting slant to ‘non-conformance to group think’: ‘anybody who showed any sort of initiative was squashed fairly quickly’ [P14/PG10/L20-21].

**Non-Conformance to Individual Biases**

The next dimension of ‘out group perception’ provides examples where individuals, because of their own motivations, beliefs and agendas collectively deemed as biases, viewed the participant’s beliefs and behaviours as in conflict to their own. Thus the participant identified that they were not conforming to the biases of the individual which for the most part were the participant’s supervisor.

Participant 11 provides the following insight:

A lot of the issues on the ward were determined by whether people fitted into her perspective of the world. She very much had an agenda in setting up a ward that was very different to anywhere else I had worked. For example there were a number of deaths in this ward that were reviewed by the Coroner. The Coroner made specific mention that the ward had been set up as the patient’s home rather than as an acute psychiatric unit. [P11/PG04/L23-30]

Another case in point is presented by Participant 12. He describes the difficulty he had with one particular person:

I felt she was very negative with her comments to me, nothing she said to me was constructive. It was difficult to warm to her manner, she was very abrupt and always in a hurry. I you made a mistake she was the worst person to deal with it. I was always worrying about making another mistake in front of her, I just couldn’t relax. She would criticise everything I did, from showering a patient to giving a medication. [P12/PG04/L6-19]

In another example where the views and subsequent actions of an individual came to bear on a participant is described here. This participant was
working in a hospital as an agency nurse. The complainant was a patient who ‘from the sidelines’ observed what transpired for the shift and chose to report a number of allegations from her perception to the respective NRA and the participant’s employer. The biases of this individual cannot be known but some insight is offered. A précis of the complainant’s allegations are provided:

This nurse was intimidating and cold, whose attitude was picked up by visitors and patients alike. There was no warmth or caring about her. It was in my best interests to keep on the right side of her, this included keeping my mouth shut. [P20/PG04/L24-33]

The participant failed to make sense of the allegations. The manager of the agency she worked for countered this negative view of her by saying that he had reports on her practice and that they were all positive [P20/PG05/L11-12]. Her lawyer felt that she just (for whatever reason) took a dislike to me [P20/PG05/L39].

Looking back on the situation I think she was sitting in the chair and writing the letter while I worked [P20/PG06/L15].

I asked Participant 20 in an attempt to better understand the motivations of the complainant, whether she felt that this patient may have felt that she was missing out on her attention? She replies:

It is a possibility, but I didn’t have anything to do with her, she was an ambulant patient, sitting there reading her book, she wasn’t on any medication, and at some stage I would have done her vital signs but that is about it. She never made any comments to me and it wasn’t until two months after working that shift did the letter arrive. I don’t know what it was but I definitely ruffled her feathers. [P20/PG09/L16-19]

Judas Phenomenon

The implications for nurses who were involved in a ‘whistleblowing’ event, including Participant 6 who contacted the union after her wages were reduced without the proper authority, and Participants 7 and 11 who had reported other nurses for sub-standard practice are then seen outside the group. Nurses
who are seen as whistleblowers may be viewed as a ‘Judas’\(^{10}\), that is someone who is disloyal and a troublemaker (Johnstone, 2004, p. 545). Erlen (1999) and Rosen (1999) explain that nurses who whistle blow may find themselves being intimidated, scrutinised to the nth degree, and have their employment status threatened. This was the case for Participants 6 and 7 who found themselves the victims of harassment and intimidation. In particular, Participant 7 found herself being accused of issues that she had reported another nurse for, and identifies the punishment for this, she explains:

> I would say to my husband, well here we go, I wonder what is going to go wrong today because they were just nit picking. I mean, I was blamed for things when I wasn’t even there. All this sort of thing was going on. There was a real vendetta to get me out. Management would say, we are sticking up for this particular person that I reported for unprofessional conduct and I was just paying the consequences of being a whistleblower.

Out-group perception either with or without actual dissenting behaviour of the participants provide the link to isolating strategies. Isolating strategies provided further impetus for constructing the motivation to report the nurse for an allegation of unprofessional conduct and contributed to the deconstruction of the personal and professional self. Reporting the nurse to the NRA was viewed as the ultimate isolating strategy in the process of de-professionalising out group individuals.

**Isolating Strategies**

Isolating strategies were for the most part directed to the participant because of those behaviours identified in the property, out group perception and

\(^{10}\) On Holy Saturday in Corfu the people still throw crockery into the streets, enacting their traditional stoning of Judas Iscariot. Thousands of years have passed, but Christ’s betrayer remains the most infamous traitor of all time. His name recorded in many expressions, including
linked in some cases to individual causal attributes, specifically physical and mental health issues and dissenting behaviours. In some of the reported cases more than one dimension of the property isolating strategies are evident and therefore there is a blurring of these strategies. The dimensions of the property are (a) scapegoating; (b) workplace bullying and mobbing; (c) performance management strategy; and (d) interruption of employment.

Scapegoating

The following case provides an example of ‘motivation to report’ when a scapegoat\(^\text{11}\) was needed after a medication error was reported to the hospital board. The details of the case are complex and provide a number of questions as to why this matter was reported to a NRA, and why had the matter not been dealt with using a performance management processes.

Participants 3 and 8 were involved in the administration of an ‘unordered’ oral narcotic to a patient, one as the checker and the other who administered the medication to the patient. The medication error was not recognised by either nurse, but recognised and therefore reported approximately ten hours after the event. Neither nurse received any form of performance management regarding the situation and it was not until a family member wrote to the Board of the hospital with a number of complaints and concerns regarding the care of a family member that the DON then ‘decided’ or was ‘directed’ to ‘do something about it’. Her solution to a matter which I believe could have been resolved with conciliation with the family and a performance management strategy was to report

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\(^{11}\) A person made to bear the blame for others. In the Old Testament a goat was used in the ritual of Yom Kippur (Leviticus 16). It was symbolically laden with the sins of the Israelites and sent into the wilderness to be destroyed. C 16: from ESCAPE + GOAT, coined by William Tyndale to
both nurses to the NRA. One of the participants expressed in her interview that she believed that the Board had pressured the DON ‘to do something’ and in her solution ‘chose’ to scapegoat two nurses involved in this medication error.

Participant 3 explains: ‘She [the DON] decided that we were going to be made an example of’. [P03/PG07/L35-36] When the complainant realised that these two nurses had been reported to the NRA, tried a number of times to have the complaint withdrawn, but to no avail. Participant 3 goes on to say ‘we were the scapegoat’ [P03/PG09/L4-5] in what was a culture of longstanding problems and less than satisfactory operating systems finally brought to a head when a relative made a formal complaint to the hospital board.

The person who made the initial complaint regarding the standards of care afforded to her relative asked that no-one be vilified or scapegoated. She stated that ‘scapegoating served no purpose but to shift the blame and muddy the underlying causes of the error.’ What she wanted to happen was for systems issues to be addressed so this would not happen again. [P08/PG07/L17-20]

In her letter to the NRA the DON had clearly articulated that she did not believe it was the nurses’ fault that the medication error had occurred but rather, that they had been put in a near impossible situation because of the context and her reason for writing was to provide an impetus to address these issues, like workloads and staffing levels. Her contending this is somewhat incongruent with her decision to report the matter to the NRA in the first instance. The participant who shared this excerpt from the DON’s letter to the NRA also expressed confusion at what she had written and then choosing to report her. I suggest that has included this ‘explanation’ as a way of revealing that either she didn’t want to

translate Biblical Hebrew azâzêl (probably) goat for Azazel, mistakenly thought to mean ‘goat escapes’ (Collins Australian Dictionary, 2003, p. 1443).
report the nurse and was trying to soften the allegations, or, she in fact felt some guilt over doing it and thus was trying to off burden some of this guilt.

This case implores the nursing profession to address the question of exactly what is unprofessional conduct. These nurses were reported to the NRA for unprofessional conduct for the administration of a narcotic which had been written up, but without a specific dose. During what was an extremely busy shift they confused the order before them with a similar order for another patient. Therefore the patient in question received an un-prescribed order of a narcotic which was deemed to be an overdose. The patient was assessed, as already stated, to be over sedated from the actions of the narcotic and required two doses of naloxone [a narcotic reversing agent]. There is no question that an error was made, but the error should have been assessed through an in-house performance management system and not through legislative processes. Both nurses were very experienced and clearly competent, as expressed by the DON in her covering letter of complaint to the NRA. The DON made comment of this and explained that she did not see any point in disciplining these nurses because they were aware of their mistake. Therefore, her ‘true’ reason for reporting them must be questioned along with her ability to identify a performance management issue versus an allegation of unprofessional conduct. As read from the letter by the DON to the NRA by Participant 8:

Both these nurses are senior staff who have significant respect amongst their peers – there have been no previous problems with either of them in relation to their nursing practice; and ‘it would seem counterproductive to instigate any form of internal disciplinary action towards these nurses as they are very aware of their mistake and they take full responsibility for their actions and I have no doubt that their practice is at a high standard following this incident. [P08/PG08/L34-35/PG09/L1-34]

Participant 1 provides another example of scapegoating. The example
concerns a patient who died as a result of an overdose of a narcotic where there was a perception by the participant that the nurses involved in the case were disproportionately blamed by the hospital in comparison to the attribution of blame to the medical officers who were also involved. She provides details of the situation and in doing so demonstrates her vulnerability with respect to the strategy taken by the hospital to get a statement from her. The message for any nurse who may find themselves in this situation is clear.

At about 12 o’clock the phone rang, it was the DON; could I come in and make a statement? So like a lamb to the slaughter in I went. I should have called the ANF, I should have taken a lawyer with me, I didn’t have to go in at all, actually I should have told them no I was not coming in - but you are so vulnerable. Anyway in I went, it was her and the hospital lawyer taking a statement from me. They were getting it from their perspective.

Later on this nurse did seek legal counsel:

The hospital was only looking after their interest, they didn’t actually want to look after the nurse and I did contact the union and I got my own lawyer which I am very glad that I did because obviously there was someone gunning for me if you like, you felt like the hospital were only looking after their interests, they certainly weren’t looking after ours.

It is important to note here that with all of the participants’ accounts it is their version of events and the view of the employing agency or the reporting person were not sought. Nonetheless, the pattern of reasons that the participants share as being central to them being reported reveal the apportioning of blame with them as opposed to the role played by the medical practitioner. The need to apportion blame is not a new concept and it has been proposed that it is common for the nurse to be blamed for an error (Stewart-Amidei, 2003) as opposed to the medical practitioner or the pharmacist.

Participant 11 contends that he was seen as a scapegoat in a situation
where he challenged some inappropriate practices that were encouraged by the manager. The clinical context was a closed mental health ward. The manager was encouraging what he viewed as disruptive practices to patient rest, for example encouraging cups of tea and conversation during the night. He would come into meetings and question these practices. [P11/PG05/L8-11]

**Workplace Bullying and Mobbing**

*Workplace bullying* and the specific type called *mobbing*, were experienced by some participants. Participant 6 in telling her story reveals how she was bullied. The allegations which included an accusation that this nurse was dependent on a medication were not upheld. Accordingly, the participant suggests that the motivations in this case were malicious. Participant 6 provides a number of examples ‘isolating strategies’. Reporting her can be seen to be in response to whistleblowing and bringing in the union:

> At the beginning of the year I found a sexually offensive calendar and I was continually harassed by staff about it. I ended up having to telephone the equal opportunities commission for what I viewed as harassment. There was a debacle about that and the clinical nurse continued to target me. The union had to be brought in because my wages were cut without authorisation by over $8000 net income. [P06/PG03/L22-34]

Participant 10 also provides evidence of workplace bullying as an isolating strategy. After a letter written to the individual who alleged unprofessional conduct and who subsequently reported him to the NRA on behalf of the nursing staff in the unit, the individual would not talk to him for a month at a time, ignoring him if they passed in the corridor. He also describes where a minor incident or matter would be identified and he would be called to question in front of other people. [P10/PG16/L27-32]
Already introduced is the out-group perception experienced by Participant 15. This perception progressed to an isolating strategy of ‘workplace mobbing’. Workplace mobbing has been defined as ‘a malicious attempt to force a person out of the workplace through unjustified accusations, humiliation, general harassment, emotional abuse and/or terror’ (Davenport et al, 1990, p 40). The following I believe provides an example of mobbing in the workplace:

So it was a daily battle. Things happened like all the razors would be ‘lost’, things would be broken, you’re makeup case would be messed up, my makeup would be smashed. They were out of control, nobody in the echelons could control them, all the way up to the DON. I had fifteen months of ostracism, they ran the gamut from rudeness to not using my name, to excluding me from group activities like morning teas, they made a point of letting me know I was not welcome. They would ridicule me and mock me. They accused me of playing God, anything I ever said or any idea I had or any opinions they would ridicule it without even listening to it or evaluating it.

Performance Management Strategy

The issue of matters which could have been managed, initially at least, through a performance management system were identified in two cases involving registered mental health nurses. At the core of the allegations were clinical decisions outside the expected, and written policy regarding medication administration. While their practice was not parallel to policy, no harm came to either patient. Again, the reasons for these nurses being reported to a NRA in this case were not only about the actual clinical practice but rather, the political agendas of ‘professional posturing’ by senior staff. Participant 9 describes the situation he was involved in, the related allegation, and his opinion of the reason he was reported to the NRA. The nurse he speaks about was the nurse involved in another reported case in this study. This information is provided to demonstrate that the true causes may not lie with the accused but maybe the accuser:
I was working on the mental health ward. There was a patient who was getting up early, he said he couldn’t sleep because he was in pain. Because I was on night shift I didn’t get to see his doctor and discuss the matter with him. The patient was prescribed Endone\textsuperscript{12}. On my own initiative I told him that I would give him half the dose at 6 and let the day staff know and they could give him the other half at 8 o’clock as prescribed by the doctor. They could then speak to the doctor about it that day to review the times that it was prescribed. The nurse at the handover had forgotten that I had said this and gave the full dose of the drug at 8 o’clock, without looking at the chart and of course the patient was given more than the total of what was prescribed.\textsuperscript{[P9/PG01/L1-17]}

And later:

I came into work one evening and the level 4 coordinator was there waiting for me with a witness to interview me and he told me that it was a primae facie case and that I had given a narcotic without a prescription. He told me that there would be an inquiry and that I would be disciplined and I would have to go to the nurses board.\textsuperscript{[P9/PG01/L1-17]}

In response to being asked the following question, why do you think it was reported to the NRA, was it a personality issue? The participant responded:

I suspect that the nursing coordinator may have thought I’ve been engaging in practices like this for ages. The medication order was ‘double signed’ in the dangerous drugs book\textsuperscript{13}, but there was an allegation on another occasion that I had given a person Temazepam that wasn’t prescribed. That allegation wasn’t proven against me and I just suspect that he thought he would use this occasion of giving the narcotic without a prescription as an opportunity to bring me to heal.\textsuperscript{[P9/PG02/L8-12]}

The NRA during the inquiry was able to identify that the matter was one that should have been managed as a performance management issue as this participant explains: The nurses’ board said at the formal hearing that their finding was that it was a quality assurance matter or appraisal matter for the hospital to deal with.\textsuperscript{[P9/PG05/L6-10]}

The orchestration of an allegation under the artifice of a performance management strategy is presented by Participant 11. This example also reveals

\textsuperscript{12} A narcotic medication
\textsuperscript{13} Narcotic medication register as specified in the drug legislation
undefined, but probable motivations of a second person, in this case his supervisor:

The series of complaints went back over a three year period, and only one allegation was addressed at the time. Each time a complaint was made against me I was told there was a letter saying I had a disciplinary hearing. There was no discussion between the unit manager and the persons I was working with to clarify what had happened. It escalated to a disciplinary hearing with the unit manager and the human resource manager. After I queried the timesheet of the nurse who I thought was falsifying her hours, I received copies of about five complaints from patients. They were all typed out on the ward computer with the knowledge of nursing staff and basically cut and paste, so I considered it a fairly orchestrated process.

By making the allegation against Participant 11 (which was in response to him making a complaint and questioning a nurse’s timesheet) there was a deliberate attempt to isolate him through the allegations. Further isolating strategies in response to this matter included moving the participant onto day shift despite having a permanent night duty position. He explains that the reason he was given for this was so ‘that my behaviour and practice could be assessed’.

**Interruption of Employment**

Interruption of employment was evident in four ways. These processes were in response to the perceived need to isolate the nurse. The first process of isolating the nurse was by moving them to another area of the hospital. The second process was to demote the nurse. The third process of suspending the nurse was because of perception that the nurse was not safe to practice and needed to be removed from the practice context until an investigation had been carried out. The fourth process was to terminate the nurse’s employment contract.
After Participant 7 was telephoned to be advised that she was facing very serious allegations because she administered a double dose of a medication to a patient was moved to a different ward. She says:

I was shoved up on the top floor. It got me out of the way while the investigation took place. It was pretty dreadful as one nurse said to me ‘what are you doing up here? They only send people up here who have done something wrong’. [P07/PG17/L1-24]

Participant 11 was moved from night duty to day duty so that his behaviour and practice could be assessed.

Suspension of employment was experienced by Participant 5, 13 and 14. Participant 13 offers this account:

I was called to a meeting with my supervisor and the human resource manager. I detailed exactly what had happened in response to their questioning of events. So that meeting finished up, at the end of it they just said that I was suspended. I had to hand my keys in and I was told to collect my belonging and leave. [P13/PG04/L2-9]

One participant tells how his employment was terminated in response to the out-group perception. He explains the events leading up to this:

At one stage I was working about 60 hours a week. I got a cold and requested some time off because I just couldn’t get over the illness. I was told that I couldn’t. I ended up talking to the boss for over an hour and eventually insisted that I take time off. A few weeks after that I came into work on a Sunday afternoon and was presented with an envelope by the boss, he said ‘this is the hardest thing I have had to do’. I called him a liar and left. The letter listed 9 allegations of sub-standard care and I was sacked. [P04/PG02/L1-20]

This participant was the only one to have their employment terminated in the immediacy of the situation. He explained that he ‘knew’ what the letter was as soon as he saw it. He believed that it was the employer’s way of getting back at him (along with reporting him to the NRA) and a way to keep him quiet. [P04/PG/L1-20]
Participant 14 also had his employment terminated. They had wanted him to resign. He explains: ‘they were going to make sure I did, but I hung on for how long as I could’ [P14/PG08/L26-30]. Participant 16 stated: ‘I was eventually fired from my job after they reported me to the board’ [P16/PG02/L29]. Participant 9 explains that once the allegation had been made he found himself demoted from a level 2 position\(^\text{14}\) to a level 1.

In keeping with the main objective of any NRA, to ensure the safety of the public: anyone can report a nurse to a NRA for an allegation of unprofessional conduct. Under Section 45 of the Nurses Act 1999 (SA) it is contended that employers have an obligation to report to the Nurses Board of South Australia (SA) a matter where they believe an employee to be guilty of unprofessional conduct. The problems of this will be expounded in later chapters. The NSW Nurses Registration Board in their published Case Book of Disciplinary Decisions Relating to Professional Conduct Matters (2001, p.6) provide a number of reasons why people should complain about nurses. The reasons like wanting to improve health care services are reasonable. The reality and challenge that is presented from these findings is that reasons and motivation for reporting these nurses are questionable. The NSW Nurses Registration Board explains that they may decline to deal with the complaint if it is ‘trivial, frivolous, vexatious, not made in good faith, or if it can be dealt with in another way, like performance management (2001, p 11-12). Questions arise on two fronts: firstly, the identification of reasons other than that of clinical competency and therefore the inappropriate use of the NRA to either ‘manage’ or to ‘get at’ the nurse; and secondly, the unnecessary reporting of a clinical matter to the NRA, which could and should

\(^{14}\) Level 2 positions are promotional positions
have been managed ‘in house’ using performance management systems. The link with professional vulnerability, specifically individual nurse risk factors is also clear in that it was an individual nurse behaviour that has been promoted as being the reason for being reported to the NRA rather than an accurate assessment of clinical competency. These sub-categories provide explanation as to the development of the trajectory for the motivation for reporting these nurses to a NRA.

The sub-category professional vulnerability will now be explored. The risk in nursing is sometimes not fully appreciated until something goes wrong, then it becomes the centre of the universe for the nurse concerned. The following will provide an exploration of the vulnerabilities this cohort of nurses experienced and in turn a description of the day to day risk inherent in nursing practice.

**Professional Vulnerability**

Professional vulnerability and the associated causal attributes, individual and contextual were identified in part as antecedents to the identified social phenomenon of an allegation of unprofessional conduct. The dimensions of the contextual casual attributes are: organisational culture; systems issues; and practice contexts. The property individual causal attributes is composed of two dimensions clinical knowledge and working around nursing practice standards. These properties, dimensions and dimensions are listed in Table 4.9.

The contextual causal attributes contain the following properties: workload, specifically an inappropriate and unsafe workload; systems issues; and the practice context. Professional vulnerability also emerged as a conceptualisation of the ever present risk or threat that exists with every patient
encounter, including every clinical decision and subsequent nursing action. The dimensions of this property provide a continuum of minimal to significant relevance to the causation of the breach of, or failure to meet the nursing practice

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<td>SUB-CATEGORY: PROFESSIONAL VULNERABILITY</td>
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**PROPERTIES and DIMENSIONS**

**Contextual Causal Attributes**

1. Organisational culture
   - Not knowing the rules
   - Just accepting the rules
   - Physician-nurse relationships

2. Systems issues
   - Workload
   - Interruptions
   - Medication practices

3. Practice context
   - Specific contexts
   - Not knowing the patient
   - Patient imperative

**Individual Causal Attributes**

1. Clinical knowledge
   - Clinical knowledge deficit

2. Working around nursing practice standards
   - Unknowingly bending the rules
   - Knowingly bending the rules

Table 4.9: Sub-category: Professional vulnerability - properties and dimensions.

standard. The individual causal attributes also contribute to the reason to allege and report the matter.

The sub-category professional vulnerability in some situations is linked to the sub-category, personal vulnerability. The properties of all the sub-categories personal and professional vulnerability are intertwined and overlapping to varying degrees and therefore the following examples and discussion should be examined in the context of vulnerability as a whole, including the complexity and high paced clinical context that some of these nurses found themselves in. There is a
vulnerability about, and in, being a nurse. Vulnerability exists in all that we do. This vulnerability may be amplified through the behaviours or omissions of the individual or by the imposed context, including not responding correctly or assertively to the context (Johnstone, 2002). The concept of professional vulnerability is a constant for all nurses in all contexts, and is not just a challenge for the novice nurse. This vulnerability while constant, ebbs and flows in response to other components of personal and professional vulnerability.

It is evident from the participants’ stories that the concept of vulnerability transcends the potential for making an error of judgement and is also revealed in the way nurses are viewed within the broader health care system. Therefore, I propose that there exists a vulnerability in terms of how we are judged as nurses and where blame is apportioned. Vulnerability can then be viewed as a continuum within the experience of an allegation of unprofessional conduct and its aftermath, and within the broader domain of nursing practice. This vulnerability exists pre-event and during the actual allegation in the form of the behavioural and contextual risk factors. The professional vulnerability continues after the allegation in that the nurse in response to the stresses created by the allegation, and particularly if still practising nursing during the investigation and inquiry is vulnerable to further allegations because the personal and professional self has not yet reconstructed. This vulnerability continues even during the reconstructive phases of the experience. It is the ‘how’ of the reconstruction which provides impetus for how this continued vulnerability is viewed and reacted to. Nurses either learn from it, or continue to practice in opposition to the risks, or may not even recognise it. Contextual causal attributes of professional vulnerability will be examined first. It is important to set the contextual scene
Contextual Causal Attributes

Nursing practice does not occur in isolation. In analysing the data it was found that three causal attributes contributed to the professional vulnerability that nurses experienced. These are: (a) organisational culture; (b) systems issues; and (c) the practice context. There are identified influencing relationships with these dimensions and those found in the property, individual causal attributes. Considering them singularly and collectively will provide depth to this property. The first to be discussed is the property of organisation culture.

Organisational Culture

The first dimension to be discussed within the contextual causative attributes is the culture of the organisation or the work unit. Organisational culture is defined as ‘what employees perceive, and how this perception creates a pattern of beliefs, values and expectations’ (Gibson, Ivancevich & Donnelly, 2000, p. 30). Three dimensions were identified, they are: not knowing the rules; just accepting the rules; and physician-nurse relationships.

Not Knowing the Rules

There is a need for nurses to recognise the ‘culture’ of their organisation and in particular the ward or unit they work in, or ‘work out the rules’. The challenge for the nurse includes the following: (a) when the culture is either misinterpreted with respect to what actions they should choose relating to nursing practice within that culture; (b) when the culture and its meaning are not clearly
seen or commonly understood; and or (c) the nurse is powerless to do anything about problems created by the culture. These issues are also discussed in the dimension of not knowing the rules within the organisational culture. Knowledge of the organisational culture is defined as the knowledge, and understanding the individual possesses regarding the culture of the organisation as a whole and/or as a unit. It is about understanding the written and unwritten rules and how well they engage with these cultural nuances that has a direct link to the dimension and its constructs, organisational culture.

The following will primarily address the issues which emerged from the cultures the participants found themselves in. Participant 4 provides an example of an organisational culture. Typically cultures are defined by those who live them. Not knowing the rules can be problematic as he demonstrates:

There were several things on the ward that weren’t done according to protocol, by everyone, but I figured the best way to do things was to do things the way everybody else did. Every couple of weeks I’d be called into the manager’s office about something or another and she’d challenge me about something I’d done. I said that’s the ways everyone else does it. [P04/PG11/L23]

Conforming is an acknowledged social endeavour. Should the individual not conform then this may contribute to the vulnerability they experience, particularly if the conformance is not possible or not a priority for the individual. The reasons for choosing to conform to the culture of a ward are not unexpected and may include the need to be seen as one of the team and to ‘fit in’. What in turn happened here was that choosing to practice like everyone else rather than in accordance with documented standards, provided the nurse manager with an opportunity to challenge this nurse.

It is posited that other issues were present here and contributed to the nurse manager not accepting his attempts at conforming. For example: ‘everyday
she would speak to me about the fact that I hadn’t shaved saying, that’s unprofessional’, or ‘the ‘clothes you are wearing are unprofessional’. Such comments might equally sit in the construct of non-conformance to group think and the fact that his face may not have fitted.

Another account that provides evidence to support not knowing the rules as contributing to professional vulnerability is offered by Participant 15. This following extract demonstrates a lack of organisational knowledge of the unit culture where she had obtained a position after a significant time out of the nursing workforce. Some background is provided along with the initial reason why there was an out-group perception which has already been discussed. It is important to revisit this out-group perception in the context of organisational knowledge because it was a significant factor in the very destructive experience for this participant.

I went to see about a job. Initially they were not too interested until I let them know I had a certificate in the area that I was seeking a position. They talked amongst themselves and then asked me to wait. Someone from the unit came to the office and said that they were having a lot of conflict in this particular unit and because I was mature aged they thought that I might be able to sort the problems out.

She goes on:

In the meantime someone had gone back to the unit and said we are hiring this person for four months and she is going to resolve all the problems. So by the time I got there about a week later they were all standing there waiting for me with these barrels aimed at me and they let me have full barrels right from the start.

The second dimension ‘just accepting the rules’ provides an illustration of the vulnerability that can be found when the rules within an organisation are just accepted without challenge. The following discussion reveals this culture.
Just Accepting the Rules

The identification of a culture of just accepting the rules was articulated by the DON in the case shared by Participant 3 and 8. Participant 8 relays what the DON had put into her initial letter to the NRA.

Throughout the process there was a clear breakdown of the processes required by the RNs for the checking and administration of a narcotic. The mitigating circumstances surrounding the error are as follows: (a) the ward was very busy; (2) the order for the medication was not complete; and (3) a culture had developed in the hospital over sometime whereby processes had not been followed. [P08/PF12/L2-16]

The concept that is emerging here is that the culture of not following the standards had become the ‘standard’. Nurses had fallen into the trap of doing things because ‘that’s how things were done’. The risk for the nurse who questions practices where the rules are not followed can find themselves being viewed as an outsider, particularly if the questioning draws attention to nurses and increases their workload. Contending what should be done to effect quality outcomes is not without risk.

An example of this complacency within a culture is provided by Participant 3 when she was talking about a situation she was involved in after the allegation of unprofessional conduct was made against her. This passage provides insight into her being able to effect change, but the challenge she faced with another nurse who was accepting of things as they were without demonstrating any critical thinking. She explains:

I was working on a medical ward and had been handed over the care of a patient with dementia. There was a discrepancy with her ordered medication and what she told me she took. I rang the GPs rooms and asked that they call me back to clarify the orders. I wasn’t happy to give the ordered cardiac medications to someone who may not have been on them normally. I started to wonder if I was being stupid about all this, a bit over the top. I decided to run it past my supervisor. She said oh just give it. So I went and asked another nurse who also replied that she would give it. Eventually the medical officer called me back and advised that in
fact the patient wasn’t on the ordered medications. I felt vindicated.

A further dimension of this concept of ‘just accepting the rules’ follows. Participant 8 in the prelude she provided to the nature of the allegations give illustration to vulnerability that a nurse may face in working in a culture where contemporary practice is not evident.

I was a bit gob smacked you might say by going to a fairly rural and small hospital, less than 40 beds. I don’t think the hospital was particularly proactive or up to date.

**Physician-Nurse Relationships**

Positive relationships between physicians and nurses are a necessary component in engineering positive patient outcomes. The next case provides a demonstration of what can happen when these relationships are less than positive. The consequence of the nurse not being comfortable to seek timely advice is evident. Participant 3 explains:

In our hospital we don’t have doctors on site, we have to ring the doctors each time if you need anything. They frequently don’t get back to you for sometime or they tend to be rude about it because you are interrupting them. You only ring the doctors if you really have to because it is pretty belittling.

This is not an example of positive professional relationships and collegiality. This sort of behaviour has been allowed to become part of the culture of this organisation. Both the participants involved in this matter (Participants 3 and 8) were senior nurses. To have them explain their hesitancy and fear in contacting these particular doctors is a both disheartening and confronting. Two issues are evident. Firstly, this fear led to the nurses ‘choosing’ not to call to clarify a drug order. Secondly, what are the implications for the novice nurse who would have to navigate this contextual vulnerability? Comments from Participant 8 provide further insight to this dilemma they faced with not being able to ‘freely’
contact the physicians. In a letter written to the Director of Nursing she describes the impact of the abuse they were receiving from the medical practitioners and the need to move beyond such behaviours.

I want to bring to your notice the verbal abuse nursing staff are encountering from some doctors on two occasions in the past two weeks. I have had doctors verbally abuse me and reduce me to tears. I believe that the verbal abuse is unnecessary, unwarranted, unprofessional and unacceptable. The doctors need to be reminded that we are all on the same side and are all working in the best interests of the patients, nurses are not trying to make life difficult for doctors but we have professional requirements and legal obligations that guide our decisions and actions as do the doctors. [P8/PG25/L33-35/PG26/L1-20]

Participant 8 goes on to explain the continual battle she experienced contacting the medical officers:

It is usual for the RN to have to call the medical officer at home or in their surgery which is not always well received. Many times I have received snide comments from these medical officers when I have interrupted them at home or in the surgery. I have been told not to ring them again and have had their spouse tell me that they are with their children and are not to be disturbed. This becomes very wearing for the nurse. I have become conscious of the response I might get when calling them, feeling intimidated is not uncommon. [P08/PG18/L24-36]

Participant 1 provides her view on how nurses should interact with medical officers in an attempt to address this ‘doctor-nurse game’. In response to being asked of and how she practices nursing differently after the event she replied with the following:

We are just nobodies, they are gods and we are not, but I believe we can change this. To change this we don’t have to be aggressive and break out in a fight with them every time but we have to be on their level. For example, when we do the rounds, don’t push the trolley around. When I do a round I walk with (emphasis added) them, I never walk behind them. When they discuss things I make sure I contribute to the discussion. I think it is important not to nurture the doctors, we are on the same level and it is the small things that matter and these can be changed. We are not their servants. [P01/PG47/L5-17]

This participant has chosen strategies to reduce what she perceives as an
area of vulnerability. Engaging with medical officers at what she calls ‘their level’ provided a foundation for professional and contemporary dialogue. This participant has made herself ‘visible’ to the medical officer and in doing so has reduced one area of vulnerability that nurses may encounter. Developing trusting relationships with medical officers is important to ensure effective communication and with this the knowledge for accurate patient assessments and care. The next property to be illustrated is systems issues. Two dimensions, workload and medication practices were identified.

**Systems Issues**

Along with the vulnerability imposed by the culture of the organisation, *systems issues* also posed problems and risks for the nurse. The systems issues identified from the data analysis centred on *workloads, interruptions* and *medication practices*. Workload issues included inadequate staffing levels, patient allocation decisions, patient acuity and the unrealistic overall expected workload, including the undertaking of non-nursing duties. Data analysis revealed that medication practices were a significant area of professional vulnerability.

**Workload**

In the narrative of Participant 1 a clear sequence of events is demonstrated which lead to the allegation of a nursing error. In this particular case the allegation was upheld by the respective NRA. The medication error and subsequent lack of appropriate assessment after the patient received an overdose of a narcotic led to the death of a patient. The case was investigated by the
Coroner. In this recollection a number of systems issues transpire to provide a less than adequate context to enable the nurse to practice safely.

I was the Shift Coordinator that night for both areas [the ICU and the CCU] and I was also allocated a ventilated patient to care for. In the CCU there were two nurses and four patients and there was a sheath (post coronary artery angioplasty) to be removed. The nurse had to come into the ICU to check the dangerous drug out of the cupboard [there was no dangerous drug cupboard in the CCU] for the patient having the sheath removed. I didn’t go back out there which obviously the checker should do, I didn’t go back out there (because I had a ventilated patient to look after), I gave it to her and she said I will check it with the doctor as he is out there. I went back to my ventilated patient, and rightly or wrongly that’s how it occurred. [P01/PG01/L7-18/PG02/L1-18]

A number of risk factors and processes are evident in this scenario. The first risk is the workload of the nurse. She was required to coordinate two geographically different areas and care for a ventilated patient. This was unrealistic and ultimately unsafe. The fact that there was no dangerous drug (DD)\(^\text{15}\) cupboard in the CCU meant that a nurse had to leave the clinical area and go into the ICU to check out a DD, which in turn meant, that the checker did not go to the bedside and witness the safe administration of the drug to the patient because of competing locations and demands. There was a breach of hospital policy in this respect. However, the incongruence of the context that this nurse found herself in meant that the choices were made to allow the administering nurse to go back to the patient and give the drug. It is easy to look at this situation at arms length and say that the nurse should have followed the other nurse to the bedside and delegated another nurse to look after her patient. The reality is however, that sometimes the associated decision making in relation to a series of contextual risks means that the nurse tends to make what she/he view as the best

\(^{15}\) Represents a narcotic medication.
decision at the time. I also propose that nurses tend not to practice with the worst case scenario in their mind and therefore tend to take such risks.

The concept of inappropriate workload, patient allocation and demands is demonstrated in the experience of Participant 2. A glimpse of a typical chaotic shift in an aged care context is provided:

On an evening shift there are hospital patients downstairs and nursing home patients upstairs. The nursing home has demented and wandering patients. The evening shift staffing is typically staffed with 3 personal carers\textsuperscript{16} downstairs and 5 upstairs, this changes at night to 2 and 2. After 1900 hrs there is only 1 registered nurse to approximately 100 patients and so you are responsible for the whole lot, which is rather hard sometimes. It is OK if everything is going smoothly, but if anything goes wrong. As the only RN you would be expected to give out medications to all the patients. You would go upstairs at 1600 hours and do one drug round and then go downstairs at 1800 hours and do the other drug round.\textsuperscript{[P2/PG07/L11-27]}

With respect to the allegation of unprofessional conduct the reality of the context is played out for Participant 2:

I was working as the RN to a hundred patients and I was really stressed. I had one lady who tried to commit suicide by jumping out of a window and apparently I didn’t sign some of the drug sheets and I gave a drug that I thought was the right one but it wasn’t.\textsuperscript{[P2/PG07/L27-30]}

Participants 3 and 8 were involved in the same nursing error and subsequent allegation of unprofessional conduct. They provide a perplexing example of contextual risks, perplexing in that any nurse who has worked in a smaller hospital will be able to relate to the notion of ‘jack of all trades master of none’ and unrealistic workload expectations in terms of patient-nurse ratio and necessary scope of practice. This case could be viewed as ‘a disaster waiting to happen’. Participant 3 sets the scene in terms of an unrealistic workload:

Being a country hospital we had people coming in for fit packs\textsuperscript{17}, the phones ringing and having to answer them, people popping in here and there and everywhere, there were quite a few interruptions while we were

\textsuperscript{16} Denotes an unregulated health care worker

\textsuperscript{17} Denotes a pack containing a sterile needle, syringe and alcohol wipe made free to intravenous drug users.
trying to work this out [the medication order] and in the meantime this patient was calling out in pain and the other RN said look he is really in pain we really need to get this done. [P03/PG02/L15-24]

Participant 8 supports the comments by Participant 3 by saying that they were ‘horrendously busy’ [P08/PG02/L28] and that it took her two and a half hours to complete the drug round [P08/PG16/L5-6]. Participant 3 goes on to explain how she received another interruption and consequently, and not unlike the experience of Participant 1, does not follow the administering nurse to the bedside:

I checked [along with the other RN] 4 mls out of the cupboard and we were going down to check it to the patient when I got interrupted, I got called back to the surgical ward and I didn’t follow her into the room, so I didn’t follow the DDA [Dangerous Drugs of Addiction] procedures. [P03/PG26-34]

Participant 8 had recognised the extensive workload for this shift and that she was experiencing difficulty completing what was required. She explains:

The day in question was one of the busiest I had experienced. I went to tea at 1030 hours. The ward was that busy that one would not normally take a break but I was feeling that my blood sugars were low so I went to morning tea. At this time I mentioned to my supervisor that the ward was diabolically busy and I was doing 44 things at once, I was dealing with numerous interruptions and I was having difficulty coping with the workload. There was no further discussion and no offer of help. [P08/PG/L25-35]

In the case presented in the experience of Participant 17 the Coroner who investigated the death of a patient made a finding that the excessive workload of the nurses contributed to the death of this patient. [P17/PG11/L23-24]

Participant 7 provides a description of the context at the time of the allegation and as such details contextual risk factors. This scenario is not unlike that described by Participants 3 and 8. The issue of an unrealistic workload again emerges:

I went to work the next morning at 0700 hrs and was told by the night staff that I was in charge of the ward for the day and by the way you are three nurses down. I said well it’s a wonder you haven’t organised it overnight
and I was told that I had to organise it. So we had 28 patients on the ward and we should have had six staff but we only had three. So consequently I was three staff short, and I was overworked with the actual workload, telephones and the doctor’s round. [P07/PG28/L2-11]

This participant identifies the vulnerability she experienced the morning of the medication error by using the word vulnerable. This indicates that for this nurse at least the vulnerability was recognised but the reality of the situation meant just having to work through it.

I was very vulnerable that morning, being called away, having to respond to patient calls, and being short of staff. [P07/PG32/L5-12] Self identification of vulnerability is also presented by Participant 8. Her choice of the word vulnerability gives shape to the findings of this concept:

I clearly remember thinking that I had no control of the interruptions that day and I could not put off or shut out the interruptions to concentrate fully on the job at hand, this made me feel very vulnerable. [P08/PG17/L30-35]

This nurse summarises her experience on this terrible morning:

The day in question was an example of a nurse’s nightmare with many contributing factors leading to the error. The main being extreme workload pressures to perform and no support and only one pair of hands to achieve the unachievable. [P08/PG20/L27-33]

**Interruptions**

Interruptions to work practices combined with excessive workload and lack of staffing either in terms of number or having to work with non-registered nurses proved a foundation for clinical calamity. A number of participants described interruptions as being a factor in distracting them from the task at hand. Participant 8 makes this point:

I experienced many interruptions that morning during the drug round, including telephone calls from family members and doctors. I specifically recall being interrupted twice by phone calls from doctors while I had the drug cupboard open. [P08/PG/L1-4]

Participants 7 talks to the complexity of the shift this day, and in turn sets
the scene for understanding how the allegation of the nursing error occurred, with an emphasis on interruptions:

In the meantime we had handover, we then go around and check the patients, see that they’re sitting up and everyone is alright. Then we start the medication round at about half past seven and then breakfast comes at about quarter to eight. One RN usually does the medications on half of the ward and the other does the other half, and the other nurses go around and help the patients, quite a few of them need to be fed. In the meantime I thought right I’d better get the staffing situation fixed up. I was told by the nurse manager that the staff won’t be able to come immediately. In the meantime an enrolled nurse came to me and said I am doing my endorsement do you mind if I come around with you. The phone continued to ring, so backwards and forwards I went. Consequently it was a very long medication round that morning. The practice of Participant 2 was compromised while undertaking a lengthy medication because of the many interruptions she experienced, including those which could not be ignored.

**Medication Practices**

Medication practices are a practice area with significant vulnerability, and is extensively documented in the literature. From interpreting the written order for a medication, calculating the correct dose, and giving it to the right patient on time is not without challenge or potential significant risks. The dimension of vulnerability was identified in the circumstances that Participant 3 and 8 found themselves in. Participant 3 explains what happened in the lead up to the making of a medication error. In doing so a number of areas of risk associated with medication practices are highlighted:

The other RN made the comment that there was no dosage documented for the ordered drug but I thought that he was having 4 mls (of the written narcotic). I assumed it was for the patient that I had looked after the other day. Unfortunately we gave patient A the medication was written up for patient B. On the drug chart there was no sticker on the page that the order was written.

These nurses administered a medication that was not (completely) ordered, the medication name was documented on the chart but the dosage was not.
Another patient on the ward was receiving the same medication. The dose he was receiving was given to the patient in question in the misguided belief that they were the same patient. The risks in the scenario are multiple, the two medication practices which contributed to this cascade of events were (a) that a dose was not documented by the medical officer and (b) there was not a patient identification sticker on the page where the medication order was. These participants were presented with a situation where a considerable degree of vulnerability existed. The workload and expected scope of practice were unacceptable. Both nurses were confronted with a number of interruptions, the medication order was incomplete and they were confused with another patient who had been administered the same narcotic. The ability to go back in time and isolate that exact moment when sound clinical decision making became fragmented may never be possible. What is necessary is the continued need to apportion accountability to all of the responsible players and processes and seek remedy to these contextual causal attributes, including providing an environment where nurses are empowered to continue the pursuit of the right clinical decision whatever the vulnerabilities they encounter or bring to the situation.

The events leading up to medication error that Participant 7 was involved have been presented. What actually happened is described:

This nurse came to me and said the patient was nauseated and could she have some metoclopramide (an antiemetic). I gave the metoclopramide to the enrolled nurse who was doing her endorsement to give to the patient. She was meant to sign for it and I didn’t check if she had. Later on another nurse came to me and said that this patient stills feels nauseated and can she have some medication for it. So I looked at the medication chart, nothing had been signed as administered so I gave this nurse the medication to give to the patient. So the patient received a double dose of the metoclopramide. [P07/PG30/L1-17]
Unsafe medication practices, specifically the unsafe disposal of syringes and needles, contributed to Participant 18 engaging in unsafe medication practice. The event is explained:

I had to give an injection of ordered medication to a patient. I read up on the drug. I then got out the syringe. As I drew up the medication it was brought to my notice that I had not used the syringe I had taken out of the drawer. I changed the needle and put the solution into another syringe. The patient was agreeable with these precautions, so I then administered the medication to the patient.

The vulnerability in this situation included the fact that a used syringe had been left in an area that meant when the nurse picked it up she thought that it was the one she had taken from the drawer, or at least it was a sterile syringe, not a used one. The other vulnerability was the decision to transfer the drawn up medication into a new syringe and not recognising that the contents had been in a dirty syringe and therefore were no longer sterile. This is another example where preceding events effect onward decision making.

**Practice Contexts**

The property practice contexts, was identified as posing a degree of vulnerability for some participants, with specific dimensions being: *specific contexts; not knowing the patient; and the patient imperative*. The nature and processes of the context provided in some cases challenges for the individual to navigate.

**Specific Contexts**

Emergent from the narratives was the identification of a particular professional vulnerability grounded in the context that the nurse was working in. From analysis of the data two were identified, aged care and mental health. This is not to say that other practice domains do not have their own particular
vulnerabilities. However, those study participants who were working in aged care settings and mental health when the allegation was made, made particular reference to the vulnerability that was attached with these contexts. A future area of research could be to examine specific contexts and identify those vulnerabilities particular to the domain of nursing practice for this context.

At this point the question arises whether some nursing contexts provide greater risk and therefore a greater vulnerability? For example, Participant 10, who at the time of the allegations was an expert mental health practitioner in a community setting, primarily worked as a sole practitioner, consulting with physicians when needed. It is posited that nurses who are very experienced, or considered expert and work outside the safer framework of a hospital setting are more vulnerable to having an allegation of unprofessional conduct made against them. The difficulty for this nurse was the blurring of professional boundaries of practice, the broad scope and depth of knowledge and the greater repertoire of experience to base clinical decisions on. Another dilemma for the expert nurse is the paucity of context-specific nursing practice standards, or standards which are too prescriptive and do not allow for clinical decision making based on experiential and intuitive knowing.

The following from Participant 11 provides a clearly self identified vulnerability because of the mental health nursing context he was working in. He recognises his vulnerability and explains:

About ten years ago in mental health nursing there was an expectation from management that the patients we dealt with were going to be unhappy, the nature of what we do is to confront people’s behaviour and we are going to make them unhappy and they are going to complain. In the past there was a mechanism or a system in place whereby if a complaint was made against a staff member by a patient there was an assumption that the patient was complaining, probably, because they’d been confronted and they wanted to get back at that person. The culture
when the complaints were made against me was that because the complaint had been made by a patient then they had to be right.

In terms of the risk of having a patient make a complain against you,

Participant 11 believes that a greater risk for this exists in mental health nursing,

he explains:

I got the feeling where I was working that management believed that if a patient made a complaint then it had to be founded. In general nursing it is very different. I was a general nurse before I became a mental health nurse and I find that patients in general settings don’t complain as much as do patients in mental health settings. These patients can be psychotic, deluded, and who have got all sort of substances on board. So I think their credibility can be less. But the complaints in my situation were believed.

Not Knowing the Patient

A more specific practice context risk factor emerged in the narrative of Participant 8 in that she did ‘not know’ the patient. Not knowing the patient or ‘unknowing’ in a general context has been identified in a number of nursing studies (Munhall, 1993; O’Connell, 1997; Pugh, 1999)

Participant 8 provides her slant on this causal attribute. Specifically along with experiencing the same risks that Participant 3 did, she articulates the implications of ‘not knowing the patient’ or in this case, a number of patients.

As part of her formal response to the allegations, she explains:

I was not familiar with any of the patients. There were ten patients mostly ill, frail and dependent with myself and an enrolled nurse to look after them.

It is a risk that all nurses are confronted with, coming on to the shift from either days off or as an agency nurse and having the responsibility of caring for up to ten patients with no ‘real sense’ of them as individuals or in terms of their clinical history. Handover, nursing care plans and standards for practice can go someway to alleviating the ‘not knowing’ but I argue that they fall short in terms
of being able to always provide individualised, timely and importantly safe care. The current practice in some clinical settings of using tape recorded further removes the ability to obtain a salient sense of the patient as an individual and their needs.

With a slightly different perspective, the following is provided as another illustration of professional vulnerability situated in ‘not knowing the patient’. The following provides a reminder of the vigilance that is required in all that one does and says in the practice setting. Participant 20 presents her account of the vulnerability that led to her being reported to a NRA. She explains what transpired as an agency nurse on a morning shift:

One of the patients this day was very demanding. She was insisting on an orange juice, I had to go to the kitchen and find one for her. After complaining about not liking the orange juice, she continued to call out to me asking for this and that, she was loud and referred to me rudely. I may add that I had a very busy workload that morning and I felt that if I did not say something to this patient I wouldn’t have been able to get my work done. So I said to her that ‘there is no need to speak to me like that I have other people to look after’. [P20/PG01/L13-35]

Participant 20 goes on to explain that she reported this matter to the shift coordinator explaining why she had to speak to the patient like this. What then transpired was that another patient whom she had very little interaction with for that shift chose to write a letter to the nurses board and the participant’s employer alleging a number of behaviours that she viewed as unprofessional. [P20/PG02/L1-5]

Not knowing both of these patients increased this participant’s vulnerability. Not having an understanding of the ‘problem’ patient’s behaviour meant that her behaviour in response to this challenge triggered an interest by another patient who reported her. Coming onto a ward in such a state of not knowing requires particular skills and qualities to be able to assimilate the nuances of the situation before you. Not knowing the patient in any situation
means a degree of vulnerability, but this vulnerability is heightened for the agency nurse who does not know the context or the culture of a unit.

The Patient Imperative

The final dimension of the property systems issues is what I have identified as the patient imperative. This construct was revealed with examples from the participants where their decision making was guided by the imperative of responding to a patient need. Two examples are provided. The first is from Participant 9 who explained his decision making:

I was quite distressed by the allegations and by the fact that it had been reported to the nurses board. I had this patient in front of me in a lot of pain and who couldn’t sleep because of it, and I had the means to relieve his pain. Even though I hadn’t done it by the book, I had tried to put things in motion to help the situation and relieve his pain.  [P09/PG04/7-15]

Another illustration of patient imperative is shown in the experience of Participant 3 and 8. Participant 8 explains how this factor influenced their decision making:

The patient was in considerable pain. He was calling out and saying ‘when is this torture going to end?’  [P08/PG06/L13-15]

A further example of patient imperative is demonstrated. Patient advocacy is an expected role of the nurse. In opposition to this notion Participant 10 reveals how his commitment to this expectation increased his vulnerability:

I wear my heart on my sleeve. I always try and advocate for the client, you know what I mean, it just sets me up, and I know that. The people who don’t do that are the ones that tend to cruise and they get the promotions, but they certainly don’t speak up.  [P10/PG56/L1-6]

Participant 15 describes the difficulties she had when she advocated for a patient’s well being:

I found myself letting one elderly patient go back to the ward in pain. But because he wasn’t outwardly demonstrating the pain he was in, which he said was tremendous, the other nurses did not believe that he was in pain.
Anyway, because I had tried to put up a fight for this poor man, they
forced me to send him back to the ward in absolute agony.

Trying to advocate for the patient was established a reason for being
vulnerable to having an allegation of unprofessional conduct made against
Participant 16. He describes how this made him unpopular:

I felt that I made myself unpopular because I let them know what my
position was in regard to professional practice, including the importance of
patient advocacy.

Individual causal attributes contribute to professional vulnerability. A
knowledge and understanding of the organisational culture, knowledge of nursing
practice standards and sound clinical decision making are factors which may
reduce the individual’s vulnerability in the practice context. They are now
discussed.

Individual Causal Attributes

The identified individual causal attributes which comprised the sub-
category professional vulnerability are: (a) clinical knowledge and (b) working
around nursing practice standards. While nursing and the role of the nurse has
been defined, it could be argued that the reality we find ourselves in is such, that
definitions and related scopes of practice do not capture the complexity and
challenges that confront us on a minute by minute and shift by shift basis. The
cases and narratives presented in this thesis attempt a glimpse of this complexity
and in doing so reveal the vulnerabilities that nurses experience.

Clinical Knowledge

Clinical knowledge is a necessary foundation for sound clinical decision
making. What emerged from this property was the dimension of clinical
knowledge deficit. It is not unusual to at times have a knowledge deficit.

Constructs of safe nursing practice include knowing when and what you don’t know and seeking the information before actions are undertaken. This dimension will be explored.

**Clinical Knowledge Deficit**

In some descriptions it was evident that a lack of knowledge about a particular task meant that the individual was vulnerable to ensuring an appropriate practice outcome. This lack of knowledge can be demonstrated in the following ways. Knowing the standard is much more than reading a ‘prescription’ to do a nursing task. Knowing when to seek out a standard, knowing how to read and interpret it for the specific care task or patient, and being able to make clinical decisions in what is likely to be a complex situation is challenging for the novice nurse. The following example from this nurse reveals the impact of a clinical knowledge deficit:

I was working on a medical ward in a graduate program. I had a patient who was being barrier nurse. He was due for an intravenous antibiotic. Because the patient was being barrier nursed we couldn’t take the medication charts into the room. I un-gowned and went outside to check the medication with a senior nurse, but we didn’t check the route. I didn’t check the book [medication administration guide] and have just gone on my memory. So I went into the room and went to give the medication by IV push, I had 10 mls in the syringe and I had given about 7 mls of it and the nurse who checked it with came into the room and saw what I was doing and realised I was giving it the wrong way. [P12/PG01/L1-20]

Accountability for this incident can be apportioned to both nurses. The contention is in this situation that if the standards for the checking and administration of medications, specifically that the two nurses had worked through the preparation of this medication and had checked it to the bedside would probably have meant that the medication would have been correctly administered. While at a legal standard there is no excuse for not knowing the
standard, the fallibility of individuals’ practice and practice contexts provides a
more realistic understanding of non-conformance.

**Working Around Nursing Practice Standards**

The second property of individual causal attributes is *working around nursing practice standards*. This property has two dimensions: *unknowingly bending the rules and knowingly bending the rules*. The following discussion will reveal that nurses do work around nursing practice standards for different reasons and motivations. This finding requires further inquiry as the important question is why, despite a plethora of written standards, policy and procedures and associated education nurses do ‘bend the rules’?

Central to the allegations of unprofessional conduct by all participants was the concept of clinical decision making and importantly a fragmentation of this decision making. Clinical decision making is defined as a process nurses use to gather information, evaluate it and make a judgement to guide nursing care (Benner, et al, 1999; White, et al., 1992) and as such is at the core of all nursing practice. A plethora of research and subsequent discourse exists surrounding clinical decision making in terms of how decisions are made and the influences, both negative and positive. Clinical decision making is influenced by personal vulnerability and professional vulnerability. Importantly, clinical decision making does not occur in a vacuum (Pratt, 1996). The practice of nursing is always situated within a particular context which can be multifaceted and may critically influence the delivery of nursing care. The interplay between personal and professional vulnerabilities provides a plethora of choices and importantly mischoices in every decision making scenario. While the overriding concept in a
A number of these cases has at its core decision making, the following will provide a particular illustration of how the participants in this study made clinical decisions incorporating the two dimensions of unknowingly bending the rules and knowingly bending the rules.

**Unknowingly Bending the Rules**

Some participants demonstrated a lack of knowledge of nursing practice standards and they ‘unknowingly’ bent the rules. Nursing practice standards are an authoritative statement enunciated and promulgated by the profession by which the quality of practice, service or education can be judged (American Nurses Association). For the purpose of this thesis a nursing practice standard will denote any written standard by any nursing or related authority related to patient care and the practices expected of a professional nurse. To illustrate this definition the following examples are provided: (1) codes of conduct, promulgated by nursing regulatory authorities; (2) clinical and professional standards developed by nursing regulatory authorities and professional practice organisations; and (3) nursing practice standards, policy and guidelines developed by the health care facility.

The first example of unknowingly bending the rules is provided from the narrative of Participant 13 where the allegation of a breach of patient confidentiality, and background are provided:

It was alleged that I had breached professional boundaries. The complainant who was a person who worked in the health care service where I was working, said that I had approached him, his wife, and another person about a business that I operated separately to being a nurse.

[P13/PG03/L1-4]
This participant in her ongoing explanation of her actions contends that she did not realise that this was in fact a nursing practice standard. She stated that she had little understanding that she was overstepping a professional boundary.

There is a link in some cases where a negative outcome of clinical decision making was compounded by either breaching the required standard or failing to meet it. Therefore there is a relationship between non-compliance with the nursing practice standard and fragmentation of decision making with a resultant negative outcome. Participants 3 and 8 were involved in the checking and administration of a narcotic to a patient without a specific documented dose. This case is particularly complicated with respect to many influencing processes, but at the crux of the analysis, the nurses in deciding to administer the medication without a dosage meant that they did not were not able to demonstrate compliance with hospital and legislative standards with respect to the administration of narcotics. It could be argued that they knowingly bent the rules in relation to this medication error. I suggest that if they did know they were bending the rules, at the time, then they would not have demonstrated such an attempt to solve the problem.

A further illustration of unknowingly bending the rules is presented. One nurse’s inability to make sound clinical decision based on her difficulty in making an accurate assessment of what was occurring for the patient. This quotation was provided by Participant 1 who witnessed this when she was called to assist the nurse. She explains:

A nurse came to me and told me that the other nurse was having difficulty stopping the bleeding from a coronary angioplasty sheath site, post removal of the sheath. I went to see the patient. There was blood spurting from the site. I told her to put digital pressure on it which she should have already done. As I looked at the patient I realised he wasn’t breathing, which she hadn’t noticed either.
The difficulty in clinical decision making was probably initiated by a competency deficit with respect to assessment parameters necessary for any patient who has a sheath removed and who has had an intravenous dose of a narcotic. While this patient did receive an overdose of narcotic which caused him to become apnoeic it could be argued, without much effort, that it is the responsibility of the nurse to assess the patient at appropriate time intervals to ensure that the effect of the medication (and importantly any medication) has had the desired effect. Competency with respect to assessment skills is imperative if the choices of nursing actions are to be appropriate. Clinical decision making exists on a cause and effect trajectory for every assessment and interaction, they cannot be separated. Not knowing the rules, and therefore bending the rules unknowingly, is a significant vulnerability.

The following passage provides another example of clinical decision making which resulted in a negative patient outcome. Participant 19 offered the following as background to the allegation of unprofessional conduct that was made:

We had this one patient in our nursing home who kept wandering. She was prone to falls. We were at that time using a physical restraint to try and keep her from getting up and falling. One day she had gotten out of the restraint, she must have fallen and was found by the handyman who helped her up and put her back into her chair. The fall was not witnessed by nursing staff. This patient was being looked after by the RN on the ward. We both had about 24 patients each. The patient was sitting there and then became unconscious. They put her back to bed. I tried to call her GP but couldn’t get hold of him. We treated her in the coma position, we tried to do her blood pressure but we couldn’t get a reading, it was difficult to obtain. After sometime the patient was still unconscious and eventually she was transferred to a hospital. A diagnosis of sub-dural haematoma was made and she died five days later. [P19/PG15-41/PG02/L1-18]

This is another example of unknowingly bending the rules. What has been described here reveals clinical decision making which is problematic on two
fronts, firstly the ability of the nurse in assessing this patient post fall, particularly when she became unconscious was lacking. She did not appear to make the connection between the fall and the unconsciousness. The nurse then did not make adequate assessment of the patient’s clinical status once she became unconscious. For example the participant describes the difficulty they had taking the patient’s blood pressure because of the positioning of her arms, this is a cardinal sign called decortication revealing elevated pressures in the brain. The decision subsequent to the inability to ascertain the seriousness of the event meant that there was a significant delay in taking the patient to the hospital.

Clinical decision making is reliant on a number of factors: the competency of the nurse in terms of knowledge and experience, an ability to accurately assess the patient and the ability to choose the correct nursing action. In the above case, the lack of clinical decision making meant that harm came to the patient. While the participant was not directly caring for this patient, she was drawn into the circle of accountability because she was the senior nurse on the ward and therefore allegations were made against her as well as the other nurse.

**Knowingly Bending the Rules**

The first illustration of knowingly bending the rules depicts the nurse’s ‘need’ to respond to a patient need, or the *patient imperative*. Participant 9 recounts his reasons for ‘stepping outside the box’ in terms of clinical decision making to the benefit of the patient and to minimise disruption to the on-call medical practitioner. While hindsight provides us with better choices, the situation he found himself in not wanting to wake the medical officer is not unusual. In providing reasoning for his decision he provides an explanation for the allegation of unprofessional conduct:
There was a patient who couldn’t sleep because he was in pain. As I was on night shift I didn’t get to see his doctor and discuss the matter with him. I knew he had been given an analgesic with a half life of 8 hrs which he was given the night before at 8 o’clock which wasn’t going to cover him overnight. On my own initiative I told him that I would give him half the dose of his oral narcotic at 6 am and let day staff know and they could give him the other half at 8 o’clock as prescribed by the doctor and could they speak to the doctor about it that day to review the times that it was prescribed – what’s happened – the nurse at the handover had forgotten that I had said this matter and gave the drug all the 8 o’clock dose without looking at the chart and of course the patient was given more than the prescription of the schedule 8 drug.

The practice of giving a medication to a patient without a written and therefore legal order is a clinical decision fraught with both clinical and legal risk. Participant 10 provides another example of the reality of emergent clinical decision making which resulted in an allegation of unprofessional conduct. To provide some background here, Participant 10 was a senior mental health nurse working in a community setting. It was common practice to respond to psychiatric emergencies and provide clinical leadership in these situations. When presented with a particular patient in the early stages of mania, the nurse administered the patient’s usual medication and received a telephone order for it after administering it. The medication was written up as an official order after the event, nonetheless, the nurse was seen to be prescribing a medication. This proved to be the crux of one of the allegations. This practice was not atypical for this nurse and was accepted as an appropriate way to manage patients in an acute stage in the community until hospitalisation could be arranged. While this was viewed as ‘normal practice’ it was ‘used’ by the individual who chose to report this nurse to the NRA. This nurse felt that he was being targeted by his manager: ‘he had it in for me’.

Participant 1 was also involved in a medication incident where the patient subsequently received an overdose of a narcotic. This nurse, ‘made the decision’
because of the limitations of the context not to follow the nurse who administered the narcotic to the patient to the bedside and therefore was not able to ensure that the correct dose was given to the patient. She explains:

She had come into the ICU to check out the drug with me because there was no drug cupboard outside in the other unit. I didn’t go back out and check it with her which obviously is what he checker should do. I didn’t go back out there, I gave it to her and she said I will check it with the medical officer who is out there. I went back to my ventilated patient, and rightly or wrongly that is how it occurred.

The following example from the experience of Participant 4 provides an example of an allegation of nursing practice which was viewed by the employer of the nursing home as ‘less than proper’. It is noted that the allegations were not upheld. Participant 4 describes a situation where he frequently cared for a ‘challenging’ patient. It was not uncommon for this patient to ‘fall’ out of bed. On one occasion this nurse decided to allow the patient to remain on the floor and covered him with a blanket for the remainder of the night. A number of issues arise from this clinical decision. The nurse decided that it was safer to allow the patient to remain on the floor. One allegation stemmed from this decision in that it was viewed as not appropriate and ‘uncaring’ to leave the patient on the floor. Although leaving the patient on the floor may have been appropriate, this nurse’s decision to do so was not supported by an individualised care plan and therefore the action could not be supported.

Fragmentation of decision making as the event which gives rise to the allegation of unprofessional conduct is now discussed. At some point the ability of the nurse to make sound decisions in the face of the vulnerabilities falls over. The effort to balance the vulnerabilities and factors presented in each case is no longer sustained and a breach of, or failure to meet a nursing practice standard occurs.
Fragmentation of Decision Making

Fragmentation of decision making was identified as a juncture on the trajectory or trajectories of vulnerability and resulted in a nursing error. Clinical decision making is central to all nursing practice. There is a plethora of literature related to clinical decision making in terms of how nurses make decisions influencing factors and methods for teaching effective clinical decision making. Little has been written about the phenomenon of deficient clinical decision making as seen in this study and none was identified that addressed the emergent concept of fragmentation of decision making. Although some studies have revealed preferred conditions and factors from the perspective of the nurse to enhance clinical decision making. To better understand the concept of fragmentation of decision making it is necessary to examine what is meant by sound clinical decision making.

Sound decision making can be determined when outcomes of patient care can be seen to parallel the objectives of the care event. I contend that the process of making sound clinical decisions presumes a number of nurse and systems qualities. ‘Balancing’ as a process for sound clinical decision making can be viewed as the ability to critically think through the challenges and questions posed by these vulnerabilities and arrive at the correct decision and correct choice of actions to match the decision.

The defining point of this fragmentation was identified as the ‘moment’ that either a breach of, or failure to meet a nursing practice standard occurred in response to the presence of personal and professional vulnerability and the subsequent inability of the nurse to continue to navigate these causative attributes. Fragmentation occurs when the causal attributes either singularly or in
combination outweigh those qualities and competencies necessary to effect the required nursing practice standard. The ‘inability’ of the nurse to navigate and negotiate these causal attributes meant that there the process of decision making was fragmented which in turn provided the opportunity for a nursing error occur. To illustrate the concept of fragmentation of clinical decision making an example from the participant’s narratives is provided. In the first example, the participants failed to follow through clarifying a medical order for a narcotic medication. The drug name, and not a dose was written on the chart. The participants [3 & 8] chose to give the drug as a dosage they ‘determined’ as being correct based on a dose of the same drug which had been given to another patient. The dose was firstly not ordered and thus was too large, causing respiratory compromise to the patient. The nurses decision making was fragmented because of a number of reasons, namely a busy workload, numerous interruptions, fear of calling the prescribing medical practitioner to clarify the order and the urgency of the situation in that the patient was experiencing pain and was distressed. The path or trajectory for sound clinical decision making was influenced to a point where a fragmentation occurred, which resulted in an ‘error’ being made.

It is important to remember that some of the allegations or the moment when the error is made sit at the end of a very long clinical encounter or are embedded in long standing organisational cultures where the risk of deconstructing professional integrity is ever constant and challenging. Nurses are frequently the end point actor in many patient encounters and therefore the risk that they are involved in allegations of error is significant.
THE ALLEGATIONS

The allegations of unprofessional conduct situated within the respective NRA legislation are linked to allegations of a breach of, or failure to meet a nursing practice standard. The allegations are a result of the first trajectory where fragmentation of decision making is a juncture, and or the second trajectory where motivation to allege is identified. A profile of the allegations is presented in the following taxonomy. The allegations have been recorded with some generality so that individuals cannot be identified. It is contended that there have been no judgements made with respect to categorising the allegations as they are based on the allegation as reported to me. A taxonomy of allegations is provided in Table 3.9. This taxonomy will provide an overview of the cases presented in this study and serve as a record for future comparisons and analysis of such allegations.

A Taxonomy of Allegations of Unprofessional Conduct

The following provides a review of the allegations using a taxonomy (Table 4.10). The reason for this taxonomy is to provide a record of the allegations. It is anticipated that this taxonomy will provide a record for further evaluation of allegations of unprofessional conduct and an opportunity to draw comparison with reported errors in the literature.

There is an enormous body of literature, too enormous to site, related to nursing errors and errors in healthcare in general. In relation to nursing practice the majority of the literature identified is in relation to medication errors and includes a number of literature reviews (Gibson, 2002; O’Shea, 1999; Baker & Naphine, 1994). This dominance in the literature is due to the fact that medication administration is a common practice in all nursing contexts. Medication
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1  Failure to check a DD to the bedside</td>
<td>Medication error</td>
<td>Wrong dose</td>
<td>Upheld</td>
</tr>
<tr>
<td>2  Administered an overdose of a medication</td>
<td>Medication error</td>
<td>Wrong dose</td>
<td>Partially upheld</td>
</tr>
<tr>
<td>3  Administration of medication without an order</td>
<td>Medication error</td>
<td>No sub-categorisation as per reported taxonomy (Benner et al 2002) and Wrong dose</td>
<td>Not upheld but acknowledged that error occurred but not deemed unprofessional conduct</td>
</tr>
<tr>
<td>4  Inappropriate care of patients, allowing a patient to sleep on the floor, rough handling of patients</td>
<td>Inappropriate nursing judgement Lack of prevention</td>
<td></td>
<td>Not upheld</td>
</tr>
<tr>
<td>5  Breaches of standards related to practice requirements in an aged care setting</td>
<td>No categorisation as per reported taxonomy (Benner et al 2002)</td>
<td></td>
<td>Upheld</td>
</tr>
<tr>
<td>6  Impairment due to chemical addiction Inappropriate care of patients</td>
<td>Lack of moral agency or fiduciary concern</td>
<td></td>
<td>Not upheld</td>
</tr>
<tr>
<td>7  Administered an overdose of a medication</td>
<td>Medication error</td>
<td>Partially upheld</td>
<td></td>
</tr>
<tr>
<td>8  Administration of medication without an order</td>
<td>Medication error</td>
<td>No sub-categorisation as per reported taxonomy (Benner et al 2002) and Wrong dose</td>
<td>Not upheld but acknowledged that error occurred but not deemed unprofessional conduct</td>
</tr>
<tr>
<td>9  Administration of a medication 2 hrs before the ordered time</td>
<td>Medication error</td>
<td>Not upheld</td>
<td></td>
</tr>
<tr>
<td>10 Administering medication without an order</td>
<td>Medication error</td>
<td>Upheld</td>
<td></td>
</tr>
<tr>
<td>11 Assaulting a patient Inappropriate behaviour and language in a clinical setting</td>
<td>Lack of moral agency</td>
<td></td>
<td>Not upheld</td>
</tr>
<tr>
<td>12 Administered an intravenous medication and signed for it in the wrong space on chart</td>
<td>Medication error</td>
<td>No sub-categorisation as per reported taxonomy (Benner et al 2002)</td>
<td>Upheld</td>
</tr>
<tr>
<td>13 Failed to treat as confidential information gained in a professional capacity</td>
<td>Lack of moral agency</td>
<td></td>
<td>Upheld</td>
</tr>
<tr>
<td>14 Inappropriate demeanour Mistreatment of a suicidal patient</td>
<td>Lack of moral agency</td>
<td></td>
<td>Upheld</td>
</tr>
<tr>
<td>15 Not meeting requirements and competencies of the role – appraisal failed</td>
<td>No categorisation as per reported taxonomy (Benner et al 2002)</td>
<td>Employment terminated</td>
<td>Not upheld</td>
</tr>
<tr>
<td>16 Intimidatory and abusive conduct towards other staff; Inappropriate response and comments to a patient; Made comments of a sexual nature; Use of inappropriate words</td>
<td>Lack of moral agency</td>
<td></td>
<td>Upheld</td>
</tr>
<tr>
<td>17 Failed to intervene and resuscitate a patient</td>
<td>Lack of prevention</td>
<td>Not upheld</td>
<td></td>
</tr>
<tr>
<td>18 Administered an intramuscular injection using an unclean needle</td>
<td>Medication error</td>
<td>Upheld</td>
<td></td>
</tr>
<tr>
<td>19 Failed to send a patient to hospital when her health deteriorated post fall and failed to notify patient’s relative post fall</td>
<td>Lack of attentiveness to the clinical condition of the patient</td>
<td></td>
<td>Upheld</td>
</tr>
<tr>
<td>20 Inappropriate language and discussions in clinical areas; Ignoring patient care needs</td>
<td>Lack of moral agency</td>
<td></td>
<td>Not upheld</td>
</tr>
<tr>
<td>21 Multiple breaches of practice standards related to assessment and management of a patient</td>
<td>Lack of prevention Lack of intervention</td>
<td></td>
<td>Upheld</td>
</tr>
</tbody>
</table>

Table 4.10: A taxonomy of allegations of unprofessional conduct.

administration practices are complex and can exist within complex and dynamic situations as some of the reported cases have demonstrated. This
translates to an unquestionably high risk area of nursing practice. Benner et al (2002) provide a taxonomy of nursing errors. It is based on eight categories of nursing error extrapolated from a review of 21 cases reported to a NRA in one state of the USA. These categories are: lack of attentiveness; lack of agency/fiduciary concern; inappropriate judgement; medication errors; lack of intervention of the patient’s behalf; lack of prevention; missed or mistaken physician or health care provider orders; and documentation orders. The initial reason for developing this taxonomy was to develop a tool which could lead to a ‘proactive reporting system to promote improvement both at individual level, and at the levels of educational and healthcare delivery and regulatory authorities’ (Benner et al, 2002, p. 510). It is also stated that the reported taxonomy will provide a systematic error reporting tool which in turn would allow for analysis and comparison of errors. The data presented in the narratives for this current study have been analysed using components of the model described by Benner et al (2002). The cases in this study were not purposively selected for the development of a taxonomy as for the reported taxonomy.

**Alleging and Reporting: Motivations**

As introduced at the beginning of this chapter one of the findings of this study were the motivations behind alleging unprofessional conduct and reporting it to the NRA. To understand and situate the ‘why’, it is necessary to consider the meaning of some relevant terms.

Motivation is defined as [1] the act or an instance of motivating; [2] desire to do; interest or drive; [3] incentive or inducement; and [4] the process that arouses, sustains and regulates human and animal behaviour (Collins Australian

Reason can be defined as \(^1\) the faculty of rational argument, deduction or judgement; \(^2\) a cause or motive, as for a belief, action; \(^3\) an argument in favour of or a justification for something; and \(^4\) as a philosophical understanding as the intellect regarded as a source of knowledge, as contrasted to experience. (Collins Australian Dictionary, 2003, p. 1351). In contrast the origin of reason, the 13th Century and from Old French, *resium*, meaning reckoning, and from Latin *ration*, meaning to think (Collins Australian Dictionary, 2003, p. 1351).

In all of the reported cases the participants provided their own understanding of why they were reported. This provided me with a starting point in terms of understanding the reasons or motives behind the matter being alleged and the subsequent reporting of the matter to the NRA. It was clear from some of the narratives that alleging and reporting was done to ‘get at the nurse’ for those reasons demonstrated in the categories of personal and professional vulnerability. There were instances where there was a clear breach of, or failure to meet a nursing practice standard and as such fell into the NRA jurisdiction to ensure safe nursing care to the public. Simply, some *reasons*, that is, the thought given to the decision, for alleging and reporting were grounded in a motivation, that is the incentive or inducement, which was beneficence: other reasons were grounded in a motivation that was maleficence. The concepts of beneficence and maleficence are explored.

Beneficence with its origin from Old French in the 14th Century, *beneficium*, means benefit; and from *beneficus*, from *bene*, meaning good and

For the purpose of this thesis a matrix has been developed to situate the extremes of motivation to allege and report (Figure 4.1). The matrix provides the four domains of causal attributes, individual and contextual in relation to either personal or professional vulnerability. The two continuums demonstrate that for either domain the motivation may primarily be grounded in beneficence or maleficence, or anywhere along the continuum.

![Figure 4.1: Motivation to allege and report unprofessional conduct: A matrix.](image-url)
Motivations presumably grounded in a reason of beneficence to allege unprofessional conduct emerged where there was some technical aspect to the allegation, that is, there was an error in nursing care. For example, the clinical knowledge and subsequent decision making by the nurses resulted in a breach of, or failure to meet a nursing practice standard and was viewed as an error. It can be presumed that, by the fact that the nurse was reported to the NRA, there was a view that public safety was a risk. Having considered the reported cases in great deal there were clearly a significant number of matters where reporting the matter to the NRA was a decision of the extreme.

Maleficence as a motivation, was realised by the participants who saw that the person, and persons both alleging and reporting had done so to get back at them. For the most part this motivation is linked to both ‘out group perception’ and ‘isolating strategies’, which in some cases have links to those relevant dimensions in the property of individual causal attributes. The identified maleficence motivation centred around the personal self, rather than the professional self. It was further understood that professional practice issues were used in some instances to ‘support’ this motivation. Participants realised that they were viewed as being different for reasons outlined in the construct of dissenting behaviours and as such ‘had to be punished’. These participants were targeted, singled out and bullied. Reporting the participant to the NRA was the ultimate isolating strategy and proved to be a devastating life event for many of the cohort.

The following descriptions provide examples of the motivations to report form the perspectives of the participants. The allegations based on the administration of a narcotic without a written order are read out by Participant 8.
In general, it was alleged that she was incompetent or negligent in nursing practice. Specific allegations were as follows:

1. Failed to check the dose of the medication;
2. Failed to contact the doctor to clarify the correct dose;
3. Failed to check for the correct patient;
4. Took from the medication supply the incorrect dose;
5. Failed to document the administration of such in the nursing notes;
6. Failed to comply with hospital policy regarding the administration of this medication; and
7. Failed to record the administration of the medication in the log.

It is overwhelming to see so many specific allegations from one ‘error’.

The above were the reasons for alleging and subsequently reporting this nurse.

The motivations to allege and report have already been addressed but will be summarised here to provide a basis for comparison. The motivations as perceived by this participant were that the DON required a scapegoat and at one point said to them that ‘their heads would roll and not hers’ over this matter [P08/PG08/L20], and that she wanted to make an example of them.

Another example of evidence to support a motivation to report versus a reason is revealed in the following:

I was reported to the NRA for unprofessional conduct because of a medication error. Normally medication errors are handled on the ward. [P07/PG01/L1-4]

For the majority of these cases I state that reporting these nurses to the NRA was ‘over the top’. There was no case that could not have been dealt with by the employing agency and reporting them to the NRA proved to be considerable traumatic. To illustrate this notion of ‘overkill’, the case of Participant 12 is presented. He was reported primarily to the NRA after being placed on a 3 month probation for administering an intravenous antibiotic via a push method instead of an infusion. It is acknowledged that this contravened the hospital policy and was not safe but to report this nurse to the NRA for a matter
which could and should have been dealt with using performance management is baffling. It should also be remembered that this nurse was in their graduate year and there should have been a greater responsibility to ensure adequate support and education. He does add that he believed he was reported by the charge nurse because of what he perceived to be a ‘personality clash’. This was then the ‘motivation’ to report as opposed to the purported reason of clinical competency.

The final concept I wish to introduce here is the notion of ‘witch hunt’\(^{18}\). After reading over the stories of the participants many times, it was apparent to me that in several of the cases, the allegations were part of a ‘witch hunt’. The allegations of unprofessional conduct clearly did not reflect the extreme way in which the matter was pursued at the employer level. The experience presented by Participant 5 is most representative of this. The participant herself acknowledged that it was a witch hunt and the story read almost like a piece of fiction because what happened to her was incredulous. She says ‘it was a big makeover job, there were pages and pages of gossip and hearsay’.\[^{[P05/PG21/L4-5]}\] Another example of the ‘engineering’ of these allegations follows:

The investigator from the nurses board told me in response to me asking her how long this was going take said ‘that they didn’t have enough information to suspend me but should we get any further information they may reverse their decision. What happens! A week later they get four new letters saying that I had said derogatory things about the staff members and the board. They got the evidence they needed to suspend me.’\[^{[P05/PG26/L11-16]}\]

Another example adds weight to this notion of witch hunt:

There was a specific allegation that a palliative care patient who had been with us for eight months had not had any nursing notes written.

\(^{18}\) A rigorous campaign to round up or expose dissenters on the pretext of safeguarding the welfare of the public. (Collins Australian Dictionary, 2003, p. 1844) The searching out of people to be accused of, and executed for, witchcraft. An intensive effort to discover and expose disloyalty, subversion or dishonesty, or the like, usually based on slight, doubtful, or irrelevant evidence.
Participant 8 disputed this and said ‘that is ridiculous’ [P05/PG28/L17]. What these staff members had done was remove the notes to support the allegation.

The concept of orchestration is revealed in the experience of Participant 11 who explains:

After putting in the complaint about the timesheets of another nurse to the nurse manager, all of a sudden I received copies of about five complaints from patients which were all typed on the ward computer with the knowledge of the nursing staff. It was obvious that what had been written in each complaint had been ‘cut and pasted’ from each other, so I considered it a fairly orchestrated process. [P11/PG01/28-32]

I asked Participant 11 if he thought that there was a witch hunt. He replied ‘absolutely’ [P11/PG04/L22]. He adds: ‘they went out of their way to get me de-registered’ [P11/PG04/L20-21]. Another example of this orchestration to obtain complaints is shown in the words of Participant 14:

Once they started looking for ammunition on me, anything and everything was open slather. When material was written by patients and that type of stuff you could almost see that it was at times written by somebody else. They had other persons write the complaints. [P14/PG12/L17-20]

In keeping with this notion Participant 16 provides this contention:

There was a wrath of allegations, everything from a look that I might have given someone, it was a heap of stuff, mostly about my attitude. [P16/PG01/L12-14]

The concept of motivation to report is important to understand. The findings suggest that some nurses are more vulnerable or prone to having an allegation of unprofessional conduct made against them and thus being reported to a NRA. This vulnerability has been explored and importantly in a manner that provides an ongoing opportunity to examine the antecedents and trajectories of vulnerability. It is hoped that by identifying these vulnerabilities, strategies to minimise such risks can be developed. Identifying and reporting these findings may allow individuals to identify where they may be vulnerable and consequently
modify their behaviours. Supervisory nurses can be alerted to this findings and ensure appropriate performance and human management practices.

It is not possible to know the intentions, reasons or motivations of the reporting person as these were not sought. Although, the narratives, powerfully augmented by the fact that all participants were able to articulate similar stories regarding their perceptions as to why they reported and provides a strong warranty to this identification of the beneficence-maleficence continuum of motivation.

**CONCLUSION**

Every nursing encounter provides the potential for a breach of, or failure to meet a nursing practice standard. If a nurse was to sit down and reflect on his/her last clinical shift and list every decision making event and associated patient encounter, there is reason to speculate that it would be enough to discourage them from coming back to work the next day. The reality is that most practice nursing with a reasonable level of care. Sometimes however, the complexity of the clinical situation, the challenges and complexities of the context, and the fallibility of human thinking can conspire against even the most experienced and conscientious nurse.

The nature of human relations and individual motivations are such that nurses may find themselves in a vulnerable situation to have allegations made against them for less than proper reasons. The ability to foresee such behaviours and navigate them is not normally in the realm of our everyday thinking and as such nurses may find themselves outside the work group and being confronted with isolating strategies.
Further to the concept of vulnerability is the dimension where the nurse is vulnerable to being reported to a NRA for matters other than competency. This is a disturbing finding and one which needs to be remedied through the recognition of a systems approach to evaluating nursing errors and sub-standard practice. Moving beyond the pursuit of the individual to an analysis of the systems and processes of error is imperative for the continued development of a sound and accountable nursing profession.

What has emerged here as the social phenomenon for these participants is a potent risk for all nurses working in clinical contexts. The social phenomenon must be examined and assimilated with a degree of urgency and transparency. The ability to deconstruct professional integrity because of this recognised constant concept of personal and professional vulnerability and make an error is a social phenomenon in need of further review by the nursing profession.

The next chapter will examine the findings of the social process in response to the social phenomenon, an allegation of unprofessional conduct. Two sub-categories emerged from the analysis of the data which along with the category describing the social phenomenon formed the core category of ‘transformation of the personal and professional self’. These sub-categories: ‘loss of the assumptive world’: the experience of deconstruction’; and relearning the world: the experience of reconstruction’ their sub-categories, properties and dimensions will be discussed in the next chapter.

*****

Abruptly, while struggling in the midst of a contraction, Charlotte’s chin shot up from her chest as she pushed with whatever strength she had left, she opened her eyes, and then exhaled with a small squeal. Her husband saw her eyes roll up, then close. My mother and Anne felt the body grow limp in their arms as Charlotte lost consciousness (Bohjalian, 1988, p. 69).
CHAPTER FIVE

Social Process

My mother did sign the affidavit. My father did try and stop her, telling the troopers, ‘She’ll be happy to sign it once our attorney has received it’, but my mother believed that she had done nothing wrong. ‘I’ll sign it’ she said to my father, and she did, scrawling her name in large, proud letters along the bottom of the eleventh page. (Bohjalian, 1988, p. 92).

INTRODUCTION

This chapter will provide an in-depth analysis and discussion of the social process in response to the social phenomenon of an allegation of unprofessional conduct by a nurse and subsequent reporting of it to a nurse regulatory authority (NRA). The over-arching social process or core category is viewed as a transformation of the personal and professional self. Transformation is viewed as a trajectory commencing from the point of fragmentation of decision making, to having an allegation of unprofessional conduct made, to the subsequent experience of deconstruction of the personal and professional self and the experience of reconstructing the self. This core category is made up of three categories: (1) an allegation of unprofessional conduct: the social phenomenon; (2) loss of the assumptive world: the experience of deconstruction; and (3) relearning the world: the experience of reconstruction. Within each category are a number of sub-categories, properties and dimensions. A spiral effect of theory development has emerged with a linkage between dimensions, properties, sub-categories, categories, and emerging as a core category. Components of this theory are augmented by articulation of dimensions which provide scope and depth to each component of this substantive theory.
To demonstrate the processes within these components a number of trajectories have been identified. The central and encompassing trajectory is transformative. This transformative trajectory is constructed with the identification of a number of other trajectories, these trajectories are: causal; deconstructive; reconstructive; and consequential. Entwined are a number of threads identified in the narratives as negative and positive influencing factors. These threads are resilience and support frameworks.

The shared stories from the participants have proven a confronting experience for me. I would listen at times, almost disbelievingly at what had occurred to these nurses and think, ‘there but for the grace of God go I’. The leap to imagine myself in these nurse’s shoes did not require much effort. I kept coming back to the words of the first participant to be interviewed, ‘we all walk a fine line’ [P01/PG36/L10]. It is in these confronting thoughts that the need to examine this phenomenon and communicate the experiences of these nurses became imperative.

Allegations of unprofessional conduct as discussed in chapter three are an end point of the interplay between personal and professional vulnerability. Nurses experienced a deconstruction of professional integrity which meant that they were no longer able to navigate or negotiate the vulnerabilities they were presented with or had to engage in. Thus, there was an allegation of a breach of, or failure to meet a nursing practice standard. There is a ‘vulnerability’ in being a nurse - a vulnerability which may be amplified through the actions or omissions of the individual or by the imposed context, and consequently the difficult decisions that have to be made in care events. The disempowerment of nurses in these difficult contexts provided a vulnerable foundation for sound clinical decision making.
In response to alleged unprofessional conduct events and being reported to the NRA, the nurse begins a dual ‘deconstructive’ and ‘reconstructive’ journey, whether the allegation was upheld or not, and despite the reasons or motivations to allege and report. The specifics of this deconstruction and reconstruction which both transform the personal and professional self may follow a number of trajectories and are influenced and therefore dependent on inhibiting and enhancing factors and processes. This chapter will expand on the findings and provide an in-depth discussion of the social process.

**SOCIAL PROCESS**

The following discussion will provide an in-depth examination of the social processes that are set into play once an allegation of unprofessional conduct has been made and reported to a NRA. The core category extrapolated from the analysis of the narratives is a transformation of the personal and professional self in response to the social phenomenon of an allegation of unprofessional conduct. What has emerged from diagramming the social process is a matrix of causation, context and consequence, demonstrated by trajectories revealing human and interactive processes and transactions. I found that the process of diagramming proved to be the most effective way of summarising and articulating data analysis. Within this experience the words of Orona (cited in Strauss & Corbin, 1997, p 181) rang true:

I believe diagrams are the least utilised tool in the analytical process yet can yield great understanding of the conceptualisations being developed. If the researcher is unable to graphically depict ‘what is going on here’, he or she is probably not genuinely clear of the process yet.
In my readings I found the following paragraph which sums up perfectly the disclaimer that I believe has to sit along side the schematic representation of the social process. While it is not provided to distract from what is relevant to this particular diagrammatic representation of the social process, it provides for a sense of movement to the processes and context:

In analysing these constructions I run the risk of ascribing false linearity to dynamic processes. It must, therefore, be emphasised that the processes are circular, simultaneous and overlapping. They are part of ongoing interventions and are therefore altered by prior incidents and affecting subsequent interactions. (Lempert, cited in Strauss & Corbin, 1997, p. 147)

In all of the discussed cases an allegation of unprofessional conduct had been made against the participant. This allegation and the subsequent reporting of the matter to the NRA provided the beginning point of a loss of the assumptive world. Regardless of whether an actual nursing error occurred, or whether the matter was upheld or not at the inquiry, and regardless of the reason and motivations to allege and report the nurse, participants experienced a deconstruction of the personal and professional self. The degree of deconstruction varied for each participant. The dimension of this deconstruction can be seen on a continuum. The end points of this continuum are fraying and unravelling. This is to say that some participants were minimally affected by the allegation and associated processes and others experienced significant and debilitating impact.

The following discussion will introduce the concept of the assumptive world and then proceed to a discussion of the category ‘loss of the assumptive world: the experience of deconstruction of the personal and professional self’. The world of the nurse is an all encompassing concept detailing the personal and professional constructs, beliefs and processes of the everyday. There is what I believe to be a notion of ‘the personal is professional’. That is, there is a dual
influencing relationship between the personal self and professional self. This notion will unfold with the subsequent discussions.

As with all the processes linked to the core category transformation of the personal and professional self they should not be seen as necessarily being sequential. That is, not all participants progressed along the transformative trajectory with any particular pattern and certainly not a pattern depicted in the order which the sub-categories have been discussed albeit with a logical approach. Therefore the reader is encouraged to view the process with the following imagery: dimensional, at times stalled, regressing, progressing and achieving some properties in sub-categories and not others. This imagery is important to give realism to the dimensions of the processes to transform the personal and professional self.

**LOSS OF THE ASSumptIVE WORLD: THE EXPERIENCE OF DECONSTRUCTION OF THE PERSONAL AND PROFESSIONAL SELF**

All participants, to varying degrees, experienced a *loss of the assumptive world* in response to having an allegation of unprofessional conduct made against them. This loss of the assumptive world was experienced through the deconstruction of the individual’s personal and professional self. The continuum of deconstruction varied for each individual, some were impacted minimally and others significantly. As well, the degree of deconstruction of the personal verus the professional self also varied. This category, sub-categories, properties and dimensions are outlined in Table 5.1. To better understand the concept of loss of the assumptive world, the meaning of the *assumptive world* is now discussed.
## Loss of the Assumptive World: The Experience of Deconstruction

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<th>Being Confronted</th>
<th>Deconstruction of the Personal Self</th>
<th>Deconstruction of the Professional Self</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Allegation</td>
<td>Time</td>
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<td>Physical symptoms and illnesses</td>
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Table 5.1: Loss of the assumptive world: Sub-categories, properties and dimensions.
The Assumptive World Defined

To borrow from other disciplines is not new to nursing and equally not surprising when the findings of any research have been articulated within another discipline so well. The findings within this study provide further dimensions to important psychological and social concepts like loss, grief, emotional pain, and trauma. Therefore, it is important to situate these findings within the contemporary literature to not only support the findings but also situate them within the research. As analysis occurred it became clear that the individual in experiencing this ‘deconstruction’ of the personal and professional self was actually experiencing a ‘loss of their assumptive world’. Kauffman (2002, p. 1-2) defines the concept of the assumptive world as ‘the assumptions or beliefs that ground, secure, or orient people, that give a sense of reality, meaning, or purpose to life’ and ‘that the assumptive world is constituted by the psychological act of believing’. To further illustrate this concept Kaufman (2002, p. 3) goes on to say that the assumptive world serves to help ‘frame or organise’ what it is before us that requires understanding or analysis. The assumptive world is comprised of beliefs, that is, illusion believed to be reality, and it is these that are shattered when for example the individual experiences a psychological trauma (Janoff-Bulman, 1992). This notion of ‘illusion’ can be better understood by considering the following statement: ‘the assumptive world is illusion believed to be reality’ (Janoff-Bulman, 1992, p. 21). Kaufman (2003) further explains that what is shattered in trauma is beliefs…or more specifically the ability to believe or assume. Put more simply, an ‘illusion’ is the way we see or view something – it is our minds eye of what our world is and what it should be.
A number of further explanatory examples of the concept of the assumptive world are provided and include one of the very first definitions of assumptive world. Parkes (1971) defines the assumptive world as ‘the only world we know and it includes everything we know or think we know’. Therefore, the world of the nurse, including the personal and professional is ‘lost’ through deconstructive processes which stem from their involvement in the allegation, being confronted with the allegations and the subsequent processes and the physical, psychological, sociological, and professional constructs of the self. The self, that is, the individual when confronted with this trauma responds by attempting to normalise their world. This process is seen in response to the specifics of the deconstruction and through narrative explanation of reconstructive processes. The loss of the assumptive world is represented in Figure 5.1. The concept of the assumptive world will be discussed in more detail within each category. The beginning point for deconstruction of personal and professional self, being confronted is now presented.

**Being Confronted**

The beginning point with respect to deconstruction of the personal and professional self is seen in the identified sub-category being confronted. This sub-category on the trajectory of transformation of the personal and professional self commenced for some participants at the moment of deconstruction of professional integrity. For others, it was further along the trajectory as will be shown shortly. The sub-category, being confronted is comprised of a number of properties: the allegation; employer, NRA and legal processes; time and the conundrum of justice. Each of these properties has a number of dimensions which
Figure 5.1: A schematic representation of the loss of the assumptive world.
are detailed in Table 5.2. The overriding dimension to the sub-category encompasses the way influence of being confronted on the degree of deconstruction the individual experienced and their coping strategies. For example a number of participants demonstrate that they were able to face the components of being confronted with reasonable objectiveness. They were able to seek legal counsel and address the allegations in a professional and articulate manner. Other nurses, despite the intervening years are still dealing with being confronted with the allegation, the way in which the matter was dealt with by the employer and the NRA and its associated aftermath.

This category demonstrates that all of the participants were confronted because the allegation had been made and processes stemming from the allegation and the duration of time. The category is made up of three properties: the allegation; employer, nurse regulatory authority and legal processes and time.

The findings and examples presented here provide evidence that a number of the allegations ‘came out of the blue’ and subsequently, as a shock for many of the participants. Participants were also confronted by a lack of knowledge regarding employer, NRA and legal processes associated with the allegation, investigation and inquiry. This lack of knowledge therefore meant some participants were inadequately prepared to navigate these challenges which in turn contributed to the degree of deconstruction they experienced. The other confronting issue was the length of time taken to deal with the matter. The waiting was traumatic in itself.
The Allegation

All participants were confronted by the alleging. In one case there was a significant self detection that an error had been made and realisation of the implications. The remainder of the cases reveal that the participants were notified either by the employer or by the NRA. Some didn’t find the allegation too surprising, but for others it was an astounding moment.

Self Detection

Participant 1 provided the most compelling story of self detection of her involvement in a nursing error and as such reveals the moment when she was confronted. The allegation centred on her checking a narcotic out from the dangerous drug register and cupboard and not proceeding to the bedside, as per hospital policy, to check that the medication as per order was administered to the patient as per the policy. The second registered nurse (RN) involved proceeded to the bedside and administered a fatal dose of the narcotic. The patient subsequently died despite extensive resuscitation and life support measures. The
realisation of the gravity of the situation was clearly apparent to this participant
and, while senior nursing staff did not specifically allege unprofessional conduct
or that the matter might be reported to the NRA, it was communicated that this
was now a legal matter. Participant 1 tells:

A nurse came to me and said, the nurse outside is having a problem, she
can’t stop the bleeding from the man who has had his angioplasty sheath
removed. I went outside and found blood spurting from the puncture site,
I put digital pressure on and then I said this man is not breathing, so I
pressed the bell, jumped on the bed and started resuscitation…we moved
the patient into the ICU for advanced airway management…anyway the
nurse said…he’s had some Fentanyl and I said how much did you give?
and she said I have given him the lot, I thought oh Christ… [after some
time] the DON came in and said this is a legal affair and you are not to
talk about it to anyone…can you imagine how we felt? It was like my
worst nightmare was about to begin. [P1/PG03/L1-9]

Being Notified

Some participants knew the gravity of the situation almost immediately
and therefore recognised that the matter was going to be reported to the NRA as in
the example of Participant 1. Others were told by their employer that the matter
had been reported to the NRA, and others only knew that the matter had been
reported once they received notification from the Board. The first aspect of this
dimension is revealed in a number of experiences where the nurse found out about
the allegation in a non-private forum.

Participant 3 provides this example of being confronted by her employer.

One of the distressing aspects to the encounter was that the allegations were made
in front of other staff members:

The week before Christmas the other RN and I were called up to the
Hospital for a ‘please explain’. This involved the DON, the Clinical Nurse
Consultant and two of the clinical nurses and we were just basically grilled
for two hours about this medication incident. It was at this time that the
DON said she was going to report us to the Nurses Board and
subsequently on the 2nd of January the DON wrote a letter to the Nurses
Board alleging unprofessional conduct. [P03/PG07/L3-12]
This participant expressed the inappropriateness of addressing this matter in this way. She stated that they should have at least been warned. Participant 3 asked the DON who convened the meeting why the other attendees knew about the complaint and she didn’t? As well she asked why she hadn’t been spoken to separate to other nurse who was also on the receiving end of the allegations.

Another example of being confronted with an allegation of unprofessional conduct is presented in the words of Participant 10. Participant 10 illustrates a very public confrontation and an immediate challenging of the allegations. The allegations were levelled during a meeting of the multi-disciplinary mental health care team.

This psychiatrist just stood up and said ‘well I must apologise to [the nurse], I can’t work with him anymore and my apology to him is because I should have been supervising him closer. He stood up and spoke for about 10 or 15 minutes, produced photocopied pages out of the [patients’] notes, handed them around to the team. So it all happened in front of the team and I am just sitting there gob-smacked, thinking not only are you unprofessional with the patients, now you are unprofessional instead of coming and discussing this with me you’re discussing it in front of the team.

He responds to the alleger:

I consider this a breach of natural justice for this to be spoken about in front of everyone and to expect me to answer in an organised manner after having heard these serious charges laid at my feet just now, I’m sorry it is not natural justice and I’m not answering, I am not responding.

My sense of this participant and his ability to ‘protect’ himself, or minimise his vulnerability was possible because of his maturity and considerable experience as a mental health nurse. To be able to ‘step away’ from the allegations at such a crucial time provided an opportunity not to be swept away with the trauma and obvious disbelief of the moment. He explains his ability to respond like this despite the realisation of the gravity of the situation. In doing so
he realises the gravity of the situation and as such the moment of ‘being confronted’. He explains:

I think I was probably the calmest and rational out of all them, because straight away I thought I have had it here, I really had it. [P10/PG16/L1-4]

The harshness of being confronted is demonstrated with the following scenario described by Participant 4:

He came into work on a Sunday afternoon, just before knock off time and handed me an envelope and because of the feeling between us over the previous months I realised immediately what is was and he said to me ‘this is the hardest thing I’ve had to do’, I said, you’re a liar, stick it up you’re arse and I walked out. I went home and opened the letter and stewed about it and it listed the allegations. [P04/PG02/L10-18]

Participant 4 was asked how he felt when he received notification from the NRA: ‘furious, but it wasn’t unexpected. Participant 8 had already been advised by her Director of Nursing that she was going to be reported to the NRA. The letter she subsequently received from the NRA read as follows:

We have received a report at the Nurses Board which raises concerns about your professional conduct and competence as a registered nurse and midwife in relation to concerns regarding a medication incident… the Board has a role legislated by the Nurses Act to ensure the community is provided with nursing care of the highest standard [and] accordingly the registration and investigation area is required to investigate all alleged breaches of the Nurses Act. [P08/PG13/L5-18]

The notification by the employer in terms of actually being told that there was a problem was for some of the participants the first that they had heard of the matter:

The program manager telephoned me and said he wanted to see me. I went to see him that afternoon and he gave me a letter outlining a number of complaints against me, it was the first I’d heard of it. [P14/PG01/L35-37]

Some participants were confronted with the allegations by a process other than that instigated by the employer or the NRA. In some cases matters were reported to the Coroner or another health care authority. Nurses were also confronted with the processes associated with the enquiries undertaken by these
agencies and in other cases industrial matters. Participant 5 was confronted by the allegations from a health care authority. The participant explains:

Well she said we’ve got some complaints about you. I said have you? Because you know you get them from time to time, they (the residents) don’t like the food or whatever and that is fine because it means that the residents know their rights and are comfortable enough to complain. She said there are far too many, some will have to go to the Nurses Board, some will stay with us, some will have to go to the police and some will have to go to the Australian Taxation Office, I said what! [P05/PG14/L23-32/PG15/L1-2]

Another example of a matter being reported to the NRA via another agency is provided in the next passage. This participant was involved in the care of patient who died and where the matter was investigated by the Coroner. This particular NRA was aware of coronial matters involving nurses. This participant was notified by letter from the NRA that they were investigating the matter. She explains:

I received a letter just stating that they wanted to have an inquiry about certain allegations about my professional conduct. [P17/PG02/L26-27]

The next illustration of being notified is offered by Participant 13:

I was still on leave but I telephoned by supervisor to find out about work availability. She greeted me with the fact that there had been a complaint made against me from a client where I was working. She wouldn’t give me any indication over the telephone what it was about. She told me that she wasn’t at liberty to say. She told me that a meeting had been organised with herself, the human resource manager and myself for the next Monday and advised me to bring a union representative. [P13/PG01/L23-33]

Later on this participant received notification that the matter had been reported to the NRA. Initially her employment was suspended while the employer investigated the allegations. The employer then terminated her employment after they upheld the allegations. This was rescinded through a conciliation process. Thinking that the matter albeit traumatic, was behind her Participant 13 offers this:
So by late September it was all settled and I thought OK I’ll put it behind me and then in late November I received the complaint from the nurses board, which floored me again, it was totally unexpected. My supervisor had sent the complaint to the nurses board even before we had had the conciliation process and my termination was rescinded. [P13/PG08/L22-29]

The shock of being notified of allegations and having your employment terminated at the same time is described in the next quotation. This piece picks up from the participant just having ‘failed’ a competency review:

They said we are taking you off to the director of nursing (DON). So we went into her office. They presented her with the appraisal that I had done and the one they had done. They said to her, ‘you can clearly see that it [the appraisal] is good enough’. So the DON turned around and said, ‘well we have no alternative but to dismiss you’. I was sitting there agog, I just opened and closed my mouth, and I just couldn’t say anything. [P15/PG06/L18-29]

The next quotation reveals the notification process for one participant and how confronting this was for her. She was notified that the matter had been reported when she received a letter from the NRA. She explains her response to it all:

Absolutely nauseated; by this time I had extreme reactive depression. I think at that stage I had a colleague and friend contact me. She told me that she hoped I had everything in my name because she had heard on the grapevine that they were going to sue me for everything. So on the strength of that I decided to commit suicide. [P18/PG03/L27-32]

Participant 20 was notified in the first instance by her employer who told her that he had received a letter of complaint about her from a patient. The employer tried hard to reassure this participant and told her that she would be fully supported. This was reassuring to her. [P20/PG05/L11-14]

Being notified of the initial matter and ongoing procedural matters as directed by the NRA are captured in the harrowing words of a number of participants. The following quotations introduce the concept of having the notification delivered via the mail or via a courier system. The symbolism of a harbinger of doom is soon evident. These provide some insight to what was no doubt an awful experience and one which probably continues to live in their
minds each time an official envelope is received. Participant 7 describes her experiencing of receiving notification from the NRA. In doing so she introduces the notion of the ‘mailman’ as the harbinger of doom.

You get a knock at the door and you get this certified mail, in a brown envelope…you have to sign for it to say that you now in disciplinary action [sic] and we want you to send in your full registration and your badge, everything that I had that associated me with the Register. Well I was dumbfounded; I thought my goodness, how far is this going? [P07/PG08/L5-11]

The concept of waiting for the mail is continued with the following. Participant 8 reveals how having to collect the mail proved to be a constant reminder of the process she was going through:

I hated getting the mail, for that whole year I had to drive to the letter box. Everyday without fail I would put the key in the letter box and think, is it here today? So collecting the mail was not a happy experience because it was an every day reminder. [P08/PG42/L8-14]

Participant 3 who was involved in the same allegation as Participant 8 provides an almost exact recollection of the symbolism of waiting for the mail. She recounts the anguish of receiving the mail when she confronts the Director of Nursing about the lack of support she received throughout the whole affair.

I said to her that she had no idea what it is like to be waiting at home for the postman, desperate to get the mail to see if you are going to get the letter, you hear the postman, you know he has stopped and you are too afraid to go out to the letter box in case the letter is in there. I said you have no idea what it is like, it is just awful. [P3/PG11/L23-30]

Participant 13 describes the reaction of her children when they see a courier van:

All the notifications from my employer were delivered by courier. We hated seeing the courier van pull up and coming up to the door. We all acted very negatively. Even now when my children see a courier van they hiss and say he was the one who used to bring us those nasty letters. [P13/PG04/L35-42]

This symbolism is continued in the words of Participant 15. She explains
the moment when she received written notification of the allegations. This moment proved very confronting:

They had compiled a pile of criticisms of me and I received that in the mail. I wasn’t expecting it I thought that it would me just the normal mail. There was this big envelope with this material in it. I took it out and walked back to the house. Opening that envelope was the worst thing that could have happened to me in my entire life. It was quite thick, over half an inch thick. I pulled it out and I looked at all of these personal criticisms of me. [P15/PG08/L28-35]

When I asked this participant what had been the lowest point of the whole experience she replied with the following. In this it can be seen that the allegation and the associated symbolism, was that this participant as a person and as a nurse, was ‘bad’. Her words support the crux of the impact of the social phenomenon:

I was like being blown away by a big explosion when I received the allegations in the mail. All that personal criticism. The destruction of my person. That was absolutely horrendous. [P15/PG18/L3-5]

Employer, Nurse Regulatory Authority and Legal Processes

The second property (being confronted by) employer, nurse regulatory authority and legal processes reveals that for the most part the participants were confronted by degrees of unknowing, disempowerment, process and procedure, (being) ‘on the stand’ when it came to the processes of the employer, the NRA and other legal forums. It is contended from the narratives that the majority of nurses do not know why the NRA exists. Some participants were able to navigate and negotiate the associated processes whereas others were completely blind to what was required in these situations. Some participants were daunted with knowing that they would have to go before the board, and others saw it as an opportunity. The following quotations will demonstrate these dimensions.

It is not uncommon to hear nurses complain that the nurses’ board only wants to take your money but what do they do for us. The NRA exists as per the
objectives of the legislation, to protect the public. While there are collective and individual benefits for nursing and nurses, the NRA at the end of the day is concerned with monitoring and investigating nursing practice to ensure that it is safe and appropriate. Therefore, it is not surprising that the associated legal processes, despite being available to the enquiring nurse, are not well known. What emerged from the narratives was not only a lack of knowledge about the NRA processes but a difficulty of the nurse to find out what was happening once they realised they were the subject of an investigation. This finding should be of concern to all NRA in particular when combined with the time taken to deal with the matter and the impact this had on the nurse.

**Lack of Knowledge**

The first account provides invaluable message for any nurse who may find themselves being confronted by an allegation of unprofessional conduct by the employer: ‘I should have rung up the ANF, I should have taken a lawyer with me’. While it was clear that this nurse was in no fit state to make clear judgements there is a responsibility by the employer to ensure the nurse is understanding of their rights in these situations. I would further argue that they should also have a sense that, although a nurse may be able to voice back an understanding of their right to both a support person and legal counsel, the reality that they have the capacity should be assumed to be impaired. Therefore the onus is on the employer to provide a neutral person to advocate on the nurse’s behalf.

The following description demonstrates the degree of not knowing, or ignorance about due processes and rights by employers during performance management meetings. While this participant states that he did not know that he
could have someone with him during these meetings, there is also an obligation from his employer to ensure he is aware of this ‘right’:

Of all the meetings I attended, I was on my own. I didn’t realise that I could have someone with me. That was never told to me.  

An illustration of not knowing with regards to employer processes is offered. Participant 13 in trying to find out a bit more about the allegations that had been made to her and the fact that her supervisor refused to provide specifics of the matter over the telephone pursued the matter with her. Her immediate reactions to this not knowing are provided:

I called her again and I said to her I am asking you what is this all about. She still refused to tell me exactly what it was about but she did say that I could lose my job. I just couldn’t get my head around it. I was absolutely overwhelmed and sickened by it.  

Not knowing with respect to the workings of the NRA investigative process is expressed by Participant 15:

We went backwards and forwards with trying to work things out with the board. I really didn’t understand the mechanics of all of that’  

She goes on to express the frustration with the whole event:

I think it was about the seventh hearing I had been to and I was just an absolute mess. If they had of said to me ‘look if you jump off the tenth floor we’ll close the case’ I probably would have said OK. I was so bamboozled by the whole thing.  

Participant 1 provides a further example of not knowing. There were things I should have asked, like how long does this stay on my record

**Disempowerment**

Disempowerment as a dimension of being confronted by NRA and legal processes was demonstrated by a number of participants. This disempowerment and the frustration it brought proved to be confronting. The following account by
Participant 3 provides an illustration of her frustration of navigating the NRA process and in doing so provides some sound recommendations of her own:

We had our first interview in April where it was decided if the charge would go through, we knew it would because it was an error involving a narcotic. We were told it would continue through. The thing with the nurses board is I believe that when they write you a letter saying this has been reported and we will investigate it and that sort of thing they should send an outline of what the procedure is because the other RN and I had to continually ring and say what is happening, where do we go from here, what’s happening with this? It was really hard to get any information. I really strongly think it should be spelt out. [P3/PG09/L20-30]

Participant 1 expressed the disempowerment she experienced in her first encounter with the DON of the hospital and the lawyers for the hospital. This account strongly warrants that a nurse in this position should not be providing a statement in the immediacy of being involved in a nursing error, particularly one where there was a dire outcome. This participant is able to recognise her vulnerability after the event:

I should have telephoned the ANF (union), I should have taken a lawyer with me. I didn’t have to go and make a statement at all. I should have told them not I was not coming in, but I was so vulnerable, I felt so ill and sick and I didn’t know which way was which. [P01/PG09/L11-18]

A lack of empowerment was experienced by Participant 13 when she first met her supervisor, the human resource (HR) manager and union representative. She explains what transpired:

The meeting was scheduled for 1230 hours, and they turned up at five past 12 and I was still finishing up my mornings work. The union person hadn’t yet arrived. I was told by my supervisor that the HR manager was going to be a neutral person who would not take part in the discussions. I found it very difficult that they were in my work environment early and before I had a chance to talk to the union representative. The HR manager basically directed the meeting, so much for being neutral. I just found it very difficult. [P13/PG02/L16-23]

The physical environs and ‘human structure’ of the first formal meeting
that Participant 13 attended translated into a disempowering experience for her
and her lawyer: The experience of this meeting is described:

We were given the 20 page document (outlining the allegations) for the
first time at the meeting. They handed it across the table, a very large
table, about five or six foot wide, we were on one side, the other three
people were on the other. We needed time to read the document and
respond to it. The HR manager said that we couldn’t take it away with us.
So we had to read it there and take notes. We had two days to respond to
it in writing. It was awful. [P13/PG05/L26-45]

A further illustration of disempowerment is offered with the description of
‘having no voice’. Participant 13 describes feeling off centre to what had been
happening with the way her employer had managed the allegation and the
suspension and subsequent termination of the employment. She explains:

I hadn’t really felt that I had had much of voice throughout all the
processes. The way I was represented by different people, and the way
things were carried out. I just didn’t feel that they wanted to hear me. I
felt very powerless in the whole thing. [P13/PG09/L9-28]

Feeling powerless is representative of the disempowerment that was
experienced by Participant 15. She explains: ‘I was completely defenceless and
powerless’ [P15/PG06/L34-38]. She goes on to say that ‘I was absolutely impotent,
totally impotent’ in trying to challenge in the first instance the allegations of
incompetence and the employer response of terminating her employment.

Despite the obvious shock there is an attempt to remain objective:

My mouth was just opening and shutting but no words were coming out. I
was trying hard to maintain some poise, which was not dissolve into tears,
not look shocked and not look astonished, and at the same time try and
evaluate everything they were saying. [P15/PG06/L29-33]

This participant goes on to describe the helplessness she felt throughout
the NRA process. At this point they have met with the NRA for the
seventh time and are still at an impasse: ‘I felt so humiliated, I felt so defeated
and so helpless, yes, just so helpless, that is the word’ [P15/PG12/L4]
Disempowerment was also emerged because of the emotional state of the participant. Participant 2 explains that she did not seek legal counsel because she was not in an appropriate emotional state to see the need. She tells: ‘I was too upset to get a good lawyer’, but asserts, with the wisdom of hindsight, that she should have challenged the process and decisions of the board. [P02/PG03/L7-8]

A further illustration of disempowerment is provided by Participant 7:

‘They (the NRA) were very domineering. I had to go along with their wishes and their orders’ [P07/PG10/L17-19].

‘On the Stand’

A number of the study participants were confronted by the actual inquiry process, be it the NRA inquiry or the coronial inquiry. The dimension of the property being confronted has links to the property spoiled identity and dimension of criminalisation which will be examined later in this chapter. The emergent script from some of the participants provides an almost tangible sense of what they were going through and were confronted with during the actual inquiry. Illustrations of these traumatic confrontations are provided here. Participant 13 an account of her experience like it was yesterday:

To describe it? It was like pain. I got there early, I had a cup of coffee and I went up to the building in the city. We go up in the lifts, it is fairly palatial. I said that I was there for a hearing. They ushered me into a side room where my solicitor was waiting. We were then ushered into a formal hearing room and that was pretty incredible. The six board members were behind a very large desk. They looked undersized. So we sat down and the usually a desk will come to waist height but I found that this desk was higher than waist height so I just felt awkward. So the surroundings were fairly intimidating. There was a public gallery. I had been told that anyone could attend so that thought was pretty scary. I was so scared that I wouldn’t be able to handle the questioning. I didn’t know if I would just cry or breakdown. [P13/PG10/L38-44/P11/L1-10]

This participant goes on to describe the impact the behaviour of the Board’s solicitor had on her:
The other horrific thing was the way the board’s solicitor behaved. He seemed to treat the whole hearing with contempt. He actually joked with the person who was beside him, they shared jokes and they whispered throughout the whole thing. It seemed that I wasn’t important. They weren’t attending to some of the things that my lawyer said. I don’t know if it was some sort of game they were engaged in but it wasn’t very appropriate. It wasn’t very nice.

While the next participant did not feel like a criminal in the scenario he talks about there this is an illustration of the criminal setting that nurses may find themselves in. It is important to note that this participant was a senior mental health nurse and came across as confident with regards to the NRA processes. A less confident nurse may have been overcome by it as some of the other participants were. His words conjure up the symbolism of a criminal proceeding.

He tells:

It was very formal, like a court room in the board room at the nurses board offices. There were about 12 witnesses and there was all this cross examining going on, it was like Hollywood. It was quite dramatic compared to my past experience of having to appear in court to defend a traffic offence. There were hours and hours of questions and testimony.

Participant 19 was asked to tell what the inquiry was like. She provides this insight:

Actually the trial didn’t seem too bad when I was just sitting listening to everyone else give evidence. It was when I came to give my evidence and the prosecuting barrister for the nurses board was really horrible. I mean the way he treated me. I know he had to ask me questions but it was as though I was a criminal and I don’t believe that I didn’t anything to deserve that. Apparently he was a criminal lawyer and I think he was acting as if somebody had murdered someone. He said awful things about me, that I’d lied and things like that.

The following account of being a witness at a coronial inquiry is offered:

They (the lawyers) threw things at me, like ‘here is the DD book, is that your signature’? Then they threw your nursing report at you and then the empty drug ampoule. It was absolutely horrendous. There were five lawyers all lined up like you see on TV and you are in the box. They ask you things about your nursing practice and your integrity. At one point the Coroner had to say to the lawyers ‘she is not on trial’. We were just ripped to shreds.
Whose Side Are You On?

A number of participants expressed indignation of the lack of support that the respective NRA showed them. Nurses sometimes wrongly believe that the NRA exists to support them. While there is an acknowledgement that their processes and procedures should be professional and that the nurse is not disadvantaged or further deconstructed by the way in which the matter is managed and the nurse treated, it must be remembered that the NRA exists to protect and as such represent the public. This dimension provided further illustration of the nurse being confronted.

The following comment was expressed with much obvious indignation by Participant 2. This participant had to travel a significant distance to attend a meeting with a representative of the NRA, which was a major undertaking. During one of these meetings the participant arrived to find that the meeting had been cancelled. She explains that they offered her a cup of tea, as if that was adequate compensation for the inconvenience they had caused her. This participant also provides a stronger view of this particular NRA when asked at the end of the interview if there was anything else she would like to say, she responded:

I think the nurses’ board is unethical. When I told them what was happening they said they were no longer interested. They don’t care. They should encourage you to do things the right way, they are only concerned with the negative. [P02/PG13/E29-34]

A further example of the lack of support to the nurse as an individual is provided in the following:

Every time I telephoned the NRA they sent me round the mulberry bush. They really gave me the run around. That was hard to take, trying not to lose my head and get angry at them. They just weren’t supportive, they weren’t positive, they were cold and critical and not at all kind. [P15/PG11/E30-34]
At times the narratives provide a sense that the NRA had almost been obstructive and less than professional with respect to their processes. Participant 2 provides two examples of this. The first one is when the NRA came to seek information with respect to the allegations:

The lady from the nurses board turned up where I lived and stayed overnight at the hotel. She met me in the foyer so it wasn’t very private. She just asked me my opinion and wrote things down. [P2/PG05/L20-23]

This sort of behaviour may well have been purposeful, trying to set the participant at ease and creating a ‘non-legal environment’ may have been aimed at obtaining information that may have been difficult to obtain if the interview had of been conducted in a formal setting with a lawyer present.

The misperception of the purpose of the NRA is demonstrated here:

I guess my experience of the nurses board was I didn’t feel that they were on my side. I didn’t expect that after forty years of loyal service I would be treated like this. I would have thought that the nurses board could have been a bit more supportive. [P20/PG07/L35-41]

From another participant: ‘I couldn’t believe that my own nurses’ body could do that to me when I’ve been paying faithfully all these years’ [P17/PG05/L22-23].

**Time**

The concept of time emerged as a common thread linking all categories, sub-categories and constructs to the individual trajectory experienced by the participant. Specifically time existed as an issue in three dimensions: the time it took to allege unprofessional conduct; the time that it took for the matter to be dealt with by the NRA; and the time it was taking to reconstruct the personal and professional self.

In some cases the allegation was made almost immediately, in others it was a number of months after the event that prompted the allegation. The
significance of this will be explained shortly. The other confronting aspect was the length of time the NRA took to investigate the matter and bring it to inquiry. Some participants believed that this happened promptly but for the majority of participants it took many months.

The concept of time delays and the collective time to deal with the matter proved extremely confronting for a number of the participants and proved to contribute to the further deconstruction of their personal and professional self. Participant 1 demonstrates the anxiety inherent in waiting for the notification from the NRA: ‘then you were waiting to hear from the Nurses Board all the time’.

The difficulty of knowing that the bad news was going to come, but not knowing when was particularly difficult for this participant.

**Time Taken to Allege**

Delays in alleging unprofessional conduct and reporting the matter to the NRA were evident in the case of Participant 3 and 8. The incident of the medication error occurred in November, but the matter was not reported to the NRA until January of the next year. This two month delay poses a significant question: if it was alleged that the actions of these nurses was such that there was (a) an allegation of unprofessional conduct, and (b) there was an assumption that their practice was unsafe, why was there this delay? Participant 8 makes this comment: ‘I was really suspicious of the delay in reporting us to the board’.

Another example of a delay to allege emerges in the experience of Participant 5. From the time of the original allegations by a number of staff members until the framing of formal allegations by the NRA, six months had passed. This further underscores the question already posed.
An implication of the delay in formally making the allegations is questioned in the next quotation. Participant 17 states:

There was all this back and forth over a few months before they actually told me what the issue was. Yet if I’d supposedly been negligent, if I’d supposedly had criminal intent to cause this man to die then I had been allowed to continue practicing all this time. I thought that was interesting. [P17/PG04/L28-50]

The case of Participant 19 was similar. It took the NRA approximately 19 months to formally act on the allegation of unprofessional conduct [P19/PG02/L30]. During this time the NRA was undertaking an investigation but it is difficult to know what may have transpired during this time if this nurse was indeed incompetent [P19/PG03/L18-23].

**Time Taken to Make a Determination**

Time or rather the ‘waiting’ emerged as a very negative factor for a number of the participants. In two cases, the participants indicated that the matter had been dealt with and resolved in what was viewed as a short timeframe, that is, approximately three months. Some cases lived on in the hands of the NRA for three years. The main issue in relation to the category of the time it took to deal with the matter by the NRA was the waiting and the consequential anguish it caused, and captured eloquently by the notion of ‘living in limbo’. The participants provide poignant accounts of the trauma of waiting, and I must emphasise that the written word in these cases does little to express the anguish and frustration demonstrated in their voices. From Participant 3:

We had [already] been waiting four months thank you very much just to get to the preliminaries. [P03/PG09L26-27]

Participant 8 reveals the impact of this waiting:

I found the long wait terribly depressing and it increased my anxiety. Every day was agonising, waiting for the nurses’ board, I think it was the waiting and delays that killed me. [P08/PG42/L15-16].
In this account she talks about the collective time of waiting for the NRA to come to a conclusion:

It really was a big year and the time delay with the nurses board, they may as well have stuck bamboo under my fingernails because this went on and on and on from the 16th of October until the 20th of December, 14 months later. She goes on to say: It was torture of 14 months. I found the long wait terribly depressing.

The use of the words ‘bamboo under the fingernails’ and the direct use of the word torture reveals the extreme impact this waiting had on this participant. It is difficult to really understand the impact of having to wait this long, on this nurse, without living in her shoes, but I assert that the use of such words reflects powerfully that this was an extremely traumatic and tortuous event for her.

This participant found herself challenging the time it was taking for different parts of the NRA process:

After half an hour they came back into the room and we were told that they couldn’t make a decision and that they wanted to adjourn. This would have prolonged it even more. At that point I just wanted to say – just find us guilty I can’t take it anymore, it was just awful. That was the moment we were supposed to find out and it was going to take even longer. We had to wait four weeks for their decision.

Then:

Once they had their decision we were told that we could go along and hear it or we could wait for them to write it up which would take a couple of months. I rang the other nurse and said I can’t take this anymore, it’s not funny anymore lets just lay down and die. So we rang them up and said just send us a letter. Four weeks later we got it saying that although it was acknowledged that we had made an error it was not considered to be unprofessional conduct.

Other examples of the length of time taken to have the matter heard by the NRA includes the following. Participant 4 was reported to the NRA in September and the inquiry was not held until March the following year. The length of time for the matter to be dealt with by the NRA for Participants 3 and 8 was 12 months. Participant 2 endured 18 months before the NRA arrived at a
decision concerning the allegation of unprofessional conduct. These examples show that these nurses lives, personally and professionally were put on hold. To have to live with this uncertainty no doubt would have contributed to the degree of personal and professional deconstruction experienced.

Participant 7 provides an overview of the time taken from having the matter alleged until she obtained full registration status again. She tells:

The error happened in January of 2001 and the hospital told me that it was being reported to the board in February. The board told me that they were pursuing the matter in March of that year. The inquiry happened at the end of the year. After I did an oral examination in December 2002 I was finally cleared in January 2003. [P07/PG16/L1-9]

Participant 10 had the allegations made against him in the September and the matter was heard in March of the next year. This participant tells how the time delay did not really bother him and felt that the nurses board were using this time to conduct the investigation. [P10/PG43/L3-7]

Participant 11 had to endure 15 months before the allegations were heard at an inquiry. [P11/PG03/L5] The negative impact of having to wait for the matter to be finalised is expressed by the next participant:

I eventually got notice to say that my matter would be heard in March. So I had a very long period of waiting to hear what the Board was going to say and that wasn’t very nice. [P13/PG10/L23-25]

Participant 16 offered the following with respect to the time it took to have the matter dealt with by the NRA:

I was shocked by the whole thing but particularly by how long it took. The allegations happened in 1994 and the findings weren’t published until September 1997. The amount of time it took was awful because of the continual pressure of knowing that I might be struck off. [P16/PG02/L18-21]

It took three years to finally arrive at a determination in the matter of allegations against Participant 19. She tells how this time was just too long and it shouldn’t have taken so long to sort out. [P19/PG03/L19-23]
The word ‘wait’ and ‘waiting’ were frequently used by the participants. There was almost a sense of breath holding or waiting to hold, a feeling that life was on hold. After getting the initial letter from the NRA Participant 20 tells: ‘then I had to wait and wait and wait’ [P20/PG06/L29-30].

The wasting of the participant’s time is demonstrated in the next quotation:

I think the nurses board handled it very badly because they took so long. One time I went down there [a significant drive from the Participant’s home] and they said we are not ready for you today and they gave me a cup of tea, I thought oh! [P2/PG03/L19-22]

**Time Along the Transformative Trajectory**

The third dimension of this dimension was being confronted by the time it was taking to reconstruct the personal and professional self. The following provides a confronting sense of the length of time some participants have ‘lived’ with the deconstructive and reconstructive processes and impact. Fourteen years had passed for Participant 15 since the allegations were made. Only recently had she experienced a turning point. She explains: ‘for so long I was in denial and ignorant of the whole impact’ [P15/PG20/L18-22].

The following figure (Figure 5.2) provides an overview of the time taken

![Figure 5.2: Time taken by the NRAs to arrive at a decision.](image-url)
for the nurse regulatory authorities to arrive at a decision. For the most part the
time taken to arrive at a decision was greater than one year.

**Deconstruction of the Personal Self**

The second property of the sub-category deconstruction of the personal
and professional self was identified as a deconstruction of the personal self. This
property emerged with the identification of deconstruction of the physical,
psychological and social selves. The self for the purpose of these findings and
discussion represents the whole of the individual and is comprised of the physical
being, the psychological being and the social being, and the interfaces with each
other. The self can be viewed in two dimensions. Firstly, as ‘the distinct
individuality or identity of a person; a person’s usual or typical bodily make up or
personal characteristics; an individuals’ consciousness of his own identity or
being (Collins Australian Dictionary, 2003, p. 1465). The second dimension
related to the symbolic interactionist view, allows for a situating, and
understanding of the self in relation to the group. Specifically, how the individual
sees themselves within the group, the symbols they have placed on them in
relation to their sense of self and place within the group and how they enact this
through social actions and interactions (Blumer, 1969). Mead (1934) said of the
self: the human being has a self...(meaning) that the human being is an object
unto himself.

There are clear links between the impact of the actual allegation and being
reported to the NRA as causative factors for the consequences of this
deconstruction, and to each dimension. For example, it is evident that the
psychological impact of the event, did have an effect on the physical well being of
the individual with further potential to impact on the social self. The majority of
the participants experienced varying degrees of deconstruction in at least one of
the identified constructs. Some participants experienced significant
deconstruction in all three dimensions.

The following discussion will now elucidate this property with discussion
of the following dimensions: physical deconstruction, psychological
deconstruction and social deconstruction. The dimensions of each construct are
typically reflective of a common thread of deconstruction of the personal self,
although variation of how and to what degree exist within the individual
experience. Some of the participants communicated a complete upheaval of their
life, as they knew it. Other participants, although they experienced
deconstruction, the impact was less significant. The properties and dimensions of
the sub-category deconstruction of the personal self are listed in Table 5.3.

**Physical Deconstruction**

The self and its interface with stress and traumatic events have received
significant attention through the disciplines of psychology, sociology and nursing.
The findings with respect to being confronted by an allegation of unprofessional
conduct, having their life, (including their career) put in a state of flux, and the
impact of experiencing what I will argue is one of the most significant stresses
one can face.
Stress had a direct impact on the physical well being of a number of participants. The literature is replete with example of how physical well being can be, and is influenced by stress. Stress is defined as a ‘psychological state or process that occurs when we face events we perceive as threatening to our physical or psychological well being’ (Bourne & Russo, 1998, p 476). The scope of factors or experiences which can cause stress are extensive and influenced by both the severity of the stressor and the ability of the individual to ‘cope’ with or manage the stress (Bourne & Russo, 1998).

**Physical Symptoms and Illness**

The most poignant experience of physical deconstruction is shared by Participant 5. The event that this nurse was involved in was extremely traumatic and complicated by having it played out in the public domain. Her words provide
a glimpse of the devastation she suffered physically as reports of her case reached
the media:

By 11 o’clock that morning, I’d had chest pain, which I had been
experiencing for months, I knew it was stress but I just felt that I was
having a heart attack and I collapsed on the floor and I think I knocked
myself out when I collapsed. [P05/PG31/L23-26]

At this stage I am in a foetal position, I am vomiting, I have diarrhoea,
I have headaches, I haven’t eaten for months, I live on milk and milky
drinks or diet cola or coffee, I am taking anti-depressants, I am taking
medication for a gastric ulcer, I have chest pains, I am twenty kilos
overweight, I smoke like a trooper, I lost my periods, and my eyelashes
fell out. [P05/PG41/L16-20]

This account is clearly the most extreme example of physical
deconstruction provided by any of the participants, but clearly brings into
focus not only what impact stress can have on the physical integrity of the body,
but demonstrates the degree of stress the participant has endured. This participant
experienced the worst of this illness at a point where she ‘hit rock bottom’ with
this event. She now importantly realises the link between stress and depression
and the subsequent manifestation of illness. As a result her health is improving
with medical management and a self realisation of the causes and strategies for
improving.

Another participant recounts the physical impact the stress of having to
deal with an alleged matter of clinical incompetency had on her. Again, this
participant reveals that the physical illness she experienced was directly related to
the stress:

I wasn’t eating of course and I wasn’t sleeping. I was getting mouth ulcers,
my teeth were breaking down, and I was losing my fillings’. [P07/PG13/L24-26]

The dimension of physical deconstruction is further illustrated with
comments from Participant 6 who did not experience any physical illness and
provides a reason for this: ‘I can’t say it made me physically sick but I have
always been very fit and healthy and that helped to ward of physical sickness’

This participant did experience some stress but fortunately for her it did not manifest in a physical illness. It is interesting to note here that this participant demonstrated a purposeful structure to dealing with the allegations and was proactive in addressing the allegations. This raised the question whether the degree of ability to manage these events from the beginning in such a positive manner has an impact on the degree of physical deconstruction experienced.

Physical symptoms were also experienced by Participant 4 in response to be required to undergo a competency assessment, he explains:

By this time I was extremely stressed I had already been in the emergency department a couple of times with chest pain. I still had to undergo a number of tests related to that. [P04/PG14/L29-32]

Participant 13 also found that she was experiencing sleep deprivation and general symptoms of anxiety. She approached her medical practitioner with these symptoms who referred her to a counsellor. [P13/PG12/L26-28]

Participant 17 was diagnosed with diabetes a short time after the events of the allegations and inquiry had culminated. While there can be no confirming the causation of her diabetes there are well known links between stress and illness that cannot be ignored. [P17/PG11/L10]

Stress not only manifests in physical illness and symptoms but has a clear link to psychological deconstruction as well. This link was clearly evident in the participant population related to this stress. The scope of deconstruction psychologically and socially was minimal for some participants and to the extreme for others. The interconnection between psychological and social deconstruction with subsequent impact on the physical well being of the individual is noted and importantly cannot always be seen as existing separately,
that is, there are clear causative links between physical, psychological and social deconstruction and will now be discussed.

**Psychological Deconstruction**

The psychological well being of all the participants was affected. The degree of impact varied for each participant. The dimension of psychological deconstruction included: *impact on self identity; stress reactions; depression; suicidal ideation and attempts; and surrendering*. The examples of psychological deconstruction were particularly confronting, and even more so in that some of these nurses were put in almost impossible situations to adequately manage what was happening to them. It was not until some of them experienced a crisis that intervention was sought or offered. The message from these narratives is clear: psychological deconstruction will be experienced by the nurse reported to a NRA for alleged unprofessional conduct. The degree of deconstruction although variable, can be significant and in some situations life threatening. The need to support any nurse involved in a nursing error must be viewed as a collective professional responsibility.

**Impact on Self-Identity**

The impact on self identity is closely linked to the concept of *spoiled identify* as a property of the sub-category, deconstruction of the professional self. In particular this dimension of the property social deconstruction makes clear how some participants saw themselves differently, and in turn believed that they as a person would be seen differently within their social world. The following illustrates this dimension and provides support to the concept of transformation of
the personal self in response to an allegation of unprofessional conduct.

Participant 10 tells:

So this image of me as a strong person got well and truly shattered. I had gone from being the strong provider, I was very confident in my ability, very confident in my own thoughts about things and now I had gone to this person who got the sack. In a way you could say that I had failed. All of a sudden I was no longer the breadwinner. [P10/PG49/L1-9]

The perception of self identify was significantly affected by the written word. The following response indirectly illustrates how self identity can be significantly affected when confronted with words which attack ones character:

My employer had written that I had lied and I couldn’t be trusted. That was actually in the documentation. My work couldn’t be trusted. [P13/PG14/L35-37]

After receiving notification from the NRA, Participant 10 found that the hardest thing was going home to tell his wife:

It was really that day when I came home [after being notified] and I had to tell my wife that I’d messed up. [P10/PG49/L17-18]

This hurdle as also voiced by Participant 3 and reveals a reaction of shame: ‘I mean to have to come home and tell my husband’ [P03/PG25/L29-30].

Trying to comprehend the attack on the personal self through the making of allegations regarding work practices had a significant impact on the individual’s self identity. The next excerpt further demonstrates this and provides a basis for understanding for the next dimension, stress reactions:

I looked at the list of personal criticisms of me, I was even more helpless. They were lies, they were half truths, and they were so condemning of me. At that point I remember feeling that the whole world had fallen on me. [P15/PG08/L35-37]

Stress Reactions

A number of participants experienced what I have labelled stress reactions. This label has been assigned to a range of reactions and symptoms of stress,
except for physical symptoms which are dealt with under the property physical deconstruction. These include anxiety, fearfulness, nervousness, traumatisation and agoraphobia\textsuperscript{19}. The following describes a stress reaction:

\begin{quote}
I think it had an effect on my nervousness, I became scared of contending myself at work. I think it made me quite traumatised for a while.
\end{quote}

\textsuperscript{P06/PG10/L4-8}

The stress that was experienced by Participant 1 came to a climax after the Coroners inquiry into the death of the patient. This participant was required to be ‘on the stand’ for a period of five hours over a number of days and was questioned by five lawyers. This event in terms of her then requiring hospitalisation was ‘the straw that broke the camels back’. She articulates some of the stress experienced during this inquest:

\begin{quote}
It was just awful, there you are in the stand and five lawyers lined up and then Coroner and the DON was also there. All these people just boring into you, it was just absolutely ghastly.
\end{quote}

\textsuperscript{P01/PG15/L12-16}

The experience of being reported to the NRA combined with relationship problems proved very challenging for Participant 2. In her own account, the impact of the stress was reflected in her ability to make sound decisions regarding her predicament:

\begin{quote}
I was too upset to get a good lawyer, it upset my home life, and my husband didn’t have a job and one thing led to another. He met another woman and went off with her. I nearly went stupid.
\end{quote}

\textsuperscript{P02/PG03/L7-8}

Participant 7 provides further evidence of the psychological deconstruction that was experienced. In doing so the reader gets a sense of this being a desolate place to be psychologically there is a sense of ‘rock bottom’ to all of it. In listening to the narrative it is evident that this nurse had difficulty in finding the words to truly describe her psychological state. She also provides some insight

\textsuperscript{19} Noun: A pathological fear of being in public places, often resulting in the sufferer being housebound [Collins Australian Dictionary, 2004, p.32].
into the difficulty of doing her job as a nurse but equally demonstrates the
importance of trying to do the best for her patients, nonetheless. The realisation
of the difficulty at this time is firmly realised by this participant as the following
describes:

> It was a very low time, it was a terrible time, and yes it was shocking. And how could I smile? In the end I could smile, you know you have a smile on your face for the patients, to try to make them and their day happy, but in the end how could you, you weren’t happy yourself? I was doing the job [just], I worked for four months, and look I was just functional. That was it, but I really had to go on stress leave then and so the whole period was a low. [P07/PG18/L24-36]

The following quotation provides an opportunity to feel what it must have
been like for Participant 8 knowing that the letter was coming and then receiving
it and expressing the stress reaction that caused. This vignette is set against an
already bleak background knowing that it was only a matter of time until she
received notification from the NRA:

> I was feeling quite down, one day it was a lovely sunny day and I was going to the beach for the day. I actually went to the post office and I remember feeling happy, I hadn’t actually felt happy, the world had been grey but I was just having a good day. So I went to the post office and there was a letter from the nurses board, and this was the day I got the letter saying that it was going to a formal hearing. I rang my husband on the mobile and I continued driving on to the beach and I just blubbered all the way down to the beach, I felt like I was being kick, again and again and again. [P08/PG45/L12-16]

**Traumatic Stress**

I have chosen to distinguish *traumatic stress* to *stress reactions* as the
language used by some of the participants reveals the impact of stress as an
assault and the severity of it. The following provide illustrate of this dimension of
deconstruction of the psychological self.

The first example is offered from the words of Participant 15:

> The first time I had to tell the counsellor I was just too ashamed to do so. To tell them the magnitude of the psychological assault on my brain was
so difficult. I just couldn’t justify how I felt, I couldn’t do it because I felt so ashamed over this situation, so it helped to keep silent. [P15/PG15/L24-30]

She goes on to describe the impact of this experience. Although I am in no professional position to diagnosis post traumatic stress disorder, nonetheless the magnitude of what I was hearing from this participant and others can only be characterised by a major psychological traumatic event and importantly, not fully resolved. As an example of this magnitude is described in the following:

It was the experience where I couldn’t help with the anaesthetic for that child and had to run out\(^{20}\). That was the problem. I was two people, at home I was OK but at work where it really counted I wasn’t OK. I was falling apart at the seams and I couldn’t figure out why, I could relate to people normally but at the same time I had no idea that I had a problem. [P15/PG15/L1-5]

A further finding with respect to traumatic stress is the failing to provide (in any of the cases) a debriefing process and removal of the participant from the critical event. Participant 17 explains that even though the agency where she was working had a policy for debriefing, the person who was to facilitate the debriefing was on sick leave and it did not occur.\(^{[P17/PG12/L15-16]}\). She goes on to say ‘I didn’t even get any time off after the event, we just continued doing our work’\(^{[P17/PG12/L12-13]}\).

This was similar to the experience of Participant 1: ‘we ploughed on through the night, we should have gone home, and we should have been relieved’\(^{[P01/PG06/L12-15]}\).

For some participants, evidence that these events were a traumatic assault were sprinkled throughout their narratives. Participants referred to the severity of this event with words like: traumatic; horrific; ghastly; fearful; feeling sick; depression; antidepressants; hospitalisation; criminal; a nightmare; the worst time

\(^{20}\) See dimension of surrendering.
of my life; and an absolute wreck. For some of the participants this traumatic stress became depression.

**Depression**

The degree of depression experienced by Participant 1 meant that she required in-patient care:

I was an absolute wreck. I think it was about a week after the Coroner’s inquest that I was admitted into the clinic and I don’t think I went back to work for three to four months. [P01PG13/L7-10]

Participant 8 had a particularly difficult time in the aftermath of being reported to the NRA. During the time of the allegation and investigation by the NRA this nurse was pregnant with her second child. Her experience of care by the obstetrician and the staff at the hospital where the allegation of unprofessional conduct occurred fell way short of what would be expected of appropriate care. Her descriptions of care by some health care providers is of concern. This participant was cared for in the post-partum period in the same hospital where the allegation took place. During her hospitalisation, by her account, she and her baby were treated badly, to the point where her baby’s life was endangered through neglect. During a visit to her general practitioner she posed the following question and in doing so was able to recognise the reason why she had been feeling so low. The impact the stress of having the allegation made and reported to the NRA was having is revealed in the following emotional passage:

By September I was a real cot case, nearly a year had passed. I had to go to my GP for something and I just sat there blubbering. He asked me what was going on and I told him that I was so distraught at the thought of having to go to the NRA. At that point I started counselling and commenced on anti-depressants. [P08/PG24/L22-28]

Depression was also experienced by Participant 7. She provides
insight when I asked her if she had experienced depression because of what happened to her:

Well it would only have been natural for me to have been depressed. I was quite unhappy about it all, yes I was depressed.  

In retrospect, Participant 15 realised that she was depressed, when the union representative of her case advised her not to say anything at one of the meetings with the NRA:

He said to me ‘now I want you to say nothing’. It was then I realised that I was severely depressed, I was just muttering and mumbling, and I was stumbling in rage. I really was helpless and so defenceless.  

Participant 15 also experienced depression: ‘I had depression for two years and had to take anti-depressants’.

**Suicidal Ideation and Attempts**

Suicidal ideation was experienced by a few participants, and attempted by one of these participants. Their experiences of the depths of psychological deconstruction are described here.

In asking Participant 1 what was the lowest point in all of this for her she replies, and in doing so describes the depth of despair and depression she experienced and the length of time it has taken her to recover from it:

The whole bloody lot. It was shocking, just shocking. I felt at one point that maybe I would commit suicide, but I had two children, I couldn’t leave my children. It was very hard.

Depression was a common theme for these participants. Participant 3 describes how she was so affected that she contemplated suicide. This participant (and not unlike Participant 1), was able to refocus because of the realisation that her family needed her:

I became very depressed. Some days I would lie in bed and not even want to get out. I felt suicidal. It was only through the fact that my family
needed me at the time, my daughter was going through a hard time, and we were able to pull each other through. [P03/PG15/L23-30]

Depression and suicidal ideation were also expressed by Participant 4 along with the ability to pull back from it as an ‘option’ to his predicament because of his children. I asked him what was enabling him to keep going besides his resilience? His response through tears and in shame was ‘antidepressants, twice’. A silence enveloped him, providing a more positive challenge to him I asked him, ‘is it the hope?’ He replied with ‘yes’. Sensing a deeper level of pain, I asked him ‘was it that low’, again he replied with yes and then he added, I wouldn’t have made it. He provides further clarification without prompting:

I would have worried a lot about doing that to my partner but I know they could have gone on, but for my kids it would have been a lot. I have seen what that does to a family. There are still times when I want life to stop. [P04/PG32/L2-9]

Participant 5 provides the most compelling of narratives with respect to wanting to end her life and the fog of depression that she continues to live in:

I am on three antidepressants a day, still. I still cry as much as before. I’ve tried two to commit suicide twice. I am still seeing a psychiatrist and my general practitioner each month. [P05/PG32/L31-33]

The events that Participants 1, 3, 4 and 5 have described are clearly critical incidents in their personal and professional histories. There was no evidence that the nurses received a reasonable level of psychological support from the employer at the time of the matter coming to a head or throughout the investigative or inquiry process. These critical incidents caused significant psychological trauma for a good majority of these nurses. In some cases they were allowed to leave the work context after being confronted by the allegations with no support or appropriate follow up. Participant 1 provides an example of mismanagement of a critical event during the course of employment and later in
allowing her to drive home after a long and harrowing night shift. The problem of not being allowed to talk through the situation and diffuse some of the emotions was clearly detrimental. Debriefing is an accepted cornerstone to the management of critical events, this was clearly not done in the case of these participants:

We should have all gone home, we shouldn’t have been allowed to stay. After a major incident like you we should have gone or at least moved away from the area. We should have been debriefed after all that, instead we were told at the end of the shift not to talk to anyone. [P1/PG06/L12-18]

Surrendering

The dimension of surrendering within the property of psychological deconstruction provided glimpses of experiences where the participant has ‘given into’ or ‘given up’ to something. This juncture in the transformative trajectory is more positive than it is negative, as it demonstrates a ‘release’ of sorts and an opportunity to move forward. The participant consciously realises that they alone cannot prevent the self from unravelling any further.

The trauma of attending the NRA inquiry is described by this participant. There emerges imagery of the unravelling self and the need to surrender to the trauma. She tells what happened at the end of the hearing:

I got out of the room as fast as I could. I just needed to distance myself. My lawyer wanted to talk to me so we went into another room and he said that he felt that it went well. I found that I just couldn’t speak, I felt like that I’d held myself together for so long that I just couldn’t perceive that it was all fine and dandy. I had the feeling that I had to get out of there and so I said I am not pretending I can handle it anymore I have got to get out of here. I had such an overwhelming feeling of I can’t stand this anymore. [P13/PG13/L1-10]

Another example of surrendering is presented as follows. Participant 13 recognised that she was depressed after her union representative advised her not to talk at the NRA meeting, she explains further: ‘He obviously thought I was a nut case and he wasn’t wrong’ [P15/PG10/L26-27]. She goes on to say:
I was completely out of it. I was trying really hard to pretend I was normal but the whole thing really was beyond me and I couldn’t have defended myself if my life depended on it.

A further example of surrendering can be seen in the words of Participant 15. In response to being asked whether there was a turning point in her experience she replies with the following. In providing this response there is a sense of more than a turning point, but more a realisation and subsequent relief that the ‘answer’ has appeared. She explains:

I think I was in denial all along. I was in denial and ignorant of the impact that this had had on me. I felt that it was my problem (emphasis added) and I (emphasis added) to solve it. I dealt with it in my way by denying it and stuffing, you know how you stuff it down so it doesn’t hurt. I eventually came to the point where I realised that was where the damage laid, my sense of shame about it all. realising this meant I could get better.

The following narrative provides another example of surrendering in the participant’s explanation of the point at which help was sought from a professional counsellor. She explains:

I sought help because I was wondering if I was going to have a nervous breakdown. One day I was suddenly overwhelmed with fear. I was helping putting a child to sleep on the table and I just suddenly felt so sick with fear that I ran out and said to the others I just can’t do this case. I don’t know what is wrong with me but there is something wrong with me.

Surrendering for Participant 1 occurred when she realised that she was suffering from severe depression and required professional inpatient care.

Participant 5 ‘surrendered’ to the care of her partner when the matter of allegations was brought to a climax. The allegations against her had been playing out in the media. The details of her case had received much media attention, including print and television. Her partner orchestrated her leaving her home when he learnt that the matter was going to be disclosed in the parliamentary context that day. This participant was whisked away and taken to a remote
location to live until the matter died down. This participant had been experiencing severe stress reactions, both physical and psychological and she was at a point where surrendering was imperative to minimise exposure to external events which would have mostly likely caused further deconstruction of her personal and professional self.

Social Deconstruction

Social deconstruction emerged as a property of the sub-category deconstruction of the personal self. Social deconstruction was identified with the emergence of the following four dimensions: impact on self-identity, consequences on family and relationships, financial consequences, the need to relocate and isolation.

Consequences on Family and Relationships

Although participants expressed that their family and friends were the bastion of support there was nonetheless, a degree of social deconstruction experienced because of the consequences the experience had on the family and the relationships. The degree of deconstruction ranged from minimal to significant, and in some situations was seen as causative in relation to ongoing deconstruction and in some situations it emerged as a result. The following demonstrates the connection between physical and psychological deconstruction and deconstruction of the social world for Participant 5:

I have developed compulsive obsessive disorder. I am agoraphobic. My house is filthy, I just don’t have the energy to clean. The kids are living on takeaway food for a year. My son failed his exams for that year and my daughter lost her job because of inappropriate behaviour secondary to the stress we were experiencing. So we all fell apart for a while. [P05/PG41/L22-30]
This theme of family unravelling continues. As one party put it: ‘I was put through quite a bit, my family has been affected’ [P07/PG03/L22-23]. Participant 8 describes some of the impact on her family: ‘I felt sorry for my husband and my children. My children didn’t understand what was going on, but I felt sorry for my husband, I was just a blubbering mess’ [P08/PG42/L16-19]. Participant 8 further explains: ‘my children were too young, I was their mother and I was responsible for their welfare. It was difficult because that year was clouded and I was sad. When my baby was born I didn’t feel that I got to enjoy her’ [P08/PG49/L1-15].

In the next account the participant makes reference to the degree of psychological damage she experienced and tells how her marriage ended [P15/PG12/L43]. As she explains the impact of the experience was felt not only by her, but by her family who she states: ‘suffered terribly because I could not pick myself up’ [P20/PG11/L34-35].

Financial Consequences

The financial consequences for many of the study participants were significant, either because of the costs of legal advice, NRA fines and costs, and/or the loss of income. Participant 5 describes the consequences of not earning an income had on her and her family:

For many months I was just living on my savings. Then I had to live on money from my parents and then my fiancé’s money. It was a pretty hard time. [P05/PG66/L2-14]

The inability to obtain employment and subsequent financial consequences is explained in the experience of Participant 2. The conditions imposed on her registration by the NRA meant that she was required to work with another registered nurse for a 12 month period, which she was not able to obtain. She explains her predicament:
I can’t seem to get a job as anything else because I haven’t done anything else. It is difficult to get work and I haven’t got much money, so making the house payments was difficult. [P02/PG8/L34-36;PG9/L1-2]

This theme is continued: ‘my basic bread and butter money became jeopardised because of the targeting I was receiving at work’ [P06/PG9/L6-7]. Another participant explained the impact that having conditions put on her registration had for her: ‘I was unable to get any work because of the conditions put on my practice. No-one wanted to employ me in a supernumerary position’ [P07/PG03/L24-25]. She explains further: ‘I suppose I could have said I give in, but when you are the main wage earner you’ve got to stick to your job’ [P07/PG13/L8-11].

The cost of having to do NRA required courses also had an impact: ‘I had to do a course that cost a $1000’ [P07/PG03/L3-4]. Another participant had to undertake an ethics course which cost her $800 [P13/PG14/L6]. Participant 16 was also required to undertake a course which cost him a lot of money, which contributed to his grief’ [P16/PG05/L25]. Participant 1 states that the whole thing cost her lot of money. [P01/PG13/L1]

Participant 15 tells how she had lost two years of work because her employment was terminated and the length of time the NRA inquiry and industrial matters took. As described in other parts of this chapter, this participant felt helpless in the negotiating phases and when an amount of money was offered to her as compensation she took it without question. This amount was approximately a third of what she would have paid per annum. The impact of this was further worsened when she had to pay taxation on this amount. [P15/PG12/L12-14;40-41]

The cost to Participant 19 (even though she was a union member and has some access to legal advice) was $10 000. She explains:
Even though I was a union member they only covered so much of the cost. Because the trial went on for so long I had to find that amount of money and it was escalating. [19/PG04/L31-33]

Participant 20 was at a point where she was prepared to sell her house to, as she said, ‘put this thing to rest’. Very early on in the proceedings she received the first bill for legal services of $1200. [20/PG05/L20/PG06/L1]

**Need to Relocate**

The *need to relocate* emerged as a further dimension of the property social deconstruction. Reasons for moving are varied and are presented here.

Participant 15 had to relocate from a rural area to the city to find work. [P15/PG12/L43] In rural settings it is common for the choice of work to be limited, in most cases only 1 hospital exists. As well, the details of such an event would be well known in a ‘small circle of nurses’ own and prove a barrier to continuing working in the town.

Participant 4 had to move states to find work. The difficulties he had experienced with a number of health care agencies meant that it was difficult to obtain work in the state where the allegations had been made. [P04/PG09/L4-9]

Participant 2 had to relocate to be closer to her daughter. She chose to relocate after her marriage ended to be closer to her family who were her support system. Participant 5 had to move away from the town where the allegations occurred because the matter was well known to all in the town because of media coverage. This participant just couldn’t bear to face anyone. [P05/PG41/L11-12]

**Isolation**

The dimension of *isolation* with the emerging new world was felt in a number of ways. Some participants expressed a sense of isolation because some
of their colleagues couldn’t understand what they were going through as

Participant 13 explains:

I had a few of my colleagues who were supportive but not many of them. They didn’t understand what I was going through and what was happening. They weren’t really told for example why I wasn’t at meetings. So I felt very isolated. [P13/PG09/L19-22]

The property, deconstruction of the personal self is revealed with a further example of the dimension of isolation. This example shows isolation as a consequence of the experience and, while the participant has chosen this, it is important to include it because it occurred in relation to him becoming deconstructed. He explains:

I still live in the town but I have chosen to isolate myself. I was never much into socialising with people from work. The stigma attached to me also extended into the community. What was happening at the hospital was well known in the community. So my life centres round my family and my business. [P14/PG05/L29-32]

The property of social deconstruction can be summarised in the following passage from the narrative of Participant 11:

The experience interfered with every aspect of my life, what I thought about myself, my income was diminished, and my ability to relate to people, my sex life deteriorated because I felt diminished as a person. [P11/G09/L3-6]

This piece gives voice to the impact on the personal self as a whole.

Although the self is made up of components, that is, the physical, psychological, emotional and social, and each adversely affected each other and demonstrates the deconstruction of the personal self. This interconnectedness will be demonstrated in the next section of this chapter with a discussion of the deconstruction of the professional self.

Participant 1 discloses the isolation she felt in not being able to confide in anyone. She explains: ‘I think one of the problems was that we weren’t allowed
She also explains at the height of the experience she had no one to confide in until she saw a professional counsellor.

**DECONSTRUCTION OF THE PROFESSIONAL SELF**

All participants experienced deconstruction of the professional self. This deconstruction of the professional self was identified with the emergence of a number of properties: *nurse interrupted, spoiled identity*, and *punishment*. The professional self can be regarded as those internal and external identified characteristics which give definition to the view of the individual as a professional. The properties and dimensions of this sub-category are outlined in Table 5.4.

<table>
<thead>
<tr>
<th><strong>PROPERTY</strong></th>
<th><strong>DIMENSIONS</strong></th>
</tr>
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| Nurse Interrupted | 1. Losing the role  
2. Losing the passion  
3. Loss of confidence |
| Spoiled Identity | 1. Shame  
2. Stigma  
3. Criminalisation |
| Punishment | 1. Self punishment  
2. External punishment |

Table 5.4: Sub-category: Deconstruction of the professional self - properties and dimensions.

**Nurse Interrupted**

The notion of *nurse interrupted* emerged in response to the realisation that all nurses had had their role as a nurse or their view of themselves as a nurse,
‘interrupted’ at some time. The dimensions of this property are: losing the role, losing the passion and loss of confidence.

The broken chain of these participants’ professional lives (through either interruption to their employment, either internally or externally imposed, a loss of passion for the job, and paralysing self doubt) provide description of the parts that constitute the concept of deconstruction of the professional self. To grieve the professional self has proved very difficult, complicated not only by feelings of shame and embarrassment, but at a more practical level of not having a job. The dimensions will now be discussed. It is relevant to reflect on the sub-category deconstruction of the personal self when considering the category, deconstruction of the professional self because they are interrelated.

**Losing the Role**

As a consequence of the alleged unprofessional conduct event enquiry the ability to practice as a nurse, and in some cases the actual role, had been ‘interrupted’ in a number of ways. This interruption is seen as losing the role. In some cases the nurses had their employment suspended or terminated, others had conditions imposed on their registration and subsequent practice which has completely removed any possibility of practising nursing.

A further example emerges from the motivations of the participant. Subsequent to a lack of confidence and realisation that they may be involved in another nursing error, or ‘set up’ some of the participants had chosen not to practice nursing. A further illustration represents those participants who are still in a state of reconstruction and are not yet well enough yet to practice nursing. Some nurses are able to nurse but for reasons of a less than complete
reconstruction, or because of their realisation that their chosen area of nursing is problematic, are practising in areas or at a level that is not ideal.

The first example tells of a participant who was suspended while the employer conducted an inquiry. The shock of this is described:

So the meeting finished. They told me that I was suspended at the end of it. There was no consultation or anything. I had to hand the keys in for the centre and I was told to collect my belongings because they were starting an investigation. I was feeling absolutely sick. I couldn’t believe it. I left the workplace in shock. [P13/PG04/L6-11]

A number of participants had their employment terminated once the allegations were made: ‘I was fired from my job’ [P16/PG02/L29], and ‘the DON turned to me and said ‘we have no alternative but to dismiss you’ [P15/PG06/L27-28].

The inability to practice nursing for some was grounded in the fact that the degree of physical and psychological deconstruction they experienced meant that they were not well enough to nurse. This was the case for Participant 1 and still is the case for Participant 5. Participant 1 was psychologically unwell for a number of months and subsequently experienced an indefinite period where she felt she could not nurse. The experience of Participant 5 is such that she is still unwell both physically and psychologically to the point where she says she is not fit to practice nursing.

Participant 8 has decided that the risk of being involved in a similar nursing error and having another allegation of unprofessional conduct laid at her feet is possible and therefore has decided that she will not practice nursing. This is a self imposed ‘nurse interrupted’. In telling her story she makes reference to being a nurse in the past tense:

One thing I said to the counsellor and she sort of beat me over the head for it was that I said that I was (emphasis added) a nurse, past tense and she
said you are (emphasis added) a nurse. My husband would like to see me go back to work. [P08/PG49L23-26]

The implication here is that this nurse, because of the recognised risk will not be able to reconstruct her professional self. In his letter to the NRA, her medical practitioner provided this contention: ‘she has been permanently damaged to the point that she will probably never work again’ [P08/PG32/L22-24].

Participant 10 has also chosen not to practice as a nurse since the outcome of the NRA inquiry, but for different reasons. He explains in response to being asked how the experience affected him personally and professionally:

Well I haven’t worked as a nurse since and there are a couple of reasons why. The first is that I made some enquiries about working at the inpatient unit, just making enquiries and putting out feelers and there was still the issue of the psychiatrist who would refuse to work with me ever again. That was told to me by the senior nursing staff at the unit. There were a number of other people who were still working there and after giving it some thought I realised that I didn’t and couldn’t respect them so working with them would have been difficult. [P10/PG46L16-22]

This participant has consciously chosen not to return to the area of nursing he was working in and, because of living in a small country town employment options in mental health were significantly limited. In making this decision he has actively removed himself from the vulnerability of being further targeted by his allegers.

Participant 2 described an interesting penalty given to her by the respective NRA which has meant that she will not be able to nurse again. Her inability to reconcile both why the NRA did this to her and the inability to practice as a nurse again has proven extremely distressing for her. She tells her story:

They finally made their decision, they said I had to do 12 months supervised practice, but the thing is that they made it one-to-one supervision. My employer once they found this out sacked me and of
course no one will give me one-to-one supervision. So I lost my career.

Participant 18 explains that she became de-registered by default:

I don’t think I would ever return to nursing or bother getting registration. I became de-registered by default, because I didn’t bother to renew my registration. But if I did I would have to prove that I was well enough.

Losing the Passion

This dimension emerged in the experience of a few participants. For these nurses, nursing was their life. Participant 7 provides this explanation:

I was really unhappy about it all because I’d worked a long time in nursing. To give a bit of background on my nursing career, because I started in the sixties and if you were married you weren’t allowed to finish your career. I married and left nursing but I still remained within the nursing area but as an assistant and an enrolled nurse. I then got my registration by doing my Bachelor of Nursing and I went on from there. So now my nursing career is crashing [down] around me.

The idea that nursing is the professional and also the personal, is introduced with the following comments by Participant 7. There is a sense here that being a nurse was, and is [still] her life, and as such the experience of being reported to the NRA for alleged unprofessional conduct interrupted her nursing plans and proved to impact on the perception of the personal self, she explains:

Well I find my life nursing has been my game. Someone said to me gee you’ve come along way. I said well I’ve done my nursing, I’ve gone as far as I can with my nursing, I’m now in clinical nursing, next will be managerial, but I also said that I will do my PhD which is academic. For me this is fulfilling my life, fulfilling what my profession is and then I can say I have done everything I can and that would be a lovely way to retire. Well then these things happened it halted. Everything came to a halt and came crashing down. All the stuff that I’d worked for and aimed for, came crashing down.

She goes on to say how she lost the passion:

My heart just wasn’t in it anymore. I was being eaten up inside because of all the terrible stuff that was going on. It is a terrible feeling working like that.
A further illustration of a loss of passion is provided by Participant 1 who no longer enjoyed being a nurse. She explains: ‘I was not enjoying my work. I had lost everything I liked about nursing. I had no love for the job anymore’ [P01/PG29/L1-3].

This theme is continued in the next description. Participant 17 explains: ‘I just lost the enthusiasm for what I was doing, the thought of going and flogging myself and end up in the same boat wasn’t worth it’ [P17/PG09/L25-27]. When I asked her to clarify why she felt like this, she explained: ‘it was more the lack of support from my colleagues than the actual clinical risk. I was very disenchanted with the fact that they were blaming me for the extra workload we had since the death of the patient’ [P17/PG09/L28-29].

**Loss of Confidence**

Self doubt emerged in response to allegation and being reported to the NRA. Doubting the self affected the nurse’s ability to practice, with resultant changes. Participants provide descriptions of the self doubt they experienced:

I started to question myself on a regular basis, in that I had been working there for six years and I suppose I was under the impression I was doing a reasonable job and that I was fairly competent. [P11/PG03/L17-19]

The concept of self doubt was made worse for the participant in the next segment in that he felt that someone was always looking over his shoulder. The self doubt he was experiencing because of having made the error was heightened. He explains:

They were treating me like a student. I wasn’t allowed to make my own decisions and there was always someone looking over my shoulder. That wasn’t giving me any confidence. There was a lack of confidence in my own self, and because I couldn’t do the job. [P12/PG04/L13-23]
He goes on to explain that he felt that the emotional responses to the allegation and the way his supervisors were managing the situation caused his self doubt. [P12/PG04/L23-24]

Participant 3 provides an illustration of self doubt which in turn prompted a change in her practice:

I became very self-doubting in my care, I was paranoid in doing anything wrong. I double checked absolutely everything. [P03/PG08/L13-15]

In contrast Participant 16 states that self doubt was not a huge issue for him. He attributes this in part, to being ‘quite strong mentally’. [P16/PG05/L23-26].

Self doubt had a bearing on the next participant’s decision to not continue working in the agency where the allegation had been made. She provides this explanation:

Eventually I left, I got to 9 ½ year, I didn’t feel that I could get to 10. I felt enough was enough. I realised that continuing just to get to 10 years service was not enough. I felt that if I continued working in that environment, I would just have had so much self doubt in my professional practice and manner. [P17/PG04/L21-27]

A loss of confidence was also experienced by Participant 19, but this loss of confidence was tempered by a wish to continue working as a nurse. She tells: ‘I’d lost my confidence, I really had lost my confidence but I still wanted to work’ [P19/PG06/L28-29].

The following describes the impact of being advised that a complaint had been sent to her employer by a patient. Although her employer communicated his full support of her she explains what happened after she read the letter of complaint:

I felt quite reassured by his support. However, I came out of there and I cried and cried for days and weeks afterwards. I just couldn’t get myself together at all. In the end I thought I can’t let this one letter absolutely destroy my life. I never went back and worked at that agency again. I just couldn’t I had totally lost my confidence in myself. [P20/PG05/L14-17]
**Spoiled Identity**

All of the study participants experienced or recognised the concept of ‘spoiled identity’. The dimensions of this property provides a focus on how these nurses saw themselves and were seen by others because of the allegation of unprofessional conduct and being reported to the NRA. Some participants experienced *shame*, others recognised the *stigma* associated with making an error and being reported for it. For some participants the public ‘outing’ of it contributed to their spoiled identify, and others felt that they were seen as a *criminal*. These three dimensions provide scope to the concept of spoiled identity.

**Shame**

The individual also experiences feelings of shame and embarrassment because of this stigma and being viewed as different from within the professional group. The experience of feeling shame is described by Participant 3.

> It is the shame I think, it is the shame that really hits you, and you feel that you have let everyone down, your family, your children. I mean to come home and tell my husband, it was so hard.  

Participant 8 as well. She recounts: ‘I felt ashamed, I felt humiliated and I felt embarrassed’. [P08/46/L23-25]

Participant 2 alludes to the sense of shame surrounding not being able to situation:

> Even now people ask me how is the nursing going? Even some of my friends keep asking me haven’t you got a job as a nurse yet? I say how can I? I don’t think they understand.  

Participant 15 provides a harrowing sense of the shame she experienced and difficulty telling her family:

> I was too ashamed. I felt so ashamed of this whole story. I found myself
blubbing and telling my family what happened but I didn’t think that they would believe me.

Participant 16 provides further illustration of the concept of spoiled identity with the following narrative. In reading over his experience he demonstrated minimal psychological deconstruction. One reason for this is that as a mental health nurse he draws on techniques from his education to put into perspective what was occurring and the behaviours of others. Nonetheless there was some evidence of spoiled identity, he explains:

The whole thing didn’t really make me doubt myself but there was definitely a feeling of shame, you know that ‘name and shame’ thing. I had to see my name, along with many others, between two ‘creeps’ (NRA publication re inquiries held. These two other nurses were found guilty of sexually assaulting patients).

The dimension of shame is continued with the next account. I asked the participant to elaborate on why she felt so low that she wanted to take her life, she responded:

It was to do with the incredible shame that I felt. How after nearly 40 years in nursing, in a job that I loved and a love of a lot of people. It created shame that I’d not only done what they said, but how my career and my life which I was so proud of had gone down the gurgler. It was also the shame that I put on my family.

The dimension of shame as something a woman who has been raped might experience is articulated by the next participant. This participant had made a correlation between what she had experienced by named in the letter of complaint and having to go to the NRA and what a woman who had been raped would feel. I asked this participant to tell me why she was feeling shame. She responds:

I don’t know, I honestly don’t know. I do know that it’s the same shame that a woman feels like when she’s been raped and I know why they don’t tell anybody about it. Because they haven’t done anything wrong, but there is shame and I don’t know why that is. I can’t explain that but I have felt so ashamed, to have to tell my Director of Nursing.
Stigma

The notion of spoiled identity is further described with the following recounting of being ‘exposed’ in the public forum. After receiving her registration status back from the NRA, the participant believes that the complainants must have not been happy about it and proceeded to go to the media with their allegations of unprofessional conduct and sub-standard care at the nursing hostel where she was the director of nursing. She explains:

They must have been pretty upset because then it went to the media and then that’s when it all started. I was taking my son to school and I drove past a deli and there was a billboard out the front saying ‘Investigation into Nursing Home’ and I knew it was about me. I had to drive about 15 km to work and I was just a wreck. I rushed into my office with the paper. I was on the front cover of the paper, I was on page 2, and I was on page 3. I was in the paper for probably 5 times over the next 6 days. I was on the radio, I was on every station, it came on the John Laws show, and it was in a number of newspapers. [P05/PG31/L]

It was evident from the data that spoiled identity was constructed simply by the nurse being reported to a NRA:

I think the fact you have been reported to the nurses board regardless of whether you deserve it or not is always going to look bad. It doesn’t matter what you say or what you do, 10 years down the line they are going to say ‘oh she was reported to the nurses board’. [P06/PG20/L20-26]

Participant 12 also experienced similar thoughts: ‘it is every nurse’s nightmare’. The stigma of being reported to the NRA goes beyond this moment however, in that the stigma never goes away.

This theme was further evident in what Participant 17 had to say about the outcome of the inquiry she was involved in. Noting that the NRA investigation could not make a determination of unprofessional conduct. She goes on:

Even though there would be nothing written on my file regarding unprofessional conduct, they told me that the file would remain open. I thought that this was the final insult and I took great offence at that because I felt that once it’s finished it should be closed. [P17/PG04/L3-6]
When asked if she felt that there had been a stigma attached to her, Participant 7 replied: ‘Yes that’s the case, yes I’ve been well and truly labelled’ [P07/PG25/L12-13].

A further example of stigma and spoiled identity is provided in the next passage:

There was a stigma in the fact that I was isolated. Management had a practice of isolating those people who didn’t confirm. They suspended me from clinical duties and put me in an office which was the size of a broom closet to do non-clinical duties. This sent the message to the other staff. [P14/PG05/L1-8]

An example of ‘self’ realised stigma is offered in the next passage. Participant 15 tells how she sought meaning in the experience and came to perceive herself as a ‘bad nurse’:

The assault was so overwhelming, so consistent, and so relentless. There has to be some reason why all this was happening and I really did feel it was my fault and that I was a poor nurse at that time. [P15/PG09/L11-13]

When asked to elaborate on the use of the word ‘despised’ the participant responded:

I felt really ostracised. I felt like an absolute cockroach amongst nurses. I felt as I was a totally different nurse to everyone else and I couldn’t understand why. I felt that I was singled out and I felt as if the gates of hell had been opened up on me. They made me feel like hell. I felt like I was as low as a cockroach in their eyes. [P15/PG22/L6-16]

Participant 1 tells why it was difficult going to work after the incident:

It was in the newspaper, it was in the news. I mean it was shocking and you would think every time you got to work that people are looking at you [P01/PG43/L5-8]

This narrative provides a clear account of the stigmatisation that was experienced by this participant in having to go to work and knowing that everyone knew about it.
Criminalisation

Further examples of the notion of spoiled identity emerged with the nurse being seen and identified as a criminal by the public and by themselves, even though no criminal charges were laid. It must be said from the outset that no nurse interviewed was accused of any criminal activity.

The perceptions of this public and self view of criminality will now be explored. The story told by Participant 1 was already known to me in that I had observed the case in the media like many people, and as a nurse, it held particular interest to me. This nurse talks about having her photograph taken and used in the print and electronic media for a considerable length of time. This participant provides a palpable example of being portrayed as a criminal because of how she was treated during the coronial inquest. Key words informing this concept of ‘criminal’ include, ‘trial’ and ‘cross-examined’.

A couple of times in that inquest the Coroner would have to say [to the lawyers], she is not on trial here. The lawyer for the family just ripped us to shred. I was cross examined for five hours. Afterwards I was just a wreck. [P01/PG15/L.10-18]

This participant goes onto say that she felt like a criminal because she was treated like one. [P01/PG19/L.17-18]

Participant 5 provides a poignant example of her self image of being a criminal and how the public must have viewed her and will continue to view her:

You know I did feel like a criminal but I didn’t do anything wrong. It was like the Lindy Chamberlain\textsuperscript{21} situation, you know walking up and down these steps of the court. [P05/51/L.7-10]

\textsuperscript{21} A case in Australia where it was alleged that this person had killed her baby daughter. In part this case was a trial by media. See ‘Evil Angels’ by John Bryson, Summit Books, 1987.
Also:

I’ve been made to look like a criminal with allegations like defrauding and abuse, all these horrible words that will never leave people’s minds now and its imprinted in paper for life. [P05/PG51/L23-25]

The use of phrases, such as, ‘not on trial’ and ‘cross examined’ create the impression that this nurse felt like she was on trial for a crime. Not withstanding the imagery created by the narrative this participant explains: ‘you get treated like a criminal, an absolute criminal’. It is worth mentioning here that the purpose of a coronal inquiry is not adversarial but rather one of inquiry. The purpose is to arrive at a reason for the death of a person. The case might be made during the inquest to recommend to police that a person be charged with a crime but this is a secondary event.

The use of legal jargon to describe their experience provides depth to the emerging notion that nurses reported to the NRA (and who are investigated) viewed themselves as criminals. Participant 3 describes the lawyer for the NRA as the ‘prosecution’. Other phrases identified in the narratives which promote the impression and sense of criminality include the following by Participant 6: ‘clearly I was guilty before I was innocent’. There is a sense that the nurse, in this instance, is on trial and for allegations for which they will be found guilty. In fact the appropriate outcome of formal allegations is for the allegation to be upheld or not upheld. She goes on to say:

The nurses’ board told me that I had to have a drug screening profile done. The agency refused to see me (to do the drug screen) and said that it would be a waste of time and I agreed with them because I didn’t have a drug issue to discuss. When I went to the nurses board I told them that the drug rehabilitation place said that it was a waste of time and they said to me that I should have gone along anyway and I said to them that they had refused to see me. They had great difficulty in accepting that. If I ever felt like a criminal it was then because I had always said that I didn’t have a drug problem and I had all these people telling me I did and I knew damn well that I didn’t.” [P06/PG17/L1-25]
There was an overwhelming sense of frustration in this passage, in that the accusations that she was dependent on drugs were false and malicious. The fact that the respective NRA did not believe her as well, further underpinned a strong sense of her being branded a criminal. Self perception of criminality is described:

I did feel like a criminal. It was mostly because of how serious they made it out to be. They called me at home and asked me to come to the hospital regarding the error. I realised that they were using a speaker phone but they hadn’t told me. I thought what is going on here. They told me that I was facing very serious allegations and I thought goodness what have I done? [P07/PG17/L1-6]

In response to the trauma she was experiencing, a friend of one of the participants wrote to the NRA requesting that the matter be expedited. In her letter she talks about the criminalisation of nurses who make simple errors:

I am writing in response to receiving a phone call from my friend who is in a distressed state. She never once has denied the error. What is of concern is the way she is being treated by the board and the hospital. She is being treated as if she is a criminal and placed in the same category of those who wilfully harm, injure or break the law in the scope of nursing practice. She did not intentionally set out to harm or to even commit the error. While I accept that there is a need for the board to protect the wider community against errant nurses, I do not accept the criminalisation of those who have made a simple error. [P08/PG13/L17-35]

The participant referred to in the above passage tells how the experience made her feel:

We were put into the same boat as nurses who had stolen or had verbally or sexually abused their patients. We were definitely lumbered with them, so yes we felt like criminals because we were labelled as one. [P08/PG50/L7-11]

I asked Participant 20 if she felt like a criminal. She replies:

Yes, absolutely, yes. I think that is where the guilt comes in. I now know that rape victims can feel like the criminal and I don’t know why I keep comparing this with rape but the only thing that I can think of where it’s not that girl’s fault but she does feel like a criminal and she feels guilty, and I felt guilty. [P20/PG14/L31-34]

This is reflective of the notion of ‘blaming the victim’ which is not
uncommon when a person states that they have been raped. This participant went to say that the experience made her feel that she had been in jail. [P20/PG15/L12-13]

Punishment

A further property of the sub-category, deconstruction of the professional self is punishment. Two dimensions of this property were identified, self-punishment and external punishment. The dimension of self-punishment emerged in the narratives of participants who acknowledged that they had done something wrong, and as such punished themselves in some way. The second dimension was identified with the individual acknowledging that they had been punished by an external authority or by the employer.

Self-Punishment

The concept of self-punishment is explained by Participant 3:

When I realised that I hadn’t killed the patient, that was a huge thing and when I pulled myself together and looked at it more objectively and that allowed me to then stop punishing myself. I was really down on myself, I hated that I had made a mistake and let my standards slip. I am normally of those high achievers with high standards. I am not a specialist but I try to be, so self punishment up until that point was incredible. [P03/PG17/L30-36/PG18/L1-4]

In Participant 8 experience it was her general practitioner who wrote a letter to the respective NRA requesting that the matter be expedited because of the harm the waiting was having on his patient. He said in the letter: ‘She has punished herself more than the Nurses Board ever could’.

External Punishment

Examples of the dimension of external punishment revealed a variety of ways in which the participants were punished. The following is an example of punishment from colleagues who experienced increased workload in response to
recommendations from a coroner’s inquiry: ‘There was all this extra workload and the other nurses blamed me for it’ [P17/PG09/L29-30].

External punishment was also expressed with suspending and terminating the participant’s employment, and with the NRA imposing financial penalties and court costs. Other nurses were punished by having to undertake educational courses to address knowledge deficits. Punishment was also conferred with the notion of ‘name, blame and shame’ which was central to the experiences of some participants. This shaming extended in some cases to the public domain.

Punishment also was expressed by the ostracism of participants. This was partly due to the stigma attached with being reported to a NRA and for other reasons. Participant 1 explains: ‘The staff were told not to approach us [those involved in the error] and told not to talk to us or ask questions’. [P01/PG44/L11-13]

Punishment through ostracism was experienced by one participant when she gave birth to her daughter at the hospital where the error occurred. This participant explained that for the most part she and her baby were left to their own devices. The baby became ill and the participant became distressed and traumatised because of what she saw as poor care related to the staff ignoring her. She was also not able to enjoy her baby. [P08/PG38/L1-35/PG39/L1-35]

**RELEARNING THE WORLD: THE EXPERIENCE OF RECONSTRUCTION**

*Relearning the world* emerged as a concept within the overriding core category of a transformation of the personal and professional self. The experience of reconstruction viewed as ‘relearning the world’ is comprised of a number of sub-categories. They are: *preserving the self: minimising the deconstruction; reconstructing the personal self, and reconstructing the professional self and*
living within the new world. These sub-categories, their properties and dimensions are illustrated in the next part of this chapter and are provided in Table 5.5.

Relearning the world has been described in the main as a construct of grieving processes (Attig, 1996). While there are aspects of grief associated with the social phenomenon and related process, namely a loss of the assumptive world, the decision to embrace the label ‘relearning the world’ provides imagery to the collective processes the individual goes through and engages in, to transform. It will emerge that this relearning and as such the experience of reconstructing can have an active or passive focus. All participants relearned or are still in the process of relearning the world. What processes construct this concept are now discussed.

**Preserving the Self**

All participants demonstrated an attempt to minimise the deconstruction that they were facing and experiencing in response to the allegation of unprofessional conduct and as such can be seen as an example of *preserving the self*. This sub-category was identified with the emergence of three properties, *assuming a stance*, *taking a stance* and the *search for meaning*. These properties and the associated dimensions are listed in Table 5.6.
<table>
<thead>
<tr>
<th>Preserving the Self</th>
<th>Reconstructing the Personal Self</th>
<th>Reconstructing the Professional Self</th>
<th>Living Within the New World</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assuming a Stance</td>
<td>Taking a Stance</td>
<td>Reconstructing the Social Fabric</td>
<td>Getting Back on the Horse</td>
</tr>
<tr>
<td>Questioning the allegation</td>
<td>Preparedness</td>
<td>Getting better</td>
<td>The need to risk</td>
</tr>
<tr>
<td>Truth telling</td>
<td>Self defence</td>
<td>Framing the self</td>
<td>Identifying vulnerability</td>
</tr>
<tr>
<td>Anticipatory responses</td>
<td>External defenders</td>
<td>Making sense</td>
<td>Minimising vulnerability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reinventing the self</td>
<td>Questioning and affirming</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Picking up the pieces</td>
<td>Over the top</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accepting the risk</td>
<td>Psychologically stuck</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Able to risk</td>
<td>Turning points</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Demonstrating accountability</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Getting it right</td>
<td></td>
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<td>The need for vindication</td>
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Table 5.5: Relearning the world: Sub-categories, properties and dimensions.
**Category 3: Relearning the World: The Experience of Reconstruction**

**Sub-Category: Preserving the Self**

<table>
<thead>
<tr>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assuming a Stance</td>
<td>1. Questioning the allegation</td>
</tr>
<tr>
<td></td>
<td>2. Truth telling</td>
</tr>
<tr>
<td></td>
<td>3. Anticipatory responses</td>
</tr>
<tr>
<td>Taking a Stance</td>
<td>1. Preparedness</td>
</tr>
<tr>
<td></td>
<td>2. Self defence</td>
</tr>
<tr>
<td></td>
<td>3. External defenders</td>
</tr>
<tr>
<td>The Search for Meaning</td>
<td>1. Framing the situation</td>
</tr>
<tr>
<td></td>
<td>2. Making sense</td>
</tr>
<tr>
<td></td>
<td>3. Meaning found</td>
</tr>
</tbody>
</table>

Table 5.6: Sub-category: Preserving the self - properties and dimensions

In the property *assuming a stance*, participants *questioned the allegation*, and where there was culpability, demonstrated *truth telling*. Some participants were able to assume a stance, more effectively with the *anticipating of responses*. They then took a stance using *preparedness*, and then defending the allegation, this was illustrated in the dimensions of *self defence* and *external defenders*. The third property, *the search for meaning* is appropriately situated within the concept of *preserving the self* as it has been contended that those persons who can find meaning in, or able to make sense of a traumatic event, tend to reconstruct the self in a more positive way. Therefore searching for meaning, and either meaning found of the event, or recognising that there was no meaning to the event and being accepting of this, proved a formative process for preserving the self.

*Assuming a Stance*

All participants *assumed a stance* in relation to the allegations.

*Questioning the allegation* emerged as a logical approach to having the allegation made, particularly for some participants where the allegation ‘came out of the
blue’. Where the participants readily admitted culpability ‘truth telling’ was immediate.

**Questioning the Allegation**

All participants questioned the allegations that they were confronted with. This questioning took both a formal and informal structure. In response to a need to make sense of the allegations the Participant 3 immediately questioned the allegation, in particular the way in which she was told about it:

> I made an appointment to see the Director of Nursing the next day and said to her ‘why did you do it like this, we were told that nothing more was to be done about it’. She said how did you think that this wouldn’t have been followed through? You know it was a narcotic error. I said to her it was the way in which it was handled, how come everyone else knew about this letter [of complaint] and knew what was going to happen? You could have taken us in separately, warned us about it, and then made your statement. [P03/PG07/L18-36]

Some participants did not feel a need to question the allegation because they accepted they had ‘done wrong’. What they did fail to question the way in which the error had been interpreted as unprofessional conduct. The notion of error versus unprofessional conduct will be explored in more detail in chapter 7 of this thesis.

**Truth Telling**

*Truth telling* emerged as a dimension of the property assuming a stance as a response to the allegation. A number of participants emphasised that they had told the truth and in turn admitted to the allegation.

Underpinning the need to tell the truth was a personal belief this would mean that ‘all would be well’. Participant 3 explains: ‘there is nothing I am going to hide so I decided to represent myself’ [P03/PG10/L6-10]. While she demonstrated a reasonable defence at the argument and was prepared for the line of inquiry the following comment underscores the need to have legal counsel present at any
discussions and inquiries by either the employer or the NRA. Participant 3 explains:

Although I believed that by telling the truth would mean that justice would prevail, I suppose in retrospect I was a bit naïve and a friend of mine was reported [to a NRA] after me. I said to her, whatever you do don’t go on your own.

Participant 1 provides an example of truth telling and in turn demonstrates her accountability in the matter. This participant had a strong sense of the need to tell the truth and at no point shied away from this self-perceived responsibility.

I knew that (although) I wasn’t in the room when they gave the drug or I did not hear the doctor give the order I had actually signed and checked it out of the book and obviously that was accountability, I knew the consequences of my actions.

Although there may be a degree of naivety within the following statement, it equally demonstrates a level of accountability through truth telling. Participant 3 provides further insight into her decision not to have legal representation:

I didn’t want to join the ANF, it didn’t feel right, I still believed in the truth, I just wanted to tell the truth and I didn’t know where all the legal jargon was going to get me, but if you tell the truth then I honestly believe in justice (prevailing). I still believe even though I have taken a huge battering. I would do it again. I don’t know if I would do it again without legal representation but I would never hold back the truth or lie, I didn’t hide anything even if that had of gotten me into further trouble.’

I propose that it is not the dilemma of telling the truth but rather the reality of the situation this nurse found herself in that caused her to question the benefit of telling the truth. While there could be no denying that the wrong dose or the drug was administered, the motives in reporting her and the system deficits of the NRA made a simple nursing error, with no significant impact on the patient, almost into the Spanish Inquisition.

Another example of truth telling follows. Participant 13 explains: ‘I owned up to it straight away, I immediately said I had done that’
She goes on with a further illustration of ‘truth telling’. Her lawyer advised her to just be honest and write down what had happened, which she did. [P13/PG04/L18]

Truth telling is illustrated in the next quotation:

I think I made a very big error of judgement, an enormous error. I always used to teach the students that you accept the consequences of your actions, so I am wearing it because that is the way I live. I am not going to blame anybody else, there may have been extenuating circumstances but I was responsible. [P18/PG07/L10-20]

**Anticipating Responses**

Anticipating the NRA or associated legal processes was identified as being able to anticipate aspects of the investigation and inquiry meant that the individual was ultimately better prepared and better positioned, psychologically for what was to transpire.

Attending the NRA inquiry was seen as an opportunity to have their day in court. The next quotation provides a sense of full anticipation ‘I was actually looking forward to the nurses board inquiry so I could actually establish what happened’ [P11/PG14/L32-33]. He explains further: ‘ultimately it clarified that I had done nothing wrong. So I didn’t feel threatened by the nurses board’ [P11/PG15/L1-11].

Anticipating the inquiry by the NRA was also demonstrated in the words of Participant 13. She felt that because she had not had a voice in the processes implemented by her employer regarding the allegations and subsequent termination of her employment and conciliation processes, going to the nurses board would provide a forum for having her case heard. She says ‘now I would have a chance to say things’. [P13/PG09/L23-24]
Taking a Stance

The second property of this sub-category provides description of the dimensions of response to an allegation. Taking a stance revealed dimensions of self defence and professional defence in response to assuming a stance. Not all participants responded in a positive way and at times were not able to challenge, adequately at least, the allegations. Some were not in a position to seek out and obtain professional help. Some participants who did seek professional assistance found in some instances that it was lacking. Being able to respond to an allegation in a positive way proved both empowering and helpful to the overall transformative process. This property is relevant to the initial response and responding to the allegation during the NRA inquiry.

Preparedness

Analysis of the data revealed that the participants demonstrated varying degrees of preparedness for the investigative processes and the inquiry conducted by either the NRA or the Coroner. Those nurses who prepared for the inquiry revealed a more positive experience as opposed to those nurses who weren’t. Some of the ill preparedness was linked to both a lack of knowledge regarding processes, disempowerment and stress reactions.

A number of participants revealed purposeful positive strategies to their approach with respect to both the investigation and inquiry. While some received prompting from their legal counsel or support persons a common sense approach emerged in order to have a degree of control of the matters and equally to be seen in the best light.
Some participant’s ability to be prepared was stymied by the processes of regulatory and legal bodies (eg Coroners Court), which as one participant asserted that nurses were treated different to medical practitioners:

When the doctors go into the coroner’s court they are given set times. They were told that they would be on the stand at a certain time, but do you think that happened with the nurses? No. We had to go in there and sit there all day. These doctors came in, were on the stand and then they came out. It was quite different treatment for them compared to us.

Of those who were ‘better prepared’, they received more union support and legal representation:

I did contact the union and I eventually got my own lawyer which I am very glad that I did because no-one was looking after my interests.

The process of ‘being prepared’ included rehearsing responses before the hearing and ‘dressing confidently’:

I was very pleased that I had practiced my response to the allegations before I went to the nurses board inquiry. It really did prepare me. I think if I hadn’t of practiced it and prepared I would have really been done for.

I felt sufficiently confident to wear a nice dress so that I looked good and therefore I felt good. I had adequately prepared myself well before these Board members. I really took it at as an opportunity to do the best I could do.

This theme of being prepared for NRA processes is continued in the experience of Participant 8. She explains how she prepared for the initial interview:

I wrote out the statement that I planned to read to the board at home. I wrote it up at home because I didn’t want to have to think on my feet and thought that because I would probably get emotional that having the words already there would help.

The concept of trying to be ‘appropriately’ dressed backfires for the next participant. She explains:
It happened to be ‘Jeans for Genes Day’. I had worn my best suit, trying to give a very professional look. I think I dressed like that to give myself control and you know dressed as best as possible everyone else was in jeans, including my lawyer. It just sticks in my mind.

Participant 10 explains that he had attended a number of legal forums in his role as a community mental health practitioner, which provided him a degree of preparedness for understanding the allegations, the way the NRA inquiry would be conducted and the use of mitigating circumstances. Participant 10 explains:

No the mitigating circumstances had no bearing on their decision. I didn’t really have a problem with that because I’ve got a good grasp of the law. The law says that the doctor should have prescribed the drug and I gave it before I got an order so I knew that I would be found guilty. I have a pretty good sense of how these matters work. I have been into court as a professional witness many times.

Participant 10 ability to clearly think things through by ‘framing a view’, reveals a level of preparedness not commonly scene in the experiences of the other participants. He explains:

I decided you can choose how you respond to this. I really consciously went through this. I almost thought it out aloud. You can choose how you respond I told myself. I thought I can let it drag me down and ruin my career. So right from the beginning I though yep just deal with it at a very practical level.

Participant 13 also sought to prepare for the NRA inquiry by examining Some of the respective NRA annual reports: ‘I had tried to identify who they (the Board members) might be from the annual reports of the nurses board’. Participant 13 was also seeing a counsellor at the time, who provided her with strategies to help her cope when attending the inquiry conducted by the NRA. She explains:

The counsellor told me to keep my feet grounded on the floor, and gave me some breathing exercises to do. I had some flash cards with positive things written on them and other pieces of advice to help me keep it together during the hearing.

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22 A fundraising day where money is donated to genetic research in return for the privilege of wearing jeans to work.
Another example of processes to prepare for the NRA inquiry includes accessing relevant NRA documents. Participant 17 provides this example:

I asked my manager to get me a copy of the nurses board competencies. I did them by myself, going through them and signing them off. So my lawyer presented them to the inquiry panel when they made the allegation that I was incompetent. He said to them 'if she is incompetent how come she can demonstrate the competencies as stipulated by the board?'

Self Defence

The dimension self defence emerged after identifying a range of examples that demonstrated the participant taking an active response to the allegation and in turn served to challenge the allegation and afforded a degree of protection. I was struck by the particularly positive attitude of Participant 10. This nurse was at the time a very experienced community mental health nurse who had worked in largely independent contexts for a significant length of time in his nursing career. There was also an acknowledgement by him that, yes, his practice did not meet the standards, but equally saw that no harm came to his patient and his practice was in keeping with the emergent needs of his patient. I suggest that the ability to position ones practice against a backdrop of ‘more good than harm’ provides a better ability to process the allegation of unprofessional conduct and the subsequent aftermath. He explains how he was feeling and his thought processes after finding out he had been reported to the NRA:

The rest of the day was bad, I felt really stressed about it I guess, but not really after that. I decided you can choose how you respond to this. I really went consciously through this, I really thought this through, and almost aloud you know. You choose how you respond to this, you can get dragged down by this because this can ruin, if you let it, it can ruin your relationship, it can ruin everything, you know it can really stuff things around, so you choose how you respond to it. So right from the beginning I thought, yep, just deal with it at a very practical level and you know I had no problems in recognising that this part hurt and I was frightened by that, I had no problems with any of that, but I just decided to leave it at a very objective level. So I don’t think I got stressed out anywhere near as much
as what could have occurred, but it was a very conscious decision.

This participant’s ability to be objective, allowed him to be almost ‘matter of fact’ about the situation. In assuming a stance, he attempted to remove his ‘emotional self’ from the situation and just deal with the practicalities. I would also suggest that being able to assume such a positive stance also had foundation in the fact that he did not believe that he had harmed the patient and although he recognised a breach in policy and admitted to it, didn’t believe that he really did anything wrong (i.e. he did not cause any harm).

This theme is continued in the next quotation and demonstrates the need to ensure that if meeting with any person who has any legal jurisdiction then it should be done with a person who can represent legal and professional interests. Participant 17 reveals that she was able to identify the risk in going to the NRA without a lawyer and demonstrated ‘self defence’ with her decision making:

I returned this lady’s call. She said that she wanted me to come in and have a chat. I initially said yes thinking it wasn’t any big deal. She said ‘I do have to advise you that we may have to tape the interview’. So then the warning bells started ringing. I asked her why would they be tape recording it? This made me confused because they said it was just going to be an informal chat. They then said that they might need to get a statement from me. I declined to go meet with them at this time because they were not happy that I planned to bring my lawyer along.

A further example of responding to an allegation is presented in the next quotation. In conjunction with the allegation of unprofessional conduct it was alleged that this nurse was cognitively impaired. She responds:

I saw a psychologist and a neurologist. I had a CT scan done and a range of blood tests for any possible organic cause to the alleged cognitive impairment. They all came back normal.
A further example of self defence is provided by Participant 3. She explains why she pursued educational opportunities after the matter was reported to the NRA:

I sat with a few nursing refresher students when they did their pharmacology courses. I wanted to ensure that my knowledge was updated. I used this as a supporting point at the hearing. I said to them this is what I have done. [P03/PG12/L28-35]

Another example of self defence is provided by Participant 7 who had the sense of mind not to complete an incident form for a matter she could not remember:

She tells:

I said to her that I could not remember what happened six weeks ago and that I wasn’t going to fill in an incident form. I said that I am not taking ownership of anything until I have all the details. [P07/PG05/L27-32]

Participant 16 afforded himself a degree of defence by providing a statement in support of his fitness to be a nurse. As a consequence he believes that the penalty was lenient. He explains:

I told them that I believed that I was a fit and proper person to be a nurse that is why I went into nursing in the first place. If I felt that I had of being guilty of the charges then I would have resigned my position, nor would I have shown up here to defend myself. I was here because I liked nursing and wanted to stay a nurse. [P16/PG04/L26-29]

A further aspect of self defence emerged for Participant 1 who explained that as part of the strategy by the employer to protect their interests they went looking for anything which might support the concept of the participant as a ‘bad nurse’. She picks up the story:

They started pulling out things to see whether I’d done this or that. I had a very clean record and I didn’t have any issues. [P01/PG11/L9-12]
External Defenders

The dimension of external defenders revealed the experience of obtaining professional support through legal and union representation or having someone else represent them and provide assistance to defend the allegations. The experience of the participants who obtained this defence was varied. Some participants who had representation were not happy with it and others could not praise them enough. The following discussion will demonstrate the dimensions of professional support.

In response to being advised by her supervisor to bring along union representation to a planned meeting to discuss allegations of unprofessional conduct this is what one participant did: ‘I contacted the union the next day. I went in and met with them to talk about the matter’ [P13/PG02/L9-11].

Some comments in support of union representation follow:

The union representation was absolutely marvellous. I never expected in my professional career to end up at the nurses board. I can tell you it was absolutely invaluable having the ANF on my side. They knew the procedures at the nurses board and they often know who is sitting on the inquiry. They can prompt the Board members to adhere to procedures. [P06/PG15/L5-15]

Another participant was also happy with the representation provided by the union: ‘I contacted the union again and I had a fantastic solicitor. She was really on my side and really knew what she was talking about’ [P13/PG08/L30-33].

In contrast the next participant was not happy with the support provided by the union. He explains:

Unfortunately the initial union representation I had was disappointing. The guy thought he was there to hold my hand rather than advocating for me. I would have hoped for a more proactive approach from the union. [P11/PG02/L39-42]

Some participants had legal representation. An example of a positive
experience of this follows:

I had legal representation through the union. I was very happy with the lawyer. We had a couple of meetings before the inquiry which were very helpful. [P08/PG28/L12-15]

In terms of support from the employing agency it is evident from the narratives that the majority of participants received little support. This is affirmed in the words of Participant 7: ‘there wasn’t any professional support from the hospital, none whatsoever. They were only looking after themselves’ [P07/PG31/L13-16].

The next quotation demonstrates a defence instigated by a colleague. Participant 15 (who has described her powerless and impotence in relation to having the allegations made and her employment terminated) found that a colleague leapt to her cause:

There was a nurse who sort of picked up my case. After I talked to him and told him what had been happening to me he took it upon himself to stand up and be counted and act. He went and did things that I didn’t even think of doing. He contacted the union and advised them what was going on at the hospital. He organised a meeting at the hospital to address what had happening to me. He really spoke on my behalf and challenged what people were saying about me. [P15/PG07/L21-34]

**The Search for Meaning**

The search for meaning is a well described concept in the literature. Frankl (1984) emphasises the importance of having meaning or a reason to continue the struggle to live in the face of apparent hopelessness, utter destruction or helplessness. Finding and having meaning in ones life provides purpose and the energy needed to ‘rethread the self’. This property *searching for meaning*, has three dimensions which give depth and scope to the construct they are: *framing the situation, making sense* and *meaning found.*
Framing the Situation

As part of the search for meaning there emerged demonstration from some participants, of the need to frame the situation. This dimension provided impetus to ‘making sense’ of the situation and what was happening to them, and for some arriving at a point where sense has been made of the situation. The following provides an example of ‘framing the situation’. Participant 16 says in relation to the inquiry and potential outcome: ‘well they are not going to take me outside and shoot me like a dog, are they?’ \[P16/PG05/L2-3\]. By comparing the outcome of the inquiry to potential ‘punishments’ in the wider context, he was able to put what could happen to him into a ‘realistic frame’ and consequently realise that things weren’t that bad.

A further illustration of framing the situation as a dimension of ‘searching for meaning’ is offered in the following quotation. This participant talks about allegations that were made against her and how by comparing it to the worst possible allegation she was able to see the meaning in the experience. She explains: ‘I mean if I had of killed six people or something, you know by injecting them’ \[P19/PG09/L25-27\].

Another example of ‘framing the situation’ is provided here:

What has kept me going? My children, my family, close family members, all believing in me still and reviving me even though at times I actively disputed what they were telling me. They reminded me about what a good person I was and all the good things I’d done, how helpful I had been to lots of my clients. Reading my resume kept me going, realising that I was OK, that I was a decent person and a good person despite the horrible things that I’d been through. \[P13/PG17/L1-8\]

Making Sense

Making sense of what had happened to them provided opportunity to question why the allegations had been made, and why they had been targeted.
Some participants were able to make some sense of their predicament whereas others were still struggling with the experience.

An aspect of the dimension ‘making sense’ was identified with specific reference to justice by the study participants and analysis of the data which provided further scope in regard to the difficulty the participants experienced in understanding what the whole process of being reported to the NRA was going to achieve and equally the imbalance between the allegation, the process and outcome.

Questioning the sense of justice or more specifically the perceived lack of justice within the processes the participant was confronted with is provided in the next passage. This participant is making sense of what happened to her and the process that she believed was meant to ‘ensure’ justice:

I felt that I was being unfairly railroaded. There was no fairness in the whole thing. I have learned that justice is one of the greatest things you can have, and when you don’t have it, when there is no sense of justice then you’ve lost one of the greatest things there is. I really felt a tremendous loss at the lack of justice that I had experienced. [P15/PG12/L5-8]

Not being able to make sense of what happened to her is revealed in the frustration she felt in the following quotation. ‘Justice’ comes too late for this participant: ‘my life ceases to happen and they finally (emphasis added) see that the hospital was in the wrong all the time’ [P15/PG12/L9-10].

Some participants expressed a strong feeling that the investigation process did not contain any real presumption of innocence. These participants said that they felt as though they had already been found guilty before this investigation process had even started. These feelings further contributed to the challenge of making sense. Participant 17 contends:
I saw by the way they acted towards me and the way that the nurses board treat nurses like that were guilty. Why was the innocent until proven guilty [rule] reversed?  

Questioning whether she should have pleaded guilty illustrates another aspect of the dimension making sense. Participant 19 ponders aloud:

If I had of pleaded guilty right at the beginning none of this would have happened, so I don’t know. But I never felt guilty; all along I really never felt guilty so that is why I didn’t plead guilty I suppose. But maybe it would have helped me. Hindsight is a wonderful thing.

A number of participants tried to make sense of their view of themselves as a nurse and the allegation which countered this view. The notion of ‘good nurse bad nurse’ is reintroduced. An example follows:

My loss of self esteem, my loss of self respect that anybody would see me in that sort of light. I’ve always been able to hold my head up and know that I am good nurse. I don’t have to say it to anybody, I know I am. I recognise straight away patient’s needs and I respond to them, and I probably do something that perhaps nobody else had ever thought of and I love those moments. I have taken great pride in my nursing.

Making sense of the situation by questioning if they were really involved in this matters is provided in the following account. Participant 13 tells of her sense of herself in the situation when she talks about it: ‘when I’m relating it, I still have a sense that I can’t believe this is me I am talking about’.

Another illustration of making sense is revealed in the words of Participant 15 who questioned the motives of her colleagues for the workplace mobbing and harassment she experienced and the subsequent allegations of unprofessional conduct. In response to me asking her if she felt that there was an element of Tall Poppy Syndrome in why they targeted her, she responds:

I guess in an effort to try and rationalise why they treated me so badly I was searching around to try and come up with a reason why they were so vicious. I don’t know, it could have been part of it. I think they were told that I was going in there to sort them out and they just retaliated. I think they felt humiliated because they hadn’t been able to rid of me despite trying. They felt that they were really good nurses and here they have this
ugly old woman that they couldn’t get rid off. I just kept turning up like a bad penny. That’s the only reason I can come up with. I tried to be close to them, I tried to be nice, I tried to forgive and forget. [P15/PG23/L5-16]

**Meaning Found**

The narratives in this research study provide various examples of the search for and application of meaning to the experience of deconstruction and reconstruction, and as such, represent the dimension, meaning found. Finding meaning in the situation they found themselves in and went through, was realised by some participants. Others had not yet found meaning, while others realised that there was no meaning to be found.

This participant arrives at a point of meaning found by asking what positive thing could come from the experience. She explains:

I have wondered how I could turn this experience into something more positive. How could I make it better for another nurse who might be in my position? [P13/PG19/L2-3]

A further example of meaning found is provided: I have learnt that I trust people too much, and maybe I am too honest. [P03/PG23/L25-27]

Participant 1 offers the following and in doing so demonstrates finding meaning in the experience:

Even though it was a terrible time in my life, you have to get on with your life. I wouldn’t wish it upon anyone. But I think you have to learn from it and move on, but you don’t want it to happen to anyone because it was just bloody awful, terrible, just terrible. You can do it though. [P01/PG52/L9-12/PG53/L1-2]

Participant 20 illustrates this notion that there is no meaning to be found in the situation. I asked this participant if she felt that there was any meaning in this for her. She replies:

No. There would be many things in my life that I would say oh yeah I know why that happened. You can look and you can think that was because of this and it all worked out well in the end. No I can’t because I can’t get into the mind of the woman that made the allegations. If
someone said to me this was a psychopath I could understand where it was all coming from. \[P20/G16/L7-11\]

Not finding meaning in the situation could mean that the individual has not yet realised the meaning or that there is no meaning to be found. I argue that the finding and realising meaning for the most part is a matter of time and the point at which where introspection and recovery is possible.

**Reconstructing the Personal Self**

The process of reconstructing the personal self, as a category of ‘relearning the world’, emerged with two properties: *re-threading the personal self*, and *re-threading the social fabric*. Both these properties and their dimensions allowed the individual to reconstruct the deconstructed self are detailed in Table 5.7.

<table>
<thead>
<tr>
<th>CATEGORY 3: RELEARNING THE WORLD: THE EXPERIENCE OF RECONSTRUCTION</th>
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<tbody>
<tr>
<td>SUB-CATEGORY: RECONSTRUCTING THE PERSONAL SELF</td>
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<tr>
<td>PROPERTIES</td>
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</table>
| Rethreading the Personal Self | 1. Getting better  
| | 2. Reinventing the self |
| Re-threading the Social Fabric | 1. Being challenged  
| | 2. Picking up the pieces |

Table 5.7: Sub-category: Reconstructing the personal self - properties and dimensions.

**Rethreading the Personal Self**

The deconstruction of the personal and professional self was broadly dimensionalised as a *fraying to unravelling*. The concept of fraying provides imagery of minimal deconstruction, and as such examples of those participants
who were minimally affected by being confronted and associated responses.

Unravelling provides imagery of the person who has been significantly affected by the allegations and experience they have gone through. This sub-category re-threading the self provides further imagery of the individual having the personal constructs, that is, the physical, the psychological and the social being ‘rethreaded’. This re-threading provides a way forward for the transformation of the personal and professional self.

**Getting Better**

The dimension getting better can be viewed as have many ‘stop starts’, and influences, both internal and external. Some participants demonstrated a full reconstruction of their personal self and were able to function well in their new world including being psychologically and physically well. Others revealed continuing deconstruction albeit with minimal reconstruction. What has allowed some nurses to get better and was has hindered this capability will now be explored.

Support or the lack of it proved an integral component on the ‘degree’ of deconstruction of the personal and professional self and the ability to move along the trajectory of reconstruction. Support was identified in the following modes, personal and professional and are listed in Table 5.8.

The value of professional counselling is provided in the words of Participant 6. Her insight into this need and courage to seek it out proved extremely beneficial. She contends:

I think the thing that really helped me more than anything was professional counselling. I can understand that most people would find it extremely difficult to ask for help and I certainly did as well but it was so valuable.

[P06/PG09/L10-18]
### Table 5.8: Personal and professional supports.

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<thead>
<tr>
<th>PERSONAL SUPPORTS</th>
<th>PROFESSIONAL SUPPORTS</th>
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<tr>
<td>Partner</td>
<td>Legal</td>
</tr>
<tr>
<td>Family</td>
<td>Psychological through counselling</td>
</tr>
<tr>
<td>Friends</td>
<td>Professional through colleagues and the union</td>
</tr>
<tr>
<td>Spiritual processes</td>
<td>Industrial through union and industrial relations legislation and commissions</td>
</tr>
<tr>
<td>Pets</td>
<td>Medical practitioner</td>
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<tr>
<td>Hobbies and activities</td>
<td></td>
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</tbody>
</table>

The following introduces the idea of a ‘survivor group’ as a positive component of a personal support framework. Participant 7 explains:

How did I cope with it all? I have very good friends. They have stuck by me and we often go out for lunch. They have been my ‘survivor group’. We meet regularly, at least one a month. We help prop each other up. They have been a tremendous help. \[[P07/PG14/17-22]\]

Participant 7 also makes reference to the support of her family and friends as a ‘stabilising factor’. She explains that: ‘I have been able to stand things because of the support of my husband’ \[[P07/PG15/L1-4]\]. The value of support from her husband is also described by Participant 13. She states: ‘the support from my husband has been absolutely invaluable’ \[[P13/PG17/L1]\]. This participant also indicates that counselling has had a positive impact. \[[P13/PG14/L11]\]

Getting better was possible for the next participant who offers the following reasons for being able to get through this experience:

Basically between my wife, the church and the medication we were able to work through it. We kept talking about what was going on and just looking at it and discussing our options. \[[P14/PG04/L40-43]\]

Participant 17 contends that she had ‘good family support’ which minimised her need to resort to other means of coping, ‘I didn’t turn to drink or anything’. \[[P17/PG11/L11-12]\]

The following is offered as another illustration of what helped one
participant get better. I asked her what kept her going throughout this ordeal. She tells:

I think my husband was a great friend, and my friend who went with me to the inquiry. My family were non-judgmental. I had a cat at that stage and that was good for me. My general practitioner was great. I was able to have a long conversation with him. I think he saved my life. [P18/PG07/L21-30]

The type and timing of professional support is of importance. Participant 3 felt that counselling would have been more appropriate if undertaken by a nurse, someone who knew the context and could understand what they had actually gone through. She says that the counsellors that she contacted didn’t understand. [P03/PG22/L6-7]

Participant 12 talks about the benefits of seeking counselling: ‘I had counselling. It was very painful talking about it but it helped me a great deal’ [P12/PG05/L35-37].

A number of the participants who needed counselling either did not recognise the need for it and thus did not seek it in the immediacy of the crisis they were experiencing. The timing of counselling is imperative and should be sought or importantly obtained for nurses who find themselves in these situations. Participants have told they didn’t know that they had a problem and therefore did not get help. Getting better was therefore delayed.

**Reinventing the Self**

*Reinventing the self* was viewed as a dimension of the property rethreading the self. Experiencing any major life event provides for a deconstruction of the self and the impetus for reconstruction. Two participants provide examples of having to reconsider themselves differently in view of what had happened to them and accordingly recognised the need to reinvent themselves. Participant 13 explains:
Through the counselling that I have had I have taken the view that I’ll never be the person that I was before this huge challenged was put before me. I’ve grown to a different person and I don’t know when I’ll get to be whatever that different person is. I feel that I am getting to that point where I will be completely different. I have got a much healthier emotional state in that I no longer have days of feeling down. [P13/PG15/L10-16]

Reinventing the self as a way of rethreading the unravelled self is provided in the next example. Participant 18 talks about how she reinvented herself by doing different things in life. In this piece we can see that the self although made up of the personal and professional is something more, and can be rethreaded. She conveys this process of change:

I have to come out from realising that I was more than my career, and my profession. In some ways to put it in a glib way I had to reinvent myself. For instance, I am going to East Timor in May to each some basic patchwork quilting. Joining the choir meant reinventing myself. [P18/PG08/L29-31]

Participant 1 provides insight to the reinventing of the self. She explains that she has been two people, the one during the lowest times and the one now. She tells: ‘what I am now and what I was then – I can tell you are two different people’. [P01/PG21/L11-13]

The concept of reinventing the self and emerging as a stronger person is demonstrated in the next two comments: ‘I became a stronger person’ [P17/PG08/L13] and ‘I think it’s made me a stronger person in the end’ [P19/PG06/L41].

**Rethreading the Social Fabric**

The concept of *rethreading the social fabric* is illustrated with two dimensions: *being challenged* and *picking up the pieces*. The process of reconstructing the self within the social context is a necessary step in reconstructing the whole of the self.
Being Challenged

Participant 1 provides a number of descriptions of how she was challenged by other persons to examine why she was still doing what she was doing and how she came to a promotional position at another hospital sometime after the event. The following account by Participant 1 demonstrates an external challenge and subsequent positive and important factor in her personal and professional reconstruction:

I gathered up my strength for another six months, and then I met a friend of mine who said ‘what are you still doing here at this hospital?’ I said where will I go? My friend said go to this hospital, they are opening a new coronary care unit, so I said alright and I subsequently applied to this unit. [P01/PG30/L1-6]

Whether the friend was purposeful in her challenge may never be known, but the fact remains that the question was a challenge in the sense that it made the nurse stop and think, and realise that maybe a change at this time was necessary.

Participant 2 also describes being challenged by a friend and because of this changed her approach to being deconstructed.

I wanted to get some help and a friend of mine suggested that I go back to university or TAFE to help take my mind off it. [P02/PG13/L20-22]

Participant 2 goes on to give another example of an external challenge. She was able to assert to the NRA who were alleging that her memory was such that she was not able to practice safely as a registered nurse. After listening to a motivational tape, she explains:

I had listened to *Personal Power Play* by Anthony Robbins and I found them really helpful so I went back there and so go on then, tell me my memory was bad. [P02/PG06/L35-36]

Being challenged happened at various stages of the transformative experience. The following provides an illustration of this:
My friends said to me ‘now look, you’ve been cleared, you have got to get on with your life. You can either stay out of it (nursing), or you’re going to start getting on with it’. [P07/PG20/L12-16]

The son of one participant provides the challenge to get back into things. She explains:

My son said to me, ‘Mum there’s lots of agency jobs, why don’t you try that?’ I didn’t want to tell him the real reason I didn’t have a job, that I was just an emotional mess. So because of my son I went to an agency and got a job. [P15/PG13/L1-6]

Being challenged, provided at times the impetus for a turning point in the nurse’s experience. It is posited that a turning point is a necessary juncture in the journey of personal and professional reconstruction and as such provides the turn away from further deconstruction. The turning point can be realised internally or facilitated externally.

**Picking up the Pieces**

A number of participants talked about ‘picking up the pieces’. After acknowledging that her life had come ‘crashing down’, Participant 7 describes how she is ‘picking up the pieces’:

So now I am picking up the pieces and getting on with my life. The first piece I am picking up is to get my self-confidence back. [P07/PG04/L18-19]

Participant 18 in picking up the piece of her unravelled self talks about how joining a choir proved to be a saving grace. She explains:

I guess I was in a bit of a trance just wanting to sleep all the time. I saw an ad in the local paper seeking members for a choir. I had always liked singing and the theatre, so I joined. [P18/PG04/L23-31]

Picking up the pieces can be seen as a purposeful process to bring together the unravelled threads. This process can be through education, social distractions who through obtaining help to assist with the trauma that has been experienced. This participant stated that because she had experienced mental ill health before
she knew she had to, as she stated, ‘do tasks’ [P18/PG04/L35]. This participant referred to being in the choir as a ‘safe place’, ‘a path’ and a ‘lifesaver’ [P18/PG05/L1-22]. She goes on to say that ‘it didn’t matter what was happening to you as long as you sang’.

Participant 1 illustrates actions she took as part of the dimension ‘picking up the pieces’ with respect to her unravelling social life which was complicated by relationship matters:

Although my home life was disintegrating, I gathered up a bit of strength within me – I don’t know how I found it but – anyway my partner had a drinking problem. A facility was able to admit him for detoxification. I said to my friend who was organising it ‘if he goes in there he is not coming home’. So I packed up all his stuff and put it in his car and got someone to drive it to him. I changed the locks, went to a lawyer and that was the end of him. [P01/PG29/L4-18]

Reconstructing the Professional Self

*Reconstructing the professional self* was identified as a sub-category of the category ‘relearning the world’ (Table 5.9). This reconstruction was viewed as a trajectory and varied in many ways. These ways were dependent on a number of processes, including the degree of deconstruction and reconstruction of the personal self, and whether the NRA had imposed conditions which meant that the professional self was not able to be reconstructed, but rather remained in limbo.

The degree of reconstruction was seen as being influenced by a number of processes and factors, for example: not having the confidence to practice as a nurse again. Other participants were still in the process of reconstructing their professional self, but for varying reasons were stymied. That is, they were practising as a nurse, but not demonstrating a return to their pre-allegation state of competence or confidence, or not able to work in their chosen area, or still evolving toward reconstruction. The third outcome for those who had
reconstructed, was that participants were accepting of the new world imposed on them and were practising in a chosen area and with confidence. They were able to demonstrate that a different level of nursing practice was required, where they recognised professional vulnerability and were able to navigate it, and importantly, had ‘re-learnt’ the concept of accountability as it pertains to nursing practice.

<table>
<thead>
<tr>
<th>CATEGORY 3: RELEARNING THE WORLD: THE EXPERIENCE OF RECONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUB-CATEGORY: RECONSTRUCTING THE PROFESSIONAL SELF</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
</table>
| Getting Back on the Horse | 1. The need to risk  
2. Accepting the risk  
3. Able to risk |
| Lessons Learnt | 1. Identifying vulnerability  
2. Minimising vulnerability  
3. Relearning accountability |
| Finding a Balance | 1. Over the top  
2. Questioning and affirming  
3. Getting it right |

Table 5.9: Sub-category: Reconstructing the professional self - properties and dimensions.

**Getting Back on the Horse**

A number of participants made reference to the notion of ‘getting back on the horse’, or use other similar metaphors. The dimensions of this property include realising the *need to risk*, the ability to *accept the risk*; *being challenged*; and having the conditions to be *able to risk*. These dimensions are linked and construct the impetus and process for returning to nursing practice.

**The Need to Risk**

The need to risk emerged with two foci, firstly the financial need to risk and secondly an ‘inherent’ need to risk. This inherent need to risk was identified
by the individual in that it was a necessary step for reconstructing where the desire and need to be a nurse was strong. Participant 1 identified the need to ‘get back on the horse’ very early on in the piece but also acknowledges the incredible difficulty of doing so:

But then to go back to work was really hard but I got back in there, in fact I went back the following week I think but my knees were knocking. I thought if I don’t go in tonight I never will. [P01/11/13-18]

Participant 10 makes reference to the ‘monkey on his back’ in relation to not having yet returned to nursing. I posed the following thought to him, obviously this is a journey for you, you haven’t returned to nursing yet, and you may not:

I’ve put my hand up now for a job actually. Just because it has been three years since I practiced and there is this five year recency of practice rule. The other thing is there’s a monkey on my back. My penalty was a good behaviour bond for twelve months. [P10/58/15-18]

The need to risk for some participants was grounded in a financial need: ‘I needed to go back to work to have an income’ [P15/PG21/L10]. While Participant 10 needed the income he was able to obtain employment in an area other than nursing.

Accepting the Risk

Accepting the risk was not always possible. Participant 8 makes reference to the need to ‘get back on the horse’ but equally recognises that she is not at a point where she can and makes reference to being in a state of limbo because of this quandary:

Returning to nursing is the furthest thing on my mind, I don’t think it is because I have now have two children it is because I don’t want to get back on the bike, I can’t guarantee that I won’t make another mistake. I have decreased confidence professionally and I feel as if there was the threat of the grim reaper hanging over my shoulders.

This participant was challenged by her counsellor as to whether or not it
was time to ‘get back on the horse’:

My counsellor very much felt that I should get back on the bike, get back on the horse as it were and I needed to fix that. [P08/PG44/L16-18]

I asked her what she thought it would take for her to arrive at a reasonable point of recovery in this experience recognising that she hadn’t gone back to nursing:

I don’t know, I don’t know if I can answer that question. I feel in limbo actually because I haven’t worked. [P08/PG44/L30-32]

The identification of the risk inherent in nursing is revealed in the next account. In realising the degree of risk, Participant 18 states that she would not be able to accept the risk. She explains:

What I feel about how open we are to litigation means that there is no way that I would touch it with a forty foot pole. I would never recommend anyone do it. I don’t envy the nurses today. [P18/PG05/L40-45]

An example of accepting the risk is offered in the next quotation. This piece reveals a sense of ‘hitting rock bottom’ and therefore the situation could not get any worse. Participant 15 provides describes what she felt in getting back on the horse: ‘I had nothing to lose, I had lost everything. I had everything to gain’ [P15/PG13/L10-11].

**Able to Risk**

Being able to risk was identified in the conditions necessary to risk. These registration with the respective NRA, an offer of employment and the self identification of the previous two dimensions. The following describes the experience of one nurse who returned to work after having the matter dealt with by the NRA:

I thought that I would start off in a nursing home, just doing a couple of days a week and gradually build up my confidence. I started doing one
shift, then two, then three, so I am gradually building up. I am now in charge of 66 patients and things are going OK.

The ability to risk is provided in the previous account with the realisation by the participant that the risk had to be managed. The risk was managed, in part, by re-entering the practice context in a controlled way. That is, easing herself back into it by only working a couple of days a week, and to a point where she is able to be in charge of a large number of patients.

**Lessons Learnt**

The ‘learning of lessons’ as a property of the sub-category ‘reconstructing the professional self’ provided an important point on the reconstructive trajectory. Learning lessons was revealed with the dimensions, *identifying vulnerability*, *minimising vulnerability* and *relearning accountability*. Learning what constitutes vulnerability in the professional world and being able to minimise vulnerability with appropriate strategies is necessary to manage clinical risk. The following discussion will introduce the concept of vulnerability and then provide examples which provide definition to the dimensions of the property.

The concept of vulnerability was introduced in chapter three with the discussion of the social phenomenon. As already contended vulnerability is a constant in the nurses’ assumptive world. The ability to reconstruct the self and in particular the professional self meant being able to recognise the vulnerability of what had happened to them and the vulnerability within their clinical contexts. Not being able to recognise vulnerability provides a clear link, and one of concern to the next dimension ‘minimising vulnerability’. The examples will demonstrate that the participants recognised the need to minimise personal and professional vulnerability.
Identifying Vulnerability

Identifying vulnerability was revealed in various ways and to various degrees. Some participants disclosed a clear identification of the vulnerability they had experienced or continue to experience, as a result of the allegation and subsequent processes, and were then in a position to minimise this vulnerability in some way.

An example of this ‘identification’ follows. After being involved in a nursing error as a graduate nurse in a high acuity area the following nurse recognised her vulnerability in the context he was working in which contributed to him making the error. He was also able to identify this ongoing vulnerability:

I realised after doing a year in this area that it wasn’t for me. I just wasn’t suited to it. I wasn’t able to cope with the workloads and the acuteness of the patients. [P12/PG05/L7-12]

Vulnerability was identified as incongruence between personal factors and behaviours and the context Participant 16 was working in. He explains:

I am now working in a context and geographical area that is more receptive to my personality type. So making the move was for self-preservation. I had to look for a niche that suited me, as me, and I found it. [P16/PG06/L22-27]

Participant 17 was able to identify an element of vulnerability documenting patient care as comprehensively as she could have done. Her practice concerning the care of patient who died was reviewed using in part, her documentation. This quotation also reveals the benefit of documentation even if not done by a nurse. She explains in the next two quotes:

During the arrest I was calling things out as we were doing them. One of the other persons at the arrest wrote them down on a piece of paper towel. That proved invaluable at the inquiry because it showed that we had tried to resuscitate him. [P17/PG08/L17-21]

It was a learning curve for all of us. We hadn’t at the time been aware of all the aspects surrounding this patient we should have documented. We
should have included all his medical conditions. It really was a lack of nurses that meant we took this shortcut. [P17/PG05/L29-31]

Participant 19 although she is now working in an aged care facility with less risk than the one where she was when the allegation was made, she identifies a vulnerability that is particular to aged care. She explains: ‘we are still very vulnerable in nursing homes. It is a daily struggle, a juggling act. At anytime anything can happen you just don’t know.’ [P19/PG08/L5-7].

The degree and type of vulnerability experienced by Participant 20 as a result of the experience of being reported to the NRA is expressed in this account:

I am much more vulnerable now than I have ever been in nursing. I am more vulnerable because of my emotional state has been shattered. I certainly realise how vulnerable I am. I feel that every day that I go to work I just can’t wait to get it over with. I really can’t cope. I don’t want to have that continual anxiety of ‘what is going to happen to me today’ [P20/PG10/L4-8]

Minimising Vulnerability

A strategy for manoeuvring around vulnerability is provided in the following description and reveals an attempt to minimise the vulnerability that this nurse was experiencing:

There were several things on the ward that weren’t done according to the protocols, by everyone. I figured that the best to do things was the way that everyone else did them. [P04/PG11/L24-26]

An actual over compensation in the area of practice that the error was made in is demonstrated in the narratives of a number of participants. ‘Overdoing’ some aspects of nursing practice is seen as one strategy for minimising vulnerability for participant 7. She explains:

I take super-duper care with medication. I really check them. I am more attentive, much more attentive. I make sure everything is signed for and is correct. If there is any doubt I clarify and clarify until I am sure. [P07/PG23/L1-4]

A number of participants described ways of minimising the vulnerability
they might experience in a personal sense. Participant 7 explains:

There is still a lot of mistrust. I don’t think I can be completely open with my fellow workers and I am at work to do what I can for my patients and not to get involved with anything else. I just do my work and get out. I am not getting involved in the ward politics. [P07/PG21/L17-21]

Participant 11 makes clear his need to minimise his interactions with staff members and not get involved in the politics. The overriding strategy for assisting with obtaining this objective is to work as an agency nurse. He states:

I would not get a permanent job again because I guess I just can’t help myself in getting involved. There have certainly been instances that have occurred recently but since I have been working with the agency I tend to discuss the issues with the permanent staff the step back from the issues. I tend to sort things out from a distance rather than becoming actively involved with something. [P11/PG09/L38-41/PG10/L1-2]

The next participant goes on to explain other aspects of her practice where change has occurred in response to the need to minimise vulnerability. This comment is tempered as advice to other nurses:

Nurses are very vulnerable because we are always being interrupted. Don’t let yourself be in a vulnerable situation. Take extra care with medications. Also, document, document, document, document, document. Learn to speak up if you feel that staffing levels are unsafe. Be careful of what you say to others. If you don’t feel that you can be accountable for something then you need to speak out. You need to know your limitations and be honest with yourself about them. [P07/PG32/L1-30]

In response to recognising the negative working context and advice from others, this participant chose to leave the place of employment where he made the nursing error. He explains:

I told them my story and where I was working. They recommended that I leave and go to another hospital and do my graduate program. They told me a few other graduate students had had problems there. So I resigned. [P12/PG03/L28-33]

In response to self identified personal vulnerabilities the next quotation reveals one participant’s strategies for minimising this vulnerability:
I thought well, in the future I am not going to make the same mistakes twice, tone down your act and keep it in context. I realised that the workforce is not my friend. Just recently my work place organised a weekend away. They asked if I was coming to which I replied no. I like to keep my professional and personal lives separate.

He goes on to explain that should he identify any risk with respect to what he went through, he would leave immediately. He would not hesitate to make this decision. He suggests to those looking for a job to go and have a good look around the unit and facility. Ask questions and get a sense of what the organisation is about.

In an attempt to minimise his vulnerability, Participant 16 chose to see a psychologist to address behavioural issues which led to the allegations. He provides insight and strategy to minimising vulnerability:

I knew I had to be more self aware. I went to a psychologist about this and discussed what my part in all of this might have been. Although I had always been good with patients I seemed to be quite critical towards my colleagues, especially if they were incompetent or lazy. After this I realised I had to bite my tongue more and choose my words carefully. As I have aged I have become more mellow and more reserved and aware of the situation I am in.

The realisation that documentation practices had not been adequate and added vulnerability during the NRA inquiry regarding allegations of negligence, Participant 17 describes how she now minimises this vulnerability: ‘I am a good advocate for extensive documentation’.

The following is offered by Participant 19, to explain how she now practices:

I think you’ve got to make sure that you are covered all the time. Make sure you document everything and pass on everything to your manager. If you are not happy about something report it. If you are still not happy you need to go to the top. You need to follow the policy and procedures of the organisation.
The next dimension to be discussed is *relearning accountability*. This dimension emerged for the participant after experiencing ‘lessons learnt’.

**Relearning Accountability**

The dimension *relearning accountability* emerged with the identification of a number of statements related to the question posed to the participant in terms of what have they learnt or what do they now understand by the notion of accountability. Accountability with respect to nursing practice was introduced in chapter one with the premise that it is an imperative of professional practice. Accountability is the measurable end point of expected behaviour against actual behaviour and as such is inherent in all aspects of nursing practice.

The words of the participants reveal that they were able to *relearn accountability* by recognising what accountability is and how it translates to the expected standard of practice. Participants were able to articulate a new sense or knowing of what accountability was and meant for to them in their practice. Once this was achieved, the participant was then able to incorporate accountability into their practice.

Of the cohort of participants in this study, two had demonstrated through their stories a complete reconstruction of their personal and professional selves. It is in these two particular stories that the ‘lessons learnt’ come full circle and ‘accountability is relearned’.

Toward the end of the interview with Participant 1, I asked her to tell me three things she had learnt from her experience. A sense of the intricacies and scope of being accountable is provided in her account:

Accountability…I don’t know what else I have learnt but I now know what accountability is…everyday I go to work I see things differently.
There are many specifics of how you now practice nursing differently because of that or you teach differently or you communicate different.

Participant 1 goes on to say that accountability is about questioning what you do. She states: ‘I still think nurses give medications without knowing what they are giving.’

Participant 7 provides a further example of ‘relearned accountability’ and in doing so gives us a sense of its constituents. I asked her if she felt that she was now more assertive in her practice. She replies:

Oh yes, very much so because of this experience. Before this I sort of practiced in a military model, you know, yes sir, dedicated staff. But now I’ve been through all this I am definitely more assertive. Very much so, very much more aware of policies, very much more aware of the hot water you can easily get yourself in. You have to be accountable to yourself first and then accountable to everything else. You know that the hospital is important but naturally if you’re going to be accountable you will be accountable to your workplace but you’ve got to be accountable to your patients, your employer and yourself.

This participant goes on to describe she now demonstrates accountability since she experienced that situation:

Accountability to me means that you have to be accountable to yourself as a registered nurse, if you are going to follow hospital policies you’re going to do everything you should be doing, it is a duty of care as a registered nurse. Accountability to the patient, seeing that the patient is being cared for, the patient’s needs are met, the patient is comfortable, the patient is looked after, including the activities of daily living, medications, social, physical and psychological needs. As for my accountability to staff, it is to see that we have a good working relationship, to see that we have a smooth shift, to see that we have the correct resources with which to run a smooth shift, to see that nurses are doing their work and they too are accountable to me and to the patients, and to see that all the documentation is completely done and every thing is covered.

A new understanding of accountability is communicated in the next account. This nurse who had been accused of breaching professional boundaries acknowledged that she had approached a client in a work setting regarding a non-
professional matter she was involved in. In talking about the situation she reflects on her understanding of professional boundaries:

I owned up to what I had done. I felt that I hadn’t intentionally tried to harm anyone, but OK yes I overstepped boundaries. I suppose I was naïve about the power relationships that exist between nurses and clients. I’ve always worked in community settings where you have an ongoing relationship with clients. I would see my clients in community settings because I also had small children. I would see them at the swimming pool and school functions. So I just hadn’t reflected on that sort of boundary stuff and how the Board would view any of that. Obviously now I am acutely aware of it, but I wasn’t back then.

In describing how her nursing practice is now different, Participant 1 demonstrates relearning accountability. She explains:

I now follow procedures and protocols, you’ve got to know what you are doing, you can’t just do something and not know what you are doing. Everything we do as nurses is important, whether we’re checking before we come on duty, our oxygen and suction, our air viva, the drugs that we need, everything we do. Documentation is also important. Every single thing we do is important. You know even the way you allocate the patients is important, you can’t allocate someone a patient because you don’t like that nurse, you can’t give them a heavy load because you don’t like them. You look at things differently, it’s all different, I know what accountability is now. It has changed my perspective, equipment is important, patients are important, everything we do at work is terribly important.

This nurse has revealed a change in her view of the professional world and a realisation that accountability is all embracing with her repeated mention that everything we do as nurses is important. There is a sense that nothing is potentially, without consequence. Participant 3 was asked what accountability now means to her. She provided the following answers and in doing so reveals the inescapability of accountability: ‘The buck stops here’ and ‘it means your head on the line’. There is a clear reconstruction of these participants (1 & 3) nurse’s professional self, a demonstrated rethinking and subsequent relearning of what constitutes accountability and its meaning for them.

Participants who were able to recognise the vulnerability within their
nursing practice and particularly in view of what had happened to them were in turn able to relearn accountability. This relearned accountability was evident in a change in their nursing practice, or more specifically, a positive change. These participants had reconstructed their professional self in a positive way by getting back on the horse and learning lessons. What some of these participants found difficult was finding a balance within their nursing practice. This property and its dimensions are now discussed.

**Finding a Balance**

Finding a balance within clinical decision making and judgements in nursing practice is not a new concept. Emerging as a newly qualified registered nurse is an important point on the nurse’s professional development spectrum in terms of finding a balance between ‘under-doing’ and ‘over-doing’ some aspect of nursing care. For example, not assessing the patient frequently enough, to assessing them too frequently, and as such, assessing them unnecessarily. Other examples come to mind: When to call the medical practitioner? How often should I do the observations? Do I get the patient up to walk to the toilet? How much analgesia should I give? Finding a balance is an experiential process.

The participants provide examples of having to find the balance between over-doing and under-doing practices, and the difficulty of doing this. Finding the balance can be a viewed as a process the nurse goes through where practice becomes appropriately and proportionately situated to minimise risk. The participants were driven by the fear that they might make the same error and as such, had to go through a process of finding the balance. The dimensions of this property include: *over the top, questioning and affirming; and getting it right.*
Over the Top

The concept of finding a balance as part of reconstructing her professional self is provided by Participant 3. In her account she not only recognises the need to find a balance but also provides some insight into what might allow for a balance occurring, she says:

Maybe I haven’t found the balance, or maybe I am over the top. Sometimes they say that I am over the top, I am obviously not. I guess it is about finding where you really feel comfortable with yourself and where others feel comfortable with you. I try and follow things to the letter. I’ve always worked more to the letter than a lot of others but I find that I am surprised how many don’t follow policy or procedure. I still have to say come with, you are coming with me aren’t you, or wait a minute I have to come with you when I check that dangerous drug or things like that.

The main practice change for Participant 17 is with documentation practices, she comments:

You just don’t think of the mundane everyday stuff we do as nurses. You don’t see that maybe it could be better for you if you had to face court if you had the buffer of good documentation there. You know you just don’t think of those things. I do now, though. But in fact I probably over document now.

This participant is still in the process of finding a balance but in this instance being over the top with regards to how much you write will have more benefit than not writing enough.

Questioning and Affirming

Finding a balance for the next participant was grounded in a loss of her confidence, she recounts:

Well my confidence is well and truly affected. I had to ask my friends about things that I had been doing for years, asking them if I was doing something right or not.

This participant demonstrates ‘questioning’ as a strategy for finding the balance. This questioning and seeking of affirmation that she is doing the right
thing is allowing her to navigate the vulnerability that she is experiencing because of her impaired confidence.

A further illustration of finding the balance is offered:

Thankfully I got to work on a very good work in a good hospital, but as a consequence I probably drove everybody mad. I asked every person I worked with for an assessment. It wasn’t until they started saying to me, look don’t bother you are doing fine. [P11/PG03/L36-40]

In response to this I asked him what he felt it was necessary to seek these constant reviews. He replied: ‘I thought that maybe my behaviour was aggressive because that is what they kept telling me’. [P11/PG04/L1-2]

Questioning and affirming can be viewed as a necessary step in rebuilding confidence to return to the level of practice prior to the allegation. The process of finding the balance can be seen as having insight into the need to question whether more can be done to improve practice; over doing it; asking questions as to whether their practice is on track; and then coming to a comfortable balance.

**Getting it Right**

*Getting it right* as a dimension of the property *finding the balance* had only been realised by one participant. Getting it right assumes an appropriate balancing of critical thinking and safe outcomes and occurs once the participant has passed through the other dimensions, *over the top* and *questioning and affirming*. This is not to say that nursing errors are still not possible in future scenarios but the participant has arrived at being able to make (for the most part) sound clinical decisions. The experience of Participant 1 revealed a long process or minimising vulnerability, relearning accountability and regaining her confidence in her personal and professional lives to arrive at a point where she was able to get things right. Now as a senior nurse in a critical care area she is able to competently and confidently practice nursing, while advocating for her
patients. Getting it right does not remove vulnerability but reveals significant
critical thinking and foreseeability with respect to the vulnerabilities that exist.

**Living Within the New World**

Within the spectrum of the categories of reconstruction of the personal and
professional self a number of participants found themselves situated in the next
sub-category, *existing within the new world*. The dimensions of this property are:
*psychologically stuck, feelings of being let down, the need for revenge and need
for vindication*. Existing in the new world through one or more of these
dimensions provides the imagery of the participant ‘marking time’. This is not to
say that participants were not eager to ‘move on’ but had to experience either
passively or actively transformative trajectory that they were on. Some
participants although still nursing, were clearly more firmly situated as ‘existing’
within the new world as opposed to ‘moving on’ within the new world which will
be described later in this chapter. The properties and dimensions are listed in
Table 5.10. A more detailed discussion now follows.

**Existing**

It is important to recognise that no one nurse interviewed moved through
all of the identified sub-categories and associated constructs in an ‘orderly’
fashion. The visual schema has to be viewed in terms of the experiences of the
individual participants almost like a game of Twister©, with hands and feets in
different circles at different times. The sub-category *existing* emerged for all
participants and for some of the participants this is where they were either fully or
partially positioned. Others had been able to move on, either fully or partially.
The dimensions for this property are: *psychologically stuck; re-experiencing; feelings of being let down; the need for revenge; and the need for vindication*.

<table>
<thead>
<tr>
<th>CATEGORY 3: RELEARNING THE WORLD: THE EXPERIENCE OF RECONSTRUCTION</th>
<th>SUB-CATEGORY: LIVING WITHIN THE NEW WORLD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROPERTIES</strong></td>
<td><strong>DIMENSIONS</strong></td>
</tr>
</tbody>
</table>
| Existing | 1. Psychologically stuck  
2. Re-experiencing  
3. Feelings of being let down  
4. The need for revenge  
5. The need for vindication |
| Moving On | 1. Turning points: Meaning and momentum  
2. Acceptance through integration |

Table 5.10: Sub-category: Living within the new world - properties and dimensions.

**Psychologically Stuck**

Some participants were considered to being *psychologically stuck.* Different reasons and examples of being psychologically stuck were identified and represent a dimension of existing within the new world. This dimension emerged after identifying either collectively or part there off, some aspect where the participant was not able to move on completely. For the most part it was because they were not physically or psychologically well enough to do so but in some cases the participant expressed a ‘sticking point on the deconstructive trajectory’ for whatever reason and this prevented them from engaging in the momentum for reconstruction. A case in point follows as Participant 7 describes the reason for not being able to get on with her planned PhD study:

*I want to gradually work back into nursing. As for the PhD I may take the threads of that up again, I don’t know. I had the conciliation postponed until the 24th of this month, now I haven’t been to the meetings yet so I don’t know what the outcome will be. I hope it will be resolved because has been going on too long. I really want to get this thing right behind me and possibly look at picking up the threads on my PhD but until*
everything is clear, as a professional I feel that until that’s done I haven’t
got my full credibility back, from that perspective. [P7/PG24/L20-29]

The notion of being stuck is provided by Participant 3: ‘I want to move
but at the same time’ [P03/PG25/L16] and goes on to say that the shame she feels as
this time means that she is having difficulty moving through to a point of
acceptance [P03/PG25/L26].

Participant 2 provides another example of being psychologically stuck:

I was only thinking the other day about things and I was called to the
office of the place where I do some volunteer work. I thought god what
have I done wrong this time. This is how I think even if someone wants to
do something nice for me. [P02/PG12/L22-25]

The symbolism represented in ‘being called to the office’ usually only
means one thing: that you are going to get into trouble. Not being able to see
being called to the office as a potentially positive thing demonstrates a degree of
being psychologically stuck for this participant.

Although participant 3 recognises both the need to move on and the
difficulty she faces in doing so. She explains:

We had a nurses meeting the other day and in that someone asked a
question and the unit nurse manager said, the RN has to wear it, it is not
nice having to go to court just ask so and so. I was gob smacked, here we
are not in May and we had our vindication in December and it is still being
thrown up at me. I went to her afterwards and said, look I am trying to
move on, trying very hard to move on and not everyone in that room knew
about my incident. I am trying to move on, I don’t need this thrown up in
my face every time I turn around or every time you want to make an
example of someone. [P03/PG16/L24-36]

A further example of being psychologically stuck is demonstrated in a
recurring dream experienced by Participant 8. She tells:

I continue to this day to have this bad dream. I dream that I am work but
for some reason I can’t finish my tasks, it is a real issue. In the dream it is
the end of the shift and I am in a complete mess, I am completely
disorganised. I haven’t written my notes, I have forgotten to wash my
patients, and I am in a complete jumble. I just can’t do the tasks expected
of a normal nurse. [P08/PG43/L22-34]
The imagery posed by the word ‘limbo’ provides illustration of being psychologically stuck for one participant. I asked this nurse what she thought it would take to arrive at a reasonable point of recovery from this experience. She replies:

I don’t know. I feel in limbo because I haven’t worked. What annoys me I suppose is that I look back over the years and I know that I have looked after critically injured people, patients on ventilators, paralysed and sedated, chest tubes down one side, patients with ARDS and renal failure, you name it, and it was a 94 year old patient on a medical ward that let me down. I just can’t get my head around it. [P08/PG45/L1-6]

A number of issues arise here. Clearly there is a need to ‘get back on the horse’ if one is to commence reconstructing the professional self. Participant 8 is not able to surrender the fact that she was reported to a NRA for a simple error. The dilemma and frustration that she is experiencing and the belief that it could happen again provides the constraint for not being able to move along the trajectory of transformation.

A further example of being stuck is provided in the next quote. This account brings to the foreground a number of feelings and reasons for this participant who is existing in this new world rather than at a stage where she can move on despite continuing to work. She explains:

This has been the most traumatic thing that has ever happened in my life, because the most important thing in my life has always been nursing. It dominated every bit of my working life, my social life revolves around nursing and nurses. That is probably the reason for not wanting to talk about it in that it has had such a terrible impact on me. I have an opportunity at work to do an in-service on something that is of importance to nursing. I have thought about telling people of my experience because where I work now they know me quite well. . I have thought about it but there is a risk of exposure and I feel uncomfortable about that. I feel like I am telling someone that I am a rape victim and I didn’t have anything to do with it, or I feel like I am trying to cover things up and trying to prove my innocence. [P20/PG08/L1-14]

Realising being ‘stuck’ is realised by Participant 15. She states: ‘I am still
stuck with it all. I know I have to deal with it but it is difficult because I lack so
much self confidence’ [P15/PG15/L31-32]. She goes on to explain why she feels stuck:

I think I’ve got a psychological hang-up that I need to overcome, which is
I feel inferior to others. I tell myself that I am bloody hopeless. I just
shoot myself in the foot all the time. I know I have to switch from being a
negative, you can’t do it, to being really positive about myself. I think that
is the core of it. [P15/PG16/L23-27]

It was evident that for these participants the search for meaning proved a
frustrating time. Some participants were clearly psychologically stuck and not
able to move but were able to demonstrate adaptation to the situation they found
themselves. This adaptation has links to both influencing factors of resilience and
support frameworks.

Re-experiencing

Re-experiencing was uncovered during analysis of the following accounts.
Having to re-experience aspects of the experience stymied the individual’s ability
to move on in the new world. Participants were able to identify when it was or
wasn’t appropriate to be reminded of the events, and the consequences of
remembering.

When talking with Participant 18 she shared this: ‘to be thinking about it
now manifests some of the feelings, particularly the nausea’ [P18/PG04/L19]. A further
example of ‘re-experiencing’ was revealed at the beginning of the interview with
Participant 20. This participant expressed to me that that morning she had been
experiencing some anxiety related to knowing she was going to relive the
experience. [P20/PG01/L1-3]

Re-experiencing is possible when the matter has been unresolved as
Participant 20 continues to explain: ‘I feel that it is unresolved, and that I have to
tuck it away in one of those corners of one’s mind that you don’t really want to
know about\textsuperscript{1} [P20/PG08/L16-18]. The ‘flip side’ to this but not one that is positive is that it is a strategy for limiting reminiscence but does not allow the individual to move on because the matter has not been adequately dealt with.

Another example of ‘re-experiencing’ is provided by Participant 20. At the time of the interview she was working in the hospital where the allegation was made and sometimes has to go to that ward: She explains how she feels going back there:

I got sent up to that ward to relieve one day, it was absolutely horrendous. It was like looking at the scene of an accident and I was trying to place where people were that shift. But I just tucked it away and had to get on with it.\textsuperscript{2} [P20/PG14/L13-16]

Participant 3 provides this example of re-experiencing and in doing so identifies the limitations it has for being able to move on. She states:

We had a meeting the other day with some nurses. In the meeting someone asked a question and the unit manager said in response ‘the RN has to wear it, its not nice having to go to court, just ask ****. I was gobsmacked. Here we are no in May and we had our vindication in December and it is still being thrown up at me. I went to the manager afterwards and said ‘look I am trying to move on, trying very hard to move on and not everyone in that room knew about my incident. I am trying to move on and I don’t need this thrown in my face every time I turn around or every time you want to make an example of someone’\textsuperscript{3}. [P03/PG16/L18-34]

Participant 12 provides an example of the consequences of not being allowed to forget what happened. He explains: ‘you are never going to let me move on from you. You just keep bringing it up and making me live in the past’\textsuperscript{4}. [P12/PG09/L4-5].

The following is from a participant who deconstructed minimally and had good support systems. She still acknowledges that the experience is still with her. She explains:

It never had any physical toll on me, I didn’t become ill, I think I coped quite well really. I don’t know how though. But it is still with me and I can’t really let go of it.\textsuperscript{5} [P19/PG05/L1-2]
Feelings of Being Let Down

*Feelings of being let down* were evident for a few participants. The following example is provided by Participant 2. She states: ‘I am still annoyed with them (the NRA) that it wasn’t handled better’ [P02/PG13/L2-3]

Participant 8 experienced strong feelings of being let down. After the NRA decided to dismiss the allegations, the DON wrote a letter to this participant which became ‘icing on the cake’. She recalls what the DON said to her:

‘I was pleased for your sake that the nurses board decided to dismiss your case. You have experienced considerable stress over the past 12 months while awaiting the outcome. It must be a wonderful Christmas present’. [P08/PG33/L25-32]

This participant’s response to what she saw as a condescending and belated attempt at support was to seek a meeting with her. Here she recounts the meeting:

After getting the letter I think my blood pressure went up to 300/150. When I met with her I challenged her on a number of issues. I said to her ‘how do you know that I experienced stress? How do you know that? Have you ever asked me, have you ever rung me, have you ever talked to me?’ I felt that I had nothing to lose seeing that I had resigned. I told her that I felt that she had dobbed me in and then dumped me. I told her that there was a 100% lack of support. I challenged her that she was meant to be a supervisor and that in her original letter she said that she would support us. I told her that I was really really angry. [P08/PG35/L1-34]

Feelings of being let down are provided in the next account by Participant 20:

I felt unsupported, I knew that I needed counselling. I would knock myself for years afterwards but I couldn’t even go and discuss this with a counsellor, that is hard bad it was. [P20/PG08/L13-16]

The Need for Revenge

*The need for revenge* was expressed by a few participants. Participant 4 shares his need for revenge because of what was done to him:
The allegations happened four years ago, and I still loose sleep over it. I still feel like revenge. What I want more than anything is to get a job where I can tell them, ‘right, now I am in charge, you are going to be the victim now’. He qualifies this by saying ‘I know I wouldn’t do it but that’s what I feel like doing’. [P04/PG16/L9-12]

This concept of wanting revenge and its stymieing effect on the ability to move on is provided in the following quotation. I asked Participant 10 at what point did he feel he was at in terms of recovering from the experience. He tells what he believes is necessary to ‘recover’:

‘I suppose simply, revenge. These people messed with my life quite seriously with no basis to do so. And they got away with it. So I guess revenge.’ [P11/PG07/L34]

The Need for Vindication

The need for vindication was identified by a number of participants.

Participant 5 expresses the need for vindication and continues to pursue this. She considers this necessary to correct the negative portrayal of her in what was a ‘trial by media’. She explains:

A couple of years ago I wanted an apology and to sue them for millions, but you know you can’t do that. I am just hoping that my request to have the Ombudsman look into this matter will return in my favour and clear my name. [P05/51/L13-20]

The need for vindication is reflected in the next account and qualified:

I know this sounds awful and it is not part of my personality but I would have liked some satisfaction from perhaps this woman getting a letter from the nurses board saying that we’ve looked into this nurse’s record and it’s impeccable. We are not pressing charges. I am sure she didn’t get anything, except the satisfaction of knowing that I was going through hell and back. I just want her to see the pain that she has caused me [P20/PG11/L29-34].

This need for vindication translated to action for some participants:

I wanted to really show them I suppose, you know, I am not going to be beaten. I thought I am not going to give up so I joined an agency. [P19/PG06/L29-33]

Existing in the new world may be the ‘end point’ of this experience. To
illustrate this contention I asked Participant 20 if she felt that she could ever resolve this experience. She replies: ‘no, it will never be resolved’ [P20/PG10/L26]. There is hope that she will be able to move on with appropriate support and time. Nonetheless, the ability to move on within the new world is achievable, although only two participants had described what was analysed as a reconstruction of their personal and professional selves. A number of other participants were at varying points of this part of the reconstructive trajectory. The property moving on will now be discussed.

**Moving On**

Of all the participants interviewed only two, in my view, reconstructed to the point where they were completely accepting of the new world, and demonstrated a complete reconstruction of the personal and professional selves. This is not to say that other study participants were able to achieve complete reconstruction. Some participants were partially along the transformative trajectory where acceptance and closure had not yet been obtained. Some participants had expressed experiencing a turning point but were still to work through a number of issues and at times in the narrative, were still seen to be psychologically stuck. The ability to move on was identified by a number of participants in terms of the need and willingness to do so, but there was a parallel difficulty in doing so.

The dimensions of this property are: **turning points: meaning and momentum; limiting reminiscence and acceptance through integration**. These dimensions in terms of negative and positive consequences to being able to ‘move on’ are now discussed.
Turning Points

A turning point can be seen as ‘an event’ and a point ‘within an event’. This contention will become clear. The idea of a turning point in the experiences of these nurses makes sense. Turning points, real and anticipated demonstrated the grasp of meaning and provided momentum for the participants along the transformational trajectory. They also represented a moment of understanding or realisation within the experience. It has been said that the traumatic experience or loss itself is the turning point in a person’s life and was the impetus for the transformation within their life (Davis, 2001).

It is not uncommon to hear such phrases as ‘make or break’, ‘now or never’, or equally the idea that an individual at times of crisis and despair can ‘see the light’ or experience a revelation that points them back on the right path. If viewing the collective experience as journey, it is then possible to view the realisation of a turning point as an important juncture on this ‘road’. Therefore, depending on what stage the individual nurse is on this journey some have been able to demonstrate that they came to a turning point, while others are yet to experience it. It is also important to note that in some cases a turning point may never be experienced because of the individual and collective influencing factors and the outcome of the NRA investigation. The other component to this dimension was that in some situations, participants were able to identify what ‘turning point’ was needed, but had not yet ‘arrived’ at that point.

Participant 1 provides an undeniable example of a turning point:

A lady came around one day and she was taking photographs for the brochure for the hospital and I was talking to a patient and she took a photo of us. I didn’t think any more of it. A nurse came down one day and said oh I see your photo in there, I said where? She said in the brochure for the hospital and there was this big picture, I thought, bloody hell! Then one day I opened up the community newspaper and there was a
picture of me in an advertisement for nurses for our hospital. After that it was like, that is what changed me. It was quite different because my perception of myself changed.

Central to this quotation is the realisation that her self perception had changed as a response to seeing the photo and how the hospital chose to use it and subsequently what it represented. I asked her to elaborate on what it was exactly about the photo that proved a turning point for her:

I think they had the confidence in me which gave me the confidence in myself. I don’t think they realise what they have done for me, they have given me the confidence back to get on with it. I think it was the picture that changed me, I don’t think it was the actual picture, [but rather what it meant to me], but it was the turning point.

In her explanation that it ‘was the photograph’ revealed symbolism. The photograph came to represent a notion of a ‘good nurse’, for it was obvious to her that the Hospital would not have chosen a ‘bad nurse’ to represent the Hospital. Also, that others believed in her was such then that she must be a good nurse. A correlation is present here and while I have not included it in the thesis I remember when this case was being heard in the Coroner’s Court this nurse’s photo was published in the daily newspaper leaving the court. This photo symbolised the ‘bad nurse’ and contributed to the stigma that this nurse experienced. The photo in the Hospital brochure and the community newspaper is symbolic of the ‘good nurse’ and countered for Participant 1 some of the stigma she had experienced during the Coronial inquiry.

Participant 2 was asked if there was had been a turning point for her. In responding to this question it emerged that the ‘turning point’ was viewed as a self realisation that she had to do something about her predicament, although it took her a year to reach this point.
I said to myself, right I have to get up today and do something, I was just sitting around the house doing nothing and worrying. I wasn’t eating and I was losing a lot of weight, and I was depressed. [P02/PG13/L8-10]

The search for meaning by consulting with a clairvoyant proved helpful for one participant and consequently provided a turning point in the experience:

I went to a clairvoyant who told me everything that was going to happen. She said that it was going to be in the papers, but she also told me that I would get through it and be OK. I guess although I’m being a bit naughty I was really clinging on to her advice. I just wanted her to keep telling me it was going to be OK. [P05/PG57/L4-10]

Another example of a turning point is provided by Participant 3. She firstly explains that she believes that the experience, or at least the negative aspects will ‘last several years yet’ [P03/PG17/L23] but describes a significant turning point she experienced:

I realised that I [my actions] had not killed the patient and that was a huge relief. When I pulled myself together and looked at the situation more objectively, that allowed me to stop punishing myself. [P03/PG17/L30-34]

This participant also recognises another turning point that has yet to happen. She explains:

There is one more hurdle and I am waiting for that to happen, then I will know it is over. The nurses board write up the case and publish it in their newsletter. I want that out of the way then I will feel as if it is over and I can move on. [P03/PG18/L14-34]

Participant 11 describes two turning points:

For a while I personalised everything, and then somehow I realised that it wasn’t my problem. I finally got the letter from the board saying that they saw no cause to pursue the allegations, so that was a starting point. [P11/PG10/L22-25]

Some participants were able to identify a turning point that was needed but had not yet happened. Participant 12 explains: ‘I am still on the journey, I need to find ‘that’ job where I will be happy and then I can alter my career decision and settle down’ [P12/PG09/L37-38].
Participant 21 recalls experiencing a few turning points. She explains:

Suddenly I had this terrible feeling that I would be going to jail and obviously I didn’t want to be there. My lawyer said to me that I was going to go to jail I would be there already. So that was one turning point. Another turning point was when I went to the appeal hearing. After the proceedings, the lawyer asked if I wanted to come back for a drink. I thought it would be a cup of tea but they opened a bottle of champagne. I then realised that it must have been looking good for me because they opened the champagne. [P21/P02/L35-45]

The turning points experienced by these participants allowed them to be propelled and to gather momentum along the transformative trajectory. As already stated not all participants had experienced a turning point, and for a few this had not limited their ability to reconstruct. Another process which assisted participants to move on is limiting reminiscence. This is now discussed.

Acceptance through Integration

Acceptance through the process of integrating the experience into the new world and finding meaning emerged as the final defined juncture on the transformative trajectory. Obtaining acceptance through integration does not mean that continued growth from the experience is not possible, but it defines a relative end point to the experiences of the study cohort.

An example of acceptance and evidence of moving on is provided in the following account. Participant 1 reveals that she is able to talk about the situation freely and also that she has learnt from this experience and that she is comfortable talking about so other nurses might not have to go through a similar experience. This finding is in contrast to that described by Participant 3 in the above discussed dimension.

Even years later things will come up about what I went through. I will say to people if you want me to talk about it I am happy to discuss it. I think everything has been said but if you want to go through it we’ll discuss it. I am not sensitive to the situation anymore because we all walk a very fine line. [P01/PG36/L5-10]
The example of acceptance in the above account is realised as an ‘integration of the experience into the new world’. This nurse has been able to integrate or bring the experience back into her assumptive world in a positive way.

Although the following does not in itself reveal acceptance of the situation it does indicate integration of the experience and as such a sense of learning from it all. This is important dimension in moving on. Participant 6 explains:

I am now at a different level where I can address it much more logically and at a greater distance. The experience has left an impact on me but I don’t think I ever got over it. The lesson I have learnt is to have a ‘healthy’ disrespect for administrators because of what I went through. [P06/PG11/L1-12]

This theme is continued in the words of Participant 17 who reveals integration of the experience into her need to educate others:

I have no problems getting in front of health workers and telling them what happened to me. I think all of us who have been involved in such things need to be more vocal even though it is still raw at times. [P17/PG10/L36-38]

Learning lessons and incorporating them into behaviours and thinking to minimise vulnerability is seen as a way of moving on from the deconstructive effects of this experience. This participant clarifies the lesson: ‘I have been advised not to tell anyone anything about me personally or professionally because it is likely to happen again’ [P06/PG11/L14-17]. Another example of acceptance and integration is provided: ‘you can rise above it as I have and live to tell the tale from a higher level’ [P06/PG21/L16-19].

This approach is affirmed by Participant 10. He explains that if he was to go back to nursing how he would do things differently. This provides a sense of acceptance in that the key lessons from the experience have been learnt and would be integrated into the new world. He explains:
I don’t think that I would change much about my nursing practice if I was to go back to it. I don’t think that I would get involved. I used to see myself as a change agent. I would raise my hand with suggestions and ideas. I think now I would keep a bit of a lower profile. [P10/PG63/L5-14]

Participant 11 provides a further example of acceptance in the next account. He explains:

Closure, I would say that I was still on a continuum. I guess to really get closure I would like the opportunity to do something to these people who did it to me and I understand on one level that that is not going to happen. [P11/PG07/L22-24]

He goes on to provide describe acceptance and as such closure:

A lot of my thinking goes back to my training in mental health. If you can’t face your own demons then people will take advantage of them. You have to look at their behaviour and not the subjective stuff. Subjectively I would like to go around and punch them in the face, but objectively I can see that they are the ones with the issues, whereas I see myself in a better position. Albeit having gone through an unnecessary and painful process, ultimately I am better off and that is the point of closure I guess. [P11/PG11/L3-10]

Another example of acceptance of the events as they transpired is provided. In telling this part of his story, the participant discloses a degree of acceptance:

You’ve got to weight up what is going on with your family life and that type of stuff. We are comfortable in our decision to step away from it all. I’ve got no regrets whatsoever. I mean would I do things differently now, course you would but hindsight is a wonderful thing. [P14/PG15/L15-25]

CONCLUSION

This chapter has given shape to the social process that these participants both went through and engaged in response to the social phenomenon of an allegation of unprofessional conduct. The social process, transformation of the personal and professional self emerged as the core category which provided description and definition of the process these participants went through once they
were confronted with an allegation of unprofessional conduct. This core category is comprised of three categories, they are: *the social phenomenon; loss of the assumptive world: the experience of deconstruction of the personal and professional self*; and *relearning the world: the experience of reconstruction of the personal and professional self.* Each category was formed with subcategories, properties and dimensions.

While each participant’s experience was unique there was a commonality to the experience which was revealed in a transformation. This transformation formed by deconstructive and reconstructive effects and processes was different in each case. Some participants were minimally affected while others experienced extreme deconstruction of their personal and professional self. Reconstructive efforts and processes were seen as correlating to the degree of reconstruction. For the most part participants experienced a *fraying* to an *unravelling* of their personal self and an *interruption* to a *disintegration* of their professional self. Reconstruction along the transformative trajectory was influenced by a number of threads, *resilience, time, support frameworks* and the constant of *vulnerability.* Reconstructive consequences were dimensionalised as being *stymied, evolving* and *transcended.*

The next chapter will provide an overview of the substantive theory - *The Phoenix Process: Transformation of the Personal and Professional Self.* The literature relevant to the findings will be incorporated into the précis.

*****

My mother was charged with involuntary manslaughter and practising medicine without a licence on Wednesday April 9th, a little over a week after the medical examiner had filed the final autopsy report. We knew on Tuesday night she’d be arrested the next day, and I spent all of French class and most of algebra on Wednesday morning envisioning what was occurring at that moment at my
home – as well as in a police cruiser, and at the courthouse to the north of Newport (Bohjalian, 1998, p. 170).
CHAPTER SIX

A Substantive Theory of How Nurses Deal with an Allegation of Unprofessional Conduct

Throughout the long summer before my mother’s trial began, and then during those crisp days in the fall when her life was paraded publicly before the country, her character lynched, her wisdom impugned, I overheard much more that my parents realised, and I understood more than they would have liked (Bohjalian, 1988, p. 3).

INTRODUCTION

This chapter will provide a description and explanation of the emergent substantive theory which explained how participants dealt with an allegation of unprofessional conduct. The social phenomenon, an allegation of unprofessional conduct, provided impetus for the psycho-social process, or core category, transformation of the personal and professional self which the participants underwent. The dimensionality of this transformation provides detailed descriptions of the deconstructive and reconstructive processes the nurse participants experienced in response to the allegation of unprofessional conduct and situated within a number of adjunct processes and threads. The participants’ transformation, constructed from both the experience of the loss of the assumptive world and relearning the world, and their parts, is in essence, the Phoenix Process (Conti-O’Hare, 2002; Lesser, 2004). The reason for choosing this descriptor, that is, the Phoenix Process, will be introduced in this chapter and the theme continued in Chapter Seven where a focus on the theory in relation to the literature will be provided.
The purpose of this study was to discover the psycho-social processes associated with the social phenomenon of an allegation of unprofessional conduct. Using the grounded theory method, the allegations of unprofessional conduct was explored. The substantive theory of the transformation of the personal and professional self as it emerged from the participants’ psycho-social experienced and interactions explained the processes that they ‘engaged in’ and ‘went through’ in response to being reported to a NRA for an allegation of unprofessional conduct.

The social phenomenon provided the beginning point for addressing the study objectives and for this reason, those nurses who had been reported to a NRA for an allegation of unprofessional conduct were sought to provide an account of their experience. This main source of data was augmented by the literature and media accounts. Data collection and analysis occurred as a simultaneous endeavour to extrapolate the social process and provide direction for theoretical sampling which in turn provided for saturation of dimensionality and as such saturation of the theory. Figure 6.1 provides a schematic representation of the substantive theory.

THE PHOENIX PROCESS: TRANSFORMATION OF THE PERSONAL AND PROFESSIONAL SELF

The substantive theory revealed as The Phoenix Process: Transformation of the Personal and Professional Self provides a description of causation, consequence and associated processes for the nurse participant involved in an allegation of unprofessional conduct, which in turn, explain how the dealt with the allegation and its aftermath. The following discussion provides a revisitation of the social phenomenon and social processes to provide a conclusive description of
The substantive theory. The Phoenix Process contains within it, a beginning point of deconstruction and individualised markers along multi-dimensional trajectories which bridge the loss of the assumptive world and relearning the world through reconstructive processes. These markers are dynamic and are continually influenced by processes and threads internal and external to the participant. No end point to this experience was identified, as the nature and impact of the deconstruction and loss of the assumptive world forms the structure of the new world and is ever evolving. This is contended by Wade (1998, p. 716) who states that ‘transformation is a journey without a final destination’. The reason for calling this substantive theory the Phoenix Process provides visual description of the parallel between the myth of the phoenix and the transformation of the personal and professional self of these participants. The degree and consequences of the transformation while individualised can be viewed as deconstruction and reconstruction. The simile of the mythology of the phoenix describes a process of ‘deconstruction and reconstruction’. This mythical bird is said to burn to death on a nest of fragrant wood. From the reduced ashes, the phoenix would rise. Conti-O’Hare (2002, p. 96) states that the phoenix may be perceived as the ‘ultimate and inspiring example of transformation and transcendence’ It is suggested that although interpretations of this myth may vary, the ‘symbolism clearly indicates that sometimes a violent dissolution of the old must occur to make way for a transformation to the new’ (Conti-O’Hare, 2002, p. 96).

The symbolism of this myth provides for an overarching understanding to the transformative process for the study cohort. While each transformation is individualised there are properties and dimensions that illustrate and describe the constructs of the process which these participants both went through and engaged
Figure 6.1: The substantive theory: A transformation of the personal and professional self.
in. Transformation was as a result of the allegation and associated deconstruction and the reconstructive processes. Deconstruction of the personal self can be viewed on a dimension of fraying to unravelling, suggesting that some participant were minimally affected and others experienced a complete deconstruction of the personal self. Deconstruction of the professional self was viewed on a dimensional continuum of interruption to disintegration revealing again minimal to significant impact on the professional self. Some were able to minimise this unravelling and rethread the constructs of the personal. Interruption of the professional self was able to be reversed while those nurses who experience disintegration of the professional self for the main part either remained disintegrated or were able to return to nursing albeit slowly and with difficulty.

The vehicle for the transformation is the allegation of unprofessional conduct and the associated deconstruction of the personal and professional self. Transformation is recognised when the individual is able to integrate these new self views into the new self definition. It will be shown that this occurred for two of the study participants and others can be seen to be moving to this point.

Positive transformation from this potentially devastating experience is possible. What cannot be projected is who is able to transform. This study has provided a substantive theory to describe the personal and professional transformation for nurses who have had an allegation of unprofessional conduct made against them. What is described are the major theoretical constructs, or categories of this theory, their properties and dimensions. This theory does describe positive and negative influencing factors to propel the nurse toward transformation. This remainder of this chapter will describe the major constructs
of the substantive theory and provide a backdrop for integration of the literature in the next chapter.

**The Social Phenomenon: An Allegation of Unprofessional Conduct**

The social phenomenon, an allegation of unprofessional conduct, was experienced by all the study participants. The sub-categories, properties and dimensions are discussed and provided schematically in Figure 6.2.

Vulnerability emerged with the personal and professional domains of the assumptive world of the participant. Vulnerability within the context of this substantive theory has a two fold meaning. Firstly, it is defined as the degree and type of risk to cause fragmentation of decision making. Secondly, it is defined as the proneness to having an allegation of unprofessional conduct made. Vulnerability was identified as existing with the personal domain and the professional domain. Within each domain a range of individual and contextual causal attributes were identified. Specific dimensions of the causal attributes were identified as providing scope to the overarching concept of vulnerability in nursing practice and as individualised reasons for being involved in an allegation of unprofessional conduct.

The concept of vulnerability not only emerged as an antecedent for the allegation of the social phenomenon but was identified as an ongoing constant in the transformative period and as a lifelong constant. Vulnerability can be seen as those risks that are ‘put in the way of the nurse’ and the risk that the nurse brings to the role. Vulnerability is also the potential to be harmed through a lack of knowledge of the NRA and associated legal processes. Vulnerability can exist
because the nurse is disempowered either through a lack of knowledge or because of the emotional trauma they are experiencing. This example was illustrated by one of the participants who stated that ‘nurses go like lambs to the slaughter’ when she was called in to see the Director of Nursing and the hospital’s lawyer

Figure 6.2: A schematic representation of the social phenomenon: An allegation of unprofessional conduct.

after she was involved in a nursing error. The ability to navigate vulnerability through identifying and minimising vulnerability was seen to be undertaken by some nurses in the reconstructive phases. Not all nurses identified the
vulnerabilities within the context they were working in, however, nor were they able to identify vulnerability grounded in their own behaviour.

Specific causal attributes, both individual and contextual, emerged from the sub-categories of personal and professional vulnerability. For the most part, there are a number of causal attributes that were identified as providing the trigger for, or the influence and foundation for fragmentation of decision making, and the consequential reason to allege unprofessional conduct. These causal attributes also provided the impetus to allege unprofessional conduct where the motivation to report the nurse was the primary trajectory to the loss of the assumptive world.

**Personal Vulnerability**

*Personal vulnerability* emerged with the identification of *individual* and *contextual causal attributes*. Individual causal attributes were comprised of *physical and mental health issues*, and *dissenting behaviours*. The property of physical and mental ill health issues has within it the dimension of *issues of cognition* and the property dissenting behaviours is dimensionalised by: *Tall Poppy Syndrome; whistleblowing; industrial/union involvement; sub-standard performance* and *communication difficulties*.

The dimensions of contextual causal attributes emerged as *out-group perception* and *isolating strategies*. The dimensions of out-group perception were identified as: *face does not fit; non-conformance to group think; non-conformance to individual biases*; and *Judas phenomenon*. The dimensions which provide definition and scope to the property of isolating strategies were identified as: *scapegoating, workplace bullying and mobbing; performance management strategy*; and *interruption to employment*. 
There is, primarily, a cause and effect relationship between the individual and contextual causal attributes. This relationship illustrates how the attributes of the individual in terms of issues of cognition and dissenting behaviours provide impetus for out-group perception and the consequences of isolating strategies. This causative trajectory provides understanding of the reasons for alleging, but moreover the motivations for reporting participants to a NRA for an allegation of unprofessional conduct. To illustrate this contention a number of cases are explored in the context of personal vulnerability. The first case illustrates two nurses who were involved in the administration of a narcotic medication without authorisation. Both nurses admitted to this nursing error but found themselves reported to a NRA for an allegation of unprofessional conduct. It was revealed by the nurses that they believed that they had been reported because the hospital needed a scapegoat for a series of events that forced a family member to complain to the hospital regarding the care of complainant’s father. The isolating strategy of viewing these nurses as scapegoats was instigated by the complaint. Reporting these nurses to the NRA was under the guise of a performance management strategy. There is no doubt that these nurses did breach a nursing practice standard: their admission of guilt, remorse and longstanding careers as caring and competent nurses however, paled into insignificance against the need for a scapegoat.

**Professional Vulnerability**

The concept of professional vulnerability emerged with the identification of individual and contextual causal attributes. Specific to the sub-category, individual causal attributes, the following properties were identified: *clinical*
knowledge and working around nursing practice and conduct standards. The sub-category, contextual causal attributes is comprised of three properties: organisational culture; systems issues; and practice context. These properties and their dimensions are described.

Clinical knowledge is a necessary foundation for sound clinical decision making. What emerged from this property was the dimension of knowledge deficit. At times, it is not unusual to have a knowledge deficit. Constructs of safe nursing practice include knowing when and what you do not know, and seeking the information before actions are undertaken. Working around standards and unknowingly or knowingly bending the rules provided impetus for a breach of, or failure to meet nursing practice and conduct standards. Unknowingly bending the rules was demonstrated by an actual lack of knowledge of nursing practice standards. One participant contended with respect to the allegation that she did not know that what she was doing was wrong and contrary to documented standards. This dimension was revealed in the narrative of one nurse who failed to assess a patient who had fallen. Not knowing the standard for assessment of patients who had fallen or understanding the standards of neurological assessment for patients with a decreasing consciousness was found to be at the core of the allegations. This participant stated that she did not know the standards for this clinical situation. Knowingly bending the rules was identified with a few participants acknowledging that their practice was not in accordance with the standards but their motivations lay within the immediate needs of the patients.

The property organisational culture, contains three dimensions, they are: not knowing the rule; just accepting the rules; and physician-nurse relationships. The culture of the organisation contributed to the vulnerability that the
participants had to navigate. This vulnerability was revealed by not knowing the rules of the organisation, and if the rules were known, accepting them without critical thinking. Participants revealed a lack of understanding of the inherent culture. Not understanding the organisation’s culture and the rules, mostly ‘unwritten’ that govern behaviours, meant that the participant had difficulty following the rules and fitting in. The third dimension was the fear created by negative physician-nurse relationships. This fear meant that the nurses who identified this as a vulnerability were hesitant in contacting the physician to obtain a clarification of the medication order. It is acknowledged that significant in-roads have been made and in a lot of cases medical practitioners and nurses work together in the true spirit of collegiality, nonetheless a chasm still exists in some contexts and demonstrated clearly within the narratives provided by Participants 3 and 8.

The property systems issues, is comprised of two dimensions: workload and medication practices. Workload in terms of staffing numbers to patient load, patient acuity and associated geographical issues provided significant antecedents to the errors that were alleged in this study. Medication practices were revealed as a significant component of professional vulnerability.

The property practice context contains three dimensions: specific contexts; not knowing the patient; and the patient imperative. Mental health nursing contexts shared by the study participants revealed high risk domains, in that patient populations can be easily manipulated, some nurses found themselves working in relative professional isolation and there was an element of experimental ways to managing these patients which provided impetus for some nurses to challenge practices. Aged care nursing is a high risk area purely because
of the ration of registered nurses to patients. There was also a sense of patient vulnerability that did not appear to be a priority for those in positions of influence. Not knowing the patient was identified as a source of vulnerability for the nurse.

The final dimension the patient imperative illustrates motivation for the decisions that were made and the subsequent choice of breaching a nursing practice standard. Nurses were propelled by the need to address the acuity of the patient’s clinical situation, either an issue of acute pain, acute psychosis or an individualised issue. The concept as a dimension of decision making requires further formal articulation.

In summary, it is contended that the findings of personal and professional vulnerability exist in the assumptive or, everyday world of the nurse. This vulnerability and specific causal attributes both individual and contextual provided momentum, triggers and specific causation for an allegation of unprofessional conduct. The interface of the individual and contextual casual attributes of each vulnerability, and within personal and professional vulnerability provides the impetus for the allegation of unprofessional conduct along two trajectories. These trajectories which give rise to the allegation of unprofessional conduct are now discussed.

The first trajectory concludes with a fragmentation of decision making. The second trajectory is propelled by the motivations of others to allege and subsequently report the nurse to the NRA. This trajectory can exist in parallel to the first trajectory. That is, in some cases reported in this study, were nurses who were involved in a breach of, or a failure to meet a nursing practice standard which was upheld at inquiry, but the motivation becomes the primary energy
behind the allegations. The next section of this chapter will examine the concept of fragmentation of decision making.

**Fragmentation of Decision Making**

Fragmentation of decision making was uncovered by analysing the professional vulnerability the participant experienced. Decision making can be viewed as a trajectory, in conflict with the practice context and associated processes, and should be in harmony with the knowledge and skill level of the individual. This is not always the case as identified in the narratives in this study. A fragmentation of decision making occurs when the nurse can no longer navigate the vulnerability they are faced with from the context or the vulnerabilities which arrive from thinking and behaviours of the nurse. What emerges within the decision making attempt is a fragmentation of thought and action (decision making) with a resultant breach of, or failure to meet a nursing practice standard, translated to a nursing error. Fragmentation of decision making (Figure 6.3) can result in a breach of, or failure to meet a nursing practice standard. Such breaches or failures to meet can be viewed as a nursing error which in turn can constitute unprofessional conduct. The result of fragmentation of decision making for the study participants was an allegation of unprofessional conduct.
Figure 6.3: A schematic representation of fragmentation of decision making.
Allegations of Unprofessional Conduct

The allegations of unprofessional conduct are situated within the respective NRA legislation are linked to allegations of a breach of, or failure to meet a nursing practice standard. These breaches and failure to meet the designated standard in some cases culminated in a nursing error. All the participants had an allegation of unprofessional conduct made against them. Alleging unprofessional conduct is a serious matter. The implications of not practicing safely can have catastrophic implications for the patient and for the nurse involved in making the error. Nursing practice as already contended is not without risk Robinson (as cited in Milligan & Robinson, 2003). For the most part nurses enter each practice encounter with good intentions and the necessary theory and skills to effect the required outcome. This study is testament to the fact that nursing practice does not always go to plan. The vulnerability encountered and faced by these participants and the consequence of fragmented decision making provide the causative trajectory for a breach of, or failure to meet a nursing practice standard.

The allegations of unprofessional conduct were sometimes difficult for the participants to articulate. Some had kept the written allegations and others told how it was too painful to look at them. Having at my disposal the formal allegations as worded by the NRA was not possible. Nonetheless, it was possible to gleam the nature of the allegations. The following will present an overview of the allegations and associated antecedents.

Of the total cases presented in this study, nine involved medication practices and allegations of error. Not checking a narcotic to the bedside in one case meant that a patient received a fatal overdose. A number of vulnerabilities
were identified in this case including workload and geographical difficulties which meant that it was difficult for the nurse to leave the area to check the medication to the bedside. Proceeding with administering a narcotic without a fully written order placed two of the study participants at significant risk. Workload and numerous interruptions provided impetus for a fragmentation in decision making. Subsequently a patient received a dose that was not prescribed for him because of the participants’ belief in addressing the ‘patient imperative’ and the fear of contacting the medical practitioner.

The vulnerability of workload and interruptions are identified in another case. A participant administered a medication twice to the same patient because of the extent of her workload and the fact that she was continually interrupted during the medication round. Another medication error occurred with fragmentation of decision making. A nurse responding to a patient’s need and not wanting to interrupt a medical practitioner who was asleep administered narcotic analgesia to a patient two hours before the ordered time. The fragmentation of decision making continued with miscommunication and failure to read the medication chart meant that another nurse gave the ordered medication again.

A further case revealed the breach of a standard when the participant gave an intramuscular medication error with a used syringe. Work practices of not disposing of used syringes [by another staff member] added to the vulnerability for this participant. A further participant who had an allegation made against him that he ordered a medication for a patient in an acute psychotic state found that the NRA upheld the allegations. The vulnerability for this participant primarily centred round undertaking a practice where an ‘unwritten rule’ said that it was acceptable. Workload was also a significant vulnerability in the allegations that
one participant was faced with. Fragmentation of decision making in this case meant that a medication was given but was not signed for. Another participant faced allegations of unprofessional conduct when he administered an intravenous medication by the push method rather than via infusion.

Other allegations highlighted fragmentation of decision making. One case involved the allegation that the nurse in question failed to make an accurate and adequate assessment of a patient who had fallen. This patient later died in hospital from injuries allegedly sustained in the fall. A similar allegation involved allegations of failing to assess a patient in an accurate and adequate way and resuscitate them.

The next domain of allegations of unprofessional conduct was framed around a ‘lack of moral agency’ (Benner, et al, 2002) for the patients in the care of these participants. A lack of moral agency is defined as occurring when the nurse fails to advocate in the best interests of the patient (Benner, et al, 2002). This lack of moral agency causes harm and ‘may be considered a source of substandard or erroneous nursing practice’ (Benner, et al, 2002, p. 514). Allegations of unprofessional conduct relevant to the study participants which were grounded in a lack of moral agency included: failing to meet their needs; allowing them to sleep on the floor; rough handling; inappropriate language and body language; and breaching professional boundaries comprise the remainder of the allegations.

**Motivations to Allege and Report**

There is a responsibility to report and respond to allegations of unprofessional conduct where there is a preliminary determination that the nurse is unsafe to practice and where this matter cannot be addressed through
performance management and educational processes. This concept of not safe to practice may be grounded in issues of competency, physical and mental impairment, or intentional behaviours to harm. There is an imperative need to remove the nurse from the practice setting. While this contention should be at the core of making a determination to report a nurse it became evident with some of the cases in this study that while there may have been questions regarding the nurse’s ability to practice safely, appropriate strategies to address performance deficits were not adequate. The reasons for alleging and subsequently reporting the nurse to the NRA as stand alone decisions are for the most part questionable. A continuum of motivation was uncovered from analysis of the experiences of the study cohort. This continuum represents motivations that were grounded in beneficence and maleficence.

However, despite the identification of less than proper reasons for alleging and reporting some of the participants, motivations to allege unprofessional conduct and report should be grounded in the concept of ensuring public safety. The next section reviews the findings of the motivation to allege and the identified literature. The dilemma of making a determination to allege and report the nurse is further addressed in chapter 8 with the presentation of a decision making framework.

**Loss of the Assumptive World: The Experience of Deconstruction**

Loss of the assumptive world emerged as the experience of deconstruction of the personal and professional self. The *assumptive world* is defined as ‘the assumptions or beliefs that ground, secure, or orient people, that give a sense of reality, meaning, or purpose to life’ (Kaufmann, 2002, p. 1). To further illustrate
this concept Kaufman (2002, p. 3) goes on to say that the assumptive world serves to help ‘frame or organise’ what it is before us that requires understanding or analysis. The assumptive world is comprised of beliefs, and it is these that are shattered when for example the individual experiences a psychological trauma (Janoff-Bulman, 1992). Therefore, the assumptive world of the nurse is the overriding sense of belonging and understanding that grounds them in their world.

For the purpose of this thesis, the world also encompasses the day to day processes and constructs that the individual finds himself or herself in. This world is comprised of the personal and professional.

Janoff-Bulman (1992) explains that trauma and the associated loss threaten that which constructs the assumptive world and how the individual sees their world unfolding. The distress, in part, that the individual experiences because of the trauma is because there is a realisation that a fundamental assumption is no longer tenable. The assumptive world, or the expected world is ‘lost’. The way this world is lost is now described.

**Being Confronted**

The loss of the assumptive world commenced with *being confronted* by the allegation and the associated processes. Participants lost their assumptive world after the allegation was made, and they were made aware of it, either through *self realisation* or *being notified*. Once confronted with the allegation the participant was further confronted by the processes of the *employer*, the *NRA* and *other legal processes*, e.g. a coronial inquiry. This confrontation took the dimensions of *unknowing, disempowerment, ‘on the stand’ and whose side are you on?* These dimensions represent the scope of confrontation for this property.
For the most part the participants were confronted by these processes because they did not fully understand the purpose of the NRA or specific processes and strategies of a disciplinary hearing. This proved to be frustrating for some participants as they could not understand what was actually going on and they found that the NRA was not willing to advise them of procedures. Some participants were further confronted by the processes because they were disempowered. A reason for this disempowerment included not being mentally well enough to engage at an appropriate level.

‘On the stand’ represented the dimension of confrontation where the experience of going to the inquiry by either the NRA or the coroner proved for the most part an awful experience. Some participants welcomed the inquiry as an opportunity to tell their side of the story. The inquiry proved confronting in that it appeared to be a criminal trial. The language of the participants provided vivid descriptions of a trial including words, like ‘prosecution’, ‘jury’, ‘charges’, ‘cross examination’ and ‘guilty’. For some participants the dimension of whose side are you on proved the most frustrating. One participant expressed indignation at having faithfully paid her fees for many years and the NRA not being responsive to her needs. In essence, the NRA exists to protect the public, not the nurse in disciplinary matters.

Many of the participants were confronted with the concept of time and prolonged waiting. The dimensions, time taken to allege, time taken to make a determination and time along the transformative trajectory describe moments and processes where time was an issue.

In all but one case, the time taken to allege was viewed by the participants as being unacceptable. The participant who did not feel that the matter had taken
an extraordinary amount of time had the matter dealt with in less than five months. In one case, it was not until four months after the alleged error was made that the matter was reported to the NRA and formally alleged. The concern expressed by this participant was that if they considered her unsafe to practice then why did they take so long to report the matter?

The second dimension time to make a determination proved particularly confronting the majority of the participants. The time taken to deal with the matter proved confronting because it was distressing and frustrating. These participants had their lives on hold while the NRA investigated the matter, conducted an inquiry and then made a determination. Further delays were described where the NRA had to type up the findings and carry over decision making because board members were on holidays. The words of the participants reveal that this time delay proved a significant factor in their experience of deconstruction. The waiting also affected their family. Participants described the waiting as a trauma and intolerable. Some participants stated that they just wanted things over with whatever the outcome. The delays that were experienced proved causative in nature to the degree of deconstruction that the participants experienced.

The third dimension time along the transformative trajectory is the point, moving and fixed, that the participants found themselves on regarding the collective transformative experience. In the extreme, one participant had been existing in the new world, not really being able to move on for 14 years. Another participant who has reconstructed fully in a positive way shared with me that it had taken 8 years to arrive at that point. It would appear that the nurse who has difficulty and little support during the deconstructive phases of the experience,
and cannot find meaning to the event lives on the transformative trajectory the longest.

**Deconstruction of the Personal Self**

All participants experienced a deconstruction of the personal self. The physical, the psychological and the social constructs of the self were deconstructed to varying degrees. Some participants experienced minimal deconstruction represented with the visual description of fraying while others could be seen to have unravelled. The dimension of deconstruction specific to the individual in turn affected the experience of reconstruction.

Physical deconstruction was primarily in response to the psychological deconstruction and stress the individual experienced. Some participants experience very little physical illness and symptoms while others became unwell and experienced significant symptomatology of stress. Symptoms experienced included: weight changes; sleep loss; chest pain; change to integument; loss of hair and teeth; and disease. One participant developed diabetes. Those participants who did not experience physical symptoms or develop illness were those who demonstrated better psychosocial coping and who contended a conscious effort to minimising deconstruction.

For some participants there was reflected in their stories the dimension of surrendering. This moment either self realised or recognised by someone close to the participant provided an opportunity to give up or give into the deconstructive forces. This then meant that they were able to realise that what was happening to them had to stop and that they needed to get help and start reconstructing. The concept of surrender is described as ‘a purely inner phenomenon’ which enables
you [the individual] to ‘see clearly what needs to be done, and you take action’ (Tolle, 1997, p. 117-119). Day (no date, p. 80) explains that surrender is reached when ‘the connection and emotional bonds to significant people and things in this life are cut’.

Psychological deconstruction again proved variable. All participants experienced stress as a result of being confronted by the allegation and the unfolding experience. The dimensional extremes revealed minimal stress reactions including anxiety and sleep changes to suicidal attempts. There is no doubt that the majority of participants experienced psychological trauma. Johnstone when asked to comment on matters where a nurse was reported to a NRA (as cited in Prenesti, 1994) states that the experience of being reported to a NRA is traumatic, even if they should be cleared. While I am in no formal position to diagnosis post traumatic stress disorder (PTSD) a number of participants provided descriptions of what they had and were still going through that is highly suggested of PTSD.

All participants experienced social deconstruction. Dimensions of this included the negative impact on the structure and members of the family. The experience put added burden on already strained relationships and a number of participants were separated or divorced during this time. Children were also affected by the stress that the participant was experiencing. This impact translated to experiencing difficulties in their own day to day life. Some families had to relocate to facilitate the participant obtaining work. The upheaval of relocation is a stress within itself. The financial consequences of this experience contributed to the social deconstruction experienced by the participant and the family. There was an added financial burden experienced by those participants who could not or
were not allowed to work, through having to attend courses and by having to pay fines and contribute to the costs of the inquiry. One participant was required to pay $30 000 to the NRA for fines and costs. Some nurses had not worked for years and became reliant on family members for financial support.

The last dimension of social deconstruction was the isolation that the participant experienced. Some found that friends and colleagues no longer wanted to know them. Having to relocate meant leaving what support systems they may have had. Isolation also occurred because of the loss of the role as a nurse.

Deconstruction of the personal self was an individualised experience but one that has overarching dimensions. For some participants there was a clear link to the deconstruction of the personal and the deconstruction of the professional. A few participants had been a nurse for many years; two had been nursing near forty years. To separate the personal from the professional was difficult for these nurses. The next section should be considered in light of the degree of deconstruction of the personal self.

**Deconstruction of the Professional Self**

The professional self is the view by the self and others of those defining behaviours and characteristics which make them a professional, and their position in the assumptive world. The nature of the social phenomenon is central to the assumptive world of the nurse as a professional and represents a shared reality. Nursing by its nature and social perception is about doing and being good. To have an allegation of unprofessional conduct made against a nurse is to strike at the core of their definition.
Deconstruction of the professional self was attributed to the allegation being made and finding out that they had been reported to the NRA. The degree of deconstruction was influenced by the way in which the individual interpreted the social phenomenon and the way they engaged with it. All participants experienced a deconstruction of their professional self with identification of the following properties: nurse interrupted, spoiled identity and punishment.

Nurse interrupted\footnote{Nurse interrupted is used to denote the interruption of the role as a nurse. This term has been borrowed from the book ‘Girl Interrupted’ by Susanna Kaysen which was later made into a film. The notion of ‘girl interrupted’ was taken from a painting, titled ‘Girl Interrupted at Her Music’. Further discussion of the notion will be presented in chapter 7.} is illustrated by a loss of the role, a loss of passion, and a loss of confidence. Not all participants experienced each dimension, and some participants experienced all three. A loss of the role was illustrated in a number of ways along the deconstructive trajectory (and continued within the reconstructive phases). Some nurses had their employment suspended while an investigation was conducted by the employer. Some of these went on to have their employment terminated. A few participants found themselves summarily sacked from their positions. Other chose to resign immediately or sometime later. Another found that she could not secure employment once the NRA had made a determination and handed down their decision. She was required to practice (as a RN) under the supervision of another RN for a period of 12 months. Of course, no employer was prepared to do this for financial reasons. It is also imagined that this requirement would not send a positive message to prospective employers. This participant now has a permanent loss of the role. Some participants lost their role as a nurse because they were not well enough to work. For the most part these were temporary interruptions. One participant had decided not to work again. At the time of the interview she had made the decision that she was not prepared to risk
being involved in another error and had removed herself from nursing practice.

Losing the role was also evident when nurses realised that they could not work in a permanent setting or in their chosen field. Three participants had moved to agency nursing, removing themselves from the context that they felt had gotten them in this situation in the first place. Working as an agency nurse means you do not have to engage with people on a social level nor do you have to get involved in the politics. If you realise that you do not like the context you choose not to come back the next day. The second is not being able to work in the area of interest. This was a particular problem for one participant. He felt that he could not work in his chosen field because of the way patients were managed and treated in this area. He believed because of his passion for this area that he would not be able to hold his tongue when it came to poor standards of care. Figure 6.4 provides a schematic overview of losing the role.

Losing the passion was illustrated as a dimension of nurse interrupted. As already contended some of these participants had been working for many years and unapologetically contended that the experience had made them lose their passion and love of the job. It was not until one nurse was challenged by a colleague regarding her still working at the hospital where the error had taken place she decided to move. It was here that her confidence returned and she began to love the job again and ultimately reconstruct more fully. Another participant had ‘lost the passion’ for nursing and did not believe that the profession was worth the continual fight. Losing the passion was grounded the negative and traumatic nature of the experience. Having to relive this trauma and
experience ongoing bullying did not provide a foundation for enjoying work let alone having passion for it. It is contended that to regain the passion the participant has to be sufficiently along the transformative trajectory that they are able to work in a setting that is supportive and minimises remembering, along with a commitment that that is what they still wanted to practice nursing. This is and was not possible for all the participants.

Losing confidence as part of the concept of nurse interrupted was a factor for some nurses. The ongoing fear that they could make another mistake for some was paralysing. The extreme of losing confidence meant that one nurse had chosen not to practice nursing again. Loss of confidence was related to what the nurse had gone through and the affect of ongoing stressors. This loss was demonstrated in a loss of confidence within the individual’s ability to practice nursing and as one nurse explained, her colleagues had lost confidence in her.
There is a stigma associated with doing the wrong thing and being reported to a NRA. Nurse regulatory authorities are mostly misunderstood and feared. This fear lies in the fact that these authorities have the power to make some disciplinary matters public. For example, one participant was very fearful that because the inquiry was open to the public people she knew might have attended. Another nurse feared the reporting of the investigation and inquiry in the NRA newsletter. While names are not included she felt that people who know who she was. The other fear is that the NRA has the power to remove the nurse’s name from the Register and their livelihood.

The criminalisation of these participants was illustrated in a number of ways. Some participants felt like a criminal because of the way they were treated and seen, and the criminalisation of the process by the employer, the NRA and the coronial inquiry. Participants used frequent descriptions of the NRA and coronial inquiries with words depicting a criminal trial, including words like: ‘defence’, ‘cross examined’, ‘on trial’ ‘charges’, ‘guilty’, ‘not guilty’, ‘jury’, ‘witnesses’ and ‘prosecution’. They describe how they were grilled by ‘prosecuting lawyers’ and they way they were treated ‘on the stand’. They described being bullied and ridiculed while being questioned. Even one participant who was testified at a coronial inquiry felt that she was cross examined for five hours and the lawyers had to be told that she was not on trial in response to their method of questioning. One participant referred to feeling like Lindy Chamberlain as she entered a large courthouse where the NRA inquiry was held. Being seen as a criminal provided

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24 Lindy Chamberlain was charged with the death of her baby girl despite her assertion that a dingo took her baby from a tent while camping in the outback of central Australia. This much publicised case polarised the Australian community. The case was very much a ‘trial by media’. Lindy Chamberlain was initially found guilty and imprisoned. This charge was appealed and she was released. The facts of the case remain clouded with the baby never being found.
for a spoiled identity for the majority of the study participants. The identity of their professional self was and for some, still spoiled.

The third property punishment with dimensions of self and externally initiated punishment provides for further illustration of deconstruction of the professional self. One of the more poignant moments in the interviews was when one of the participants read out a letter that had been written to the NRA. In it, a friend of the participant implores them to understand that no amount of punishment could match what this nurse had already put herself through. Self punishment by reliving and regretting was revealed in the experience of deconstruction of the professional self. Punishment was also externally imposed by the employer and the NRA. Some nurses had their employment suspended and or terminated. Where allegations were upheld these participants were punished in the form of fines and directives to undertake supervision and or education. In some cases they were required to pay costs. The public outing of the inquiry outcome was also a form of punishment and contributed to the concept of spoiled identity.

**Relearning the World: The Experience of Reconstruction**

Relearning the world emerged with the individual continuing their transformation by experiencing a reconstruction of the personal and professional self. Relearning the world as a construct of grieving as received considerable attention (Attig, 1996). Relearning the world has been seen as a construct of making and finding meaning to the experience of loss of a loved one. The findings of this study reveal broader properties and dimensions to relearning the
world and reconstructing through loss as described by Attig (1996), though there are correlations. This construct of the substantive theory is now described.

**Preserving the Self: Minimising the Deconstruction**

The ability to preserve the self and minimise deconstruction was illustrated by assuming a stance, taking a stance and searching for meaning. This sub-category was influenced by resilience and the degree of support that was available.

Participants assumed a stance by questioning the allegation, telling the truth and anticipatory responses. Questioning the allegation had a pragmatic rationale. By questioning the allegation the nurse was making it clear that it was not going to be a ‘lie down and die’ situation. They questioned the allegations in light of not understanding them and as a way of instigating a challenge to them. Questioning also provided impetus for commencing the search for meaning.

Truth telling as a way of assuming a stance was common to those participants who actually made an error. Those nurses who had engaged in a nursing error and recognised it along with mitigating circumstances were forthcoming with the truth and the role they had to play. Some of them told the truth as they that they had made an error and did not see any point in denying it because errors were to be expected. They believed though that telling the truth should have afforded them some protection from the matter being reported to the NRA: this was not the case.

One participant who admitted freely to administering a medication without a written order was casual when admitting this. For this participant the issues were not about making the error but rather the way in which it was dealt with by the employer and the NRA.
Taking a stance was possible once a stance had been assumed. Taking a stance was identified with the uncovering of the following dimensions: preparedness, self defence and external defenders. The level of preparedness varied for the participants. Some undertook and received little preparation for what lay ahead in terms of the NRA inquiry and others were well prepared. The participants who were not as well prepared tended to struggle more the employer, NRA and other legal processes and consequently experienced more difficulty preserving the self. This meant that their experience of reconstruction was stymied.

Being able to defend oneself or obtaining assistance and support to defend the allegations by a third party proved effective for some participants. While obtaining an external defender was well intentioned it was not necessarily effective. Whether the use of another person to defend the allegations was effective but heavily reliant upon whether the individual understood the legal forum and the nursing context: not all did. For example even though some participants had union representation, there was a knowledge deficit pertaining to legal procedure and an awareness of the gravity of the situation.

Some participants were able to defend themselves. Those that did believed that they had not done anything wrong and spoke of previous experience in court and legal inquiries. One participant chose not to have legal representation and attended the NRA inquiry by herself. While she presented a compelling argument in relation to mitigating circumstances she did say that she would represent herself again because of the associated stress. Realising the need not to speak to the NRA without a lawyer present was also demonstrative of self defence and then led them seeking legal support.
Some participants took it upon themselves to educate themselves regarding the nature of the nursing error. They did this so that they would be able to speak more confidently to the expected standards and facts surrounding the matter. One participant took it upon herself to do a self evaluation of ANMC competency standards for the registered nurse after she was told that she was not competent to practice.

The final dimension of the property being confronted, is the search for meaning. The searching for meaning as a way of preserving the self and preventing further deconstruction was identified with the participant being able to frame the situation, making sense, and finding meaning. Framing the situation meant that the participant was able to put what was happening to them into some sort of perspective, by actually recognising what was happening, and then comparing it to the worst thing that could happen to them.

Making sense represents the processes the participant engaged in to understand what was happening, what was happening to them and why. These processes included asking questions why the allegation had been made and why they had been central to the allegation. While this proved difficult for some participants, others situated what was happening to them within a framework of sense, even if this was to acknowledge that there was no sense to make.

The lack of justice experienced by some meant that trying to make sense was grounded in the need to understand in their mind why the employer and NRA processes weren’t fair. This included attempting to understand why the allegation had been made against them in the first place. Some participants were able to reach a point of sense making when they realised that there was no justice to the
processes and outcome. They were then able to accept the sense of injustice they had experienced.

Trying to make sense of the situation did not always translate to meaning found. Meaning was found in varying ways and provided a source of resilience for some participants. Examples of meaning in and of the experience included having to endure the experience for the sake of their family. Some who contemplated suicide were tempered by the fact that their family who needed them. The meaning for these participants was found in the fact that they were a mother or father and spouse and were loved and needed by their family.

Altruism was expressed as another reason for going through the experience. Being able to help someone else from going through the experience of being reported to a NRA represented the meaning for one participant. Meaning was found in the fact that some participants had become stronger for the experience.

It was contended by one participant, that, she could not find any meaning in what she had gone through. Listening to her story there did not appear to be any rhyme or reason to why she was reported and the degree of deconstruction she has gone through. This individual is existing within the new world and is far from moving on. The point at which meaning is found in traumatic events is individualised as reflected by the examples uncovered in the analysis of data.

Meaning for these participants emerged in different ways, as a revelation, or as an acceptance of what had happened almost immediately. The search for meaning, by framing their situation, making sense and hopefully finding meaning were ways for preserving the self and provided a foundation for the reconstruction of the personal and professional selves.
Reconstructing the Personal Self

Reconstructing the personal self is described as a process of active and passive engagement where the participant transforms those constructs of the personal self in response to the deconstruction that was experienced. Reconstructing the personal self is a sub-category of the category, relearning the world. The world has the participant once knew is changed and continues to change in response to the degree and type of deconstruction they experienced, and the reconstruction they are experiencing.

Participants engaged in two processes to reconstruct themselves, rethreading the person and rethreading the social fabric. Rethreading the personal self meant getting better and for some participants reinventing themselves. Rethreading the social fabric had its impetus in being challenged either from within or by someone else to pick up the pieces of their social self. What allowed participants to get better, is now described.

The dimension, getting better revealed a number of processes participants engaged in to recover their physical and psychological well being. Support or the lack of it proved an integral component to minimising the degree of deconstruction experienced and as a way to reconstructing the personal and professional selves. Examples of this support are now described.

Support included informal and formal processes. Informally, participants sought the support of family and friends. Although this was not a conscious effort to getting better, it allowed the individual to be cared for, share what they were going through and be afforded with a degree of protection from the negative aspects of their life at this time. Other informal strategies included: seeking out
self help books, changing diet, exercising, interaction with pets and participating in distracting therapies, e.g. joining community groups and doing volunteer work.

Formal support processes included: counselling, medical advice and treatment, collegiality from colleagues, legal and industrial advice and representation. The effectiveness of these support processes varied.

The opportunity to talk things through in a constructive manner via a counsellor proved invaluable for the participants who were able to identify the need or have someone else suggest that this might be an effective strategy. In contrast, not being allowed to talk about it in the early days after the error was made, was identified as a contributing factor for the degree of deconstruction one participant experienced. This participant made specific reference to the fact that the staff involved in this error were advised not to talk to anyone about it. This lack of communication was further impaired because this participant was having relationship problems with her husband. This externally imposed silence in the early days of this experience negatively affected her recovery.

Some participants had to seeking specific treatment for depression. Two participants required admission for acute depression and anti-depressants. A few other participants also required medication to treat their depressive illness. Some participants had delayed seeking the assistance of a counsellor, consequently their ability to reconstruct has been stymied. A few participants had never seen a counsellor, including one participant whose deconstructive journey commenced over 14 years ago.

Obtaining professional counselling was hampered for some participants in that they were too unwell, mentally, to recognise this need. Advocating for the
individual in crisis is necessary for ensuring that they can get help when it is needed.

The second dimension to rethreading the personal self was seen with those individuals who reinvented themselves. Reinventing the self emerged with an uncovering of the experiences that some participants had gone through, the change this had created within them, and the realisation that they would never be the same again. An example of this is provided by one participant who decided that he could not nurse again, but instead, bought a farm and now is a fruit grower. He acknowledges that it is a challenging life but allows him more time to be with his family. He does not see himself as a nurse anymore. Reinvention for one participant was because she could not nurse again and had to seek out other avenues to construct herself. This meant pursuing other interests including volunteering in her community and joining a choir. Her view of herself is as a volunteer and choir member. Reconstructing the social fabric as a property of reconstructing the personal self was identified with the dimensions being challenged and picking up the pieces.

Being challenged came from within, that is internal, and in some situations, the participant was challenged by another person. Examples of being challenged include: being encouraged to defend the allegations; to get on with their life; to resign; or to take another path in life. Some participants were able to challenge themselves. For example one participant woke up one day and said to herself that she just had to get on with life. Being challenged, provided at times the impetus for a turning point for rethreading the social fabric.

Picking up the pieces represents that which had to be done by the participant to rethread the social fabric. One example for picking up the pieces
was described as getting back confidence before anything else could be done.

Rethreading the social fabric included re-entering the social world by participating in social activities.

**Reconstructing the Professional Self**

Reconstructing the professional self was possible for those participants who wanted to reconstruct and who were able because they had retained their licence to practice. The narratives reveal the decision making processes these participants used to decide whether to reconstruct the professional self and for those who chose to how this reconstructed occurred. The consequences of the degree of deconstruction of the professional self are now described.

Reconstructing the professional self is illustrated with the following properties: getting back on the horse; lessons learnt and finding the balance. The concept of getting back on the horse emerged with some participants talking about the need to risk, acceptance of the risk and the ability to risk returning to nursing practice. The need to risk was grounded in pragmatic reasons, e.g. the need to earn money. While some participants had not yet returned to nursing, there was a realisation that they would have to get the monkey off their back at some point and that returning to nursing.

Participants either accepted the risk that making an error was possible, while others in realising this decided that the risk to them was too great and consequently they had decided not to return to nursing. Others in accepting the risk felt that they had nothing to lose by going back to nursing. These decisions were made in relation to the degree of deconstruction the individual had experienced and the point they were at in reconstructing. Other participants
believed that they would never return to nursing. Not choosing to return to nursing means that reconstruction of the professional self is stymied.

Accepting the risk was dependent on being able to risk. For two participants this risk was far too great and therefore they were not prepared to risk. To return to nursing meant that a participant had to have a license to practice, meaning that they were physically and mentally well enough to do so. One participant who was willing to risk was not able to because the requirements stipulated by the NRA meant that she could not find an employer willing to offer 12 months of supervisory practice. For this nurse her ability to reconstruct the professional self was stymied by NRA requirements.

Motivation was seen as a factor in the ability to recognise the need and strategies for getting back on the horse. Motivation is defined as the ‘processes that initiate, energise and direct behaviour’ (Coleman, 1994). Motivation can be broadly divided into the concepts of need, drive and incentive (Bourne & Russo, 1998). Participants demonstrated varying degrees of motivation and as such, this proved an influencing factor in the ability to reconstruct personally and professionally, or in some cases, prevent themselves from being further deconstructed. Motivation was observed through the construct of a need and therefore, realised as a subsequent willingness to risk. This need to risk was constructed for the participant around the imperative need to have a job and thus, an income, and to where possible, reconstruct their personal and professional self as a matter of pride. Some participants did not explicitly express a motivation while others did. For some the motivation may have been present but was not able to be realised or acted upon because of the degree of personal and
professional deconstruction experienced, particularly in the early stages of the experience.

Lessons learnt by participants included in some cases, the ability to identify vulnerability, the ability to then minimise vulnerability and a consequential relearning of accountability. The ability to identify vulnerability and then minimising vulnerability was possible because of what had been learned. The experience of personal and professional vulnerability, including individual and contextual causal attributes and the consequence of fragmentation of decision making provided a foundation for identifying components of error making and as such, a lesson. The lesson or lessons learnt enabled the participant to identify future risks and act to minimise them.

Some participants were able to clearly identify the vulnerability they had experienced or continue to experience and were then able to minimise this vulnerability in some way. Examples of lessons learnt include the following. Realising that the context they were working in was no longer right for them in that it continued to contain within it significant vulnerability, they had decided to change contexts, either by resigning and choosing not to work casually or in a nursing agency. This was a purposeful strategy so as not to get involved with the politics of the ward. Choosing not to speak up and get involved with ward issues was another way for minimising vulnerability.

Participants sought out safe places to work and focused on safe practices as a way for minimising vulnerability. For example one participant recognised that he became too involved with patients in the aged care context: he decided not to work in this area. Participants identified from their experience specific
vulnerabilities, these included documentation deficits, workplace issues, e.g. a lack of nurses, and a lack of assertiveness.

Minimising vulnerability was possible once identification of vulnerable contexts and practice had been made. Importantly not all participants minimised vulnerability effectively. Attempting to conform to the culture of the context did not prove to minimise the vulnerability one participant experienced. Others engaged in nursing practices with extra care and attention. There was more focus with medication administration and others applied their energy to ensuring comprehensive documentation. One participant in realising that her documentation practices made her vulnerable because she couldn’t prove she had done a particular task now documents everything.

Vulnerability was also identified because of the psychological deconstruction that had occurred and the consequences of not having transcended reconstruction of the personal and professional self. In recognising this vulnerability, participants were in a better position to monitor the contexts they were working in and minimised the risk of ‘getting in too deep’.

Minimising vulnerability is relative and requires constant critical thinking and decision making. The realisation that vulnerability is a constant in the world of the nurse was recognised by many of the participants. Not being able to identify and where possible minimise vulnerability both personal and professional means that the participant has not been able to reflect adequately at least, on their experience and incorporate changes to their practice. This group of participants, albeit small, continue to be at risk because of their inability of managing their personal and professional vulnerability.
Relearning accountability was realised by a few of the study participants. To relearn accountability means knowing accountability, specifically understanding what it is and what it means for the nurse and demonstrating accountability in their everyday practice. Knowing accountability was illustrated with a new understanding of how their practice had to change in response to how they now saw things in terms of the vulnerability. Knowing accountability was also reflected as to whom the nurse is accountable to: the patient, the NRA, the employer and importantly to yourself. The most confronting knowing of accountability was expressed with the notion of it is your head on the cutting block.

Demonstrating accountability was illustrated with a change to practice. Learning from their experience and being able to incorporate this knowledge into future practice was revealed. Demonstrating this relearned accountability for one participant meant she now understood the concept of professional boundaries and knew how not to step over them. Further demonstration was revealed with participants telling how they now follow policy to the letter.

Not all participants had a lesson to learn. This was particularly so for those participants where the allegation was not upheld. Others were not able to learn a lesson where there was a lack of insight into the role in the events leading up and surrounding the allegation.

Finding a balance is the final property of the sub-category reconstruction of the professional self. Finding a balance was uncovered in the descriptions provided by some participants who had continued to practice nursing or who had returned to nursing. Finding a balance can be viewed as a process for re-
developing a realistic framework for practice where decisions are made competently and comfortably with little advice or clarification from other persons.

Some participants, particularly those who had lost their confidence had a difficult time in finding a balance. They were seen to have moved through, and for some were still moving through these three dimensions to get to this point, these dimensions are: over the top, questioning and affirming; and getting it right.

Some participants recognised that they were over the top with respect to how they went about undertaking nursing tasks. This was seen as an over compensatory mechanism to minimise missing something. Giving extra attention to documentation and an emphasis on dotting the 'I’s' and crossing the 'T’s' was seen by one participant as being over the top but a necessary strategy. The fear of making another error was a driving force in this concept of over doing things.

Finding the balance was also obtained with questioning and affirming. Participants questioned colleagues to ascertain if what they were doing was OK. They sought clarification from medical practitioners regarding the care plans for patients. This dimension was grounded in the need to be safe because they had lost their confidence and needed to frequently test and receive affirmation to determine if in fact their decision making and practices were appropriate. This is not to say that this was an easy step. One participant found that some colleagues felt that she was just being paranoid based on what had happened to her. Slipping back into a flawed organisational culture is an ever present vulnerability.

Finding the balance had been achieved by some participants. ‘Getting it right assumes an appropriate balancing of critical thinking and safe outcomes without being over the top or needing to continually question and seek affirmation. Getting it right is possible for those nurses who have experienced
considerable deconstruction of their professional self, including, a loss of confidence. To arrive at this point of getting it right required getting back on the horse, realising the lessons in the experience and being prepared to minimise the vulnerability enacted as a new accountability.

**Living Within the New World**

Living with the new world was identified a category within the substantive theory of how nurses deal with an allegation of unprofessional conduct. The new world is that which the participant is relearning and experiencing. It is the world that emerges and is constructed once the assumptive world is lost. Two sub-categories were uncovered with analysis of the data. Participants were identified as existing within the new world, while others had been able to move on.

Existing within the new world was revealed with the following dimensions: being psychologically stuck; re-experiencing; feelings of being let down; the need for revenge; and the need for vindication. Participants were identified as existing at different points on the transformative trajectory. Existing was not necessarily seen as a negative point within the transformative experience but for some participants they have not been able to process these dimensions in a positive way and have failed to move on. It is anticipated that some may never move on.

Moving on from existing in the new world was revealed with the experience of turning points, which provided the participant with meaning and momentum; and acceptance through integration in the new world. Some participants were at varying stages on this part of the trajectory, with some recognising what was necessary to move on.
For the most part participants were psychologically stuck because they were not mentally (and physically) well enough to move on. Others example reveal a sense of just not being able to move on despite a need and wish to. Not being able to accept what had happened meant that the participant was psychologically stuck. Being psychologically stuck for some participants was experienced through dreams. The dreams centred around their traumatic experience, making them relive the fear and anguish relating to the trauma they had experiencing and reliving the fear and anguish.

Other participants were considered to be existing in the new world rather than moving on because of effects re-experiencing the event had on them. Physical symptomatology associated with the stress of remembering was a real issue for some. One participant contended that re-experiencing the event occurred when she was sent relieving to the ward where the allegation occurred.

Some participants expressed feelings of being let down, the need for revenge and the need for vindication. They explained that until these could be addressed, then they felt that moving on would be difficult. Some contended that the NRA had let them down, as had their employer. Feeling of being let down by colleagues because they had not supported them was an issue for some.

The need for revenge was expressed by a few of the study participants. While they were able to demonstrate a self check with respect to the reality of revenge, it was a need for some participants in that they wanted others to realise how much this had harmed them. Conciliatory strategies may be an option for participants to seek an apology and share with their accuser the degree of deconstruction the allegation has created. This theme will be discussed in more
detail in the next chapter. Receiving an apology would provide the necessary turning point for one participant to be able to move on.

Vindication was identified as a need by a few participants and was uncovered with assertions by participants that an apology was necessary and acknowledgement that they had not done anything wrong. The challenge for these participants will emerge if they are not vindicated.

Moving on was demonstrated at various points along the transformative trajectory for some participants but only two, in my view had transacted reconstruction to a point where they were completely accepting of the new world and functioning well within it. This is not to say that remembering is not painful and that there are no regrets, but they have been able to move past those properties of existing within the world.

These two participants had experienced a turning point which provided meaning and momentum to their reconstructive experience. They had demonstrated acceptance and integration of their experiences into current practices revealing that lessons were learnt and applied in their new world, thus they had successfully re-learnt the new world. Nursing practice has changed to minimise vulnerability and incorporate a new understanding of accountability. Nonetheless, these two participants are able to recognise the personal and professional vulnerability which is constant in the new world: they are able to maintain a safe level of integrity of the personal and professional selves.

For the other participants who had not fully transacted the transformative trajectory, some had experienced a turning point. These turning points were represented and viewed in different ways. Some participants could not identify a turning point, this may be because it had not yet happened, there may not have
been one, or it was not clear in their experiences, so they couldn’t identify it. Some turnings points were a significant moment in the reconstructive experience and were the impetus for realising meaning and providing momentum to being able to move on.

Examples of turning points included recognising that they were not a ‘bad nurse ‘and that others believed in them. A significant turning point was realised by one participant when she accessed the patient’s notes and read that she had not been responsible for his death. Finding this fact out cleared her conscious and provided a much needed boost to her confidence. Turning points were able to be projected as something that had to occur to assist in them being able to move on. One nurse was waiting for the findings of her inquiry to be published in the respective NRA newsletter. She believed that once this happened she would be able to progress her recovery, specifically, move on. Turning points were sometimes happenchance. One participant woke up one day and thought I have to get on with life.

**Consequences of Reconstruction**

The overarching consequential dimensions of the learning the new world through a reconstruction of the personal and professional selves were identified as stymied, evolving and transcended. There was no identified sequence to these dimensions or time intervals. The transformative journey was different for each participant.

The ability to minimise deconstruction and to reconstruct is grounded in a number of processes and within the individual nature of the individual. All experiences are unique, but a number of contentions are proposed. Firstly, those
individuals who struggled more with the allegation and its impact on their identity as a person and as a nurse have a more difficult time in reconstructing. The question that is subsequently posed is: is being a nurse who *I am*, rather than ‘it is just a job’? Is the personal self the professional self, and is the professional self, the personal self?

From the experiences of the participants, a number of patterns along the transformative trajectory to the consequences of reconstruction were identified (Figure 6.5). The following diagram illustrates the potential sequences of moving, or not moving along the reconstructive trajectory.

**Influencing Factors**

The transformative experience and consequences of reconstruction were influenced by a number of factors. Four domains of influence were identified: resilience, support, time and vulnerability. These influencing factors can be seen as threads (Figure 6.1), which link the three categories: social phenomenon, loss of the assumptive world and relearning the world. These threads influenced the transformative processes in negative and positive ways. Support influences, the impact of time and vulnerability have been discussed in chapters 4 and 5 but are reviewed and situated in this chapter.
The concept of resilience was uncovered throughout the reported experiences of all the participants. Resilience as an internal quality and characteristic was identified as a constant thread in the experience of loss of the assumptive world and relearning the world. The degree of resilience ebbed and waned for the participants over the course of their transformative journey, but was seen as a constant thread ‘tying’ everything together even when the fraying and unravelling seemed too much to bear. Even for those nurses who were probably at the end of rope, resilience however small, was a ‘thread for survival’.

The dimensionality of this construct clearly existed in the fact that some participants were more resilient than others. It is posited that the other identified influencing factors, inherent individual factors and the specific nature of the experience influence the degree of resilience the individual is able to muster in face of extremely challenging times. Some participants demonstrated the ability
to be more resilient than others and were able to respond more positively to the range of influencing factors. Resilience is viewed as a force of momentum on both the deconstructive and reconstructive trajectories. The resilience experienced and demonstrated by the study participants is now described.

Resilience was demonstrated very early on for Participant 1. In her return to work one week after the incident where a patient received a fatal overdose of a narcotic, she both acknowledges the difficulty and the need to get ‘back on the horse’, and in doing so demonstrates a starting point of resilience:

"To go back to work was really hard but I got back in there, in fact when I went back the following week my knees were knocking but I thought if I don’t go in tonight I never will." [P01/PG11/L14-16]

Some participants demonstrate a degree of resilience although the outcome is not necessarily the one they wanted. This is true for Participant 2 who has not been able to return to nursing, but demonstrates the ability to not only bounce back, but in doing so to gain something that she might not have achieved otherwise:

"Maybe something good has come out of this. I have been doing a psychology course and I have been doing voluntary work at our community house doing cooking." [P02/PG11/L24-27]

Participant 6 provides a number of unsolicited examples of the notion of resilience. Her ability to be resilient is best provided in the following quotations from her narrative. In doing so a connection is made to resilience being about inner strength:

"I am sure that in the future there will be traumas and tribulations as well but I think I have the inner strength to cope with it and as I keep saying and it probably sounds like a religious thing, my strength definitely comes from within me and therefore I am able to deal with these sorts of situations relatively well." [P06/PG30/L6-13]

Further to her situation she viewed herself as the only one who was able to
emerge from the situation in a positive way: ‘the experience can set you back, but in my case they have never won.’ [P06/PG09/L22-24] The concept of resilience for this participant was demonstrated as a conscious thought.

Another example of resilience as ‘strength’ is provided in the following.

When I went to see the psychologist and after hearing my story she said ‘I can well understand why you are depressed’. I explained to her how I had kept my study commitments separate to all of this and she said by being able to separate these showed that I had strength. [P07/PG14/L3-5]

This participant explains that while the whole experience has been ‘sad’ for her ‘she can’t lie down and die, you’ve got to get on with your life, and you have to try and clear it and smile again’. [P07/PG25/L21-23]

Resilience emerged as a component of belief systems. For example, Participant 11 tells how he lived with the thought shared by his father that ‘you don’t let the bastards get you down’ [P11/PG08/L32].

Other belief systems discussed by participants included religious beliefs and practices. A further example is provided by Participant 15. She explains:

I am a Christian, I have a lot of faith and that has kept me going. At one stage I was talking to God and I said to him, ‘look God I can’t take any more of this it’s just too much. And it was like he was saying, ‘please yourself, you know, you can take the easy way or pull yourself together. There is something seriously wrong with you and you’ve got to accept this’. And I am saying there’s nothing wrong me, I’m trying really hard to do the right thing by everyone and I’m just getting pushed over. And he said, ‘you are allowing them to do it’. At that point I discovered that I had the power to change. [P15/PG25/L1-11]

In response to being asked why he didn’t give up, Participant 12 explains:

Because I didn’t want these people ruining my life and my career. I knew I could be a good nurse. I have been told I have a great manner and a great bedside manner, that I am good with people, and communicating with them. Yes the technical stuff was a bit challenging sometimes but it was something I could learn. [P12/PG12/L19-22]

An acceptance of what life throws at you is portrayed in the words of Participant 14. In this description a sense of his resilience emerges: ‘things are
still up and down, that’s life though, you just work through things’. [P14/PG05/L2-3]

He goes on to explain that ‘there is only so much you can control’. [P14/PG11/L1]

Resilience as a ‘self kick start’ was demonstrated in the next account by Participant 20:

I had months where I just couldn’t do anything. I think I had two or three months off work with no pay coming in at all. I then thought I really have to get on with it, nobody is going to support me. [P20/PG15/L17-20]

Although some participants were clearly less resilient than others were and at different stages on the transformative trajectory, the degree of resilience demonstrated by these participants was surprising considering the degree of personal and professional deconstruction that they had experienced. Even with descriptions of the lowest point these participants could have faced, they were, and are able to continue to cope what they were faced with and the impact it had on them personally and professionally.

It is posited the ability to navigate the experience and the interface with the extrapolated influencing factors culminates in a demonstration of resilience. The dimensionality of this construct clearly existed in the fact that some participants were more resilient than others were. It is posited that the other identified influencing factors, inherent individual factors and the specific nature of the experience influence the degree of resilience the individual is able to muster in face of extremely challenging times. What immediately struck me was, and maybe this is what Wolin and Wolin (1993) call ‘general resilience’ was the actual ability of the individual to have moved through these events, the mere fact that they (for the most part) could get up in the morning and just keep going, demonstrated resilience. Resilience was demonstrated throughout the deconstructive and reconstructive phases. Participants recognised the need to do
things to start of the journey of recovery. One participant recognised that she needed to go back to work as soon as possible after the event where she was involved in a nursing error. She recognised the fear in this but did it anyway realising that if she did not go back to work that particular night she never would have. Having this foresight and the energy to act reveals resilience.

Some participants demonstrate a degree of resilience although the outcome is not necessarily the one they wanted. This was true for one who has not been able to return to nursing, but demonstrates the ability to not only bounce back, but in doing so to gain something that she might not have achieved otherwise by undertaking a course other than one in nursing.

A further illustration of resilience was revealed when a participant spoke of the strength that is within her that enabled her to be able to cope with what was happening. This participant also acknowledged that resilience was grounded, in part, by ones motivations. That is to say if the motivation to remain resilience is great enough then resilience is possible. The need to be resilient was also grounded in hope for better things. As such, this provided the impetus to keep at things to arrive at a better place and time. This promotes the image that resilience can be a conscious effort grounded in motivation, as well as an inherent characteristic. Resilience as a conscious energy is further demonstrated with the realisation that while things can be bad you have to keep smiling. Therefore, resilience can be viewed as a conscious effort to turn negatives into positives.

A component of resilience emerged with the identification of internal belief systems. Some of these beliefs had been learnt from significant people in their lives and the other main belief system was grounded in religion. These belief systems provided the necessary script by which to live one’s life.
Resilience was identified as being grounded in internal strength, motivations and belief systems. From the narratives of the participants resilience emerged as an energy to minimise the loss of the assumptive world and to relearn the world. Resilience can therefore be viewed as a ‘force causing momentum, on the both the deconstructive and reconstructive trajectories and as such an energy for minimising deconstruction and for reconstruction.

The Thread of Support

The narratives of the participants provided descriptions of negative and positive support processes and strategies. Support was seen as personal and professional, informal and formal. Personal support was predominantly sought and obtained from family and friends. In some cases, family members and close friends held the participant together through this traumatic experience. Some participants did not have the support of family or friends. This was seen in those cases where there was strain or pre-existing problems in their relationship. Some participants found that at the height of their experience some friends and colleagues were not supportive. As one participant stated the experience sorted out who your friends really were. Support from family and friends also came in the form of them challenging the participant to get professional help or to ‘pull up their socks and get on with things’.

Professional support was sought and obtained from union and legal representation. Those participants who did seek counsel from their union or lawyer expressed varying levels of satisfaction. Those that did not believe that their industrial adviser or lawyer was effective made the comment that they believed this was because they (a) didn’t understand the nursing context, (b)
didn’t understand the potential gravity of the situation, (c) were not proactive in arguing their case and (d) at times appeared disinterested.

The other dimension to professional support revealed positive and rewarding experiences with the union and lawyers. Some participants had to rely on their lawyer to provide ‘voice’ to their case. These participants were virtually incapable of speaking at the inquiry because of the consequences of the deconstruction of their personal self. Despite recollections of good and bad experiences, I would advocate that all nurses reported to a NRA seek legal representation. The challenge lies in identifying a lawyer with a sound knowledge of nursing and an understanding of the nuances of both the NRA and why the nurse was reported. This discussion will be continued in chapter 8 which details the recommendations from this study.

Professional counselling for those who obtained it proved effective in assisting the individual to confront and address the nature of their psychological distress. For the majority of the study participants the experience was traumatic. The statistic that 6 out of 20 of the participants contemplated suicide and one of them admitted to attempting suicide twice, provides evidence to support the contention that any nurse reported to a NRA should seek or be encouraged to seek professional counselling as soon as it occurs. One participant sought out the services of a professional counselling as soon as she was reported. This act allowed her to make sense of the situation and evaluate her responses to it. When talking with her it became evident that while it was still an awful experience she had managed it well, and was able to minimise the degree of deconstruction of her personal self. Professional counselling is a well accepted strategy for assisting victims of trauma, whatever the etiology. Two participants did not say that
counselling had been helpful. The first participant who did not feel that it was helpful said that she would have felt better talking to a nurse. This participant believed that only a nurse would understand what she was talking about. This comment will be addressed in more detail in chapter seven.

A second participant also felt that counselling was not helpful. In analysing what he had to say about this, it was evident that the counselling had been ad hoc. At one point the counsellor attempted to obtain a sense of his childhood: this made him angry and he stopped going.

Aside from these two examples professional support through the services of a counsellor, psychologist or psychiatrist were positive. Some participants who were seen to be existing within the new world and not able to move on had not sought counselling.

*The Thread of Time*

The thread of time was introduced in the sub-category being confronted. The schematic representation of the substantive theory includes the thread of time to represent that the transformation of the personal and professional self is linked to, and influenced by time. Time to allege, time to deal with the matter and the time taken along the transformative trajectory were influencing aspects to the experience.

The trauma and frustration of ‘waiting’ proved almost too much for some participants. The experience of waiting was likened to torture. Waiting meant not knowing and not knowing meant a state of limbo which proved very frustrating and emotionally draining. The influence of time, in particular the delay in addressing the allegations and arriving at a decision caused for some participants
further deconstruction of the personal and professional selves. The need to address unsafe practice promptly and to minimise unnecessary waiting is required. A number of participants had their lives ‘put on hold’, which stymied their ability to reconstruct. The anxiety and distress caused by ‘waiting to exhale’ have to be considered as a significant consequence of being reported to a NRA. The participants in attempting to deal with the time delays sought contact with the respective NRA, although this was not helpful. It seemed that the NRA had their own time frame and reason for delay which increased the frustration the participants were feeling. Some participants were told that the matter was on hold because inquiry panel members were on holiday and not available. It was difficult to understand that their life was on hold because of such a reason.

The Thread of Vulnerability

The concept and consequences of vulnerability was uncovered as a constant thread within the assumptive world and with the loss of the assumptive world. The degree and type of vulnerability as a constant within the experience of these participants, was particular to the individual and their experience. Participants also demonstrated individuality with the ability to navigate this vulnerability.

The concept of vulnerability was identified as both personal and professional as causative factors in the social phenomenon discussed in chapter four. Within the concept of personal and professional vulnerability there were identified a number of individual and contextual causal attributes which provided in combination the environment for a nursing error to be made or (where an actual error was not made), an allegation of unprofessional conduct.
Vulnerability as a concept within nursing provides to illustrate actual and potential risks in nursing. It is posited that vulnerability is a constant in the assumptive world of all nurses. This statement is supported by what some of the study participants recognised when talking about their experience of vulnerability. Some participants provide specific mention of the vulnerability that nurses face in their day-to-day practice but problematically the vulnerability has only been conceptualised after the event. Participant 1 summarises the idea of vulnerability when she said that ‘we all walk a very fine line’ [P01/PG36/P10]. This statement by Participant 1 is central to the concept of vulnerability. It is a fine line between every clinical encounter and the potential for error and patient. How do we educate nurses to ‘realise’ or ‘see’ this vulnerability, to always be aware of the risk? Are the causative attributes or risks manageable or are they beyond, in the whole, the nurses reach to do anything about? These questions must be embraced as an imperative foundation for developing practice models which identify and manage such risks. It is important for nurses to be central to the models of clinical risk management because they are central to patient care.

For this nurse at least, it is almost as if the vulnerability becomes a positive reminder of the need for an increased sense of accountability. I further propose that it is the nurse who does not reconstruct in a positive way who fails to see the continued professional vulnerability inherent in practice. The other risk is that the vulnerability is palpable for some participants and as such, they choose not to practice again. This outcome was demonstrated by Participant 8, she affirms: ‘I don’t think I will ever have the confidence to nurse again’. [P08/PG51/L9-10]. Therefore, any post education plan for managing nursing errors must incorporate an analysis of the broader concept of professional vulnerability.
The concept of vulnerability as the ‘ever presence’ of the experience is articulated by Participant 10 by stating that he has a ‘monkey on his back’ \[P10/PG57/L21-22\]. When asked to clarify this he explained that because of the allegation there would always be a stigma, an embarrassment or a bit of a suspicion attached to him particularly by those who did not really know him. So although he felt he could go through the motions of the good behaviour bond that he received by the NRA his reputation would always be somewhat tarnished.

One final aspect of vulnerability is introduced and has relevance to the personal self once psychologically deconstructed has occurred. The nature of healing and transforming the personal and professional self suggests a need to understand one’s vulnerability as a key issue in dealing with traumatic events. It is contended that no one wants to appear vulnerable and the wounded individual may attempt to hide his or her trauma, and in turn, inhibit healing. It is questioned why nurses seem to have a tendency toward ‘wounding’.

The concept of vulnerability both in a personal and professional sense emerged as causative processes leading up to the alleged event and clearly became a constant in the nurses’ experience of the allegation and being reported to the NRA. I posit that the vulnerability caused by the experience never goes away, even for the nurse who is able to fully reconstruct their professional integrity in a positive way, it is just that it is managed better. This contention is supported by Participant 1 who states: ‘you wonder if years later it will come around and catch up with you?\’ \[P01/PG46/L11-12\].
Figure 6.6: The experience of deconstruction and reconstruction: A case study.

Involved in the checking of a narcotic, not checked to the patient, given wrong dose

Patient deceased

Loss of the Assumptive World

Coronial Inquiry

Being Confronted

Deconstruction of Personal Self

Deconstruction Professional Self

Being Notified
Immediate self recognition of error and realisation of significance of error

Time
Took approximately 18 months to reach a determination 8 years along transformative trajectory

Physical
Psychological
Psychological Trauma
Depression
Suicide Ideation
Admission to hospital
Antidepressants

Social
Relationship breakdown

Nurse Interrupted
Loss of the role
Loss of passion
Loss of confidence

Spoiled Identity
Shame
Stigma
Criminalisation

Relearning the World

Preserving the Self

Reconstruction of Personal Self

Reconstruction Professional Self

Truth Telling
Admitted to role in error immediately

External Defenders
Did not have immediate legal or union representation, later regretted this, obtained legal advice for Coronial and NRA Inquiry

Getting help
GP
Psychiatrist
Hospitalisation

Reinventing the Self
Two different people

Rethreading Social Fabric
Resolved relationship issues

Getting Back on the Horse
Returned to work almost immediately though fearful

Navigating Vulnerability
Able to identify and minimise vulnerability
Became more assertive
Physician-nurse dynamics changed

Relearned Accountability
Knowing accountability realised
changes to nursing practice

Moving On
Experienced a turning point which provided meaning and momentum. Turning point revealed the view by others that she was a good nurse, this was able to be internalised. Return of confidence and passion for the job. Able to limit remembering. Has integrated the experience in a positive way, and is able to talk about it with the purpose of educating others.
Bringing it Together

The next part of this chapter provides a schematic representation of how one nurse dealt with an allegation of unprofessional conduct, see Figure 6.6 on the previous page. The allegation and consequences to the assumptive world and the experience of relearning the world is provided. This case reveals that the participant was able to transcend the reconstructive trajectory, although it took her eight years. This schema provides visualisation of the nature of deconstruction and influencing factors for the degree of reconstruction. The consequences are also included. The participant code is not identified to afford an added level of anonymity.

This schematic representation should not be separated from the anguish and loss this individual experienced. The intricacies of the minute by minute and day by day struggle to prevent the self from unravelling any further and trying to reconstruct the self are impossible to capture in a one page overview. As already contended no two experiences are alike. It is proposed that if adequate numbers of this schema were developed nurses who had been reported to a NRA for an allegation of unprofessional conduct could look at them and identify with them.

CONCLUSION

This chapter has provided a description and explanation of the substantive theory of how nurses deal with an allegation of unprofessional conduct. The social phenomenon, allegations of unprofessional conduct, and the subsequent reporting of the matter to a NRA revealed a transformative process of the personal and professional selves. Specifically the participant experienced a loss of the assumptive world and the challenge to relearn the world.
This theory provides illumination of the impact of the social phenomenon on the personal and professional self and the degree and ways of reconstructing the self. The trajectory of transformation is viewed as being unique for each participant and influenced and enacted to different degrees and different consequences. It is evident that it is possible to transcend from being deconstructed to fully reconstructed, albeit over some time and with a lot of support for the personal and professional selves. The theory represented by the mythical phoeninx who is reduced to ashes and then is able to be re-born provides an imagery of the deconstruction and reconstruction experienced.

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This trial had become everything for my family, it was our lives; it was in our minds every moment we were awake, and I can’t imagine my mother escaped it in her dreams (Bohjalian, 1988, p106).
CHAPTER SEVEN

A Discussion of the Literature in Relation to the Substantive Theory

It would not be accurate to write, that the night before she was scheduled to testify, my mother feared she was going to be convicted. The word fear suggests that the prospect frightened her, and I think by Tuesday night her fear – her notebooks indicated that there were moments earlier when she had been very scared indeed – had been replaced by numbness and shock (Bohjalian, 1998, p. 282).

INTRODUCTION

This chapter will provide a discussion of the literature in relation to the explicated substantive theory. The substantive theory provides description and explanation of how the study cohort of nurses dealt with an allegation of unprofessional conduct. The individual was confronted with the allegation, and experienced a subsequent loss of the assumptive world realised as a deconstruction of the personal and professional selves; and a relearning of world, where the participant reconstructed, personally and professionally to varying degrees. The transformative process was viewed along a trajectory individualised by the individual’s internal resilience, support processes, and the influence of time and the degree of deconstruction they experienced.

THE PHOENIX PROCESS: TRANSFORMATION OF THE PERSONAL AND PROFESSIONAL SELF

The experience of dealing with an allegation of unprofessional conduct can be viewed as the ‘Phoenix Process’. For two of the participants, at least, they demonstrated in their narratives the ability to rise from the deconstructive point of their personal and professional selves. The reason for choosing this label,
Phoenix Process, is that the ability to reconstruct to a point where the new world is able to be positively integrated is possible, through reconstructive processes.

Conti-O’Hare (2002, p. 96) states that the phoenix bird can be perceived as the ‘ultimate and inspiring example of transformation and transcendence’. Although interpretations of this myth vary, the symbolism of the mythical bird reveals that ‘sometimes a violent dissolution of the old must occur to make way for a transformation to the new’ (Conti-O’Hare, 2002, p. 96). Lesser (2004, p.56) provides her account of the Phoenix Process. She explains:

It is a journey that is different for everyone, and therefore it is a trek into uncharted territory. It is erroneous, and even unhelpful, to compare one persons journey with another’s, all are different, and one is not more profound or important than another. The most momentous situation, the loss of a child, a serious illness, a national tragedy, has the power to transform one’s life, but so do less traumatic events. It’s all in the way we approach the changing nature of life, it’s all in the courage to say yes to whatever comes our way; it’s in the way we listen for the messages in the flames and dig for the treasure in the ashes.

A number of clinical psychologists, Grossman, Cook, Kepkep and Koenen, undertook a study to examine the experiences of ten resilient women who overcame the trauma of childhood sexual abuse (1999). These authors called the collective experience ‘with the phoenix rising’. Grossman, et al (1999, p. vii) contend that the resilient survivors who shared their stories, revealed that they ‘have been…consumed by destructive power of the horrors visited upon them and then have reconstructed themselves out of the ashes’. Although the nature of the trauma of the participants in the reported study and in this study are different the concept of deconstructive and reconstructive processes are the same. Participants in the reported study talked about different aspects of their transformative journey and provide insight into the aspects of their selves and lives in relation to the experience of being sexually abused. The participants in this study revealed
processes in response to the experience of being reported to a NRA for an allegation of unprofessional conduct. The differences in the way both cohorts dealt with the ‘trauma’ centred on the nature of the trauma and its connection to parts and stages of their lives. For example, participants in the reported study talked about the experience of forming intimate relationships because this area of their personal self had been significantly impacted (Grossman, et al, 1999). Similarities are now discussed.

The need to make sense of what happened and realise meaning was common to both cohorts. Grossman, et al (2004, p. 189) state that: a traumatic event is something that is so outside the realm of normal experience that it does not fit into a person’s existing framework of understanding about the world. Therefore, when something bad happens then it is usual to want to understand why (Grossman, et al, 2004). While the questions and ponderings to help find meaning and to make sense differed for the cohorts, the need to make sense was similar. Another similarity is the concept of resilience. All participants revealed resilience in different ways and in different degrees. This resilience allowed them to continue on their reconstructive trajectory. Participants in both studies revealed the value of support through friends, mentors and professional counselling (Grossman, et al, 2004). Other similarities include ways of coping. Participants in both cohorts demonstrated processes which assisted with minimising the degree of deconstruction and reconstruction. These included: taking action, avoidance, and diversionary strategies (Grossman, et al, 2004).

Of the 21 cases presented in this study, all represent the Phoenix Process either wholly or partially. That is two participants had fully reconstructed their personal and professional selves, while others were at varying stages of
deconstruction and reconstruction. The experiences of these two participants can be viewed as case studies to demonstrate the Phoenix Process in its entirety. These nurses who had been involved in an event where a patient had died represent the deconstruction of the phoenix and the reconstruction of the phoenix. They are both still nursing, having moved on in their new world in positive ways. They have been able to learn from their experience and incorporate these lessons into their professional lives, turning the experience into learning situations for other nurses.

The symbolism of the myth of the phoenix bird provides for an overarching understanding of the transformative process for the study cohort. While each transformation is individualized, there are properties and dimensions that illustrate and describe the constructs of the process which these participants both went through and engaged in. Transformation occurred as a result of the allegation and associated deconstructive and reconstructive processes. The literature in relation to transformation of the personal and professional self is now discussed.

Transformation of the professional self has received minimal attention in the literature. The majority of it lends to the transformation of the nurse in terms of ‘normal’ development within the scope of nursing (Stein, 2000). Others addressed what constitutes personal transformation (Haddkins, 2001a; 2001b). One significant study describing the transformation of professional identity of nurses who had been reported to a NRA in the USA will be integrated into the findings of this study. A grounded theory study of 30 nurses who were accused of violating a nurse practice act in Florida was interviewed to seek insight into the following questions:
1. Tell me about your alleged violation of the nurse practice act. What was the problem? How did it occur? How did you get reported to the NRA? After you were reported, what happened?

2. What was it like to go before the NRA? Best/worst thing?

3. How could the NRA experience be better?

4. What would you tell other nurses who have to go before the NRA?

5. Where do you go from here?

This reported study correlates the most closely to the objectives and findings of this study. The findings of the reported study in relation to the recommendations of this study are similar and will be discussed in more detail in chapter eight.

A concept analysis of personal transformation was undertaken by Wade (1998). Central to this analysis was a derived definition:

Personal transformation is defined as a ‘dynamic, uniquely individualised process of expanding consciousness whereby an individual becomes critically aware of old and new self views and chooses to integrated these views into a new self definition (Wade, 1998, p.715).

Defining characteristics included antecedents, critical elements and consequences. Central to the discussion related to this study personal transformation is preceded by a ‘disorientating dilemma’ (Wade, 1998, p. 716). Examples include stressful life experiences and transitions. The dilemma reveals ‘a problematic cognitive and affective meaning scheme that conflicts with one’s self view and produces a painful, threatening and challenging opportunity for reflection and expansion of consciousness’ (Duff, 1989; Ferguson, 1980; Loder 1981; Mezirow, 1991, as cited in Wade, 1998, p. 716; Watson, 1989).

A further interpretation of transformation is offered by Adams (1986). Transformation evolves when there are fundamental changes in thought and action
which creates dissonance in the individual’s experience. The individual is uncomfortable with prior behaviours and thoughts and so changes them.

Consequences of transformation include feelings of ‘excitement, satisfaction and freedom’ (Adam, 1986, p. 716). It is contended that individuals who transact transformation have more freedom, creativity and an increased ability to manage stress’. The two participants who transcended transformation revealed an increased ability to deal more fully with the vulnerabilities that they encounter.

The importance of dealing with psychologically harming events is well known (Attig, 1996; Kauffman, 2002; Neimeyer, 2000). Some consequences of psychological trauma include the following. It is contended the individual is at risk of addiction and suicidal attempts if trauma goes unchecked (Conti-O’Hare, 2002). Belanger (2000) states that the cause of death for nurses may be at least six times higher than that of the general population.

Transformation of the personal self as already stated as received minimal attention in the literature with a nursing focus. One text, *The nurse as wounded healer: From trauma to transcendence* provides evidence of the nature of trauma to nurses and strategies for dealing with it. Buyssen (1996) has studied nurses with psycho-trauma. It is proposed that the degree of the psycho-trauma is related to vulnerability and protective risk factors. This vulnerability is explained as the degree and duration of the exposure to the causative events, a self or family history of trauma, anticipation of the occurrence and degree of control, strong identification with the victim, and the associated imagined guilt.

Day (no date) states the last stage in recovery from a traumatic event is where the individual undergoes transformation of the self. The emerging self is
different to the pre-trauma self. The significant difference is that transformation within this study is seen as the embedded connecting trajectory, from the beginning of the experience.

The vehicle for the transformation is the allegation of unprofessional conduct and the associated deconstruction of the personal and professional self. Transformation is recognised when the individual is able to integrate these new self views into the new self definition. The individual is able to change their frame of reference (Stein, 2001). This was the case for a number of participants who were identified as transforming in a positive way, and very definitely seen in the two participants who had transformed fully. They were able to see many aspects of their personal and professional lives with a different frame of reference, from realising the need to make significant changes in their personal life to changing their practice to minimise risk.

Positive transformation from this potentially devastating experience is possible. What cannot be projected is who is able to transform. This study has provided a substantive theory to describe the personal and professional transformation for nurses who have had an allegation of unprofessional conduct made against them. What is described are the major theoretical constructs, or categories of this theory, their properties and dimensions. This theory does describe positive and negative influencing factors to propel the nurse toward transformation.

It is contended that the transformative journey does not end. Rather, once transformation has occurred, the individual does not return to their ‘other self’ (Duff, 1989; Ferguson, 1980; Mezirow, 1991). The process of transformation demands that the individual approaches their assumptions of their world in a
different way (Stein, 2001). To return to the beginning of the concept of transformation as uncovered for the study participants the literature related to the loss of the assumptive world is discussed.

**Loss of the Assumptive World**

Loss of the assumptive world emerged as the experience of deconstruction of the personal and professional self. The *assumptive world* is defined as ‘the assumptions or beliefs that ground, secure, or orient people, that give a sense of reality, meaning, or purpose to life’ (Kaufmann, 2002, p 1). To further illustrate this concept Kaufman (2002, p. 3) goes on to say that the assumptive world serves to help ‘frame or organise’ what it is before us that requires understanding or analysis. The assumptive world is comprised of beliefs, and it is these that are shattered when for example the individual experiences a psychological trauma (Janoff-Bulman, 1992). Therefore, the assumptive world of the nurse is the overriding sense of belonging and understanding that grounds them in their world. For the purpose of this thesis, the world also encompasses the day to day processes and constructs that the individual finds himself or herself in. This world is comprised of the ‘personal’ and ‘professional’. Janoff-Bulman (1992, p. 71) provides this narrative in relation to a loss of assumptions:

> Traumatic events force a sudden realisation of the Pollyanish nature of victims’ fundamental assumptions. They cannot account for the trauma. Victims experience the loss of old, deep positive views of the world and themselves. This loss is experienced primarily as depression, a common psychological response in the aftermath of victimisation. No longer is the world viewed through rose-coloured lenses. Joy and happiness seem emotions of the past. Victims are not longer able to sustain their prior optimism; their worldview is pervaded by pessimism, the element that turns simple sadness into depression (Janoff-Bulman, 1992, p. 71).
Put more simply, trauma and the associated loss threaten that which constructs the assumptive world and how the individual sees their world unfolding. The distress, in part, that the individual experiences because of the trauma is because there is a realisation that a fundamental assumption is no longer tenable. The assumptive world, or the expected world is ‘lost’ (Janoff-Bulman 1992).

The loss of the assumptive world commenced with the individual being confronted by the allegation, the NRA and legal processes and the time taken to deal with the matter. Moreover, individuals deconstructed the personal and professionals which resulted in a further loss of their assumptive world. The literature related to these concepts is now discussed.

**Being Confronted**

A grounded theory study conducted by Hutchinson (1992) revealed that a construct of the substantive theory ‘transformation of professional identify’ emerged as ‘being confronted’. Properties of this construct were ‘fear’, ‘ignorance’, and ‘confusion’. This finding is similar to the dimensions of the property being confronted in this study. Specifically the study participants revealed dimensions of unknowing, disempowerment, and confusion regarding the purpose of the NRA and the perceived lack of support. Nurses in this reported also experienced the problem of being in limbo because of the length of time the matter took to deal with by the NRA. Periods of one to two years were reported and are similar to the lengths of time that had to be endured by the participants in this study.
Nurses who were confronted with the allegation and the experience provide similar descriptions to those of the study participants. One nurse stated ‘the whole event it took the wind out of my sails’ (Prenesti, 1994). One nurse explained that she did not know anything was wrong until three days later: she was then grilled in a room full of strangers about her care of the patient in question (LaDuke, 2001). Participants 3 and 8 also didn’t find out there was a problem until 24 hours after the event, they too were questioned in a room of people.

Some participants were confronted by employer, NRA and legal processes, including those who were not prepared for the way in which the NRA procedures were conducted. These participants felt that the process was more in line with criminal proceedings using terms to symbolise a criminal court and inquiry. Two nurses reported to the NRA contended that the room where the inquiry was held was similar to a courtroom. This and the fact the inquiry was open to the public added to the distress.

A nurse involved in the death of a patient provides this insight into her experiences, specifically with the realisation that she had a role to play:

Mr T’s heart beat suddenly stops, and M and I hold our breath and our hearts stop beating too. We hope that the reanimation (resuscitation) will succeed, but after a long effort, the reanimation team has to give up the fight. The patient has lost too much blood. ‘He is dead’ runs through my body like a knife. The reanimation team gather up their equipment and disappear. The duty surgeon says, more blaming than asking: ‘How could you both let such a thing happen?’, adding under his breath ‘and that’s what you call registered general nurses’ (Buyssen, 1996).

The same nurse provides further insight into the realisation of the gravity of the situation (Buyssen, 1996). She wrote in her diary:

Help! I let a patient die this morning. Why didn’t I check him more often? It’s my fault. He was my patient. How can I answer for this? I have phoned my best friend, but she is out. Whenever I close my eyes I
see the patient before me. It is like a film in slow motion. I am hit by every kind of emotion, but am unable to vent them. Oh God, help me please!

This piece not only reveals the nature of being confronted, but the degree of suffering this nurse was experiencing. The anguish experienced by the nurse is obvious.

Duffin (2001, p. 12) reported the findings from a case in the UK where a nurse had to endure 18 months of ‘agony’ while authorities investigated whether she had any involvement in the deaths of 18 children. It is contended in this report that many nurses reported to the NMC for an allegation of unprofessional conduct have to face long delays, with many finding out that they have no case to answer. During this time these nurses have been suspended from their employment and have been forced to play the waiting game.

Nurses in the study conducted by Hutchinson (1992) experienced waiting time of up to two years for the NRA to deal with the matter. Hutchinson (1992) found that the experience of waiting contributed to the anxiety the nurses felt. All the nurses in Hutchinson’s study commented on the length of time they had to endure: creating a state of limbo. This was also the case for participants in this study: also creating a state of limbo.

**Deconstruction of the Personal Self**

There was limited literature identified related to the consequences on the personal self in response to being reported to a NRA for an allegation of unprofessional conduct. While there is a significant body of literature (too much to list here) related to psychological trauma, stress and reactions, and professional helping responses, little correlated to the context of a professional harm, such as,
that that comes with being reported to a NRA. Despite this paucity of literature, the following is provided to situate the findings of this study.

Many of the study participants experienced physical ill health as a result of the stress they experienced, and in some situations, continue to experience. In a study conducted by La Duke (2000) 97% of the 33 nurses questioned regarding their experience of being reported to a NRA in New York for allegation professional misconduct reported impact on their mental and physical well being.

The concept of surrender is described as ‘a purely inner phenomenon’ which enables you to ‘see clearly what needs to be done, and you take action’ (Tolle, 1997, p. 117-119). Day (no date, p. 80) explains that surrender is reached when ‘the connection and emotional bonds to significant people and things in this life are cut’. Some participants revealed surrendering in their narratives. They revealed a letting go to that which was preventing their ability to reconstruct. It was in a sense a realisation that they could move on.

Johnstone (as cited in Prenesti, 1994) states that the experience of being reported to a NRA is traumatic, even if the individual should be cleared by the investigation. While I am in no formal position to diagnosis post traumatic stress disorder (PTSD) a number of participants provided descriptions of what they had and were still going through that is highly suggested of PTSD. Psychological trauma and its management are well represented in the literature and in counselling programs. A plethora of books directed either at the ‘self help’ market or for professionals provides many examples of psychological trauma and its management.

In one media case the enormity of what a nurse can experience is presented. While there is little doubt about the nurse’s accountability in this
matter the trauma she faced is almost palpable. The Age newspaper (August 11, 2003) carried the headlines ‘I killed him, didn’t I’. The case reported here tells of a nurse working in a neonatal unit in Australia who carried out a procedure that she was not competent to do which subsequently caused lung trauma to the baby and ultimately his death through air embolism. The article reports that the nurse sat by the baby’s cot and cried ‘I killed the baby, I killed the baby’. The nature of her actions were not fully comprehended at this point. The devastation and trauma associated with the realisation at this point must be overwhelming. Any nurse who had made a mistake will know this sickening feeling.

The case of Sophie Heathcote, reported in *Australian Story* (ABC, 2000) provides some insight into the degree of psychological trauma experienced. Her husband provided this comment:

Sophie’s personality changed – the ramifications of the court hearing…she couldn’t think properly, she was having bad dreams and kept referring back to the court sittings, and the death. She hasn’t got over the terror that she used to have. If anything slightly went wrong, she wouldn’t have been able to take it. Yes she’s slowly getting out of it.

Buyssen (1996) provides a range of possible causes of psychological trauma which can affect nurses. The nurse can be exposed to or experience any of the following:

- Physical aggression
- Almost violent incidents
- Infectious diseases
- Caring for patients of trauma, particularly children
- Caring for patients who have suicided
- Victim of sexual harassment
- Witness of the death of assault of a colleague
• Sudden confrontation with death
• Disaster victims
• Caring for a patient who is suffering greatly
• Several small but disturbing incidents within a short period of time; and of relevance to this study
• Serious nursing error, regardless of whether the consequences are fatal or serious (Buyssen, 1996).

Buyssen (1996) states that some nurses are more prone to developing psychotrauma than others. Some nurses are more vulnerability, some may have more or less protective factors. Vulnerability causing factors include: the length and intensity of the trauma; pre-existing mental health issues (also found in this study); family history of mental illness; limited degree of expectation of the trauma event; limited degree of controllability during the event; strong identification with the victim; imagined or real guilt in respect of the event (Buyssen, 1996). Protective factors include: degree of expectation of the traumatic event; degree of controllability over the event; adaptive coping style and social supports (a finding in this study) (Buyssen, 1996).

All of the study participants experienced social consequences. Participants experience relationship problems, financial difficulties and hardship. Some had to move to find work in another state, some experience social isolation. The literature in relation to social consequences is presented.

Financial consequences were also an identified finding in the study conducted by Hutchinson (1992). Nurses in this reported study were required to pay for educational courses, psychological testing and impose on family members to assist with mortgage repayments. Financial hardship was a reported finding from the survey conducted by La Duke (2000) of nurses reported for alleged
professional misconduct in New York. Eighty five per cent of the 33 nurses experienced financial difficulties with some having to declare bankruptcy.

Williams (2005) in her book *Death of a Doctor*, documents the professional demise of a medical practitioner in the Australian context after a number of female patients accused him of sexual assault. This medical practitioner was working, at the time, in alternative therapies in a climate where they were viewed for the most part as quackery. This medical practitioner was eventually struck of the medical register in the state of New South Wales. The social consequences for this individual are summed up in the following paragraph:

John is today as poor as he was when he first started out as a student back in the mid-60’s. He has no assets, no savings, owns no property. Even though he’s now discharged his bankruptcy, he’s unable to get a credit cared, obtain a loan or even run an overdraft. Once, he lived in a large house overlooking the ocean in one of Sydney’s most picturesque beachside suburbs. Today, he rents a rundown 1940s fibro in Sydney’s south, and drives a second hand 1990 Holden Commodore (Williams, 2005, p. 286-287).

**Deconstruction of the Professional Self**

The limited literature surrounding the concept of deconstruction of the professional self is presented. The one formal study conducted by Hutchinson (1992) arrived at a major finding the nurse who is disciplined by a NRA for an allegation of unprofessional conduct has a ‘transformed professional identity’. While other literature and fictional works provide insight into this deconstruction, for example LaDuke (2001) and through the storyline of ‘Midwives’ presented at the beginning and end of each chapter in this thesis little study has been conducted into this phenomenon.

Nurse interrupted is illustrated by a loss of the role, a loss of passion, and a loss of confidence. All participants experienced a degree of ‘nurse interrupted’.
This label was chosen based on the non-fiction book, titled *Girl Interrupted* by Susanna Kaysen, later made into a movie. This book provides insight into the mental illness and hospitalisation of the author during her adolescence. The following extract from this book provides insight into why this sub-category was titled in such a way:

I walked past the lady in yellow robes and the maid bringing her a letter, past the soldier with a magnificent hat and the girl smiling at him, thinking of warm lips, brown eyes, blue eyes. Her brown eyes stopped me. It’s the painting from whose frame a girl looks out, ignoring her beefy music teacher, whose proprietary hand rests on her chair. The light is muted, winter light, but her face is bright. I looked into her brown eyes and recoiled. She was warning me of something – she had looked up from her work to warn me. Her mouth slightly open, as if she had just drawn a breath in order to say to me, ‘don’t!’ I moved backward, trying to get beyond the range of her urgency. But her urgency filled the corridor. ‘Wait’, she was saying, ‘wait!’ ‘Don’t go!’ I didn’t listen to her (Kaysen, 1995, p. 166-167).

*Years later...*

It was a beautiful October day in New York… ‘let’s go to the Frick’, he said. ‘I’ve never been there’ I said. Then I thought maybe I had been there. I didn’t say anything. I’d learned not to discuss my doubts. When we go there I recognised it. ‘Oh’, I said. ‘There’s a painting I love here’. She had changed a lot in sixteen years. She was no longer urgent. In fact, she was sad. She was young and distracted, and her teacher was bearing down on her, trying to get her to pay attention. But she was looking out, looking for someone who would see her. This time I read the title of the painting: *Girl Interrupted at Her Music*. Interrupted at her music: as my life had been, interrupted in the music of being seventeen, as her life had been, snatched and fixed on canvas: one moment made to stand still and to stand for all the other moments, whatever they would be or might have been. What life can recover from that? (Kaysen, 1995, p. 166-167).

Nurse interrupted as a property was made up of the following Dimensions, losing the role, losing the passion and loss confidence. A loss of confidence has been identified in a number of experiences of nurses outside those of the study participants. One nurse stated that the experience of having an
allegation made against him and the NRA experience caused him to lose his confidence (Prenesti, 1994).

Being interrupted in one’s life and one’s career proved incredibly difficult and challenging for many of the participants. For a number of them ‘nurse interrupted’ is now a permanent consequence of having being reported to a NRA for an allegation of unprofessional conduct. The implications for a few of these participants were worse because of how they defined their ‘self’, in that being a nurse was who they were, it was not just a job. Those participants who saw that being a nurse was just a part of their life were able to ‘let go’ of being a nurse and pursue other options, like financial advising, farming and construction. Interestingly these participants who were able to move away without significant emotional distress were men.

During the interview of Sophie Heathcote in Australian Story (ABC, 2000) she spoke of the consequences of her being reported to the NRA. She tells:

It’s not a lot of fun to just have everything wiped from underneath your feet. It’s pretty soul destroying and something that I’d worked for a long time was just wiped off, in a letter. I was deregistered so I had to attend the Nurses Registration Board for another court case and then I attend the court in Sydney for my appeal.

Spoiled identify for this study cohort was dimensionalised by shame, stigma and criminalisation. These three labels were chosen to represent the words and beliefs of the participants although it is noted that there is crossover in meaning. The concept of spoiled identity was first articulated in the literature by Goffman (1963). Since the release of his landmark text ‘Stigma: Notes on the Management of a Spoiled Identity’ there has been a profusion of interest and research into this concept (Link & Phelan, 2001).
Stigma is ‘an attribute or characteristic that conveys a social identity that is devalued in a specific context’ (Crocker, 1999). It is the perception that an individual or group possesses a ‘discrediting, exaggerated, and misunderstood flaw’ (Halter, 2004, p. 43). Spoiled identity can be defined as an identity derived from membership of a group that puts a person at a disadvantage. For the most part this disadvantage exists because of perceptions by the group that the individual is different. That is, stigma is seen as the relationship between an attribute and a stereotype (Goffman, 1963). An example of this for nursing, is, the notion of ‘good nurse, bad nurse’.

Another definition is provided. The stigmatisation process can mean social marginalisation and devaluation, causing a loss of respect and a belief that the individual cannot function as expected or needed. Stigma is not only confined to the views of others but can then become problematic as it is internalised by the individual. (Goffman, 1963). The literature revealed that a number of who have been, and continue to be stigmatised, including, the disabled, the mentally ill, the criminal, the alcoholic and the drug user (Halter, 2004).

This difference can have its origin in concepts like race, gender, religion, tribal stigmas, abominations of the body, and blemishes of individual character (Goffman, 1963). It is this later group which has relevance to the findings of this study. A blemish of individual character was experienced by all of the participants in essence because they were identified publicly, be it at a hospital level or within the broader public domain for having (allegedly) ‘made a mistake’. As already discussed, the issue of innocent until proven guilty has in reality little bearing on these matters. These blemishes have their origins in the stigma of both having done something wrong and the associated view of a criminal.
There is a stigma associated with doing the wrong thing and being reported to a NRA. A study conducted by La Duke (2000) revealed that 97% of the 33 nurses who were surveyed reported feelings of shame because of being reported to a NRA for an allegation of professional misconduct. Nurse regulatory authorities are mostly misunderstood and feared (Prenesti, 1994). This fear lies in the fact that these authorities have the power to make some disciplinary matters public. For example, one participant was very fearful that because the inquiry was open to the public people she knew might have attended. Another nurse feared the reporting of the investigation and inquiry in the NRA newsletter. While names are not included she felt that people who know who she was. The other fear is that the NRA has the power to remove the nurse’s name from the Register and their livelihood.

A number of participants in this study experienced shame. They felt ashamed because they had made a mistake, they had been reported to a NRA for it and their colleagues and family knew about. In some situations they were identified in the media. Shame is a broad term used to describe a range of experiences and emotions from slight social embarrassment to an acute level associated for example with an individual who has been raped (Wheeler, 2000). Shame can be experienced as a feeling: ‘I feel shame’. This is usually because of a sense of personal inadequacy. Shame experiences can be the most intense negative and debilitating experience, where there is a lack of basic self worth (Wheeler, 2000). Kaufman (1980) contends that shame is rooted in significant interpersonal failure. This notion of causation of shame is similar to that of this study. The shame reported by the participants was grounded in their sense of
failure as a persona and as a nurse. One participant recalled that it was the shame she experienced when having to tell her husband that she had made a mistake.

Nurses in a number of reported studies also experienced a spoiled identity. This finding of being made to feel like a criminal was also a finding in the grounded theory study conducted by Hutchinson (1992) who examined the experiences of nurses accused of violating the nurse practice act for the state of Florida. Nurses told how ‘they treated like a criminal’ (Hutchinson, 1992, p. 137). Another nurse stated that she was so ashamed, interestingly not just for making an error but for being investigated by the NRA (LaDuke, 2001). She was so ashamed that she couldn’t even have her husband present during a home interview with representatives from the NRA. This level of shame was also experienced by a participant in this study who said that she was too ashamed to have to tell her husband that she had made a mistake and been reported for it.

Relearning the World: The Experience of Reconstruction

Relearning the world emerged with the individual continuing their transformation by experiencing a reconstruction of the personal and professional self. Relearning the world as a construct of grieving as received considerable attention (Attig, 1996). Relearning the world has been seen as a construct of making and finding meaning to the experience of loss of a loved one. There was no identified literature related to loss of the professional self and associated personal self. The findings of this study reveal broader properties and dimensions to relearning the world and reconstructing through loss as described by Attig (1996), though there are correlations.
Preserving the Self: Minimising Deconstruction

Janoff-Bulman (1992, p. 142) powerfully contends that ‘it is by taking action, rather than giving up, that survivors (of traumatic events) can get constructive feedback about the possibilities of a benevolent, meaningful world and a worthy, effective self’. These actions can be as simple as, making an appointment, getting out of bed, writing a list or going to the shops (Janoff-Bulman, 1992). Action through the processes of assuming and taking a stance, for those who could, proved the impetus for the onward transformative journey.

The ability to preserve the self and minimise deconstruction was illustrated by assuming a stance, taking a stance and searching for meaning. All participants assumed as stance, although this was not always effective, which in turn impacted on their ability to take a stance.

In the grounded theory study of nurses reported to a NRA who were accused of violating the nurse practice act in Florida ‘assuming a stance’ emerged as a construct of the social process (Hutchinson, 1992). Assuming a stance was composed of the following properties: reliving, evaluating and generating a story. Reliving the experience meant a process of going over and over the event in the individual’s mind and a way of making sense out of the matter. Evaluating the situation revealed questioning what was happening at the time, were there issues of personality that played a part. The third property saw the individual constructing a story line to the event. As the story evolves for the individual, they assume a stance with affective and behavioural components. Examples which are similar to this study include the following feelings: guilty; remorseful, angry and suicidal. Behaviours included: admitting to the violation, partial admission, partial
denial and complete denial (Hutchinson, 1992). These findings are reflected within the property assuming a stance and deconstruction of the personal self.

This finding was shared by a nurse reported to a NRA in North America for alleged violation of the nurse practice act. She too said ‘I chose not to have an attorney because I made the mistake and couldn’t deny it’ (LaDuke, 2000, p. 32) While some participants had a negative experience and felt that they had been let down, this is an contention that defence by external persons is a necessary strategy for all participants, but particularly those who are unwell or feel overwhelmed by the experience.

Searching for meaning as a way of preserving the self was illustrated in different ways for the study participants. The process of meaning making can be seen as containing two constructs. Firstly, making sense of the loss and secondly finding benefits (Davis, 2001). The need for meaning and the way meaning is found in relation to the experience of loss and trauma is well represented in the literature. A number of different notions of meaning have been identified.

Interpretations of meaning include:

- Meaning is obtained at an emotional level (Frankl, 1969);
- Meaning is one’s ability to develop new goals and purpose, or to reconstruct a sense of the self that incorporates the significance of the negative experience (Thompson & Janigian, 1988);
- Meaning is found by considering the positive implications or benefits that have occurred from the experience (Taylor, 1983); and
- Meaning is attributed to God’s will; believing that the event was fate (Janoff-Bulman, 1992).

Davis et al (1998) states that benefits from being able to find meaning from loss or trauma include: (a) growth in character; (b) a gain in perspective; and (c) a strengthening of relationships. These findings are not necessarily connected
to the nature of the event, except that the event was the catalyst for benefit
making. For the most part those participants in this study who found meaning
benefited in some way. For some this meant a new knowing of accountability, a
new way to navigate vulnerability and the realisation of what was important for
them in their social world and the need to release that which was no longer
positive in their life.

Meaning contends Day (no date, p. 200) has relevance because it is a way
of ‘attributing logic to the event so as to incorporate it into the global picture of
one’s life in a way that is comfortable’. Meaning for these participants emerged
in different ways, some as a revelation, others as an acceptance of what had
happened almost immediately. Meaning was a way for preserving the self and
provided impetus to move on in the new world.

In research conducted by Janoff-Bulman (1992) individuals stated that
they were able to suffer if the suffering had meaning. For example, if the
suffering meant that a person had not died in vain then the individual was able to
go through it. One specific example is ‘MADD”, Mothers Against Drink Driving.
Mothers in the US who had lost a child to a drink driver have come together to
educate and lobby for harsher penalties for drunk drivers (Janoff-Bulman, 1994).
Some study participants revealed similar thoughts. They shared that they were
happy to talk to me if it meant someone else not having to go through the
experience. Experiencing the experience and finding meaning is a significant
process in the transformation of the personal self and professional self.

Reconstructing the Personal Self

Janoff-Bulman (1992) states that most people are able to reconstruct from
a traumatic event, although for some it takes weeks and others years.
Janoff-Bulnan (1992) further contends that some are never able to reconstruct.

Participants in the study reflected the above contentions. Reconstruction of their personal self was identified at different points along the transformative trajectory.

Janoff-Bulman (1992) contends the following in relation to the benefit of support for those who have been traumatised. He states:

The support of close, caring others is of crucial significance during the survivor’s recovery. It provides direct evidence that the world is not necessarily malevolent and meaningless, and that the survivor is worthy of support (Janoff-Bulman, 1992, p. 173).

The ability to find a supportive person can mean the opportunity to talk about, discuss, vent and share, openly, the traumatic experience (Janoff-Bulman, 1992). He goes onto contend that the individual who has this level of support is better able to rebuild their assumptive world. The thread of support for the participants in this study meant support for the personal and the professional self. Participants were supported by family and friends and through professional process including lawyer, union representatives, counsellors and medical practitioners. One nurse in a report of first hand experiences of nurses accused of professional misconduct in the USA ‘urged nurses to identify and mobilise their support systems, fast’. She goes on to say that it is important not to underestimate the effect of this experience can have (La Duke, 2001 p. 371).

**Reconstructing the Professional Self**

The ability to ‘get back on the horse’ was not a choice or reality for all the study participants. Some participants were willing and able to risk, while others were denied this opportunity or recognised that the risk was too much. To understand this ability and willingness to risk, the concept of motivation is introduced.
Motivation was seen as a factor in the ability to recognise the need and strategies for getting back on the horse. Motivation is defined as the ‘processes that initiate, energise and direct behaviour’ (Coleman, 1994). Motivation can be broadly divided into the concepts of need, drive and incentive (Bourne & Russo, 1998). Participants demonstrated varying degrees of motivation and as such, this proved an influencing factor in the ability to reconstruct personally and professionally, or in some cases, prevent themselves from being further deconstructed. Motivation was observed through the construct of a need and therefore, a realised as a subsequent willingness to risk. This need to risk was constructed for the participant around the imperative need to have a job and thus, an income, and to where possible, reconstruct their personal and professional self as a matter of pride. In terms of dimensionality, some participants did not explicitly express a motivation while others did. For some the motivation may have been present but was not able to be realised or acted upon because of the degree of personal and professional deconstruction experienced, particularly in the early stages of the experience.

Not all participants were able to accept the risk and return to practice. This finding was similar to comments made by nurses reported to a NRA in the state of Florida (Hutchinson, 1992). One nurse in this reported study stated: ‘I’ve learned to protect myself, to trust no one. I am leaving nursing, it’s not professional’ (Hutchinson, 1992, p. 138).

One participant who was willing to risk was not able to because the requirements stipulated by the NRA meant that she could not find an employer willing to offer 12 months of supervisory practice. For this nurse whose ability to
reconstruct the professional self was stymied by NRA requirements. This was the case for some nurses in the reported study by Hutchinson (1992).

The ability to identify and minimise vulnerability on a personal and professional level could only be achieved by a small number of the study participants. The need to change practice, to reduce or avoid risks to both the personal and professional selves was seen as an important point of the transformative trajectory. It represented the lessons learnt and their relevance to contemporary practice. The following discussion provides a review of the literature related to the experience of changing practice post allegation.

Learning lessons and incorporating them into practice were identified in the study conducted by Hutchinson (1992). Nurses who were able to reflect and integrate the experience expressed as change in practice. Specific examples of minimising vulnerability include the following contentions: ‘I’ve learned to pull out of situations before they get worse’ and ‘the legal aspects course taught me to be more diplomatic and to cover myself’ (Hutchinson, 1992, p. 138). One nurse realised like Participant 8 that the risk was too great to nurse again. This nurse stated: ‘I have to learn to live with the fact that I killed a man and it is too emotional for me to work in a hospital (Hutchinson, 1992, p. 138).

Changes in practice were identified in the study of 175 nurses who had made a nursing error (Meurier, Vincent & Parmar, 1997). Two types of change were identified, constructive and defensive. Changes that were constructive included: paying more attention to detail; increased documentation; reading patient notes more carefully; asking colleagues what they have done in the past; seeking advice and doing more observations. Findings reflecting defensive
change which are similar to those found in this study include: worry; loss of confidence and less trusting of people.

Newman (1994, p. 116) stated that ‘whatever transforms you, transforms your practice’. For some participants the need to change practice was recognised by identifying vulnerability and enacted by realising the need to minimise this vulnerability was achievable. In considering Newman’s statement the recognition of full transformation occurs therefore when a change in practice has been achieved. This was the case for the two participants who had fully reconstructed.

The ability to recognise and as such minimise vulnerability was evidenced in the experiences of nurses in the study by Hutchinson (1992). One nurse stated: ‘I’ve learnt to pull out of bad situations before they get worse’. Another nurse stated that they recognised less vulnerable practice contexts. Participants in this study were also able to move to a practice area which was less vulnerable for them.

The need to relearn accountability was realised by a few of the study participants, and as such, they demonstrated a ‘relearned accountability’. Those participants who had made an error, and who were able to recognise the significance of it, in turn, were able to reflect and understand what accountability really (emphasis added) meant. Accountability is that which goes beyond the ‘here and now’, it is the length and breadth of answerability for decision making and actions, and it is knowing the implications of these. As one participant put it, you are accountable for everything you do.

The Nursing and Midwifery Council defines accountability as ‘responsible for something or someone’ (Tilley & Watson, 2004, p. 24). Therefore accountability from the perspective of the individual nurse, can extend to all
customers of the position, the NRA, and other legal forums. Tilley and Watson (2004) contend that each nurse is ultimately answerable to his or her own actions. It was this, that some of the participants truly realised.

There was little research identified with the concept of relearned accountability. In the study conducted by Hutchinson (1992) participants expressed comments which parallel this concept of relearned accountability. For example, one participant in the reported study stated: ‘I will not care differently for patients but I did learn a lesson, I will not take a pill at work again’; and from another: ‘I’ve learned to pull out of bad situations before they get worse’.

Finding a balance between being ‘over the top’ and ‘getting it right’ in terms of clinical decision making and actions was achieved by some participants. The degree of professional deconstruction for some in the wake of the experience of being reported to a NRA was significant in terms of the degree of loss of the role and a loss of confidence. For those nurses who were able to return or continue practicing there were implications with respect to finding a balance with their decision making, including the degree of questioning and need to know if what they were thinking and planning was safe.

Finding a balance in relation to clinical decision making and associated actions in the wake of an allegation of unprofessional conduct was not identified in the literature. The study conducted by Hutchinson (1992) revealed that nurses did in fact change their practice in response to their experience, but there was no mention of the processes they engaged in with respect to finding a balance with decision making.
Living Within the New World

Living with the new world as a category within the substantive theory was identified as coexisting with the category of loss of the assumptive world and within the category, relearning the world. It was uncovered that participants were situated within ‘existing’ in the new world, or had ‘moved on’ within the new world. Of the 21 participants, only two were viewed as having fully moved on, although others had moved into this part of the transformative trajectory.

Existing

Some participants in this study, revealed through their stories that they were psychologically stuck, and as such were existing within the new world rather than being able to move on. From the study conducted by Hutchinson (1992, p. 137) this theme was also realised. One nurse stated: ‘the patient died, I will never get over it. From another in the same reported study: I can’t make plans or set goals’.

Davis (as cited in Neimeyer, 2001) states that an extraordinary amount of research has been conducted to find out why some people succumb to the negative effects of trauma and loss, and others recover. Three broad approaches to understanding this quandary have been used: a personality approach; a coping approach; and psychological issues approach. In the personality approach, pre-existing individual differences on key traits play an important role in predicting those people at greater risk of non recovery. These traits include, for example, a ruminative coping style. The personality approach has realised factors like optimism and mastery which increase the likelihood of a positive outcome to experiencing trauma or a loss. Psychological issues can include such things as the
‘if only’ attitude, which if present, can inhibit recovery; and the need for meaning, which if present, provides impetus to recover (Davis, as cited in Neimeyer, 1992). Thus, participants who were psychologically stuck, may have been for reasons just discussed.

Re-experiencing is the process of remembering and reliving parts of the experience. This dimension was uncovered as representing one reason why a participant in this study could not move on. This dimension was also experienced by nurses in other studies. One nurse contended:

I am still looking forward to the day when I can walk into my former workplace and not experience a flash of fear or painful memory at the mere sight of a nurse from my past (LaDuke, 2001, p. 371).

The implications of re-experiencing are described in the next statement from a nurse in a study conducted by LaDuke (2000). The nurse comments:

What plagues me is that if I ever wanted to pursue a different job, I’d have to revisit this ugly story. People will sit in judgement of me without knowing what a good employee I would be – all this for one mistake in 20 years (LaDuke, 2000, p. 27).

This reveals an ability to move on because of the anticipation of having to relive and remember the experience.

**Moving On**

Moving on from ‘existing’ within the new world was possible for two of the study participants, while others had experienced some advance into this transformative stage. Moving on was characterised with recognising and experiencing turning points and acceptance through integration. The literature, although limited, in relation to the concept moving on is presented.

Janoff-Bulman (1992, p. 174) contends that the survivor can remember the traumatic event, without remembering it all the time. They are able to minimise,
over time, the extent that the event defines ‘their fundamental assumptions’. The new world of the survivor now reflects the acknowledgement of misfortune and an awareness of vulnerability: they now see that no one is invulnerable. Survivors balance what they know can happen with more benign views of themselves and the world (Janoff-Bulman, 1992).

A turning point can be defined as: ‘a moment when the course of events is changed’ or ‘a point at which there is a change in direction or motion’ (Treffry, 2003, p. 1736). A study to examine turning points and protective processes in the lives of people with chronic disabilities was undertaken by King et al (2003). From qualitative analysis of the reported study’s participants, turning point was defined as ‘a compelling experience and realisation that involved meaning acquired through the routes of belonging, doing or understanding the world’ (King et al, 2003, p. 184).

Davis (cited in Neimeyer, 2002) states that some persons have contended that the traumatic experience or loss is a turning point in itself. The trauma or loss is the watershed, which is the vehicle for transformation of their sense of identity or purpose in life. For those participants in this study who experienced a turning point, they were realised from within, or it came as an external challenge.

Of all the participants interviewed, two had fully reconstructed and demonstrated a ‘moving on’ within the new world they were presented with. This moving on was made possible by ultimately being able to accept what had happened to them and integrated into the new world. Some participants demonstrated acceptance of some parts of their experience but had not yet fully integrated the experience into the new world. This meant for some individuals that there were still relearning parts of the new world.
‘Reflection’ and ‘integration’ was a property of the construct ‘re-visioning’ described in the reported study of transformation of professional identity (Hutchinson, 1992). Reflection and integration occurred over time with the nurse being able to ‘transcend their own personal horror and re-vision their interpretation of the experience’ (Hutchinson, 1992, p. 138). There was integration of many pieces of the experience into a complex puzzle which becomes clear as a complete picture. Nurses in this reported study were able to eventually, ‘become aware’ of themselves because of their experience. They were able to examine their personalities, their likes and dislikes and find a position that matched this introspective analysis.

Janoff-Bulman (1992) contends that the rebuilding of shattered assumptions involves (in some way) integrating the old and the new. He goes on to explain that while simply put, integration is not simple. He contends that the individual through cognitive strategies is to minimise the differences between the old world and the new world. Janoff-Bulman (1992) goes onto to say that those individuals who have recovered, or reconstructed their world, are now able to reflect and acknowledge their misfortune and their vulnerability. He furthers states the survivors do remember but not all the time. This is in contrast to the individual who just exists within the new world in that remembering has a focus in their world.

Consequences of Reconstructing

The nature of reactions to trauma continues to receive considerable attention as a research topic. Davis (2001, p. 138) states:

The question of why some people succumb to the negative effects of loss and trauma while others are quite resilient and are at times even
transformed by them has been the focus of volumes of research.

The ability to grow from traumatic events have been demonstrated in a number of life challenges: death of a love one; serious self illness; intense military combat; motor vehicle accidents; natural disasters; assault and job loss (Tedeschi & Calhoun, 1995). It has been found that a substantial percentage of persons who experienced significant loss reported themselves as being stronger because they had been able to survive the trauma and its aftermath (Aldwin, Levenson & Spiro, 1994). Some participants in this study reported that the experience had made them stronger. Some findings provide answers to why some individuals experience growth and why some don’t. One question that requires answering is ‘do individuals who experience greater degrees of loss experience commensurately greater degrees of posttraumatic growth (Calhoun & Tedeschi, 2001). The research has revealed that a number of individual differences have been identified as influencing the ability to grow from trauma. These include: personality traits; gender; and adaptation characteristics (Tedeschi & Calhoun, 1996). Individuals who are extraverted, are open to their own subjective experiences, and those who have complex belief systems are viewed as being able to grow from trauma more than those individuals who don’t have these attributes (Tedeschi & Calhoun, 1995; Tedeschi & Calhoun, 1996). It is well contended that women obtain more growth than men (Tedeschi & Calhoun, 1996).

One nurse in the study conducted by LaDuke (2001, p. 372) describes how the experience of making a mistake and being reported to a NRA went through a ‘healing process’ and is now practising at the bedside. Healing from such a traumatic experience is possible, as this nurse has shown.
The Thread of Resilience

Tusaie and Dyer (2004, p. 3) states that ‘resilience is a vital attribute for nurses in their everyday work…it denotes a combination of abilities and characteristics that interact dynamically to allow an individual to bounce back and cope successfully. The word resilience is from the Latin, re-silere, which means to bounce back (Deveson, 2003). Resilience is defined as:

The state or quality of being resilient…resilient in turn means (of an object or material) capable of regaining its original shape or position after bending, stretching, compression, or other deformity…(of a person) recovering easily and quickly from shock, illness, hardship (Treffry, 2003, p. 1377).

A number of words conjure up the concept of resilience. Synonyms of resilience identified in the Macquarie Concise Thesaurus (2003, p. 634) contribute to a visualisation of the concept of resilience: happiness, health and pliability. Other words that conjure up an understanding of what resilience is include: springing back; rebounding; recoiling, (Deveson, 2003). The overriding interpretation of resilience which emerged from a number of readings is: the ability to bounce back (Deveson, 2003; Flach, 1997).

The concept of resilience has been identified and reported in the literature. Brehony (2000) states that psychologists (in particular) have only recently demonstrated an interest in learning more about resilience. There is a contention that resilience is a vital attribute for nurses in the current climate (Tusaie & Dyer, 2004), although no specific studies addressed the resilience of nurses who had been reported to a NRA for an allegation of unprofessional conduct. These authors reflect that resilience is ‘a combination of both the ability and characteristics that interact dynamically to allow an individual to bounce back, cope successfully, and function above the norm in spite of significant stress or
adversity (Tusaie & Dyer, 2004, p. 3). Wolin and Wolin (1993) in their research into resilience identified a number of characteristics of persons who were viewed as being resilient, they are: insight; independence; relationships; initiative; creativity and humour; ethicality; and general resilience.

Resilience and the degree that an individual exhibits may be linked to attribution theory. Consideration of this emerged after I was discussing the progress of the findings with a colleague who has qualifications in psychology. I acknowledge that there was no intent to seek out those persons with a particular locus of control but questions did emerge as to whether those participants who transformed in a more positive manner had an external locus of control versus an internal locus of control. After reading about this theory it was easy to situate the participants into one or other locus of control groups. This finding has not been explored with specific questioning or analysis of individuals but potentially provides a beginning point for further research into this area and those nurses at risk of having allegations made against them of unprofessional conduct and the ability to cope.

Attribution theory is a domain of social psychology which examines how people identify causes (Moghaddam, 1998) and how these then influence the behaviour of the individual. Although a number of individual theories and associated factors have been proposed by psychologists, namely those by Heider; Jones and Davis; and Kelley (Moghaddam, 1998) the particular relevance of the reviewed literature is that of personality, that is locus of control and attributional style. Rotter (1954) introduced the term locus of control to distinguish between those persons who believe they control their own destiny that is an internal locus of control, versus those who believe that their destiny is determined by factors.
external to themselves, that is they have an external locus of control (Moghaddam, 1998). The significance of locus of control from research studies (Phares, 1978; Strickland, 1988) is that those persons with an internal locus of control have been identified as being better able to cope with a wide range of challenges versus those with an external locus of control. A continual theme within the experiences of all participants was resilience. Day (no date, p. 145) states that what is usually associated with the concept of resilience are: ‘a strong self concept; a support network; a broad perspective on life; flexibility; and a previous good awareness of feelings and the world around them’.

Of the participants who were interviewed it was felt that while the majority of them appeared to fall into the internal locus of control category, a small number demonstrated through the narrative qualities of someone who might be viewed as having an external locus of control. This factor became evident to me through the review of one particular narrative and after talking about some preliminary findings with a colleague with a background in organisational psychology. Going back to the narrative and reviewing the literature provided evidence to support the identification of this construct as relevant and equally as a stepping point for further review into personality types of nurses who may exist within a ‘different dimension’ of risk of being involved in an unprofessional conduct event and subsequently being reported to a NRA.

Tusaie and Dyer (2004) state that area of resilience is of interest to researchers, clinicians and educators. The workplace is full of examples of stress and adversity, and they argue that the opportunity to better understand how individuals cope with this stress and adversity is important to understand. Therefore, the identification of resilience in this research study is of particular
interest in that articulation of coping mechanisms and contexts will provide valuable information to this body of knowledge. It is suggested that the concept of resilience and nurses be further considered in a specific study.

Resilience has been widely explored in studies of persons who have experienced trauma (Brehony, 2000; Devenson, 2003; Janoff-Bulman, 1992; Lesser, 2004; Grossman, Cook, Kepkep & Koenen, 1999). The narratives of holocaust survivors have uncovered a significant body of descriptions of resilience (Frank, 1981; Frankl, 1984; Lengyel, 1967; Nyiszli, 1971; Rees, 2005). Frankl (1984) describes his ability to survive internment in a German concentration camp in the Second World War because he was able to recognise that the meaning in his life, and importantly that his life had meaning. This was his resilience. Frankl (1984, p. 94) provides this account of seeing beyond the horror of the moment:

Almost in tears from pain, I limped a few kilometres with our long column of men from the camp to our work site. Very cold, bitter winds struck us. I kept think of the endless little problems of our miserable life. What would there be to eat tonight? If a piece of sausage came as extra ration, should I exchange it for a piece of bread? Should I trade my last cigarette, which was left from a bonus I received a fortnight ago, for a bowl of soup? How could I get a piece of wire to replace the fragment which served as one of my shoelaces? I became disgusted with the state of affairs which compelled me, daily and hourly, to think of only such trivial things. I forced my thoughts to turn to another subject. Suddenly I saw myself standing on the platform of a well lit, warm and pleasant lecture room. In front of me sat an attentive audience on comfortable upholstered seats. I was giving a lecture on the psychology of the concentration camp! All that oppressed
me at that moment became objective, see and described from the remote
viewpoint of science. By this method I succeeded somehow in rising above the
situation, above the sufferings of the moment, and I observed them as if they were
already of the past.

Bachay and Cingel (1999, p.163) note that resilience is emerging as ‘an
interactive and systemic phenomenon, the product of a complex relationship of
inner strengths and outer help throughout a person’s life span’. This is similar to
the findings of this study, in that resilience become apparent from inherent
qualities and external challenges and forces. The ability to ‘bounce back’ or
‘spring back’ has been identified in the literature as a trait of resilience (Dyer &
resilience is the search for meaning.

CONCLUSION

This chapter has presented a discussion of the literature in relation to the
concepts of the substantive theory. While there is a plethora of literature related
to the theory or error, specific examples of and profiles of error in health care and
the consequences of a traumatic experience, there is little literature which explains
the experiences of nurses reported for an allegation of unprofessional conduct.
The literature that was identified in relation to the social phenomenon reflected
the experiences of the nurses in this study.

The importance of story telling is gaining momentum. Caroline Jones in
an interview with McLeod (2005) contends that:

Everyone’s story is important but not everyone realises that…when a
person loses sight of their story or loses sight of the importance and uniqueness of
it, then they are in peril. I think that’s what happens when people think they can’t
go on living. I’m interested in encouraging people that their story is important.

Nurse researchers are best positioned to identify social phenomenon
within nursing that require examination. This includes the need to recognise the
importance of story telling as a way of communicating social phenomenon and the
experiences of nurses. From this study, the challenge for researchers is to
continue to pursue scholarly inquiry into the vulnerabilities nurses experience in
the work and personal lives so that vulnerability can be better managed with the
aim of enhanced patient safety. The area identified as lacking in the literature is
the support of nurses who experience traumatic experiences in their professional
lives. While it is contended that ‘negative experiences, however painful, can be
transformed and result in positive outcomes’ (Crigger, 2004, p. 572), the need to
support and nurture the ‘wounded nurse’ through this experience can not be
overestimated.

The next chapter will provide a summary of the achievements of the study
objectives. A number of recommendations have been developed from the analysis
of the data which will also be presented.

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It was sometime near eleven o’clock that my mother’s answers started sounding
less precise and some of her responses began to grow slightly fuzzy. She had been
on the stand for close to two hours, answering questions for Stephen that ranged
from such generalities as the sorts of words she might use to convey risk to
parents at a first trimester meeting, to the specifics of why she had ruptured the
membranes that dammed Charlotte Bedford’s amniotic fluid (Bohjalian, 1998,
p.286.
CHAPTER EIGHT

Achievement of the Study Objectives and Recommendations

Not long after she paid the fine, my mother returned to midwifery. It lasted almost a year, and for a time her life was filled with activity, if not exactly joy. There were the pre-natals and the consultations, the women – sometimes women and men – coming and going at our house. It was clear to us all that she would be able to rebuild her practice (Bohjalian, 1988, p. 305).

INTRODUCTION

This chapter will provide a summary of this study by revisiting the objectives and associated accomplishments. From this discussion, implications and recommendations for nursing practice, theory, research and education have been explicated.

The purpose of this study was to discover the process nurses used to deal with an allegation of unprofessional conduct. Specifically, the substantive theory, ‘transformation of the personal, and professional self’, viewed as the ‘Phoenix Process’ provides a description and explanation of the deconstructive and reconstructive processes of the personal, and professional self in response to the social phenomenon, an allegation of unprofessional conduct, and in particular how these participants dealt with it.

ACHIEVEMENT OF THE STUDY OBJECTIVES

The objectives of this study were to (1) develop an operational definition of unprofessional conduct within the nursing context and (2) generate a substantive theory to explain the nature, processes and outcomes of the phenomenon of unprofessional conduct within nursing practice, with specific objectives being to develop the following:
(i) a model for clinical risk management of unprofessional conduct in nursing; and a
(ii) theory that provides understanding and operationalisation of a framework for support for nurses during and after the event.

The outcomes from these objectives are now discussed along with relevant recommendations. The recommendations have been developed from the findings and gaps within the literature.

**Toward a New Understanding of Unprofessional Conduct**

The definition of unprofessional conduct was explored in chapter one and is briefly revisited here. Unprofessional conduct is defined in the broadest sense as conduct which is divergent from the agreed upon and accepted standards of practice of the respective profession (Johnstone & Kanitsaki, 2001). Wallace (2001) explains that the nursing regulatory authorities have varying defining components, but generally fall into similar domains, that is a deviation from the prescribed standards of contemporary nursing practice, a breach of the relevant Act and/or code, regulation or order, any conduct that indicates that the nurse in question is not fit to practice nursing or any behaviour that brings nursing into ill repute may be indicative of unprofessional conduct.

Clearly the literature and legislation articulates therefore that *any* (emphasis added) deviation from the required standard of nursing practice could be judged to be unprofessional conduct. The significant anomaly with the definition of unprofessional conduct proposed in the literature is the difficulty in interpreting ‘unprofessional conduct’ versus a ‘single nursing error’ which emerged as the case for a number of the participants in that they were both reported to a NRA for unprofessional conduct for, in some cases, a single nursing
error and formally had allegations of unprofessional conduct brought against them because of this. This proved incomprehensible to some participants and is best summed up by Participant 8: ‘I mean, [everything] down the drain for one little error, I’ve made errors before and I can’t guarantee that I won’t make another error.’

The lawyer for Participant 8 provided this argument as the basis for her defence: ‘you cannot be accused of unprofessional conduct on the basis of one mistake’. This concept is explored in the following reported case, Pillai v Messiter. A medical practitioner appealed to the Supreme Court of NSW after being deregistered for transcribing a drug wrongly which in turn contributed to the death of a patient (Staunton & Chiarella, 2003). The Supreme Court held that ‘mistakes can happen to the most conscientious professional person’.

It is contended from the outset, that an allegation of unprofessional conduct should not be made based solely on a single breach of a nursing practice standard. Nonetheless, allegations of unprofessional conduct can be made based on a single breach of a nursing error or error. If this was to be the criteria for determining an allegation of unprofessional conduct and subsequent reporting to a NRA, then it is possible that many nurses could be reported, based on a single error. To destroy a nurse’s personal and professional life over one medication error serves no purpose. The motivation of nurse supervisors and NRAs must be in reducing harm to patients through the systematic review of errors, the provision of safe and supportive working contexts and contemporary education.

Participant 8 in her letter to the NRA regarding the allegation of unprofessional conduct that was made against her identifies the conundrum evident with the definition and interpretation of ‘unprofessional conduct’. This
nurse also provides a summary of the experience of being reported to a NRA and
of the key issues in this phenomenon. She explains:

By definition unprofessional conduct according to the Nurses Act is very
broad. It is possible that you might find us guilty of unprofessional
conduct. You have heard the testimonies, statements and references. You
are aware of my nursing history and you have a copy of my curriculum
vitae which details my commitment to nursing education. I will speak for
myself but I am sure you will agree that we and our families have gone
gone through considerable stress and anxiety during the process of this enquiry.
The doctor who wrote the initial complete medication order has gone
unchecked. To be found guilty of unprofessional conduct over a single
error is harsh and being branded with this will stay with us forever. I do
believe that someone should not be labelled like that if they have
demonstrated the exact opposite over the past 23 years. I believe I made a
simple human error and was placed under excessive pressures by the
prevailing hospital environment. When and if I return to nursing this
experience will always stay with me. In today’s nursing climate and with
the difficulties encountered I cannot guarantee that I will not make a
mistake again. [P08/PG29/L1-22]

A review of the literature in relation to the management of reportable
matters to NRA reveals limited guidance for nurse supervisors. Information is
provided by nurse regulatory authorities regarding which matters can be managed
through performance management strategies and those which can be reported.

Two examples of such information follow:

- Guidelines for employers and managers in respect to reporting
  complaints about nurses to the Nurses Board of Western Australia’,
  (NBWA, August 2005); and
- Complaint process: Employer’s obligation to report unprofessional
  conduct (NBSA, 2003).

The reality is that not all persons who may have to make such a
determination are adequately prepared to do so. As well, the reasons to report
nurses may not be legitimate or proper. Porter-O’Grady and Malloch (2003, p.
153) contend that ‘reporting minor errors with low risk for harm does not appear
to be worth the trauma caused to the care providers’. For this reason they suggest
that remediation should be the strategy of choice, versus discipline. Remediation,
using counselling and guidance, can protect the dignity of the caregiver and minimise shame. As well, the approach of remediation parallels the need to consider errors as an opportunity to learn more effective behaviours (Porter-O’Grady & Malloch, 2003). It is suggested by the authors that remediation be considered when:

- The potential risk of harm to the client due to the incident is very low;
- The incident is a singular event as opposed to part of a pattern of sub-standard practice;
- The employer exhibits a conscientious approach be accountable for his or her practice; and
- The employer appears to have the necessary knowledge and skill to practice safely (Porter-O’Grady & Malloch, 2003).

It is timely to remember that the domain of professional practice includes a philosophy and commitment by nurse supervisors to support and educate nurses. This includes those times when things go wrong. Reporting a nurse for a matter which could be adequately managed in-house through normal and individualised performance management strategies is counter-productive to the personal and professional development of the nurse, nor does it (necessarily) address the requirements to ensure patient safety. Clearly, a well defined approach to determining which matters should be reported to a NRA is needed. It is contended that nurses who make ‘genuine practice errors’, or an ‘honest mistake’ should not be reported to a NRA (Johnstone & Kanitsaki, 2005). Johnstone and Kanitsaki (2005) argue that the competent nurse who makes an error needs to be distinguished from the nurse who is assessed as incompetent, impaired, uncaring or who may have criminal intent. This belief is supported by Connor, Ponte and Conway (2002) who state that a non-punitive environment must exist if there is to be a successful error management program. It is stated though that approach should not remove the notion of accountability. Johnstone and Kanitsaki (2005)
further contend that the majority of nursing errors co-exist within systems issue.
This correlates to the findings of this study. The following framework is suggested as one strategy for making these determinations.

The following is provided as a decision making framework (Figure 8.1, *in three parts*) for managing a situation where there has been a breach of, or failure to meet a nursing practice standard. This tool is designed to provide an overview of the key points of consideration and choices to ensure that the nurse is safe to practice and as such able to provide safe patient care which is cornerstone to professional practice. This decision making processes outlined in this tool will provide a new concept of unprofessional conduct, i.e. it will identify those matters where the nurse is not safe to practice and the point where the matter is then best dealt with by the NRA because of the need to ensure patient safety.

This decision making framework provides prompts for the nurse supervisor to analyse the breach, or failure to meet the nursing practice standard including interviewing the nurse. Three decision making trajectories are provided. The first one allows for identifying the nurse who was involved in an isolated event and who is assessed at being safe to practice. The second trajectory provides descriptors which reveal a nurse who requires re-education to meet the required competencies to practice safely and the point where the nurse is not able to meet these competencies and as such is not safe to practice and the matter is then reportable to a NRA. The third trajectory provides a clear distinction for the nurse who is not safe to practice because of either a physical or mental illness,
Figure 8.1: A decision-making framework for breaches of, or failure to meet a nursing practice standard [Part A].
Figure 8.1: A decision making framework for breaches of, or failure to meet a nursing practice standard [Part B]
Figure 8.1: A decision making framework for breaches of, or failure to meet a nursing practice standard [Part C].
including chemical and/or alcohol dependency. This decision making framework is grounded in the need to ensure that nurses are competent and supported to provide safe care, it is not punitive in nature.

Substantive Theory

The primary objective of this study was to develop and then describe a substantive theory giving construct to the social phenomenon of an allegation of unprofessional nursing and the related social processes. This transformation of the personal and professional self emerged as the substantive theory for this cohort of participants who were reported to a NRA for an allegation of unprofessional conduct. This theory describes the transformation that is possible and which many of the participants at the time of the investigation, were still going through. The process of transformation is unique for the individual and while there is no wrong or right way to transform it became evident that many of the participants had difficulty reconstructing their personal and professional selves to transcend the transformative trajectory.

Transformation is influenced by a number of factors and processes with negative and positive effects. The actual nature of the allegation proved confronting for all participants and in the extreme proved devastating. The ability and time taken to transform was influenced by the degree of deconstruction experienced. The extreme point of this deconstruction revealed significant psychological trauma. For example, on nurse contemplated and attempted suicided. Two participants required hospitalisation for severe depression and suicidal ideation.
The deconstruction of the professional self was seen with a loss of the role, a loss of passion for nursing and a loss of confidence. Participants experienced varying degrees within these dimensions. Spoiled identity revealed that participants experienced shame, stigma and were seen as a criminal by others and themselves. All participants experienced punishment either self imposed or through the nature of the experience and formal penalties imposed by the NRA.

Reconstruction was influenced by the degree and type of resilience exhibited by the individual, the meaning attached to what happened to them, the type and degree of support, including industrial and legal representation that was personalised and reflected a degree of knowing and commitment to nursing. The time taken to deal with the matter proved frustrating and complicated the ability to effectively reconstruct.

Participants were seen to be living in a new world, either (just) existing or be able to move on within this newly learned world. Those participants who were not able to move on struggled with aspects of their experience which revealed being stuck, wanting revenge and vindication and not being able to minimise the remembering. Those participants who were seen to be moving on had experienced a turning point or recognised that a turning point was needed to give them momentum to move on. Turning points represented for some a moment of meaning and recognition of their worth as a person and as a nurse.

Transformation of the personal and professional self is an ongoing process commenced once the nurse is confronted by the allegation and continues through the deconstructive and reconstructive phases of the transformative trajectory. The nature of this transformation is influenced by the nature and outcomes of the breach of, or failure to meet the nursing practice standard, the degree of
deconstruction and the ability to reconstruct in a positive way in response to positive influencing factors and processes. A positively transcended transformation is possible. What is proposed in the remainder of this chapter are recommendations to both minimise the vulnerability of the nurse to being exposed to an allegation of unprofessional conduct and minimise the degree of deconstruction should an allegation occur.

A Clinical Risk Management Model Applicable to Vulnerability in Nursing Practice

Sharpe (1999) provides insight into the characteristics of the nurse most likely to be sued. While these characteristics are particular to nurses in the North American context where it is commonplace to be sued for negligence, they nonetheless can be viewed as having relevance to the practice of all nurses. Sharpe (1999) states that the nurse at risk of being sued include the following:

- One who appears oblivious or who does not respond to the needs of the patient;
- One who fails to identify and/or respond to the needs of the patient and/or significant others;
- One who may be rigid, autocratic and peremptory in his or her personal relationships with patients and peers. This nurse can be viewed as giving care, but seen as not caring;
- One who accepts a care assignment that they are not competent or prepared to undertake (Sharpe, 1999, p. 42).

There is a contemporary focus on clinical risk management, clinical governance and the need to understand clinical practice errors using a systems approach. Clinical risk management is defined as a systematic, multidisciplinary approach to the management of risk to patient and staff (Wilson, as cited in Tingle
& Williams, 1999). The scope of clinical risk management for health care services and practices can include: identifying risk and modifying risk. A number of tools exist to identify clinical risk, these include: incident reports; clinical audit; committee reports and minutes; claims data; consumer complaints; policies and procedures; service agreements; survey reports; clinical indicators; patient records; and communication channels (Wilson, as cited in Tingle & Wilson, 1999). Modifying risk involves the process of changing circumstances, environment and behaviour. While it is beyond the scope of this study, and probably unnecessary because many excellent texts are available on this topic (Tingle & Wilson, 1999; Reason, 1990; Vincent, 2001) it is relevant to address the behavioural nature of risk modification. Although individual and contextual causal attributes were identified from the reported narratives, the ability of the nurse to navigate between these risk and vulnerabilities and to critically think through the situations they found themselves in is, I believe, an approach that the individual nurse can engage with.

What has been described in a lot of these reported cases are contextual and human risk factors which had a large part to play in the causation of nursing errors. It is usual to view these risk factors as a cascade or sequence of events and which clearly have their origins as a systems error rather than anyone isolated behaviour. It is clear then, that behavioural risk factors usually exist within a number of contextual risk factors and it is hypothesised that if contextual risk factors could be better managed then the likelihood of a wrong behaviour will be significantly minimised.
To this end, it is proposed that nursing practice be positioned within a model of clinical risk management to minimise and prevent the concepts of personal and professional vulnerability. Specifically, the model (Figure 8.2) articulates the scope of personal and professional vulnerability that the study participants experienced. Therefore this ‘risk management model’ goes beyond the much discussed models of clinical risk management and importantly incorporates other aspects of professional vulnerability and required positive behaviours. It is further argued that clinical risk management programs require evaluating to determine if they in fact provide a measure of protection to the individual nurse.

A further recommendation is the use of critical thinking as a vehicle for minimising nursing errors. While this study was not about apportioning blame, analysis of the event that the participant was involved in suggested that a formal application of critical thinking may have produced a different outcome. This contention will be explained.

Critical thinking, the choosing of an optimal action or support of a belief (O’Neill, 1997; Paul 1990), represents ‘purposeful thinking that takes into account focus, language, frame of reference, attitudes, assumptions, evidence, reasoning, conclusions, implications and context (Miller & Babcock, 1996). Bennett and Dune (2002) states that critical thinking can increase quality outcomes and reduce errors. They further state that ‘purposeful thinking with an understanding of human factors can be the practical framework that places safe quality practice within the reach of all health care’ (Bennett & Dune, 2002, p. 385). This is supported by Jenkins (1985) and Malek (1986) who state that critical thinking is a requirement for nurses to be safe, competent and skilled practitioners.
Figure 8.2: A model for minimising vulnerability for the individual nurse.
Reason (990) explains that critical thinking is well suited to minimising human error. Error types originate in the conceptual, storage and action stages of the thought process. Because error types are grounded in the range of cognitive activities critical thinking is an appropriate strategy for identifying potential error and managing it (Bennett & Dune, 2002).

A number of models of critical thinking have been identified in the literature (Bennett & Dune, 2002; Miller & Babcock, 1996) and it is not the intention of inventing another framework. What is emphasised though is those components and qualities which produce critical thinking. Characteristics of critical thinkers as described by Paul (1990) include: active thinking; curious and insightful; fair-minded; realistic; and team players. A range of critical thinking skills is offered: interpretation; analysis; evaluation; inference; explanation; and self regulation. There are potential limitations to critical thinking, time, educational and experiential preparedness and a lack of willingness to go to another level in terms of commitment to quality and decision making.

Critical thinking is viewed as the lynch pin for navigating the four domains within the ‘Model for Minimising the Vulnerability for the Individual Nurse’. The domains are: competencies; resources; responses; and qualities. At the core of these domains is the concept of synergy. There must be a synergistic relationship between all the domains to provide a foundation for minimising vulnerability for the personal and professional self. Importantly, a distinction between the two selves has not been made. As vulnerability diminishes, integrity or the wholeness of the nurse is increased, thus minimising the potential for harm. Critical thinking is viewed as the mechanism for purposeful thought for each practice encounter and for wider professional decisions and development.
decisions. Critical thinking is not a new skill, but one that requires further articulation in the day to day practice of the nurse. The nurse, until able to think critically without being prompted should be assisted to develop this skill.

A number of factors within each domain are commented on. I have decided to include choosing the right practice context. This was included because it became apparent that a number of the participants were not working in a context that was conducive to their personality or coping abilities. I have also decided to include foreseeability. It was clear that some participants were not able to foresee that a breach of, or failure to meet a standard may have implications for effecting good patient outcomes. Some experienced difficulty in being able to project how their behaviours in some situations may be viewed as unprofessional. The domain of resources includes dimensions for development and support revealed as lacking in the experiences of these participants. These dimensions include: a systems approach to error management; performance development reviews; appropriate nurse-patient ratios; professional support framework; participatory context model; facilitation of learning; social support framework; mentor program; and education.

**A Support Framework for Nurses Reported to a Nurse Regulatory Authority**

Early on during the recruitment phase I had a telephone call from a nurse who had just found out she had been reported to a NRA. She had telephoned seeking my advice. It was clear that she was not eligible to be a study participant. I advised her of this fact, and that I was not in a capacity to provide her with advice. After some persistence I told her that ‘if I was her then I would contact a lawyer immediately’. Her response and questioning to this statement made it
clear that she had very little insight into this legal process and I felt that she was leaving herself particularly vulnerable. I only hope that she called a lawyer.

This conversation coupled with the stories provided by the participants provides the impetus for the following recommendation. A support framework is proposed for all nurses. Firstly for those nurses who might find themselves involved in having made an error or breached a standard and for those who are already in the midst of an unfortunate situation. It is hoped that this tool may be useful for family and friends of nurses who are in crisis and not able to determine what to do next. Castledine (2003) explains that many nurses who find themselves before the Nursing and Midwifery Council of the United Kingdom are there because they have made a mistake in the face of stress created by extensive workloads. While he notes that some nurses who make the headlines may be criminally motivated or have their actions determined as premeditated, they are the minority. Castledine (2003) further contends that nurses who are reported to a NRA must be helped and supported as a matter of urgency. He tells of the nurse who received papers from the NRA referring to a complaint that had been made against her; she had been too scared to open the letter.

The following framework (Figure 8.3) outlines strategies and processes necessary and useful to support the personal and professional needs of the nurse who finds themselves reported to a NRA for unprofessional conduct. The components of this framework have been extrapolated from what the study participants revealed as useful to their experience. It also provides strategies for personal and professional support identified in the contemporary literature.

Support can be obtained through a professional counselling service and through industrial and legal representation. Although some participants expressed
Figure 8.3: A support framework for the nurse reported to a NRA.
the view that the representation from the union and their lawyers was less than positive it is contended that if a nurse belongs to a union then they should contact them and if not they should seek legal counsel. Two factors prohibited timely and effective representation, the cost and not being able to understand the need for it. One method for dealing with legal costs, in part, is union membership and professional indemnity insurance. It is also contended that industrial and legal representation is best provided by persons who have an understanding of nursing practice and an understanding of NRA processes, and the personal and professional consequences for the nurse.

It is contended a nurse who makes an error where the employer deems it necessary to report the matter to a NRA should seek legal representation. This does not mean an assertion of guilt, but the implications of not having legal representation is clear from the experiences of some of the participants. In one study conducted by La Duke (2000) 75% of the nurses in her study stated the need to obtain the best possible legal representation possible. The other thing they said was that if this ever happened again they would fight harder and longer. There would be no way that they would be again ‘outed’ for professional misconduct. The value of professional counselling emerged with one participant who sought the assistance of a psychologist as soon as she realised that she had been reported to a NRA. This strategy proved effective and while the ability to do this is framed within the degree of impact already experienced and the foreseeability of the value of counselling this strategy should be considered by any nurse reported to a NRA. Many of the participants sought professional help for the problems they were having but for many it was after they had experienced some
very significant lows in their experience. Others had not yet sought the help of a counsellor and could clearly benefit from this.

The nature of experience to the allegation and being reported to an NRA revealed elements of post traumatic stress disorder (PTSD). It is again contended that while it was not my intent to diagnosis, some of what was told to me revealed that the event for some was extremely traumatic and for some of the participants they had been living with the effects for a long time with little resolve. The most disturbing account was one participant who could only describe what she had gone through by comparing it to someone who had been raped. A number of participants were psychologically stuck and continued to relive the pain of this psychological trauma. Although for the most part the employer was the reporting agent and therefore were seen as an opposing force to the participant the employer has an obligation, legally and professionally to provide support to the nurse involved in a critical event. Nurses involved in breaches of, or failures to meet nursing practice standard where there is harm to a patient or where the matter is serious enough to warrant reporting to a NRA should receive independent debriefing.

Support from family and friends are not guaranteed. Some friends deserted the participant and family members were not support because there were already problems with the relationships. Nonetheless, when this support was offered it proved very effective. For some participants their mainstay was their partner who helped them shoulder the experience and were able to listen. This support for some was stymied because of the shame they experienced, and they felt bad about the shame they brought on their family. Some felt that their family would never understand what they were going through. The support of willing
family and friends is an important component in a support framework and can invariable.

A review of the world wide web revealed a site ‘Nurse Protect’ based in North America. This site (www.nurseprotect.com) managed by a registered nurse has as its by-line ‘balancing the need to protect the public with the need to protect the nurses’ rights’. This web site details cases where nurses have been reported to a NRA, provides information and resources, along with the ability to engage with the managing RN as an avenue for support.

A number of participants recognised the need for a ‘support group’ of nurses who had been involved in being reported to a NRA for alleged unprofessional conduct. Some of these participants recognised the potential difficulty of both organising a support group and although they saw it as a very real need, equally some recognised that they were too ‘raw’ to have initiated it at the time. The difficulty arises with respect to a formal support group because of the not only the nature of the allegation and experience, but the difficulty of being able to hang a shingle and have nurses attend meetings.

In view of these difficulties the following support network is proposed with recommendations for its instigation. The support network is suggested as just that, a network of persons who have experienced being reported to a NRA and where the matter has now been dealt with and are willing to receive and make contact to a nurse who may find themselves in the same situation. One nurse expressed the difficulty she had when speaking to a counsellor offered through the employee program. She contended that the counsellor did not understand the nursing context and was not as helpful as she hoped. Another participant expressed the value in being able to talk to me had had. While this
recommendation is made, a separate scoping paper will be undertaken to identify need and willingness of adequate numbers of persons willing to provide peer support. This paper will also attempt to determine the suitability of peer participants. It would be necessary to assess their readiness to and thus ability to provide effective support.

A review of the literature identified model for transcending trauma with particular relevance to nursing (Conti-O’Hare, 2002). It is introduced in the context of this study as a beginning point to consider its applicability to the deconstructive of the personal and professional self experienced by nurses who are reported to a NRA.

The ‘Q.U.E.S.T. Model’ (Conti-O’Hare, 2000) is aimed at assisting nurses and other health professionals in healing themselves and at the same time avoid vicarious re-traumatisation in the workplace. The theoretical basis for this model includes the experiences of health professionals, the trauma literature and other models for reflective practice. A number of assumptions underpin this model, they are:

1. Growth and transcendence are without end;
2. Trauma patterns, such as parentification, may appear more commonly than realised within all types of relationships;
3. Recovery begins only when the nurse remain open to the possibility of trauma occurring in their lives;
4. Transformation and transcendence becomes possible through understanding the pain caused by the trauma, both personally and professionally;
5. Therapeutic use of self can be facilitated when practitioners consciously and deliberately apply their knowledge of trauma to foster mutual growth between themselves and their patients. (Conti-O’Hare, 2002).
A number of major influences which have relevance to this phenomenon are noted: feelings of hopelessness, family history and the employment context (Saakvitne & Pearlman, 1996, as cited in Conti-O’Hare, 2002). The consequences of this phenomenon, wounded healer, include symptoms of anxiety, depression, intrusive thoughts, alienation, dissociative episodes and despair, and are not uncommon to those identified in PTSD. Other symptoms include paranoia, hypervigilance, disrupted personal relationships, psychic numbing and a feeling of being overwhelmed (Blair & Ramones, 1996; Saakvitne & Pearlman, 1996, as cited in Conti-O’Hare, 2002). The model includes a self assessment guide and description of what each strategy entails. These strategies are summarised in Table 8.1. A preliminary review of this model to deal with the nurse as a wounded healer reveals similarities to the findings in this study and as such provides promise of its suitability as a framework to guide the healing of the nurse who finds themselves reported to a NRA whatever the degree of deconstruction. This model has potential as an overarching framework for healing the nurse who has deconstructed personally and professionally. This model should be examined in greater detail.

<table>
<thead>
<tr>
<th>Q.U.E.S.T.</th>
<th>Strategy</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q</td>
<td>Question</td>
<td>Self examination of the possibility of trauma and its subsequent impact.</td>
</tr>
<tr>
<td>U</td>
<td>Uncover</td>
<td>Uncovering the causes and patterns of trauma.</td>
</tr>
<tr>
<td>E</td>
<td>Experience</td>
<td>Experiencing the trauma with insightfulness.</td>
</tr>
<tr>
<td>S</td>
<td>Search for meaning</td>
<td>Most critical of the strategies. Meaning is sought to put the trauma into perspective which in turns promotes healing.</td>
</tr>
<tr>
<td>T</td>
<td>Transform and Transcend</td>
<td>The individual develops the capability for examining past events with renewed awareness.</td>
</tr>
</tbody>
</table>

Table 8.1: An overview of the QUEST model (Conti-O’Hare, 2000).
Saying Sorry

Sparkman (2005, p. 263) states that ‘learning to say I’m sorry is one of the first lessons of childhood’. Sparkman (2005, p. 263) goes on to contend that the act of apologising is an opportunity to mend relationship breakdowns and it has the ability to ‘release amazing healing energies’. Benefits of apologising for a ‘wrong’ can have benefits. Some of these include:

- Restoration of the aggrieved person’s dignity;
- Minimises anger;
- Assists to prevent antagonistic behaviour;
- Allows for natural, open and direct dialogue;
- Provides a foundation for reconciliation; and
- Provides evidence that both parties share similar moral beliefs (Sparkman, 2005, p. 263).

Studies have revealed where hospitals and medical practitioners have disclosure policy related to error and apologise law suits are less (Zimmerman, 2004). In one British study it was found that 37% of patients and family members who brought a law suit against their medical practitioner may not have done so if they had been given an explanation and apology (Vincent, Young & Phillips, 2004). A further study supports this statistic (Keeva, 1999).

The Safety and Quality Council of Australia has developed a handbook for health care professionals detailing the process for open disclosure (Safety & Quality Council of Australia, 2003). The principle of open disclosure is to provide an ‘open, consistent approach to communicating with patients following an adverse event’ (Safety & Quality Council of Australia, 2003, p. 3). It is further stated that the ethical basis for an open disclosure policy is congruent with ‘evolving ethical practices in medicine supporting openness with patients and
increased involvement of patients in their own care’ (Safety & Quality Council of Australia, 2003, p. 3).

The act of apologising has been criticised because of the concern that it may convey an admission of guilt (Sparkman, 2005). The practice of open disclosure does come with some cautions, including the need to confer with a clinical manager or other senior staff to ensure that the approach and use of words are appropriate (Safety & Quality Council of Australia, 2003). Despite such concerns there is a trend to say sorry when a mistake has been made. In the study cohort, one of the participants engaged with a family member of a patient who had received an overdose of a narcotic. The expression of genuine apology and distress the nurse was experiencing allowed for a dual sharing of this situation and provided the participant with an unusual avenue of support when the family member wrote in support of the participant.

A policy of open disclosure has a place in health care. Nurses should be supported when making an apology and discussing errors that they were involved in. This strategy in turn can be therapeutic for the nurse involved in the error. This process allows them to express their remorse and distress, providing for a degree of catharsis (Sparkman, 2005).

The Recommendations

In summary, a number of recommendations have been promulgated from the analysis of the data, discussion and consideration of the literature. This study had revealed the nature of traumatic events in the lives of nurses. The degree of deconstruction some have experienced for the making of one error is at times incomprehensible. These recommendations are grounded in the need to minimise the potential for the making of errors and the minimisation of deconstruction of
the nurse should an error be made and should the matter require reporting to a
NRA. The recommendations are:

1. That a new understanding of unprofessional conduct be considered,
   embraced and as such, define those matters that must be reported to the
   NRA, that is, only if there is a fitness to practice issue; or the nurse is
   considered to be unsafe to practice after support and education have
   been provided;
2. That a systems approach continue to be promoted as the most
   appropriate way to manage nursing errors;
3. That nurses who make a nursing error are not punished but rather
   supported and educated with the aim of minimising the deconstruction
   of the personal and professional self; and future nursing errors;
4. That nurses who find themselves reported to a NRA for an allegation
   of unprofessional conduct seek immediate union and/or legal
   representation;
5. That nurses who find themselves reported to a NRA seek advocacy to
   ensure that they are able to seek legal counsel; and formal and informal
   support, including counselling;
6. That a scoping paper be written to examine the need and commitment
   to a peer support group for nurses reported to a NRA; and
7. The Model for Minimising Vulnerability for the Individual Nurse be
   presented in nursing fora to determine its value to nurses, including
   emphasis on critical thinking.

The findings of this study will be presented through a number of planned
journal articles and presentations. It is envisaged that these findings will continue
to provide the impetus for scholarly inquiry, research and education.

**CONCLUSION**

Conti-O’Hare (2002, p. 87) contends that it is necessary to examine the
nature and effects of the trauma that nurses can experience. This study explicated
a substantive theory to explain how nurses deal with an allegation of unprofessional conduct. The symbols, language and shared meaning uncovered within the narratives reveal a transformative process, at times stymied, at times evolving, and for a few, close to or transcended. This transformation is in response to having an allegation of unprofessional made against them, deconstructing the personal and professional selves and engaging in and going through a reconstructive processes. Transformation is possible, that is the ‘phoenix’ within the nurse can re-new, but needs to be purposefully constructed with positive influencing processes and advocacy for the nurse.

*****

Nevertheless, my mother never did catch another baby after that final November birth. Exactly as she told her own mother she would, she pulled down those prenatal posters and covered the walls of what had been her office with blue iris wallpaper. She then read in that room and quilted in that room, and I’m sure when the house was quiet she sat alone in that room and stared at the mountains in the distance (Bohjalian, 1998, p. 306).
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APPENDIX A

Nurses

Have you at any time in your nursing career been reported to the Nurses Board for unprofessional conduct? Did this report result in you appearing before a disciplinary panel? If so, would you like to share this experience by volunteering to participate in a PhD research study?

Would you like to be interviewed?

If you would like to participate and tell your story, please contact Dale Pugh on 0402 585 550.

Dale Pugh is a registered nurse and currently a PhD student at RMIT University, Melbourne.
Exploring the issue of unprofessional conduct

Anonymouse
Australian Nursing Journal, May 2003; 10, 10, ProQuest Nursing Journals
pg 16

This working life

Exploring the issue of unprofessional conduct

Appearing before a disciplinary panel is often described as one of the most stressful events a nurse will have to endure in his or her career. Whatever the result - whether a nurse continues to practise or is removed from the nursing register - the experience can have profound effects on the individual concerned. However, as Perth RN Dale Pugh told Steven Harulow, there is little international research into the phenomenon of unprofessional conduct in nursing and almost none in Australia; a situation she aims to redress with her PhD study.

Dale Pugh says she has had a long interest in the legal and professional aspects of nursing.

"Even as a student I was interested in standards of practice and the rules and I think it's grown from there," Dale says. "I'm interested in the legal and professional side of nursing because at the end of the day it's the foundation for all our practice. You can't get away from it."

Dale is using this interest as the driving force behind her PhD study into the phenomenon of unprofessional conduct, undertaken as an external student at Melbourne's RMIT University.

"I am looking for nurses who have been reported to a nursing regulatory authority, such as a board of nursing, and have appeared before a committee to examine the allegation."

Dale intends to complete a qualitative study of alleged unprofessional conduct events reported to nurses boards. Her study is being supervised by RMIT's Professor Megan-Jane Johnston, an eminent scholar in the area of nursing law and ethics and the author of "Nursing and the Injunction of the Law," and Professor Olya Eason-Wright, Head of the Department of Nursing and Midwifery at RMIT.

"It doesn't matter what the content of the allegation was or the outcome. I'm interested in people's stories and I'm not about reporting the matter again or repercussions," Dale says.

"I want to talk to people whose cases have gone through the board and where there's been an outcome, so there's no further obligation for me to report on what is said. This process is confidential and people can have confidence in it."

Dale aims to explore and describe the nature of alleged unprofessional conduct events, specifically the behavioural and contextual risk factors that contributed to the incident and the impact on the nurse involved.

"We've got two main objectives which I hope to translate into nursing practice to develop a risk management tool that minimises and prevents those events occurring and, to develop a framework of support for nurses."

"In my experience of seeing these events happen, support is very ad hoc and depends on the ability of the nurse to access resources. Unless a nurse knows quietly to call someone like the ANF they can find out."

"What I can do is seek the stories of nurses who have "been there", and re-tell them."

Dale hopes to develop a theory which will explain the nature, processes and outcomes of the phenomenon of unprofessional conduct within nursing practice.

"I can't pretend to know how it feels, what it's like to be reported to a nurses board, to have the letter arrive out of the blue, to have to expose myself and my practice to the scrutiny of strangers."

"What I can do is seek the stories of nurses who have "been there", and re-tell them."

Any nurse interested in taking part in the study can phone Dale to discuss the project.

"I've got a plain language three-page letter explaining what individuals would be required to do."

"If they're interested, I'll send them a demographic form which details their age group and the nature of the event, and a consent form which they can fill out if they choose to participate."

"I'll contact people I want to interview and carry out a telephone interview."

Dale acknowledges that for some, picking up the phone will be difficult, but says talking will proclaim a nurse's experience and contribute to a collective voice on this under-researched phenomenon.

Contact Dale on 0403 668 569 to share your story. Your contribution could help other nurses facing the same situation.

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**APPENDIX C**

**Interview Summary Sheet**

<table>
<thead>
<tr>
<th>Participant Code</th>
<th>Interview Date</th>
<th>Start Time</th>
<th>End Time</th>
</tr>
</thead>
</table>

**Location of Interview**

**Non-verbal behaviour** [eg tone of voice, posture, facial expressions, forcefulness of speech, body movement, hand gestures]

**Affect**

**Content of interview** [eg keywords, topics, focus, exact words or phrases which stand out]

**Researcher’s Impression** [eg discomfort of participant with certain topics, emotional responses to discussion of event]

**Analysis** [eg researcher’s questions, tentative hunches, trends in data, emerging patterns]

**Technological Problems** [eg audio tape issues]
<table>
<thead>
<tr>
<th><strong>Participant Code:</strong></th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interview Date:</strong></td>
<td>15/03/04</td>
</tr>
<tr>
<td><strong>Start Time:</strong></td>
<td>1230 hrs</td>
</tr>
<tr>
<td><strong>End Time:</strong></td>
<td>1400 hrs</td>
</tr>
<tr>
<td><strong>Location of Interview:</strong></td>
<td>Telephone</td>
</tr>
</tbody>
</table>

**Non-verbal behaviour** [eg tone of voice, posture, facial expressions, forcefulness of speech, body movement, hand gestures]

*Appropriate tone*

**Affect**

*Appropriate*

**Content of interview** [eg keywords, topics, focus, exact words or phrases which stand out]

*Questioning of self*

*My face didn’t fit*

**Researcher’s Impression** [eg discomfort of participant with certain topics, emotional responses to discussion of event]

*Face didn’t fit*

*Orchestrated process against him – had made a complaint about another nurse*

**Analysis** [eg researcher’s questions, tentative hunches, trends in data, emerging patterns]

*Living within themes already identified with some dimensionality; not significantly physically deconstructed. Insight and ability to step away from some of the happenings – good insight and sense of the self.*

**Technological Problems** [eg audio tape issues]

*Nil.*
**APPENDIX E**

**RMIT HUMAN RESEARCH ETHICS COMMITTEE**

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

<table>
<thead>
<tr>
<th>FACULTY OF</th>
<th>Life Sciences</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEPARTMENT OF</td>
<td>Nursing and Midwifery</td>
</tr>
</tbody>
</table>

Name of participant: 
Project Title: A Grounded Theory of Alleged Unprofessional Conduct by Nurses

Name(s) of investigators:  
(1) Dale Pugh
  Phone: 0407 427 777

1. I have received a statement explaining the interview/questionnaire involved in this project.

2. I consent to participate in the above project, the particulars of which - including details of the interviews or questionnaires - have been explained to me.

3. I authorise the investigator or his or her assistant to interview me or administer a questionnaire.

4. I acknowledge that:
   (a) Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
   (b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
   (c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
   (d) The confidentiality of the information I provide will be safeguarded. However, should information of a confidential nature need to be disclosed for moral, clinical or legal reasons, I will be informed of the terms of disclosure.
   (e) The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to the research participants (if requested) and to interested professional nursing organisations. Any information which will identify me will not be used.
   (f) I have been informed that should I provide any information relating to the unprofessional conduct event reported to the nursing regulatory authority, then there is a risk that information documented or known by the researcher can be sought using a subpoena or search warrant where an allegation of a civil or criminal offence exists.

**Participant’s Consent**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Participant)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Witness to signature)</td>
<td></td>
</tr>
</tbody>
</table>

*Participants should be given a photocopy of this consent form after it has been signed.*

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745.
Dear Colleague,

Thank you for responding to my advertisement to participate in a research study and please accept this letter as a formal invitation to participate. I am studying nurses’ experiences and involvement in alleged unprofessional conduct events which have been reported to a nursing regulatory authority (Nurses Board) and where the nurse has been required to appear before a disciplinary committee. Whether the allegation has been upheld (i.e. enough evidence was found to support the allegation) or not upheld (i.e. not enough evidence was found to support the allegation) is not relevant to determining your suitability to participate. This study has been reviewed and approved by the RMIT University Human Ethics Committee.

Before you decide whether to accept this invitation, it is important that you have an understanding of what this research study is about and what is required of you. Information about these things is given below. I invite you to read this information and if there is anything that is not clear, or if you would like more information, please feel free to contact me.

What is this study about?

There has been little research undertaken, particularly in Australia, looking at why and how nurses were involved in unprofessional conduct and the impact on the nurse, both personally and professionally. This study would provide important and useful information to allow nurses, employers and professional nursing organisations to better understand unprofessional conduct events. This information will then be used to develop strategies to prevent their occurrence and to provide assistance to nurses during and after the event. Unprofessional conduct is a broad term that includes any breach of the required standards of nursing practice. These standards may be set down by the hospital or health service that you have been or are working in, and those set down by professional nursing bodies. The general purpose of this study is to identify and describe the risks factors that contributed to the alleged unprofessional conduct event that nurses were involved in and the impact that this event has had on the nurse. This information will be obtained by doing a ‘one-off, face-to-face’ interview with me.

Do I have to take part in this study?

You are under no obligation to participate in this study. Your decision to participate is entirely voluntary. Should you decide to take part and then change your mind, at any stage of the study, even after the information has been collected, you are still free to do so without giving a reason and without prejudice.
What do I do if I wish to participate?

If you decide to participate please complete the demographic questionnaire and consent form and return it to me in the addressed, stamped envelope provided. Once I have received these two documents I may contact you to organise a convenient interview time. I am planning on interviewing approximately 20 to 30 nurses. Should I receive a larger than expected number of responses then you may not be interviewed. This is not a reflection of the quality of the information that you have provided or your suitability to be interviewed. Should I not require an interview with you, then I will send you a letter to confirm this. At this point the demographic questionnaire and consent form you have forwarded to me will be destroyed by incineration.

There is a chance that I may not receive the number of participants required for the particular qualitative research methodology being used, therefore there is a chance that I may like to interview you again.

What are the possible costs, benefits and risks to should I participate?

There are no financial costs to you, apart from the initial telephone. Should you be selected to be interviewed, then at least one hour of your time will be required, maybe more depending on how much you wish to talk about.

Talking about the unprofessional conduct event and the impact on you may cause you to feel upset or distressed. Should this occur then you are free to stop the interview at any time and not continue it if you do not feel comfortable in doing so. Should you continue to feel distressed and feel that talking about this with a professional counsellor would help, you will be encouraged to contact a counsellor independently. Should you have been in a previous working relationship where I was in a supervisory position then it is not appropriate that you participate in this study. Should you find yourself in a future professional relationship with me, the principles of confidentiality will extend to this situation. That is, the matter that you discuss with me during this interview will not be mentioned, written about or alluded to during the course of the professional relationship.

It is acknowledged that there may be no immediate benefits to you; nevertheless your input would make a valuable contribution to knowledge of the field and discipline of nursing and will be used to inform nursing practice related to unprofessional conduct events to prevent them from occurring and to assist in designing a support model for nurses involved in these matters.

Will the information that I provide to you be kept confidential?

Your responses will be kept strictly confidential and your anonymity assured by the following processes: demographic questionnaires and envelopes will not have any personally identifying codes or markings on them; the information collected will be presented in a manner that would make personal identification of either you or your work place impossible.
I must advise you that information that is provided in a research study is not privileged, that is, information could be subpoenaed or requested using a search warrant. Therefore to protect yourself, you will be asked to speak only about the reported unprofessional conduct event that you were involved in. If you do wish to talk about any other unprofessional conduct events or particular issues which have not already been dealt with by a nurse regulating authority then I must advise you that you do so at your own risk.

The interviews will be audio-taped and erased once I have transcribed the interview. The findings of this study will also be made available through the publication of articles in professional nursing journals or conferences but will contain no personally identifying information.

**What do I do if I know of other nurses in similar situations?**

Should you know of a nurse in a similar situation to you and she/he is known personally to you, then you may contact him/her provided you agree to maintain strict confidentiality about that nurse’s identity, the nature of the unprofessional conduct event and their potential/actual involvement in this event. If you agree to the principles of confidentiality you can provide to the nurse a copy of this letter and advise them that they can contact me if they are interested in participating.

**When should I send this information?**

I would appreciate it if you could return your completed demographic questionnaire and consent form as soon as possible. This will assist me to plan my travels to interview nurses.

**Who should I contact if I have any concerns?**

In the first instance please contact me if you have any general questions or concerns. It is probably best to email me: researchstudy2003@msn.com or by telephone on 0402 585 550.

My supervisor is Professor Johnstone (Department of Nursing and Midwifery RMIT University) and can be contacted by email: megan.johnstone@rmit.edu.au or by telephoning 03 9925 7453 should you wish to clarify any matters.

Also, should you have any complaints about your participation in this study you may contact the Secretary of the RMIT University Human Research Ethics Committee, University Secretariat, RMIT GPO Box 2476V Melbourne 3001 or by telephoning 03 9925 1745.
APPENDIX G

Demographic and Alleged Unprofessional Conduct Event Data Form

Important

Please complete the bottom section on this form so that I have your current contact details.

Please tick the appropriate box.

If you are unsure of any of the above items, do not worry, if needed I can clarify this information if we proceed to an interview.

1. Age
   - 20 – 25
   - 26 – 30
   - 31 – 35
   - 36 – 40
   - 41 – 45
   - 46 – 50
   - 51 – 55
   - 56 – 60
   - 61 – 65
   - 65 – 70

2. Gender
   - Male
   - Female

3. State/Territory
   - WA
   - NT
   - QLD
   - NSW
   - ACT
   - VIC
   - TAS

4. Registration details
   - Registered
   - Provisional registration
   - Not registered
     - Reason ____________________
   - Division 1
     - General
     - Comprehensive
     - Mental Health
   - Division 2
   - Division 3
   - Midwifery
501

Other _____________________

5. **Nature of alleged unprofessional conduct event – brief summary**

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

6. **Where did the event allegedly occur**

   - Public Hospital [ ]
     Area ____________________
   - Private Hospital [ ]
     Area ____________________
   - Community Nursing [ ]
     Clinic [ ]
     Patient’s home [ ]
   - Pre hospital nursing setting [ ]
     Area ____________________
   - Non professional setting [ ]
     Area ____________________

5. **Reported to nurse registration authority/Nurses Board**

   - Yes [ ]
   - No [ ]

6. **Reported to the police** [ ]

7. **Reported to the coroner** [ ]

8. **Reported by whom** ____________________

9. **Outcome of the nursing regulatory authority investigation**

   (a) Allegation upheld [ ]
   (b) Allegation not upheld [ ]

10. **Disciplinary action** [ ]

    By Whom ____________________

    Penalty ____________________

Please complete this section so that I have accurate contact details:

Name:
Telephone number: