Managing Medical Deviance: Organisational Responses in the UK Private Healthcare Sector

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Abstract

This thesis explores how noncriminal professional misconduct by doctors, referred to as medical deviance, is perceived and managed in the UK's private healthcare sector. Unlike much of the existing literature, which focuses on criminal acts or regulatory failures, this study examines behaviours that breach professional norms without constituting criminal offences, such as inappropriate communication, poor clinical judgement, or unsafe prescribing.

Through qualitative interviews with private healthcare professionals, the research investigates how organisations define acceptable conduct, manage deviance, and navigate power dynamics in their responses. The concept of medical deviance is developed to offer a cohesive framework for understanding how private healthcare providers address these behaviours amid commercial pressures and regulatory constraints.

This thesis contributes to sociological and criminological discussions of professional misconduct, highlighting the complexities of regulating clinical conduct beyond criminal or statutory boundaries and laying the groundwork for future research and policy developments.

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Contents

List of Acronyms

AA- Anaesthesia Associates

CAQDAS- Computer-Assisted Qualitative Data Analysis Software

CEO- Chief Executive Officer

CQC- Care Quality Commission

EMR- Electronic Medical Record

GMC- General Medical Council

GP- General Practitioner

IDT- Incident Decision Tree

MPTS- The Medical Practitioners Tribunal Service

NHS- National Health System

PA- Physician Associates

PALS- Patient Advice and Liaison Service

PCA- Professional Qualifications Act

PMI- Private Medical Insurance

PP- Practising Privileges

RCA- Root Cause Analysis

PSIRF- Patient Safety Incident Response Framework

RO- Responsible Officer

WCC- White Collar Crime

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1 CHAPTER 1- INTRODUCTION

The fundamental purpose of hospitals is clear: they exist to provide solutions for both minor and major health problems. However, reducing hospitals to this single function overlooks the complexity of their internal operations. Hospitals reflect the structural characteristics of society itself. Within them, there is a high degree of specialisation, with numerous distinct wards that ultimately collaborate. Additionally, hospitals are structured and managed hierarchically, yet this does not mean that they can fully monitor all staff members or ensure that every healthcare professional consistently adheres to the principles of patient well-being.

I first encountered this situation when I was nineteen years old. After examining me, an orthopaedic doctor in his forties contacted me via social media later that evening, expressing his desire to meet. This incident left me feeling both shocked and outraged. At the same time, I realised that I did not know where to report such behaviour. When I shared my concerns with my mother, she dismissed them, saying that my word alone would not be enough to prove anything against the doctor. As a result, I did not pursue the matter further. However, for the next ten years, several questions lingered in my mind: What could I have done in response to the doctor's actions? How could he behave this way? If I had reported him, would the hospital have you taken any action?

The experience led me to understand that the doctor- patient dynamic does not always unfold in the idealised way it is often perceived. The professional objectives of healthcare workers may not always align with the hospital's institutional mission. In fact, even the hospital's core purpose may not always be entirely centred on the patients' well-being. This realisation laid the foundation for my research.

One of the primary challenges in the healthcare sector is ensuring that patients receive the best possible care and that healthcare professionals fulfil their duties responsibly. To achieve this, hospitals must oversee and regulate a range of behaviours, some of which involve ethical violations, such as doctors shouting at each other, while others may constitute legal offences, such as a doctor stealing medication from the hospital or intentionally harming a patient. The extent to which unethical and even unlawful behaviours are addressed depends on several key factors: the conflict between altruistic service and personal interest, the dynamics of autonomy and authority, and the structure of the organisation itself- how the hospital is structured and how it operates. These factors shape the decision-making processes within healthcare institutions and influence how deviance is identified, reported, and managed (Jaslow et al., 1985).

While trying to narrow down my thesis topic, one of the most extreme examples that I found in the field of health occurred in the UK. In the case of Harold Shipman, who was convicted of murdering 15 patients, the authorities estimate that the real number is over 200, although they cannot prove it. The case underscores the limitations of existing systems in detecting and addressing criminal and deviant practices. General practitioners must confront the critical question: What aspects of general practice allowed a practitioner to murder over 200 patients before raising suspicion? (Baker,2004). Shipman's colleagues and managers must have been aware of some strange behaviour or complaints from patients before the incident became this big and scandalous. How could Shipman's colleagues and managers have been unaware of his strange behaviour? This question was combined with the questions that were on my mind before I started my research. To answer these questions, I analyse how private hospital managements perceive and address deviant practices in their institution by interviewing board members, hospital managers and medical directors. In doing so, I aim to understand the official perspectives regarding medical deviance. By embracing a critical approach which allows for

exploring deeper and questioning the existing and accepted practices and analysing how private hospitals' organisational structure understands and tackles medical deviance, I am able to examine the nature of the medical deviance phenomenon and unpack the deficiencies built into the complexity of the health system.

1.1 A Criminological Study of Private Healthcare and Its Significance

This thesis examines private healthcare in the UK. My research focuses on how private healthcare perceives, observes, and addresses deviant behaviour among doctors. In particular, I explore how hospitals, specifically those in managerial positions, define deviance and the criteria they establish in this process. Additionally, I demonstrate how definitions of deviant behaviour influence both the practice and the responses of hospital management when addressing such cases. This research addresses two main questions, initially formulated during the research design phase and subsequently refined through the literature review and fieldwork. These questions have guided and shaped the analytical process and have been further refined based on insights gained during the study, resulting in their final version.

My research questions are as follows:

1) How do private hospitals in the UK perceive doctors' clinical and behavioural deviant actions?

2) How do private hospitals tackle the clinical and behavioural deviant actions of doctors?

Using the semi-structured interview technique, I conducted interviews with a total of 19 participants, including five board members, four hospital directors, three medical directors, two directors of clinical services, one president of quality, and one head of clinical training. These interviews were designed to answer this study's two central research questions. This study should be understood as an exploratory investigation into how medical deviance is

perceived and addressed in private healthcare in the UK, with a particular emphasis on the role and involvement of hospital management.

Medical deviance, as used in this thesis, refers to noncriminal breaches of professional, ethical, or clinical norms by doctors, as perceived and managed within healthcare organisations. This includes both clinical and behavioural misconduct, such as inappropriate communication, reckless prescribing, or sexualised comments, that fall short of criminality but nonetheless disrupt institutional expectations of professional conduct. The term is employed as an umbrella concept to analyse a spectrum of behaviours that may not always result in formal sanction but still elicit internal responses.

For the purposes of this research, I propose the following expanded definition: medical deviance can be understood as a spectrum of behaviours that, while not severe enough to fall under criminal law, are psychologically or physically disruptive to patients and colleagues at a low to moderate level. A behaviour that qualifies as medical deviance must involve the misuse of the trust inherent in being a physician or healthcare worker for personal gain, such as maintaining favourable relationships with hospital management, seeking psychological or physical gratification, or pursuing financial benefit. This misconduct occurs through actions that deviate from the guidelines and rules established by the hospital, management, or other governing bodies, thereby representing a breach of ethical or institutional standards.

In the existing medical literature, such behaviours are typically categorised under distinct and often siloed labels such as misconduct, error, unprofessional behaviour, or disruption. While these terms serve important regulatory and clinical functions, they also risk masking the common underlying issue: violating professional or organisational norms. Whether labelled as an error, a lapse, or misbehaviour, these acts function as deviance in the sociological sense because they breach the expectations that structure professional life within healthcare settings.

Therefore, as Faria (2018) suggests, criminology provides the necessary theoretical and methodological tools to study research misconduct in a way that other disciplines cannot, particularly in terms of understanding the causes, consequences, and social reactions to deviant behaviour within institutional settings. Similarly, I believe that criminology can offer an innovative approach to studying medical deviance, bringing new insights into how the actions of medical professionals are perceived and addressed.

By adopting the term medical deviance, this thesis offers a flexible but focused conceptual lens to explore how healthcare institutions, particularly within the UK private sector, define, interpret, and respond to such breaches. The approach here understands deviance as not a fixed category but an organisationally mediated and context-dependent designation. As such, this definition enables a consistent analytical framework across cases while remaining sensitive to variation in institutional norms and responses.

This research addresses this gap by conceptualising medical deviance as a systemic phenomenon. It explores how the hierarchical and monopolistic structures of the medical profession contribute to deviant practices and their management. Moving beyond focusing on individual cases or isolated incidents, the study adopts a broader perspective to examine institutional and systemic factors—such as organizational hierarchies and regulatory frameworks—influencing responses to deviant behaviours. This approach enhances our understanding of medical deviance and its implications for patient safety, professional accountability, and healthcare policy.

Another critical gap in the literature is understanding how private healthcare institutions perceive and manage medical deviance. The private sector, driven by economic incentives, introduces unique challenges in detecting, enforcing, and reporting deviant behaviours. Control mechanisms within private hospitals, the types of contracts offered to doctors, and the

relationships with regulatory bodies have not been adequately explored in existing research. Furthermore, this study highlights the role of profit motives in shaping institutional trust in doctors and influencing how deviance is addressed. By examining these dynamics, the research sheds light on the systemic vulnerabilities of a profit-oriented healthcare model.

The unique features of the private healthcare sector—including economic motivations, limited transparency, and the complex relationship between hospitals, doctors, and regulatory bodies—demand dedicated research. By adopting a critical criminology perspective, this study analyses medical deviance not as isolated incidents but as a systemic phenomenon shaped by structural and economic factors. The study challenges traditional notions of deviance and explores vulnerabilities embedded within the private healthcare system.

The study's significance lies in its ability to advance academic understanding of medical deviance, inform policy development, and improve patient safety and trust in healthcare institutions. The study provides empirical data through semi-structured interviews, offering a foundation for future criminological research. The findings emphasise the need for systemic reforms that address institutional and economic drivers of deviance rather than focusing solely on individual misconduct.

1.2 Theoretical Framework

1.2.1 Differential Association Theory

Sutherland (1949) developed differential association theory to explain white-collar crime (WCC), arguing that criminal behaviour is learned through association with those who define it favourably. He emphasised that individuals acquire deviant behaviours through exposure to pro-criminal attitudes, motivations, and techniques. Akers (1998) later expanded this

perspective, highlighting how situational pressures, imitation, and differential reinforcement shape deviant conduct within professional environments.

While differential association primarily focuses on interpersonal learning, Sutherland acknowledged that deviance could extend beyond individuals to organisational behaviour. He noted that when companies adopt unethical strategies and regulatory bodies fail to intervene, competitors may feel compelled to follow suit to remain viable. Sutherland's statement suggests that deviance is not only learned within companies but also between companies, shaping industry-wide norms. However, Sutherland's framework does not fully account for economic pressures, market competition, and structural incentives that drive deviance in professional and corporate settings.

One area where Sutherland's analysis fell short was his treatment of physicians. He assumed that doctors were more honest than other professionals due to their professional status. However, later research (e.g., Burgess, 1981; Jaslow et al., 1985) has demonstrated that physicians, like others in positions of power, can exploit their roles for personal or financial gain. The high societal standing of doctors often complicates efforts to hold them accountable for misconduct, as their actions are frequently framed within the context of professional discretion rather than deviance.

Despite these valuable insights, Sutherland's framework does not fully explain why deviant behaviours persist in private healthcare settings, mainly when economic profitability and institutional priorities influence decision-making. His theory focuses primarily on learning processes but overlooks how organisational structures, regulatory gaps, and economic incentives actively shape and sustain deviance. It is necessary to shift the focus from individual learning to a broader framework of institutional corruption, where structural conditions, rather than just interpersonal influence, drive the normalisation of deviant practices in private hospitals to address these gaps,

1.2.2 Institutional Corruption

The academic literature on corruption - originating from discussions on white-collar crime- has historically concentrated on individual misconduct, such as fraud, bribery, and embezzlement, with a primary focus on illegal acts within political and corporate contexts (Transparency International, 2006; Vian, 2008). Recently, however, the scope has broadened to include forms of corruption that, though not necessarily illegal, can still undermine the objectives of systems like healthcare (Wilmshurst, 2002; Rodwin, 2013). This shift is encapsulated in the concept of institutional corruption, which is distinct from individual corruption in its systemic nature. Unlike traditional corruption, which involves personal misconduct, institutional corruption arises when the structure of an institution creates conflicts of interest that hinder its primary objectives, often without direct illegal activity (Thompson, 1995; Lessig, 2011).

Institutional corruption does not require intentional misconduct by individuals. Instead, it emerges from the interaction between institutional procedures and external influences that distort decision-making processes. These influences, such as financial pressures, political motives, or market forces, can be legally permissible and customary within the institution, making corruption challenging to identify and address (Thompson, 2018). As Thompson (1995) notes, institutional corruption is not necessarily illegal, but it occurs when the practices within the institution deviate from its intended purpose.

In healthcare, institutional corruption manifests when financial relationships between pharmaceutical companies, medical professionals, and healthcare providers create conflicts of interest. Such relationships can distort medical research, treatment guidelines, and clinical practices, even if they remain within the bounds of legality (Thompson, 2018). For example, financial ties between the pharmaceutical industry and healthcare providers can result in biased

medical research, promoting certain medications over others, or influencing prescribing practices in ways that do not align with patient welfare (Institute of Medicine, 2009; Moore et al., 2006; Whitaker & Cosgrove, 2015). Institutional corruption in healthcare, particularly within the pharmaceutical industry, manifests through conflicts of interest that compromise the integrity of medical research, education, and practice. Pharmaceutical companies frequently exert influence over physicians and medical researchers through financial incentives such as consulting fees, research funding, and speaker honoraria. For example, the Sunshine Act in the United States was implemented to increase transparency by requiring pharmaceutical and medical device companies to disclose payments made to physicians and hospitals (Sismondo, 2013). However, while such measures expose conflicts of interest, they do not necessarily prevent undue influence, as companies often use key opinion leaders to shape medical discourse in their favour. Key opinion leaders, often influential physicians or researchers, receive substantial financial incentives to promote specific drugs or treatment approaches, effectively serving as intermediaries between the industry and the broader medical community (Sismondo, 2013).

Beyond direct financial relationships, institutional corruption extends to how medical research is conducted and disseminated. Robertson et al. (2011) indicate that pharmaceutical industry sponsorship often results in biased research findings favouring the sponsor's products, sometimes at the expense of patient safety. Ghostwriting practices, in which companies commission and draft research articles that physicians then sign their names to, further distort medical knowledge and create misleading perceptions of drug efficacy (Brennan et al., 2006). In addition, conflicts of interest arise in the development of clinical practice guidelines, as many of the experts involved have financial ties to the pharmaceutical and medical device

industries, potentially skewing recommendations in ways that benefit corporate interests rather than patient well-being (Institute of Medicine, 2009).

Such practices highlight how institutional corruption can undermine public trust in healthcare (Calnan and Sanford,2004), necessitating stronger regulatory frameworks and independent oversight to ensure medical decisions are based on scientific rigour rather than financial incentives.

This form of corruption is particularly damaging because the practices that contribute to it are often legal and widely accepted as normal within the organisation or profession. The financial incentives embedded within the system may prioritise private interests over public health goals, leading to poor outcomes for patients and undermining trust in healthcare institutions (Thompson, 1995). As Thompson (1995) explains, legitimate gain becomes a corrupting force when it compromises the institution's fundamental mission through financial incentives or other means.

Thompson's framework for understanding institutional corruption provides a critical lens for examining corruption in healthcare. Thompson (1995) distinguishes institutional corruption from individual corruption by focusing on structural conflicts of interest. In healthcare, these conflicts often arise from external financial pressures, such as the influence of pharmaceutical companies or private donors. These pressures may not be overtly illegal, but they create systemic biases that lead to decision-making that is not aligned with the public good.

Thompson (1995) highlights three key aspects that differentiate institutional corruption from individual corruption: the nature of the gain, the characteristics of the service provided, and the relationship between the gain and the service. In healthcare, the "gain" is often institutional, such as financial contributions or professional recognition, which are essential for the

institution's functioning. However, when these gains create conflicts of interest, they can undermine the institution's ability to fulfil its primary purpose, such as patient care.

Institutional corruption can have severe consequences for healthcare systems. It leads to resource misallocation, reduces the quality of care, and weakens health policies and reforms. For instance, biased research funded by pharmaceutical companies can influence treatment guidelines, causing healthcare systems to prioritise certain products over others, not based on their clinical effectiveness but on financial considerations (Sommersguter-Reichmann et al., 2018). This misalignment of interests is detrimental to patient outcomes and the credibility and legitimacy of the healthcare system as a whole.

As Sommersguter-Reichmann et al. (2018) note, the financial losses associated with healthcare corruption have risen dramatically, with the UK National Health Service experiencing a 37% increase in financial losses due to corruption since 2008. The data highlights the reason for the growing recognition that individual or institutional corruption substantially disrupts healthcare objectives and wastes valuable resources. To effectively address institutional corruption in healthcare, reforms must target structural and procedural elements that foster conflicts of interest. Regulatory mechanisms to reduce the influence of external stakeholders, such as pharmaceutical companies, are crucial. For example, policies that limit financial ties between healthcare providers and industry stakeholders or require full disclosure of potential conflicts of interest could help mitigate corruption risks (Thompson, 2018). As Thompson (1995) argues, it is essential to focus on the systemic forces that create opportunities for corruption, ensuring that healthcare institutions are designed to prioritise public health over private financial gain.

1.2.3 Neutralisation Techniques

Neutralisation techniques, first conceptualised by Sykes and Matza (1957), describe cognitive strategies used by individuals to rationalise behaviours that violate societal norms. These techniques enable individuals to reconcile their actions with broader societal values, mitigating guilt, shame, or external condemnation. Five foundational techniques were proposed: denial of responsibility, denial of injury, denial of the victim, condemnation of the condemners, and appeal to higher loyalties. This framework has since been expanded and adapted for use in various disciplines, including organisational ethics, legal systems, and healthcare contexts (Kaptein and van Helvoort, 2019; Kvalnes, 2014).

Despite its foundational significance, neutralisation theory has faced criticism for its limited scope and conceptual ambiguity. Early models were critiqued for their inability to capture the complexity of modern ethical dilemmas. Maruna and Copes (2005) argued that the distinction between neutralisation and rationalisation is often blurred, challenging the theoretical clarity of the concept. Kaptein and van Helvoort (2019) addressed these limitations by proposing a systematic taxonomy of neutralisations, categorising them into four domains: distorting facts, negating norms, blaming circumstances, and self-exemption. This model was designed to provide a cohesive framework for future research and reduce the inconsistencies in categorising neutralisation strategies.

Additionally, Entwistle and Doering (2024) used the example of Stafford Hospital.[1], explain the processes of neutralisation and normalisation through the lens of diffusion of responsibility, prioritisation of the bottom line, and fostering organisational identification. Wallach et al. (1964) demonstrated that group decision-making promotes riskier choices as individuals share

[1] The Stafford Hospital scandal involved substandard care and elevated patient mortality rates at Stafford Hospital, managed by the Mid Staffordshire NHS Foundation Trust, between 2005 and 2008. Investigations revealed that the hospital's management prioritised financial targets over patient care, leading to severe understaffing and inadequate treatment. A public inquiry led by Robert Francis QC, published in 2013, detailed numerous instances of neglect and made 290 recommendations to prevent future occurrences. The scandal prompted significant scrutiny of NHS practices and led to reforms aimed at enhancing patient safety and care standards (Francis, 2013).

accountability, diluting the consequences for any one person. Similarly, Darley and Latané (1968) found that in emergencies, individuals are less likely to intervene when others are present, as responsibility is perceived as shared among all bystanders.

In organisational contexts, Whyte (1991) showed that group decisions reduce the emotional need for self-justification in escalating commitment to failing projects, as responsibility is distributed among participants. Mynatt and Sherman (1975) directly confirmed this phenomenon, finding that group members assume less responsibility for adverse outcomes than individuals acting alone, thereby mitigating personal blame. In the hospital example, with multiple layers between frontline clinicians and decision-makers, critical concerns such as understaffing were often ignored or diluted. This fragmentation allowed managers to avoid taking responsibility for operational and ethical failings, thereby normalising deviant behaviours across the organisation (Entwistle and Doering, 2024).

The concept of "prioritising the bottom line" refers to an exclusive focus on achieving the most important organisational or business priority, often at the expense of ethical considerations or other responsibilities (Mesdaghinia et al., 2019, p. 492). This approach often elevates economic success, profitability, or the organisation's financial interests as the sole barometer of achievement. Palazzo et al. (2012, p. 325) suggest that this approach can lead to "ethical blindness," where the law is viewed as the only limit to achieving profits.

When it comes to fostering organisational identification, institutions often cultivate a strong connection between employees and the organisation, where the organisation becomes a central part of the individual's self-concept (Umphress and Bingham, 2011). This process can result in employees aligning their values and behaviours with organisational goals, often prioritising the organisation's success over broader ethical considerations. Employees with high organisational identification internalise the company or institution's successes and failures as their own, leading to behaviours that support the institution, including increased loyalty, job

performance, and willingness to engage in unethical pro-organisational behaviours if they perceive such actions as beneficial to the organisation (Ashforth and Anand, 2003).

When organisational identification becomes overemphasised, it may neutralise moral standards, allowing individuals to justify unethical behaviours that protect or enhance the organisation's reputation. These behaviours may include lying, manipulating information, or other actions that, while unethical, are viewed as serving the greater good of the organisation (Carter and Dukerich, 1998). In addition to conceptual challenges, neutralisation theory has been criticised for underestimating the influence of contextual and situational factors. Traditional approaches tended to focus on individual moral character, an assumption challenged by Kvalnes (2014), who argued that situational pressures often play a significant role in ethical decision-making. Empirical research has supported this view, demonstrating that external circumstances frequently shape the application of neutralisation techniques, particularly in professional and organisational contexts.

Applications of neutralisation theory have been diverse, highlighting its relevance across various domains. In healthcare, deviance can provide a shortcut to increasing productivity; therefore, personnel might adopt deviant practices (Reid, 2014). However, deviant behaviours and shortcuts are normalised over time, leading to an organisation developing a spoiled safety culture. Once low-security standards are tolerated, they spread among organisations. Organisations become vulnerable to error, and adverse patient events increase in healthcare (Wright et al., 2022). In short, organisations tend to ignore or encourage deviance as long as it is functional.

Neutralisation techniques can be started during medical training. Shoemaker (1984) highlights interviews with pre-medical students, revealing how they rationalise cheating on exams. Some students viewed it as a necessary strategy in a competitive environment, believing that taking advantage of opportunities was essential to avoid falling behind their peers. Others dismissed

their actions as not being real cheating, arguing that they were still good students who deserved success. This mindset demonstrates how ethical compromises can become normalised early in medical education.

In a hospital setting, Altamimi et al. (2018) demonstrated how medical interns justified privacy violations in Saudi Arabian hospitals using techniques such as denial of responsibility and appeal to higher loyalties. These justifications were influenced by systemic pressures, such as inadequate training and institutional norms, underscoring the importance of addressing structural factors in mitigating unethical behaviour. Similarly, Kvalnes (2014) explored the use of neutralisation techniques by business leaders to rationalise ethically questionable decisions, emphasising the interplay between organisational goals and individual moral reasoning.

1.3 Regulatory Bodies and Political Reforms

In the UK, a regulated profession is defined by the Professional Qualifications Act (PCA) as any profession governed by law that requires specific qualifications, experience, or other legally prescribed criteria to engage in certain professional activities or use a protected title. This encompasses various occupations, trades, and specialisms, ensuring that individuals meet strict professional standards to protect the public and maintain trust in these professions (UK Government, 2024). A regulator, as defined in the PCA, refers to a person or entity tasked with overseeing the regulation of a specific profession. Regulators are critical in ensuring individuals meet the required qualifications or experience, monitoring compliance, and enforcing standards as necessary. Depending on the profession, these regulatory functions may be managed by a single regulator or distributed across multiple bodies. Additionally, regulatory functions may be delegated to specific organisations, as authorised by legislation, regardless of whether the regulator is explicitly named in the law (UK Government, 2024b). This PCA framework establishes the foundation for robust oversight and accountability in professional

practice. Notable examples of regulators within the healthcare sector include the General Medical Council (GMC) and the Care Quality Commission (CQC), which serve critical roles in ensuring the competence of professionals and the quality of care provided (UK Government, 2024a).

The GMC is responsible for ensuring good and safe patient care across the UK by working with doctors, physician associates (PA), anaesthesia associates (AA), patients, and other stakeholders (General Medical Council, n.d.). The GMC sets standards for patient care and professional behaviour that doctors, PAs, and AAs must meet and ensures they receive appropriate education and training to deliver safe and effective care. The GMC also checks the eligibility of these professionals to work in the UK and monitors their adherence to professional standards throughout their careers. The GMC provides guidance and advice to help professionals understand their responsibilities and investigates concerns related to patient safety or public confidence, taking action when necessary. The GMC operates under the Medical Act 1983 and the AA and PA Order 2024, which outline its statutory purpose, governance, and responsibilities, including education, registration, revalidation, fitness-to-practise processes, and guidance on professional conduct, performance, and ethics (General Medical Council, n.d.).

The GMC conceptualises deviance primarily through its “fitness to practise” framework, which focuses on behaviours or competencies that fall below the standards outlined in its ‘Good Medical Practice’ guidance (GMC, 2023). This encompasses both clinical failings and professional misconduct, but the emphasis remains on individual breaches rather than systemic or institutional contributors to deviant behaviour. Critics argue that this approach may isolate wrongdoing to the actions of particular professionals, neglecting the contextual or

organisational factors that contribute to poor practice (Waring, 2007; Dixon-Woods et al., 2011).

The CQC is the independent regulator of health and adult social care in England, ensuring that services are safe, effective, compassionate, and high-quality. The CQC registers and monitors healthcare providers, requiring organisations such as hospitals, GP practices, care homes, and home-care agencies to meet fundamental standards of quality and safety before offering services. The CQC inspects and rates services based on five key questions: are they safe, effective, caring, responsive, and well-led? The organisation publishes reports and ratings to help the public make informed decisions and takes enforcement action when standards are not met, including fines, restrictions, or closures. The CQC also monitors the use of the Mental Health Act, safeguards the rights of vulnerable individuals, and promotes improvement by sharing best practices and providing insights into the quality of care at local and national levels (Care Quality Commission, 2017).

However, concerns have been raised about the effectiveness and reliability of the CQC's rating system, particularly in private sector oversight. For instance, the CQC has been criticised for failing to detect serious failings at Spire Healthcare, where surgeon Ian Paterson continued operating despite multiple concerns being raised (Francis, 2013). Additionally, CQC's inspection regime has been found to rely heavily on provider-submitted documentation and scheduled visits, which may present a distorted view of actual practice (National Audit Office, 2017). Research by Dixon-Woods et al. (2014) found that inspection frameworks may lack the sensitivity to detect emergent, covert, or cultural issues within institutions. The rating categories (e.g., "good", "requires improvement") can oversimplify complex organisational conditions and make it difficult to identify early warning signs of deviance (The King's Fund, 2018).

Briefly, we can explain the difference between the two regulatory bodies as follows: The GMC regulates individual healthcare professionals, such as doctors, ensuring they meet standards of education, ethics, and competence, and investigates concerns about their fitness to practise. In contrast, the CQC regulates health and social care organisations, such as hospitals and care homes, ensuring they provide safe, effective, and high-quality care. While the GMC focuses on individual accountability, the CQC ensures the quality of healthcare systems and environments.

Regulatory bodies are crucial in detecting and addressing medical deviance; however, their effectiveness and accessibility can vary across sectors. While the CQC monitors private hospitals, they often face challenges accessing sensitive business-related information. Private hospitals may restrict CQC's access to critical documents, claiming confidentiality concerns. Additionally, as discussed later in this thesis (Chapter 4), private hospitals often employ doctors as independent contractors rather than employees, allowing the hospitals to deflect responsibility for clinical misconduct by asserting that the consultant is not their employee. This approach weakens accountability mechanisms for private hospitals, as consultants fall primarily under the jurisdiction of the GMC.

The inefficiency of the CQC in fully regulating private hospitals could lead to an increased reliance on the GMC. However, while the CQC investigates hospitals themselves, the GMC monitors and investigates doctors, and the investigation begins with hospitals referring doctors to the GMC, which may not happen due to the doctors' economic contribution to the private hospital. Moreover, doctors might hide that they work in a private hospital from the GMC to protect their professional standing, further complicating accountability processes.

However, as mentioned earlier, the efficiency of regulatory bodies may not be the same in the private sector, primarily because the NHS has an additional layer of regulators. The

accountability structure of the NHS in England operates through a multi-tiered system, beginning with NHS providers and integrated care boards and extending to NHS England, which is ultimately accountable to the government and Parliament. NHS England's operating framework (2022a) defines roles for integrated care boards, NHS trusts, and NHS England, including oversight responsibilities, financial objectives, and intervention powers in cases of system failures. NHS bodies are also monitored by external organisations, such as the CQC, Healthwatch, and local authorities through health overview and scrutiny committees, which ensure that local health priorities and patient needs are being addressed. Additionally, the Secretary of State for Health and Social Care holds overarching responsibility for the NHS, with the power to set strategic directions, intervene in service changes, and ensure compliance through the Department of Health and Social Care. This system aims to balance accountability across national, local, and public levels while addressing systemic challenges in health service delivery (Powell, 2023).

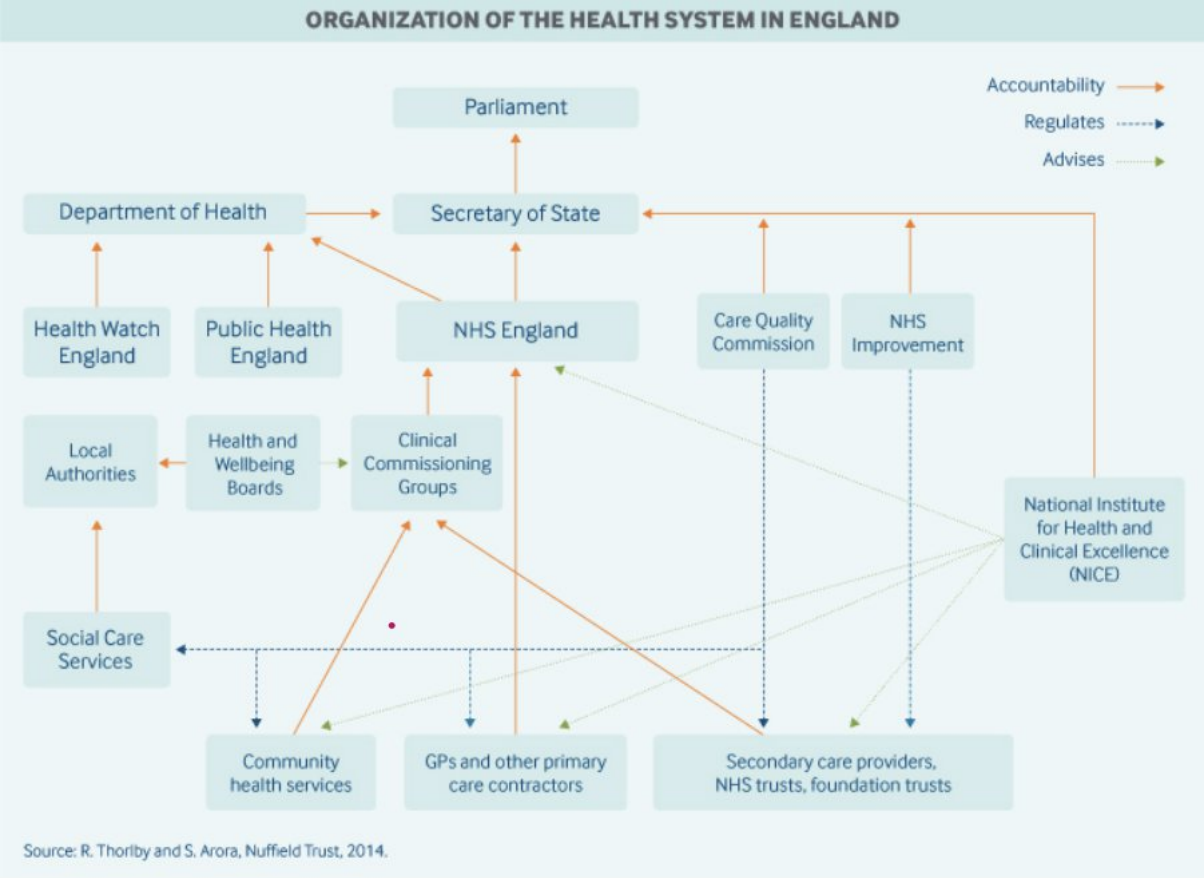

Figure 1: Organisation of the Health System in England(Source: Thorlby and Arora, 2014, cited in Thorlby and Arora, 2020. p.60)

While the NHS has to go through legislation, private providers are also required to register with the Care Quality Commission and NHS Improvement (Thorlby, 2020). However, for-profit hospital owners maintain control over their organisations and are entitled to all "residual claims" (profits) remaining after fulfilling prior financial obligations (Furubotn and Pejovich, 1972). As given, there are some differences in regulatory oversight between the private sector and the NHS; however, both systems have internal and external monitoring mechanisms in place. Despite these mechanisms, scandals in the healthcare sector, such as those involving Harold Shipman and Ian Paterson (which will be given later), continue to emerge. The occurrence of such scandals raises critical questions regarding the effectiveness and rigidity of these regulatory mechanisms.

1.3.1 The Impact of the Harold Shipman and Ian Paterson Cases on the UK Healthcare System

One case that illustrates this issue is the Shipman case, which contributed to the creation of a more robust system. Shipman, a general practitioner, was convicted in 2000 of murdering 15 patients, though investigations suggest he may have killed up to 250 people over two decades. His actions led to significant changes in the medical field, including stricter regulations on the use of controlled substances, enhanced monitoring of death certification processes, and increased scrutiny of doctors' practices to prevent such abuses in the future (Queiro, 2014).

First, the Shipman Inquiry highlighted significant shortcomings in the General Medical Council (GMC), criticising it for prioritising doctors' interests over patient safety. The report (Smith, 2003) documented several instances where the GMC acted more to support doctors than to protect the public, failing to establish a culture focused on patient protection (Jewell, 2005). The report showed that the system relies heavily on the honesty and competence of medical professionals (Smith, 2003). While medical professionals are generally trustworthy, this was not always the case. The Shipman case highlighted that existing procedures are insufficient to safeguard the public, as a doctor could hide a homicide, medical error, or neglect while certifying a death without involving the coroner. At that time, the system in England allowed a single doctor, usually the attending GP, to certify the cause of death without mandatory independent verification. This autonomy enabled Shipman to falsely record natural causes of death for patients he had killed, without automatic triggers for investigation. Although some claim Shipman is an anomaly, other medical professionals have also been found guilty of similar crimes, and the extent of undetected killings or errors remains unknown (Smith, 2003). Therefore, it is no longer acceptable for a single doctor to certify the cause of death, and the current method of cremation certification is ineffective (Smith, 2003).

The Shipman inquiry emphasised the need for a more robust revalidation system, which is a structured, recurring process through which a doctor must periodically demonstrate that they remain competent and fit to practice medicine, dismissing the existing five-year appraisal process as insufficient for ensuring doctors' fitness to practice (Jewell, 2005). The inquiry recommended introducing a knowledge test and extending revalidation intervals to seven years for a more stringent and reliable process. The recommendation to extend the revalidation period from five to seven years was tied to the idea that revalidation would become more rigorous in content rather than frequency. The inquiry proposed strengthening the process by introducing formal knowledge assessments and more thorough evaluations, making each revalidation more substantial and in-depth. Therefore, while the interval between assessments would lengthen, the quality and stringency of each revalidation cycle would increase, moving beyond basic appraisals to robust examinations of competence and fitness to practice.

Additionally, the GMC was criticised for its lack of separation between investigative and adjudicative functions, leading to potential conflicts of interest. The investigative function covers the process of gathering evidence and conducting inquiries into a doctor's fitness to practice, while the adjudicative function refers to the process of making judgments or decisions based on the evidence collected during the investigation. The report also called for reducing the dominance of elected members on the GMC to enhance objectivity. Before the Shipman Inquiry, the GMC was heavily dominated by elected medical professionals, which made the GMC too inward-looking and more focused on doctors' interests rather than public safety and patient protection. To overcome this, the report recommended increasing the number of lay members who are not doctors (Smith,2004).

Fundamentally, balancing elected and lay members demanded a cultural shift within the GMC, urging it to adopt strict, patient-focused standards and enforcement mechanisms to restore trust in the medical profession and ensure accountability (Jewell, 2005).

In response to the Harold Shipman case, the UK government introduced the Controlled Drugs (Supervision of Management and Use) Regulations 2006, with the Care Quality Commission (CQC) tasked with overseeing regulatory implementation. Shipman exploited lax controls to obtain large quantities of diamorphine. In response to this, the new regulations require healthcare organisations to appoint accountable officers who are responsible for ensuring the safe use and management of controlled drugs. The duties of these officers include monitoring controlled drug use, investigating discrepancies, promoting proper handling and recording procedures, and reporting any suspicious activities. The regulations also mandated improved tracking systems for controlled substances throughout the supply chain, from acquisition to administration. These measures were designed to prevent misuse, reduce malpractice risks, and enhance transparency and accountability, addressing the specific vulnerabilities exploited by Shipman (CQC, 2009).

Another case is the Paterson Inquiry, which is important because it provides context for private healthcare settings. The Paterson Inquiry is an investigation into the systemic failures that allowed Ian Paterson, a rogue surgeon, to continue practising for years despite performing inappropriate and unnecessary procedures on thousands of patients (James, 2020). The inquiry revealed that the actions of Paterson were not merely a case of individual malpractice but instead indicated a broader indictment of a dysfunctional healthcare system across the NHS and independent sectors, marked by poor governance, a lack of accountability, and a culture of avoidance and denial (James, 2020).

In the Paterson case, patients were failed at multiple levels: by Paterson's actions, by healthcare providers who inadequately supervised him and ignored complaints, by ineffective recall

procedures, by regulators who treated complaints with disdain, and by an indemnity system that left many without compensation for the harm they experienced at Paterson's hands (James, 2020). The report highlights a failure to analyse and act on available data, a culture of "wilful blindness" among managers and clinicians, and a reluctance to challenge or investigate Paterson's aberrant practices (James, 2020).

The Paterson Inquiry (James, 2020) highlighted significant failures in governance and patient safety within the independent healthcare sector, recommending systemic reforms to prevent future harm. Key recommendations focused on improving transparency and accountability in private healthcare, including creating a public repository of consultant performance data and clarifying differences between the NHS and private care arrangements, such as emergency provisions and indemnity. The inquiry underscored the importance of equitable care, revealing that many private patients did not receive the same follow-up or ongoing care as NHS patients, particularly those treated by Paterson, which emphasised the need for robust governance systems to address consultant behaviour, more decisive clinical leadership at the board level, and better engagement with frontline professionals.

Spire Healthcare, for whom Paterson worked, faced criticism for its delayed action, as Paterson could have been stopped from practising as early as 2003 and should have been stopped by 2007 (James, 2020). However, Paterson continued to practice until 2011 due to a lack of vigilance and accountability. The inquiry exposed the absence of a culture that encouraged challenging inappropriate behaviour and reporting concerns, as well as the lack of transparency in providing patients with accurate and timely information about treatment options. These failings highlighted the urgent need for systemic and cultural changes in private healthcare, prioritising patient safety, equitable care, and timely interventions to rebuild trust and prevent similar incidents in the future (James, 2020).

Given its prominence on the political agenda, the frequent scandals within the medical sector, the inherent weaknesses of health regulatory systems, and the societal challenges it poses, such as compromising patient safety and eroding trust, medical deviance represents a critical area of study within criminology.

1.4 Thesis Structure

The dissertation is structured into eight substantive chapters, each of which contributes to the overarching objective of this thesis. This is to explore how private healthcare perceives and addresses doctors' deviant behaviours in their institutions.

Chapter 2, *Literature Review,* presents the literature review covering the theoretical framework, medical deviance as a concept, different perspectives, and grey areas in deviance and the private healthcare context.

Chapter 3, *Research Methods and Methodology*, explores the historical trajectory of interviewing as a method to gain more detailed information. Therefore, it presents how interviews have been used as a method to understand a certain group of people better. Also, it highlights the strategy of James (2006) to recruit participants and the challenges in interviewing with elites.

Chapter 4, *Operational Priorities in Healthcare,* is the first chapter of three analysis chapters (4,5 and 6) and conducts the thematic analysis. It focuses on participants' discourses to understand what else the private sector provides doctors, while the private sector has certain expectations from the doctors. It specifically focuses on how private healthcare operational priorities and management expectations shape doctors' roles, behaviours, and relationships. It examines how training, hierarchies, and financial pressures influence the perception and

management of deviant behaviours. This chapter also benefits from media examples to show how participants' discourse positions are in the current dynamics.

Chapter 5, *Monitoring and Assessing Deviance,* is the second chapter of the analysis. It details how private hospitals monitor and address deviant behaviours among doctors, focusing on identifying patterns and distinguishing between errors and intentional deviations. It explores the use of tools like regulatory guidelines, data collection, and appraisals while also addressing the influence of economic priorities, hospital reputation, and patient safety. The chapter highlights the challenges of interpreting behaviours in grey areas and emphasises the critical role of safeguarding patient well-being in decision-making processes.

Chapter 6, Balancing Leniency and Punishment, is the final chapter of the analysis and examines how private healthcare addresses doctors' deviant behaviours. It explores mitigating factors, such as workplace stress and personal challenges, that often result in leniency, before discussing sanctions ranging from informal warnings to the suspension of practising privileges, with a prevailing preference for resolving issues locally. Finally, the chapter highlights cases referred to the General Medical Council (GMC) for formal investigation, emphasising the balance between professional accountability and institutional priorities.

Chapter 7, *Discussion,* aims to synthesise and discuss various results from the analysis chapters by utilising the theoretical framework that covers institutional corruption, neutralisation techniques, and differential association (Chapter 1). It examines how individuals involved in the private healthcare sector defend their positions in healthcare. I argue that participants develop their own strategies to balance the private sector's profit-driven understanding with healthcare.

Chapter 8, *Conclusion*, and lastly, this chapter summarises the main findings of the study while containing policy considerations and recommendations for future research.

2 CHAPTER 2- LITERATURE REVIEW

2.1 Introduction

This chapter provides a systematic and detailed literature review of criminological, sociological, and organisational perspectives on occupational crime and deviance, power relations at work, and institutional corruption. It examines how deviance manifests in various professional settings, including healthcare, education, the food industry, and banking (see Morrow, 1982; Hargreaves et al., 2012; Rizzuti, 2021; Lawrence et al., 2014), with a particular focus on the healthcare sector. Within this context, the discussion will explore medical deviance as it pertains to doctors, nurses, and pharmacists, considering both individual and systemic dimensions of misconduct.

A key theoretical debate in the study of white-collar crime (WCC) concerns whether traditional criminological theories—originally focused on the poor, marginalised, and powerless—can adequately explain the crimes of the powerful (Carrabine et al., 2020).The concept of medical deviance has evolved from early white-collar crime theories, particularly Sutherland's (1940) framework, which challenged the assumption that crime is confined to the lower social classes. Developed to provide an alternative perspective to dominant views, white-collar crime (WCC) now encompasses a wide range of issues, including financial scandals, fraud, and hazardous practices that endanger both employees and the public (Croall, 2001).

Due to its broad scope, the concept has been categorised into four distinct types by Clinard et al. (2014), one of which is occupational crime. Green (1979) referred to this category as professional occupational crime, offering the example of unnecessary surgeries performed by doctors. In healthcare, these forms of deviance intersect, as both individual misconduct (e.g., overprescribing medications for financial gain) and organisational failures (e.g., hospitals

concealing or neglecting misconduct to safeguard their reputation) contribute to systemic issues (Friedrichs, 2002).

Friedrichs (2002) argued that the concepts of occupational crime and occupational deviance have often been used interchangeably, which complicates efforts to distinguish between them. Nevertheless, scholars have attempted to clarify these terms, differentiating occupational *deviance*—where professionals violate ethical or fiduciary duties for personal benefit—from organisational deviance, where unethical practices are normalised or even incentivised within the institutional structure (Clinard et al., 2014; Croall, 2001). Still, as Friedrichs (2002) himself notes, the interchangeable use of these terms makes it difficult to draw clear conceptual boundaries.

Medical deviance operates within a landscape of ambiguity, as professional misconduct often falls within grey zones where ethical boundaries are unclear (Hamill,2023). This chapter will critically analyse the ways in which systemic factors, such as hierarchical power structures, organisational cultures, and regulatory gaps, shape these grey areas and contribute to the normalisation of deviance in healthcare settings. It will also examine different conceptualisations of medical deviance, including disruptive behaviour, unprofessional conduct, and financial crimes, highlighting how these classifications influence responses to misconduct.

Beyond individual and organisational explanations, this chapter will explore strategies for preventing and mitigating deviant behaviour in healthcare. It will assess the role of regulatory frameworks, deterrence mechanisms, and interventions aimed at fostering ethical work environments. The review will also consider how privatisation and market-driven reforms have influenced patterns of deviance in private healthcare systems, particularly in the UK, where the National Health Service (NHS) has undergone significant structural changes (Nuffield

Trust, 2022). The shift from patient-centred care to consumer-oriented healthcare has altered professional accountability mechanisms, raising important questions about how privatisation affects deviance and oversight in medical practice (Gusmano et al., 2019).

By integrating insights from criminology, sociology, organizational studies, and healthcare research, this chapter seeks to provide a comprehensive understanding of medical deviance. The literature review will argue that while individualistic explanations of misconduct remain relevant, a more nuanced approach—one that accounts for systemic, cultural, and economic factors—is essential for addressing deviance in the medical profession.

2.2 Concept Of Medical Deviance

The concept of medical deviance has evolved significantly, shaped by its roots in white-collar crime and occupational deviance and by the critical need to address its implications within healthcare systems. Historically, the framing of deviance in medical contexts has been influenced by the recognition of unprofessional behaviours' (Pavithra et al., 2022) impact on patient safety and organisational efficiency (Mawuena et al.,2024).

Medical deviance originates in the broader category of white-collar crime, first defined by Sutherland (1940). Sutherland's offender-oriented approach challenged prevailing notions of crime by emphasising that high-status individuals could also commit socially harmful acts. This shift laid the groundwork for examining deviance in professional settings, including medicine. However, debates soon emerged over the scope of this definition. Tappan (1947) argued for a narrower, legalistic view of crime, excluding breaches of ethical or occupational norms that do not violate criminal law. This narrower focus aligns with the scope of this thesis, which centres on noncriminal breaches of conduct in medical practice.

Building on Sutherland's framework, scholars such as Bloch et al. (1962) and Quinney (1964) introduced nuanced categories of white-collar crime, distinguishing between corporate crime

(organisational gain) and occupational crime (personal gain). This distinction is critical for framing medical deviance as a form of occupational crime, where breaches of trust, ethical norms, or fiduciary duties occur for personal or professional motives (Clinard et al.,2014; Croall, 2001). As criminology shifted focus from offender characteristics to the nature of offences, the understanding of occupational deviance expanded. Edelhertz (1970) categorised white-collar crimes into personal crimes, abuse of trust, business crimes, and con games. The abuse of trust category is particularly relevant to medical deviance, where breaches of fiduciary responsibilities—such as prescribing unnecessary medications—undermine trust between patients and providers (Ungureanu et al.,2018).

Green (1979) refined occupational deviance into organisational, state authority, professional, and individual occupational crime. Within this framework, professional occupational crime, which includes unethical but noncriminal acts like overprescribing antibiotics for profit, is particularly pertinent to healthcare. Friedrichs (2002) emphasised that occupational deviance arises from breaches of professional norms, ranging from unethical conduct to actions that compromise patient care.

Historically, the Hippocratic Oath[2] highlights awareness of deviant behaviours within the medical field, emphasising the importance of acting solely in the patients' interest and avoiding harm. This acknowledgement of potential misconduct underscores the enduring controversies

[2] Hippocrates, a Greek physician and philosopher who lived between 460 and 377 BC, is widely regarded as the "father of modern medicine" (Grammaticos and Diamantis, 2008). Among his notable contributions is the Hippocratic Oath, which established a foundational ethical framework for medical professionals. Although the original Oath has been both translated and subject to various interpretations over time (Hurwitz and Richardson, 1997), its core principles have informed contemporary versions. While the public often assumes that all doctors take this Oath, it is not a formal requirement. Nevertheless, many medical schools hold ceremonies where graduating students pledge an updated version of the Oath. In 1997, the British Medical Association proposed a modernised Hippocratic Oath to the World Medical Association, though a universally accepted version has yet to emerge (Hurwitz and Richardson, 1997). Some institutions instead adopt the Declaration of Geneva as their professional oath (World Medical Association, n.d.), while others create institution-specific pledges.
By 1997, only half of the UK's medical schools incorporated any form of the Hippocratic Oath. However, by 2017, research indicated that this had risen to 70%, with 19 out of 27 medical schools requiring students to take an Oath, suggesting a renewed emphasis on professional ethics in medical education (Green, 2017).

surrounding appropriate medical care. Ambiguities in medical practice, such as differing treatment opinions and the lack of universally agreed-upon rules, have created grey areas that allow for deviant behaviours to arise (Jesilow, 2012). The concept of medical deviance has gained prominence as its critical impact on healthcare systems has made research in this area unavoidable. The growing body of studies reveals that unprofessional behaviours not only impair interprofessional communication, psychological safety, and the clinical learning environment but also lead to adverse events, medical errors, and increased patient mortality (Wiegmann et al., 2007; Rosenstein and O'Daniel, 2008; Saxton et al., 2009; Cochran and Elder, 2014; Cooper et al., 2019). Furthermore, these behaviours significantly affect healthcare providers, fostering self-doubt, reducing morale, and contributing to burnout (West et al., 2018; Hodkinson et al., 2022). Given these far-reaching consequences for patients and providers, addressing medical deviance has become an essential and urgent focus of healthcare research.

While medical deviance has become more specific, the field lacks consensus on terminology. Terms such as deviance, negligent adverse events, unprofessional behaviour, and disruptive behaviour are often used interchangeably but highlight different aspects of the same phenomenon. For example, Gaba et al. (1994) define deviance as intentional actions that stray from prescribed practices but are not inherently blameworthy. Brennan et al. (1996) focus on negligent adverse event**s**—injuries caused by medical care failing to meet expected standards. Dabekaussen et al. (2023) employ the term unprofessional behaviours as an umbrella term encompassing dismissive behaviour, yelling, and public denigration.

Pontell et al. (1993) used medical deviance as a term; however, they emphasise the financial part of the medical deviation. They include illegal activities such as fraud and unnecessary surgeries, often exploiting systemic vulnerabilities in healthcare systems. Fee-splitting, where physicians receive financial incentives for patient referrals rather than prioritising competence,

exemplifies economic motivations behind deviant practices. Similarly, unnecessary surgeries highlight how physicians may prioritise financial gain or convenience over patient welfare. For instance, some surgeries are conducted based on dubious second opinions or fabricated diagnoses to justify billing insurance companies, resulting in harm to patients and substantial financial costs (Lanza-Kaduce, 1980; Pontell et al., 1993). While they limit the term medical deviance to financial crimes committed only in medicine, the literature predominantly favours the term disruptive behaviour (Rosenstein et al., 2002; Cochran & Elder, 2015), which refers to verbal or physical actions undermining team dynamics and patient safety, particularly in hierarchical settings like operating rooms (Cochran & Elder, 2014; Patel et al., 2011).

Other studies emphasise the variability in how disruptive behaviours are defined and perceived: The American Medical Association (2024) defines disruptive physician behaviour as any verbal or physical conduct negatively impacting patient care. Since the literature in this area is predominantly American because healthcare is private there, it is essential to see how this concept is used in the UK. In the UK, regulatory bodies such as the GMC and the CQC have neither categorised these behaviours as ‘disruptive behaviour’ nor provided an explicit definition of this concept. An examination of the guidelines (GMC,2023; CQC,2024b) provided by these two institutions reveals that the expected professional behaviours for doctors are outlined in detail, and deviations from these expectations are classified as non-compliance. In other words, rather than explicitly defining medical deviance, these institutions create a framework in which deviations from clearly defined professional standards can be interpreted as medical deviance. This situation can confuse doctors. Patel et al. (2011) note that surgeons often struggle to reach a consensus on what qualifies as disruptive, highlighting the subjective nature of these classifications.

While the debates on the definition of the concept continue, the literature also highlights trends toward labelling individuals rather than behaviours, using terms like disruptive doctor or problematic doctor (Morrow, 1982; Donaldson, 1994; Roback et al., 2007). This terminology shifts the focus of medical deviance from systemic factors to the individual behaviour of the doctor. Roback et al. (2007) investigate the personality profiles of problematic physicians involved in different types of offences, categorised as sexual boundary violators, behaviourally disruptive individuals, and other misconduct offenders. He suggests that future research should focus on identifying predictive factors for impairment during medical training, empirically defining subgroups within each offence category, and determining the most effective therapeutic or clinical management strategies for different offender types. However, this approach would be incomplete without considering the organisational culture.

Although disruptive behaviour is the prevailing term, some studies addressing specific forms of such behaviour adopt alternative terminology, creating a distinct sub-branch of the literature. These behaviours often fall under the same conceptual umbrella without explicit classification. This umbrella includes hierarchy and conflict in healthcare teams (Grade et al., 2020). Incivility and rudeness undermine team dynamics and patient safety (Holloway & Kusy, 2011; Riskin et al., 2015; Bradley et al., 2015). Bullying and harassment harm individual well-being and team cohesion (Porath & Erez, 2009; Vessey et al., 2009). Sexual harassment and sexism erode trust and equity in professional environments (Ahmed et al., 2021; Freedman-Weiss et al., 2023).

After outlining how the concept of medical deviance has developed in the field of criminology and medicine and the current state of the literature, it is necessary to look in depth at the definition of medical deviance. Leape et al. (2012) and Hastie et al. (2020) provide comprehensive frameworks for understanding disruptive and unprofessional behaviours in healthcare, highlighting overlapping and distinct aspects of these actions. Both emphasise

behaviours that undermine teamwork, respect, and the quality of patient care, categorising them into various types based on intent and impact.

Leape et al. (2012) describe disruptive behaviours as actions or words that interfere with or hinder the delivery of quality healthcare. These include overtly aggressive actions such as angry outbursts, verbal threats, shouting, swearing, and physical aggression, including throwing objects or unwanted contact like sexual harassment. Demeaning language and intimidation are also central to this framework, involving profane or belittling comments, public shaming, or undermining a colleague's competence or reputation. Additionally, they identify bullying and hostile actions, such as attacking integrity, making derogatory remarks, or fostering hostility through insensitive jokes, as key contributors to a toxic workplace. The framework also includes disrespectful behaviours towards patients, like dismissing concerns, failing to listen, or making disparaging remarks. Finally, non-compliance with professional norms, such as neglecting safety protocols or resisting collaborative improvement efforts, is highlighted as disruptive behaviour.

While focusing on unprofessional behaviours, Hastie et al. (2020) provide a more categorised breakdown that overlaps significantly with Leape et al.'s (2012) framework but introduces additional distinctions. Their typology includes incivility, which consists of low-intensity actions such as shouting, swearing, refusing collaboration, failing to listen, or taking undue credit—behaviours that align closely with Leape et al.'s examples of demeaning language and intimidation. Microaggressions, a category unique to Hastie et al., involve subtle biases or prejudices targeting identity markers like race, gender, or religion, including joking about identity, using slurs, or stereotyping abilities. Bullying and harassment, consistent with Leape et al.'s disrespectful behaviour description, involve more overtly harmful behaviours such as questioning competence, making condescending remarks, blaming in public, ignoring

colleagues, issuing threats, or engaging in physical intimidation. Lastly, sexual misconduct, another detailed category in Hastie et al.'s work, overlaps with Leape et al.'s mention of sexual harassment but is expanded to include gender harassment, unwelcome sexual attention, and sexual coercion.

Both frameworks focus on behaviours that disrupt the healthcare environment and compromise professional standards. However, Hastie et al. provide a more structured categorisation with a specific emphasis on identity-targeted behaviours (microaggressions) and a detailed breakdown of sexual misconduct. Leape et al., in contrast, adopt a broader view of disruptive behaviours, emphasising their impact on professional norms and patient care.

2.3 Deviant Actions in Grey Areas

Grey areas in ethics arise where the boundaries between right and wrong become blurred due to conflicting norms, ambiguous guidelines, or novel contexts unaccounted for in existing frameworks. These conceptual challenges and practical obstacles compel individuals and organisations to navigate uncertainty while balancing ethical integrity and operational demands (Taber et al.,2008). To fully understand ethical grey areas in healthcare, it is also important to consider the roles of medical research and the pharmaceutical industry, as both significantly influence clinical practice and the broader health system. Therefore, this review critically examines the origins, implications, and responses to grey areas in ethics, emphasising their prevalence across healthcare, technology, and organisational contexts.

Organisational culture plays a pivotal role in determining whether grey areas are navigated ethically or exploited, and the pharmaceutical industry sets a good example. Di Ronco (2013) critiques pharmaceutical companies for their selective transparency, which undermines trust and creates fertile ground for ethical ambiguity. She argued that while such companies often publicise adherence to global ethical standards, their unwillingness to disclose internal

regulations reveals a concerning tension between rhetoric and practice. This inconsistency fosters environments where employees may perceive unethical behaviour as justifiable, especially if it aligns with organisational goals. This critique highlights a structural flaw: when organisational policies are inconsistently enforced or selectively applied, they inadvertently encourage grey-area exploitation under the guise of operational pragmatism.

Similarly, grey areas frequently arise from organisational and legal ambiguities in healthcare. Kuruppu et al. (2023) examine how healthcare settings navigate child protection laws that rely on vague terms like “reasonable suspicion” and “significant harm.” These ambiguities force practitioners to make subjective judgments, often under significant pressure and with insufficient guidance. While the study calls for clearer legal frameworks, it also exposes a deeper ethical challenge: the reliance on individual discretion in high-stakes decisions risks perpetuating inconsistencies and systemic inequities. This critique underscores the urgency of developing decision-support tools and training programs that balance professional judgment with structured guidance.

With the development of technology, there are also changes in medical practices, and technological advancements add further complexity to grey areas by introducing novel ethical dilemmas that challenge traditional frameworks. Tursunbayeva et al. (2022) identify people analytics as a prime example of how technology can amplify ambiguity. While such tools can optimise workforce management, they also risk infringing on employee privacy and autonomy if deployed without adequate safeguards. The authors underscore the need for ethical charters and stakeholder inclusion to mitigate these risks, yet they also reveal a troubling technocentric bias in the organisational adoption of such tools. The tendency to prioritise efficiency over ethical considerations exemplifies how emerging technologies often outpace the development of robust ethical oversight. Davis et al. (2017) explore the ethical implications of brain imaging technologies in pain research, particularly their potential misuse in legal contexts. While such

technologies promise objective insights, their current limitations and the lack of standardised protocols make their application ethically precarious. The authors argue that using brain imaging as a "pain-o-meter" in legal disputes risks not only misrepresentation but also exploitation of vulnerable individuals. This critique highlights a broader issue: the premature application of nascent technologies in ethically sensitive domains often prioritises potential utility over rigorous ethical validation. Technological solutions, while promising, are not immune to ethical pitfalls. For example, they argued that predictive analytics and gamified compliance tools could incentivise ethical behaviour but also risk reinforcing biases or infringing on privacy. Tursunbayeva et al. (2022) warn against the uncritical adoption of such tools, emphasising the importance of rigorous testing and stakeholder consultation. This critique highlights a recurring theme: technological advancements amplify existing ethical dilemmas rather than resolve them, necessitating proactive and context-sensitive oversight.

Addressing grey areas requires systemic interventions that go beyond surface-level solutions. Organisations must establish clear ethical frameworks and actively reinforce them through consistent enforcement and cultural alignment. For instance, Ayal et al. (2015) try to solve this with the concept of ethical ambiguity. Ethical ambiguity often emerges when formal policies fail to align with informal practices, allowing individuals to rationalise questionable actions. Ayal et al. (2015) illuminate this issue by exploring self-serving justifications, such as minimising consequences or denying responsibility. Their revised framework—reminding, visibility, and self-engagement—offers a theoretically grounded yet practical approach to curbing unethical behaviour. For instance, increasing the visibility of ethical norms and linking individual identity to moral action are proven strategies for reducing ambiguity. However, Ayal et al.'s (2015) unethical behaviour framework presupposes that individuals are willing to engage with moral reminders, a critical gap in scenarios where systemic incentives contradict

ethical principles. These strategies may fall short if organisational cultures implicitly reward outcomes over integrity.

While Ayal et al. (2015) take a more individualistic approach, focusing on individual responsibility, Adams et al. (2016) highlight that although transparency tools and ethical charters are widely recommended, their success ultimately depends on how committed an organisation is to accountability. If leaders fail to model ethical behaviour or tolerate deviations in pursuit of short-term goals, these tools become performative rather than transformative (Adams et al., 2016). This critique aligns with Ienca et al. (2018), who argue that adaptive policies and interdisciplinary collaboration are essential to bridging the gap between ethical ideals and practical realities. In other words, fostering a culture of accountability and inclusivity is critical for addressing grey areas effectively. As Adams et al. (2016) suggest, integrating diverse perspectives into ethical decision-making can illuminate blind spots and reduce ambiguity. However, organisations must go beyond tokenistic inclusion and genuinely empower stakeholders to influence policy and practice. This critique underscores the need for systemic change: without a fundamental shift in how organisations value ethics, efforts to address grey areas risk being superficial and unsustainable.

In conclusion, grey areas in ethics challenge traditional decision-making frameworks by exposing their limitations in addressing complexity and ambiguity. Addressing these challenges requires a multifaceted approach that integrates systemic reforms, technological innovation, and individual empowerment. However, as the critiques in this review suggest, such efforts must be grounded in a commitment to accountability, inclusivity, and continuous learning. By bridging the gap between ethical principles and practical realities, organisations and individuals can navigate grey areas with integrity, fostering trust and resilience in an increasingly complex world.

2.3.1 Doctor's Intent in Medical Deviance

Understanding the intent behind doctors' deviant behaviours is pivotal in addressing ethical challenges like grey areas and improving organisational systems in healthcare. Intent, as described in the literature, refers to the purposeful decision-making process influenced by individual beliefs, environmental pressures, and perceived outcomes (Ajzen, 1985).

Ajzen's theory of planned behaviour posits that behaviour is driven by attitudes, subjective norms, and perceived behavioural control, which collectively shape intention. In healthcare, this framework explains why doctors may engage in or refrain from deviant actions. For example, attitudes toward incident reporting are influenced by perceived consequences; doctors may avoid reporting safety concerns due to fears of negative repercussions or beliefs that such efforts will be futile (Rich et al., 2019). Subjective norms, shaped by peer influence and institutional culture, further affect intent. When organisational norms prioritise performance metrics over ethical practices, doctors may conform to such expectations, even if they conflict with professional standards (Williams et al., 2015). Perceived behavioural control also plays a role; doctors operating in hierarchical or resource-constrained environments may feel powerless to act ethically, discouraging reporting of incidents or adherence to guidelines (Kingston et al., 2004).

Bandura's social cognitive theory complements the theory of planned behaviour by emphasising the interplay of personal, environmental, and behavioural factors. Self-efficacy—the belief in one's ability to achieve a desired outcome—is crucial in shaping intent. Observational learning plays a significant role; when senior staff engage in deviant practices without consequences, junior doctors may view such behaviours as acceptable or necessary (Kingston et al., 2004). Moral disengagement, another social cognitive theory concept, explains how doctors justify deviant actions by blaming systemic issues, such as inadequate staffing or administrative failures, rather than taking personal responsibility (Rich et al., 2019).

By integrating the theory of planned behaviour and social cognitive theory, the complexity of intent formation becomes evident. Intent in deviant behaviours is not merely a matter of individual morality but a product of interwoven cognitive, social, and systemic factors.

2.4 Different Perspectives on Medical Deviance

This section covers various dimensions of medical deviance, exploring how individual, professional, and organisational factors contribute to deviant behaviours within the healthcare sector. It begins by examining the personal aspects of deviance, focusing on individual traits and personal circumstances, such as personality traits, divorce, and substance misuse. The discussion then transitions to the impact of hierarchical structures within medical practice, analysing how rigid power dynamics, authority gradients, and normalising deviance create environments where disruptive behaviours can flourish. It also addresses organisational factors that foster deviance, highlighting how structural pressures, organisational climate, and systemic failures can normalise unsafe practices. Finally, strategies for mitigating hierarchical barriers, preventing deviance, and fostering compliance are examined, underscoring the importance of creating a supportive and accountable healthcare environment. By understanding how personal, professional, and organisational dynamics interact, this chapter aims to provide a comprehensive framework for addressing medical deviance and promoting safer, more effective healthcare practices.

2.4.1 Individual Level Explanations of Medical Deviance

This section will introduce the personal aspects of medical deviance, focusing on individual traits, personal circumstances, and internal factors like age, gender, and culture. The “bad apple” theory frames deviant actions as the result of individual choices rather than systemic or organisational factors (Monahan & Quinn, 2006). Researchers indicate that traits such as low agreeableness, conscientiousness, and emotional instability strongly predict deviance, whereas

honesty-humility and ethical decision-making are associated with lower levels of misconduct (Berry et al., 2007; Ashton & Lee, 2005).

In medicine, the role of individual traits becomes even more pronounced. Positive characteristics like empathy, emotional stability, and effective communication are essential for maintaining strong patient relationships and fostering a supportive workplace environment (Grundnig et al., 2022; Krasnov et al., 2021). On the other hand, negative traits such as arrogance, narcissism, and Machiavellianism are linked to counterproductive behaviours, including interpersonal exploitation and manipulation, which undermine team cohesion and increase workplace stress (Sharma, 2019). Arrogance in the medical sector can often emerge through dismissive behaviours, an overestimation of one's expertise, and the reluctance to admit fallibility (Milyavsky et al., 2017). Such attitudes may cause hierarchical barriers between clinicians, undermining collaborative decision-making and openness to feedback (Joffe et al., 2022). In practice, this creates a tense hospital environment: junior staff, nurses, and allied health professionals can feel devalued or silenced, while patients may not receive fully integrated care because critical perspectives or cautions go unheard (Joffe et al., 2022). Contrarily, fostering genuine clinical curiosity—actively seeking different viewpoints and insights—has been shown to promote collective problem-solving, thus reducing professional arrogance and enhancing patient outcomes (British Journal of General Practice (BJGP) Life, 2023).

Over time, persistent arrogance among physicians can corrode professional trust and strain team dynamics (Milyavsky et al., 2017). Such environments undermine person-centred care and increase clinician burnout as meaningful peer support and a sense of shared purpose become eroded (Joffe et al., 2022). To combat these tendencies, cultivating an ethos of humility—emphasising that even experienced doctors can learn from peers and patients alike—

helps sustain a respectful, collegial atmosphere that ultimately benefits patients and professionals alike (BJGP Life, 2023).

In addition to the doctor's character traits, there are factors, such as divorce and substance use, that can cause deviation in the doctor's private life. Divorce among doctors has been associated with increased psychosocial stress, which can diminish their capacity to provide consistent and empathetic care (Ghodse, 2005). When clinical responsibilities collide with the profound emotional strain that marital breakdown can impose, doctors can experience heightened anxiety and uncertainty, potentially impairing decision-making and reducing their clinical vigilance (Howe, 2015). This may lead to lapses in communication and less time devoted to supportive interactions with patients (Ly et al., 2015). Although divorce rates among doctors overall appear comparable to, or lower than, those in other professions, the personal toll of marital discord remains significant and may result in reduced emotional availability for patients (Howe, 2015). Several studies have linked high workload, irregular hours, and insufficient work-life balance with greater emotional strain and disrupted family relationships (Ghodse, 2005; Howe, 2015). The tension between maintaining clinical responsibilities and fulfilling domestic obligations can be substantial, intensifying the burden of divorce. Doctors often need to maintain a composed, conscientious demeanour in patient care settings and yet carry unresolved marital conflicts into or out of work (Marshal et al., 2021). This tension can corrode focus and impair accuracy, thus endangering the quality of clinical decision-making. Crucially, one's colleagues and workplace atmosphere may also influence the course and impact of such stressors, as inadequate institutional support may magnify the adverse effects of divorce on doctors' welfare (Ghodse, 2005).

By consequence, the psychological distress experienced during marital breakdown can exacerbate existing issues of burnout and mental ill health, which are already reported at higher

rates among medical professionals than in some other career fields (Ghodse, 2005). Such distress may also lead to communication barriers within multidisciplinary teams if doctors struggling with personal difficulties become withdrawn or display irritability. Over time, unresolved marital conflicts could threaten overall morale in the clinical environment, as empathetic collaboration and shared professional commitment are essential for patient safety (Howe, 2015). In this light, sustained efforts to foster supportive networks—through mentoring, counselling, and peer discussions—can help mitigate the corrosive impact that divorce and related family issues have on doctors' performance and well-being.

Also, substance misuse remains a critical issue in the medical field, particularly among high-stress specialities like anaesthesiology and surgery. Easy access to controlled substances exacerbates the risk of addiction, which not only impairs clinical judgment but also heightens the likelihood of deviant behaviour (Mavroforou et al., 2006). Addressing these challenges requires systemic solutions, including education on substance misuse and robust support programs for healthcare professionals (Marshall, 2008).

Deviance in healthcare extends to occupational crimes, such as drug diversion among pharmacists and other healthcare workers. These behaviours, as Dabney and Heffington (1996) observed, often stem from the unique access that medical professionals have to controlled substances. Such incidents highlight the need for better professional socialisation processes that address these risks not merely as individual moral failings but as systemic issues requiring collective action and reform.

In addition to these, the influence of internal factors, such as age, gender, and cultural background, adds another layer of complexity to understanding medical deviance. While generational differences are often cited as a source of workplace tension, research has found little evidence to support the idea that younger generations, such as millennials, have weaker

professional ethics than older cohorts (Smith, 2005; Lemaire et al., 2013). Gender, however, plays a more significant role, with female physicians frequently facing added stress from caregiving responsibilities. This dynamic can lead to perceptions of reduced professional commitment, even as women continue to excel in their roles (Lemaire et al., 2013). Further, research indicates that women in medicine, especially those working longer hours, may be more vulnerable to divorce, a reality that can exacerbate professional burnout and undermine mental resilience (Ly et al., 2015). Furthermore, increasing cultural diversity within the medical workforce challenges communication and collaboration. Differing values and perspectives can sometimes lead to misunderstandings, emphasising the need for cultural competency training to foster better teamwork and patient care (Beach et al., 2005; Holm et al., 2017)

2.4.2 Deviance Within the Profession: Culture, Norms, and Control

The hierarchical structures in medicine originate in historical exclusions and power dynamics deliberately established to maintain authority and control. Historically, access to medical education and leadership roles in the field was restricted to an elite group, predominantly white and male, creating a culture of exclusivity and authority (Hepple, 2001; Logghe et al., 2018). This exclusionary framework concentrated power within a small professional segment, ensuring that knowledge, decision-making, and leadership remained hierarchical and inaccessible to those outside the dominant group (More, 1990).

Hierarchical structures in healthcare serve dual purposes: functional and social. Functionally, they are intended to streamline decision-making and allocate responsibilities, especially in high-pressure environments such as operating rooms or emergency departments (Lyden et al., 2010). These hierarchies are structured to ensure clear lines of authority, with senior physicians at the top and nurses and junior staff occupying subordinate roles. However, the social

dimensions of these hierarchies often overshadow their functional intent, creating environments where power imbalances dominate interpersonal and professional interactions.

This rigid hierarchy was particularly evident in surgery, where authority, decisiveness, and control were prioritised as core attributes. Non-surgical specialities, while less overtly hierarchical, mirrored and reinforced these dynamics. Physicians in these specialities retained authority over nurses and allied health professionals, but decision-making processes were often more collaborative (Riley & Manias, 2005). Over time, however, the practices of authority and deference developed in non-surgical fields were integrated into surgical hierarchies, creating a feedback loop that perpetuated and amplified the rigid power structures in operating rooms (Riley & Manias, 2005; Gillespie et al., 2008).

The authority gradient is one of the most significant manifestations of these power imbalances. In hierarchical systems, lower-ranking team members frequently hesitate to voice concerns or challenge decisions made by senior physicians due to fear of retribution, professional backlash, or being dismissed (Higgins & MacIntosh, 2010; Schwappach & Richard, 2018). This reluctance inhibits open communication and undermines collaborative problem-solving, often with dire consequences for patient safety. Critical errors may go unaddressed, and unsafe practices may become routine, normalised by a culture that prioritises authority over accountability (Roback et al., 2007).

In surgical environments, these dynamics are particularly pronounced. Operating rooms are high-stakes settings where hierarchical norms are deeply entrenched. Nurses, whose roles are traditionally viewed as subordinate and supportive, often find their ability to contribute to critical decisions significantly constrained. Their expertise and insights are frequently overshadowed by the dominance of biomedical discourse, which privileges the perspectives and authority of physicians (Björnsdottir, 2001; Coombs, 2003). Surgeons, whose roles are

closely associated with authority and control, are frequently insulated from criticism, allowing deviant behaviours to persist unchecked. At the same time, the dynamics of non-surgical specialities, where collaboration and communication are more central, have begun to influence surgical hierarchies. These influences introduce tensions that highlight the rigidity of traditional power structures and the resistance to change within male-dominated fields like surgery and orthopaedics (Logghe et al., 2018).

The hierarchical structures that define medical practice are not merely neutral organisational tools; they actively shape the behaviours and attitudes of those within them. The concentration of authority in senior physicians often fosters environments where power is exercised with minimal accountability. This imbalance creates fertile ground for deviant behaviours ranging from negligence and micromanagement to overt intimidation and bullying. Such behaviours are often normalised within the hierarchy, as subordinates are reluctant to report misconduct or challenge authority figures (Schwappach & Richard, 2018).

Normalising deviance in hierarchical settings reflects a broader cultural issue within medicine. Even when aware of potential risks, team members may hesitate to voice concerns, prioritising deference to authority over patient safety. This reluctance is reinforced by structural power dynamics, which discourage dissent and perpetuate a culture of silence. In particular, nurses face significant communication barriers, further exacerbating these issues. Their subordinate status within the hierarchy often marginalises them, reducing their capacity to challenge unsafe practices or advocate for patient safety (Riley & Manias, 2005; Gillespie et al., 2008).

While much of the focus on hierarchy in medicine is vertical—senior physicians versus junior staff—horizontal stratification within ranks also plays a critical role in perpetuating power imbalances. Informal hierarchies often emerge within the same rank based on educational background, training, and perceived merit (Jenkins, 2020). These distinctions create additional

layers of stratification, reinforcing the broader hierarchical framework and influencing how individuals exercise power and authority within their peer groups.

In medical training, these dynamics are particularly evident. Trainees navigate hierarchical systems by engaging in impression management, a concept that involves performing behaviours that align with the expectations of their superiors to secure favourable professional positions (Ichheiser, 1949; Goffman, 1959). While necessary for career advancement, this performative adaptation reinforces the hierarchical culture, as trainees internalise and perpetuate the power dynamics they are navigating. These strategies highlight the role of social awareness and adaptability in navigating medical hierarchies as trainees assess the context, discern what supervisors value, and adjust their actions accordingly (Vanstone & Grierson, 2019).

Horizontal stratification also differentiates medical students and residents based on structural factors such as class, national origin, and educational background. For instance, distinctions between US-trained MDS, international graduates, and Doctor of Osteopathic Medicine often create informal hierarchies within the same clinical rank (Jenkins, 2020). These divisions are shaped by perceived merit differences and resource access, reinforcing the broader structural inequities within medical education and practice.

While designed to provide order and clarity, the hierarchical structures in medicine frequently undermine the collaborative ethos required for effective healthcare delivery. The fear of retribution or dismissal inhibits team members from addressing critical errors or questioning authority, creating a climate where deviant behaviours and unsafe practices may persist unchallenged. This reluctance to engage in open dialogue endangers patient safety and erodes trust and cohesion within medical teams (Eaton, 2017).

Interpersonal conflicts arising from power imbalances further destabilise team dynamics. Nurses and allied health professionals often report feeling undervalued and unsupported, which can lead to burnout, high turnover, and, in some cases, exposure to workplace harassment or bullying by those in positions of authority (Higgins & MacIntosh, 2010; Laschinger et al., 2010). These dynamics, rooted in hierarchical norms, exacerbate professional alienation and contribute to the normalisation of deviance, allowing systemic issues to persist unchallenged.

The interplay between hierarchical norms and deviant behaviours highlights the need to critically examine power structures in medicine. By understanding how these hierarchies were historically constructed and continue to influence contemporary practice, it becomes possible to identify strategies for mitigating their negative impacts. Future efforts should focus on fostering environments of psychological safety where team members feel empowered to voice concerns and challenge authority without fear of retribution (Schwappach & Richard, 2018).

Mitigating hierarchical barriers in healthcare requires a comprehensive approach that addresses cultural and systemic dimensions. Psychological safety is critical to creating an environment where all team members feel empowered to speak up without fear of retaliation. Leadership plays a pivotal role in this process, as those in authority must model respectful behaviours and open dialogue (Schwappach & Richard, 2018). Leadership training programs focused on emotional intelligence, conflict resolution, and collaborative decision-making can further shift traditional power dynamics. Senior physicians, in particular, benefit from training that helps them recognise and address their biases while supporting inclusive teamwork (Rosenstein, 2017).

Interprofessional education is another valuable strategy, bringing together healthcare professionals from various roles to learn collaboratively. Such initiatives foster mutual respect, improve communication, and reduce hierarchical tensions (Higgins et al., 2010). Policy

interventions also play a crucial role, with institutional policies that enforce zero tolerance for disruptive behaviours and establish precise reporting mechanisms signalling an organisational commitment to a respectful culture (De Leon et al., 2018). Additionally, promoting diversity in leadership by increasing the representation of women and minorities challenges entrenched norms, leading to a more equitable distribution of power, and enhancing decision-making processes (Logghe et al., 2018).

Together, these strategies address the root causes of hierarchical barriers while fostering a collaborative, inclusive, and respectful healthcare environment.

2.4.3 Organisational Structures and the Conditions for Deviance

Deviance within organisations is closely tied to their power dynamics, structural configurations, and cultural norms. Organisations often create environments that normalise deviant behaviours, embedding them into routine practices when such deviations benefit the organisation (Kelman & Hamilton, 1989; Gioia, 1992; Wright et al., 2022). These dynamics are especially pronounced in the healthcare sector, where systemic pressures to prioritise efficiency and productivity frequently erode safety standards and ethical practices.

Organisational structure and climate are central to understanding the genesis of deviance in workplace settings. Organisational climate encompasses the broader range of perceptual and relational factors shaping interactions between individuals and their workplace. It includes reward systems, autonomy, and job satisfaction, directly influencing employee attitudes and behaviours (Peterson, 2002; Giles, 2010). Conversely, organisational structure is more narrowly defined as the formal configuration of organisational responsibilities, roles, and authority (Greenberg in Maduenyi et al., 2015). These structures significantly influence how tasks are coordinated and monitored, shaping both individual and collective behaviours.

Researchers suggest that specific organisational structures—particularly those emphasising profit generation or efficiency—are more likely to foster deviant behaviours (Monahan & Quinn, 2006; Zey, 1999). For instance, Zey (1999) highlights how shifts in corporate forms, such as the transition to multi-subsidiary structures, facilitate independent and lucrative fraud networks. This dynamic parallels Vaughan's (1996) concept of the normalisation of deviance, where small, tolerated deviations from standards gradually escalate into systemic problems. The normalisation of deviance refers to the process through which initially unacceptable deviations become embedded in organisational practices over time (Vaughan, 1996).

Palmer (2012) expands on this idea, portraying wrongdoers as unthinking and limited in their rationality, heavily influenced by their immediate social environment, and gradually engaging in misconduct without ever forming a deliberate intent to do so. While this perspective offers a necessary counterbalance to the narrative of isolated bad actors, the more robust interpretations of the normalisation thesis risk oversimplifying wrongdoing as purely incidental. Palmer (2012) identifies five mechanisms: administrative system dynamics, socialisation, normalisation, structural secrecy, and system accidents. This concept, originating from studies on the Challenger space shuttle disaster, has been widely applied to healthcare to explain how safety standards erode under systemic pressures. In high-stakes environments like hospitals, production demands, resource constraints, and hierarchical complacency compel employees to adopt deviant practices to meet organisational goals (Prielipp et al., 2010; Wright et al., 2022).

For example, nurses in university hospitals may initially adhere to safety protocols but gradually resort to deviant actions, such as bypassing alarms or ignoring hygiene practices, due to productivity pressures (Banja, 2010). These behaviours, while seemingly minor, can culminate in severe consequences, such as tubing misconnections caused by poorly designed

medical devices, leading to preventable fatalities (Simmons et al., 2011). Rasmussen's (1997) theory of migration to the boundary further elucidates this trend by explaining how individuals working within complex systems are pushed, often subtly and incrementally, towards the edges of safe practice. Under systemic pressures such as time constraints, staffing shortages, or conflicting organisational goals, frontline workers may adapt their behaviour to maintain workflow, gradually redefining what is considered normal or acceptable. Over time, these adaptations can shift the collective operational norm closer to the boundaries of safety, increasing the likelihood of errors or adverse events.

Organisational culture plays a pivotal role in reinforcing deviant behaviours. Barach and Phelps (2013) documented how systemic shortcomings at Bristol's Royal Infirmary between 1991 and 1995, including inadequate facilities and professional hubris, resulted in the deaths of 30–35 children. Hierarchical structures and a club culture that silenced dissent normalised these deviations, prioritising institutional reputation over patient safety. These findings underscore the critical role of power dynamics in perpetuating deviance (Dyer,2001, p.1). Hierarchical structures often exacerbate these issues by discouraging open communication. The "authority" gradient in healthcare, where junior staff hesitate to challenge senior physicians, fosters environments where errors and deviant practices go unaddressed (Schwappach & Richard, 2018, p.1). This deference to authority silences potential dissent and contributes to the erosion of team dynamics and the normalisation of unsafe practices (Riley & Manias, 2005).

Interestingly, these dynamics differ across organisational contexts. While public hospitals frequently normalise deviance to meet productivity goals, private hospitals often report fewer deviant practices. Nurses in private settings feel supported and less overwhelmed, contributing to greater adherence to safety protocols and job satisfaction (Wright et al., 2022). However, in

profit-driven environments, such as operating rooms viewed as “financial hubs” (Rothstein & Raval, 2018, p.1), safety shortcuts are common, driven by prioritising financial returns over patient welfare.

External factors further complicate the interplay between organisational structure and culture. Neo-institutionalist perspectives argue that broader societal and cultural determinants profoundly shape organisations, which influence internal structures and behaviours (Scott, 2003). For example, collectivist cultures discourage deviance by compelling individuals to adhere to group norms, whereas individualistic cultures emphasise autonomy, which may correlate with higher rates of deviance (Triandis et al., 1985; Ramamoorthy et al., 2007).

These cultural influences extend to the organisational climate, encompassing job satisfaction, group dynamics, and emotional support. Research indicates that an employee-friendly environment reduces deviance, whereas climates focused solely on achieving organisational goals often foster negative behaviours (Kidwell and Valentine, 2009; Huang and Van de Vliert, 2003). This reinforces the idea that deviance is not solely a product of internal organisational factors but is also shaped by external cultural and structural influences.

The financial implications of deviance are substantial, particularly in healthcare. Severe forms of deviance, such as fraud, account for an estimated 30–40% of healthcare resources, amounting to billions of dollars annually (Gee & Button, 2015). Additionally, minor forms of deviance, such as resource wastage or deliberate slowing of work, have cumulative effects on trust, efficiency, and organisational cohesion. While more challenging to quantify, these indirect costs contribute significantly to the erosion of institutional integrity (Litzky et al., 2006).

Efforts to counter deviance's normalisation must address structural and cultural factors. Robust safety protocols, transparent accountability mechanisms, and engaged leadership are essential for rebuilding a culture of safety (Prielipp et al., 2010; Wright et al., 2022). Organisations must also address systemic design flaws, such as implementing safer medical devices and fostering open communication, to mitigate risks (Simmons et al., 2011). Moreover, understanding how hierarchical power structures and cultural norms influence deviant behaviours is critical for developing effective interventions. Organisations can safeguard patient outcomes and institutional integrity by prioritising quality, ethical practices, and employee well-being.

2.4.3.1 Prevention And Deterrence of Violations

Preventing and deterring violations in healthcare is a critical issue that intersects patient safety, regulatory compliance, and organisational accountability. Violations—whether related to unsafe clinical practices or information security breaches—can lead to devastating consequences, including harm to patients, financial losses, reputational damage, and erosion of public trust. As healthcare systems grow in complexity, understanding how to prevent and deter such violations is vital. This review critically evaluates the strategies, frameworks, and challenges identified in the literature, weaving together theoretical and practical insights.

A significant dimension of this issue involves the cognitive processes that underpin non-compliant behaviours. Neutralisation techniques, as explored by Altamimi (2022), provide a framework for understanding how healthcare workers justify violations of information security policies. Techniques such as denial of responsibility or appeal to higher loyalties often emerge when employees perceive policies as misaligned with the practical demands of their work. This misalignment exacerbates the likelihood of violations, particularly when policies are seen as barriers to efficiency rather than facilitators of safety. Addressing these cognitive strategies requires engaging employees in the development of policies, ensuring they are both practical

and equitable. Such engagement not only minimises reliance on justifications but fosters a sense of ownership, which is critical for sustainable compliance.

The deterrent role of legal frameworks further complements this behavioural perspective. Ramanathan (2014) emphasises the power of statutory, criminal, and tort law in holding individuals and organisations accountable for preventable harms, such as unsafe injection practices. Legal enforcement operates on the principles of general deterrence theory, where the perceived certainty and severity of punishment influence compliance behaviours. However, as noted, the effectiveness of these frameworks is often undermined by opaque enforcement mechanisms, such as out-of-court settlements, which diminish the broader visibility of accountability. To maximise deterrence, healthcare systems must implement transparent enforcement measures that reinforce the consequences of non-compliance.

At the organisational level, the interplay between structural factors and decision-making processes shapes the landscape of compliance. Wall et al. (2016) introduced the selective organisational information privacy and security violations model, demonstrating how organisational dynamics, such as resource strain and structural secrecy, drive selective rule-breaking behaviours. Building on theoretical foundations like March and Shapira's (1987) exploration of risk preferences, the Selective Organisational Information Privacy and Security Violations Model underscores the importance of tailoring compliance strategies to the realities of organisational pressures. These insights align with broader discussions in organisational studies, emphasising the need for adaptive policies that balance regulatory requirements with operational feasibility.

Training and capacity-building are consistently identified as critical tools for bridging the gap between knowledge and practice. Aluko et al. (2016) found that while healthcare workers in Nigeria exhibited high levels of awareness about occupational hazards, this knowledge did not consistently translate into safe practices. Factors such as inadequate safety equipment,

insufficient training, and weak enforcement mechanisms contributed to this discrepancy. This knowledge-practice gap reflects a broader challenge across healthcare systems: ensuring that awareness initiatives are reinforced through systemic improvements, such as resource allocation and continuous monitoring. Ford and Tetrick (2011) further emphasise that perceived organisational support significantly influences safety performance, highlighting the need for institutions to foster environments where compliance is both encouraged and facilitated.

Technological innovations have also emerged as valuable tools for prevention and deterrence. Integrating real-time monitoring systems and artificial intelligence into compliance frameworks provides opportunities to proactively address violations. For example, Liang et al. (2013) explore how IT compliance mechanisms employing "carrot or stick" approaches influence employee behaviours. Gamification, real-time feedback, and predictive analytics can enhance employee engagement with compliance protocols, particularly when integrated into broader organisational strategies. However, the long-term efficacy of these technologies in fostering trust and adherence remains an area for further exploration.

Effective teamwork and organisational culture are vital elements in preventing violations. Clements et al. (2007) underscore the role of interprofessional collaboration in fostering accountability and reducing the likelihood of non-compliance. Organisations can build cohesive teams capable of navigating complex healthcare environments by creating shared goals and emphasising clear communication. Policies like those developed under the Canadian Interprofessional Education for Collaborative Patient-Centred Practice initiative demonstrate the potential for teamwork to improve compliance and patient outcomes. These efforts are complemented by organisational frameworks prioritising fairness and transparency, as discussed by Lowry et al. (2015). Ensuring that employees perceive organisational policies as fair and just is crucial for fostering intrinsic motivation to comply.

Diversity and inclusion also play a role in shaping compliance behaviours. Sharma (2016) highlights how affirmative action policies and performance appraisals can incentivise adherence to regulations. However, sociocultural factors, such as hierarchical workplace dynamics, may hinder the effectiveness of these incentives. Managers must navigate these dynamics to ensure that compliance strategies are culturally sensitive and aligned with the diverse needs of healthcare workers. This requires recognising and addressing systemic barriers that may inadvertently promote non-compliance, further reinforcing the need for tailored and inclusive approaches.

Creating a safe organisational culture is an overarching theme that ties many of these strategies together. Mohr (2005) argues for the establishment of safe learning organisations, where employees feel empowered to report errors without fear of retribution. Such environments prioritise proactive risk management over punitive measures, fostering continuous improvement and adaptation. By focusing on learning rather than punishment, organisations can address vulnerabilities before they escalate into significant violations, creating a culture prioritising safety and accountability.

Despite these advancements, significant gaps remain. Much of the existing literature focuses on individual-level behaviours, with less attention given to the systemic and organisational factors that influence compliance. The interactions between legal frameworks, organisational culture, and individual behaviours are complex and require further exploration to develop integrated strategies that address violations holistically. Additionally, the role of emerging technologies in shaping compliance behaviours presents both opportunities and challenges that warrant closer scrutiny.

This synthesis of findings highlights that prevention and deterrence in healthcare cannot rely on a single approach. By integrating legal enforcement, behavioural insights, organisational strategies, and technological innovations, healthcare systems can build robust frameworks for

compliance. Addressing both individual and systemic factors is essential for creating a safer, more accountable healthcare environment that prioritises the well-being of patients and workers alike.

2.5 Neoliberal Healthcare and the Rise of the Medical Consumer

2.5.1 The Privatisation of the NHS

The evolution of the National Health Service (NHS) in the United Kingdom from a publicly funded and managed healthcare system to one increasingly influenced by private sector principles has been the subject of extensive academic and policy discussions. Established on July 5, 1948, the NHS marked a transformative shift from fragmented voluntary and insurance-based systems to a universal, comprehensive, and tax-funded healthcare model. Its founding principles, championed by Labour Health Minister Aneurin Bevan, emphasised equity and redistribution, ensuring healthcare access based on need rather than the ability to pay (Webster, 2002; Gorsky, 2008). Even Bevan said that "[The NHS] has now become a part of the texture of our national life. No political party would survive that tried to destroy it" (Burki, 2018, p.1). However, by the late 20th century, financial pressures and neoliberal policies began to reshape its structure, introducing market-driven mechanisms and expanding private sector involvement (Leys, 2001).

The NHS was initially heralded for its efficiency, equity, and role in fostering social solidarity. From its inception, it symbolised collective well-being, addressing pent-up demand for healthcare and achieving widespread public satisfaction despite inherent challenges such as financial constraints and inefficiencies (Gorsky, 2008).

Administrative costs were remarkably low, estimated at 6% of total expenditures compared to over 20% in the U.S., and health outcomes were achieved at a fraction of the cost observed in

other systems (Woolhandler et al.,2003). These successes underscored its societal value, not only as a healthcare provider but also as a metaphorical safeguard of collective well-being.

Those values and characteristics of the NHS have become so integrated with society. Richard Sullivan, professor of cancer and global health at King's College London, said, "The NHS has become hardwired into the British DNA; for politicians, not taking care of the NHS is akin to saying they do not care about society—it loses them elections" (Burki,2018).

However, the 1970s marked the onset of financial pressures exacerbated by an ageing population and advancements in medical technology. As government spending on the NHS grew to 11% of total public expenditures, debates intensified over its long-term sustainability and affordability. The NHS transitioned from a system of technocratic planning to one increasingly influenced by market principles. This shift, particularly during the 1980s under Prime Minister Margaret Thatcher, introduced internal markets and managerial reforms aimed at enhancing efficiency and responsiveness (Rivett, 1998). While these reforms sought to address capacity constraints and improve service delivery, they also invited criticism for contributing to privatisation and challenging the NHS's founding ethos of equity and comprehensiveness (Webster, 2002).

The 1980s marked the beginning of significant reforms under the Thatcher government. Ancillary services such as cleaning and catering were outsourced to private firms, achieving cost savings but often at the expense of worker conditions and morale. The introduction of general management in hospitals shifted decision-making power from clinicians to financial administrators, emphasising efficiency metrics over care quality. Additionally, real-term funding cuts forced the NHS to deliver services under increasingly constrained budgets, paving the way for private sector participation (Leys, 2001).

The NHS and Community Care Act of 1990 introduced the concept of an internal market, dividing the system into purchasers (health authorities and fundholding general practitioners) and providers (self-financing hospital trusts). This structural change aimed to introduce competition and cost-consciousness within the system by mimicking market dynamics. However, critics have noted that this reform fragmented the NHS, doubled administrative costs, and undermined equitable access to care. Moreover, it created opportunities for private hospitals to compete for contracts, embedding privatisation into public healthcare provision (Leys, 2001).

One of the most significant outcomes of these reforms was the expansion of private healthcare. The NHS's difficulties in managing waiting times and funding shortfalls led to increased demand for private medical insurance (PMI). By 1990, PMI coverage had nearly tripled since the mid-1970s, fuelled primarily by employer-sponsored plans (Laing and Buisson, 1999). Private hospitals focused on elective surgeries, which often had long NHS waiting times, while NHS consultants frequently worked in both the public and private sectors. By the mid-1990s, private hospitals accounted for a growing share of healthcare services, despite initial opposition to these reforms, the Labour government elected in 1997 retained many neoliberal structures, including the purchaser-provider split. It also introduced the Private Finance Initiative, under which private companies financed hospital construction in exchange for leasing agreements with the NHS. While the Labour government increased funding for the NHS, the reliance on private sector partnerships deepened, further blurring the boundaries between public and private healthcare provision (Leys, 2001).

By the early 2000s, significant investments under New Labour sought to revitalise the NHS, addressing capacity issues and improving service delivery. Nonetheless, debates persist

regarding the sustainability of its founding ideals amidst ongoing privatisation efforts (Gorsky, 2008).

The incorporation of private sector principles into the NHS has generated mixed evaluations. Proponents argue that privatisation introduced efficiency and innovation. However, critics emphasise its role in creating a two-tier system, where those who can afford private care receive faster and better services while vulnerable populations face reduced access to affordable care. Services such as dentistry and elective surgeries have seen significant privatisation, and the ideological shift toward market-driven healthcare has fundamentally challenged the NHS's foundational principles of universality and equity (Leys, 2001).

2.5.2 From Patient to Consumer: Understanding the Shift in Healthcare

Healthcare has historically been structured around the expertise and authority of healthcare professionals, with patients positioned as passive recipients of care. This traditional model has been disrupted by factors such as the rise of alternative medicine, the acknowledgement of patient expertise in chronic conditions, and neoliberal-inspired managerial reforms (Ignatieff, 1995). Collectively, these shifts have challenged medical hierarchies, emphasising patient-centred care and public involvement in healthcare decisions and research (Tritter et al., 2010).

Patient-centred care emerged as a response to evidence-based medical models that limited patient autonomy and decision-making. This approach reframes the doctor-patient relationship by focusing on shared decision-making and the patient's contextual needs. Programs like the Expert Patient Programme (Department of Health, 1999b) exemplify efforts to empower patients. However, the implementation of patient-centred care has been inconsistent, often yielding mixed outcomes for patients (Stewart, 2001). At the same time, the concept of patient choice began to gain prominence, becoming central to healthcare reforms, particularly within

the UK's NHS. Initiatives like the NHS Choose and Book service (Department of Health, 2003) aimed to promote autonomy by enabling patients to select from various healthcare providers, including private facilities. While choice is framed as a way to enhance access and foster competition, critics argue it exacerbates inequalities, as those with greater resources are better equipped to navigate these systems (Appleby et al., 2003). Additionally, the rhetoric of choice assumes a surplus in healthcare capacity, which can be economically inefficient and alienating for vulnerable groups (Barnes & Prior, 1995).

The promotion of patient choice aligns with broader neoliberal marketisation trends, emphasising competition and individual responsibility over collective welfare. While market mechanisms aim to improve efficiency and accountability, they often conflict with the equity-driven goals of publicly funded systems. Introducing co-payments and blending public and private providers risks creating a two-tiered system, undermining the universality of public healthcare (Björkman, 2004). Furthermore, market-oriented reforms can fragment care, reducing efficiency and continuity, particularly in systems with private providers (Rosenmöller et al., 2006). These tensions highlight the complex interplay between individual autonomy and collective equity.

During the New Labour government in the UK, efforts were made to balance marketisation with public and patient involvement. Policies such as The New NHS: Modern, Dependable (1997) and Saving Lives: Our Healthier Nation (1999) emphasised the importance of local expertise and collective decision-making. Structural reforms, including the Health and Social Care Act 2001, mandated NHS organisations to involve and consult patients and the public. Mechanisms like Patient Advice and Liaison Services (PALS) and Independent Complaints Advocacy Services are aimed at amplifying patient voices. Despite these efforts, structural imbalances often favoured dominant groups, such as General Practitioners, limiting the impact

of patient and public involvement initiatives (Tritter et al., 2010). While these mechanisms emphasised collective involvement, there was a parallel shift toward framing individuals as consumers. This consumer-oriented approach often prioritised personal preferences over collective welfare and equity.

Critics argue that the shift from patient to consumer diverts resources from addressing systemic issues like geographic disparities and underserved populations, undermining the principle of universal access (Florin & Dixon, 2004). Market-driven reforms risk exacerbating health disparities, as access to choices often depends on patients' financial and informational resources. Neoliberal framing further shifts the patient-provider relationship toward a consumer-service model, challenging the solidarity underpinning publicly funded healthcare systems (Henderson & Petersen, 2002). These changes reflect broader socio-political trends shaped by neoliberal ideologies that emphasise competition over collaboration and individual responsibility over collective welfare.

The evolution from patient-centred to consumer-oriented healthcare illustrates the challenges in balancing autonomy with equity. While patient choice and involvement aim to enhance autonomy and quality, they often conflict with equity-driven goals, posing significant tensions for publicly funded systems like the NHS. Navigating these challenges is critical to preserving the foundational values of universality, equity, and comprehensiveness in modern healthcare (Tritter et al., 2010).

2.6 Conclusion

This literature review has provided a critical and systematic synthesis of criminological, sociological, organisational, and healthcare perspectives on medical deviance, situating it within the broader field of white-collar and occupational crime. The discussion has traced the

development of the concept from its origins in Sutherland's (1940) challenge to class-based assumptions about crime, through refinements by later scholars who distinguished between occupational and corporate crime, to its current use in healthcare discourse. This trajectory highlights the persistent definitional ambiguity surrounding medical deviance, with terms such as *unprofessional behaviour*, *disruptive behaviour*, *negligent adverse events*, and *medical deviance* often used interchangeably, yet emphasising different dimensions of the same phenomenon. Such inconsistency complicates research, policy, and regulation, as the absence of a shared conceptual framework undermines the comparability of findings and the coherence of responses across jurisdictions.

The literature also underscores that medical deviance is not solely the product of individual failings, but is often embedded within, and reinforced by, organisational and systemic contexts. Hierarchical power structures, authority gradients, and entrenched professional norms shape interpersonal dynamics in ways that inhibit open communication, marginalise certain voices, and normalise unsafe practices. In surgical and other high-pressure environments, this dynamic is particularly acute, as the perceived risks of challenging authority may outweigh concerns for patient safety. Theories such as Vaughan's (1996) *normalisation of deviance* and Rasmussen's (1997) *migration to the boundary* provide valuable explanatory frameworks for understanding how small departures from standards, initially tolerated under pressure, can evolve into embedded norms of conduct that increase risk and erode safety cultures over time.

A recurring theme in the literature is the role of *grey areas*—ethical and operational zones in which professional boundaries are blurred by ambiguous guidelines, conflicting priorities, or novel circumstances. These spaces arise in diverse contexts, from technological innovation and pharmaceutical industry practices to the everyday interpretation of professional guidelines. Scholars such as Ayal et al. (2015) and Adams et al. (2016) demonstrate how ethical ambiguity can be exacerbated when formal policies diverge from informal norms, enabling self-serving

rationalisations and inconsistent application of standards. Theories of planned behaviour, moral disengagement, and social cognitive learning help explain how individuals navigate these spaces, but the persistence of deviance in such contexts points to the need for structural and cultural interventions rather than relying solely on individual moral agency.

The literature further reveals that organisational culture is a critical determinant of whether deviant behaviours are sanctioned, tolerated, or normalised. Institutions that prioritise efficiency, profitability, or reputation management over transparency and accountability create environments where misconduct can persist with minimal challenge. These dynamics are shaped not only by internal policies but also by broader political and economic forces. In the UK, the gradual marketisation and partial privatisation of the NHS have altered accountability mechanisms, professional incentives, and patient–provider relationships. The shift from patient-centred to consumer-oriented healthcare, driven by neoliberal reforms, has introduced competitive pressures and business logics into clinical governance, raising important questions about whether marketised systems increase, reduce, or merely reconfigure patterns of medical deviance.

Despite the growing body of research on medical deviance, several significant gaps remain. First, there is limited empirical examination of how individual, organisational, and systemic factors interact in the emergence and management of deviance, particularly in private healthcare contexts where regulatory oversight differs from the NHS. Second, while the literature on *grey areas* offers rich conceptual insights, it seldom examines in detail how these ambiguities are experienced and navigated by practitioners on the ground. Third, the influence of healthcare marketisation on professional behaviour, organisational priorities, and regulatory enforcement has received relatively little sustained attention, especially in relation to the UK private healthcare sector.

This thesis addresses these gaps by investigating how doctors' clinical and behavioural deviance is perceived, managed, and regulated in the UK's private healthcare sector. It will analyse how organisational structures, professional hierarchies, and regulatory frameworks shape the identification, categorisation, and handling of deviance, with particular attention to the interplay between individual conduct, organisational culture, and broader market forces. By building on the theoretical foundations and empirical patterns identified in this review, the study seeks to contribute a nuanced, contextually grounded understanding of medical deviance that integrates both micro-level behaviours and macro-level structural influences.

3 CHAPTER 3 - RESEARCH METHODS AND METHODOLOGY

3.1 Introduction

This chapter outlines the qualitative methodology employed to explore how private hospitals in the UK perceive and respond to clinical and behavioural deviance among doctors. It engages directly with the research questions, focusing on how hospital management recognises, interprets, and addresses behaviours considered deviant, such as unnecessary prescribing or inappropriate conduct, within a professional healthcare context.

The study draws on fieldwork conducted in large private hospital groups operating multiple branches across the UK. Qualitative methods were selected for their strength in capturing context-specific, in-depth perspectives on institutional practices. Unlike quantitative approaches, they allow exploration of the complex dynamics and subjective experiences that shape how deviance is defined and managed. Data were collected through semi-structured interviews with 19 participants—board members, hospital managers, and medical directors—identified via purposive and snowball sampling. These professionals were particularly well-positioned to offer insights due to their direct engagement with patient care, clinical oversight, and internal disciplinary procedures.

Thematic analysis was applied as the primary analytical strategy, guided by grounded theory techniques. While no new theory was generated, the inductive approach enabled the identification of patterns that both aligned with and extended existing theoretical perspectives. In parallel, relevant policy documents—particularly General Medical Council's *Good Medical Practice*—were analysed to highlight gaps between formal regulatory expectations and everyday institutional responses.

Reflexivity was central to the research process. As a younger, non-clinical academic interviewing senior healthcare professionals, I had to reflect critically on how my identity and positionality shaped access, rapport, and interpretation. These reflexive considerations, along with broader ethical issues and access challenges, are discussed in detail later in this chapter.

3.2 Doing Critical Research in Criminology

Unlike mainstream criminology, which traditionally analyses individuals in positions of power by focusing narrowly on their bureaucratic roles and organisational objectives, it often overlooks broader structural influences and systemic harm (Garland, 2001; Tombs & Whyte, 2003). In contrast, critical criminology significantly shifts the interpretation of motives behind crime-related agencies (Sykes, 1974; Rothe & Friedrichs, 2018) and encourages researchers to think critically and look beyond surface appearances (Carrabine et al., 2014). Critical criminology encourages researchers to challenge previously held beliefs and examine institutional and professional discourses from alternative perspectives. Becker (1967) argues that social research should deeply investigate situations to uncover and question the institutional narratives shaping top-down perspectives. Adopting a critical approach allows researchers to better understand why institutions and governments might refuse to acknowledge responsibility for incidents within their control. It also challenges the perception of immunity often associated with respected individuals, who may still violate laws or commit crimes (Helmkamp et al., 1996). While critical criminology lacks a single unified theory, it effectively highlights systemic failures beyond identifying individual offenders within medical institutions. It enables the interrogation of organisational cultures, accountability systems, and power structures that may allow or conceal deviant behaviours (DeKeseredy, 2021; DeKeseredy & Dragiewicz, 2018; Monahan & Quinn, 2006).

Critical criminologists argue for innovative data collection methods due to the secretive nature of crimes committed by powerful entities. DeKeseredy (2021) highlights the scarcity of comprehensive data sets related to crimes of the powerful compared to those for street crimes, which rely on police archives and crime reports. For instance, Lynch and Stretesky (2001) illustrate the effectiveness of using medical evidence to uncover health impacts from environmental pollution exposure in corporate crime contexts when conventional criminal justice data is unavailable (DeKeseredy, 2021). This methodological creativity parallels my own research process, underscoring the necessity of innovative approaches when traditional data sources are inaccessible. In my case, access to formal data on misconduct in private hospitals was extremely limited, requiring a reliance on first-hand accounts through interviews and critical interpretation of professional guidelines.

Investigating medical deviance through a critical criminology lens poses particular challenges due to limited systematic research on medical misconduct. Accessing relevant information is complicated by the medical profession's substantial influence and societal importance, factors which often protect it from scrutiny. Unlike corporate or state crimes that may involve whistleblower data or public scandals, medical deviance often unfolds in confidential or protected settings, making direct observation and traditional documentation especially difficult. Doctors' essential roles in public well-being further discourage thorough investigations into their potential misconduct, complicating efforts to expose unethical practices within the field (Jesilow et al., 1985). These challenges directly shaped the design of this research, reinforcing the need for qualitative inquiry and a critical lens to explore the nuances of deviance in a context where institutional protection is strong and data access is restricted.

3.3 Research Questions and Methods

This study was conducted in a way that prioritised flexibility, allowing for changes to be made based on the data collected (Robson & McCartan, 2016). The approach taken was data-driven, meaning that the research questions and methods were shaped and refined as the study progressed. Additionally, the study maintained a reflexive stance: I remained aware of my own assumptions and biases throughout and took deliberate steps to minimise their influence on the findings (Corbin & Strauss, 2014). Thorough planning was necessary to ensure the feasibility of the study and avoid spending time and resources on avenues of inquiry that were not aligned with the central research questions. Strategic research design was crucial for ensuring compatibility between the topic, methods, and questions. Selecting an appropriate research method is vital to obtaining valid and reliable findings; therefore, research questions must be carefully considered in this decision-making process (Braun & Clarke, 2013; Flick, 2018).

The success or failure of a qualitative study often depends on the formulation of its research question, which significantly shapes the study's overall design. As Flick et al. (2004) point out, well-formulated questions should be clear and unambiguous, ideally developed early in the research process. However, it is normal for research questions to evolve over time, becoming more focused and specific as the researcher gains a deeper understanding of the topic (Flick, 2018). As Bryman (2016) notes, even experienced researchers regularly refine their questions based on continued reading, fieldwork, and reflection.

While the overall focus of the research problem was clear from the outset, they were not defined in detail until the initial phases of data collection had begun (Flick, 2018). As the fieldwork progressed, the research questions were refined and elaborated further in response to insights from the data. Consequently, the final version of the research aimed to explore the following questions:

1. *How do private hospitals in the UK perceive doctors' clinical and behavioural deviant actions?*
2. *How do private hospitals address the clinical and behavioural deviant actions of doctors?*

Semi-structured interviews were chosen to explore these questions. Interviews with hospital board members, hospital directors, and medical directors provided essential insight into how these authorities perceive deviant actions within their organisations and how they respond to them.

This study relies on fieldwork involving both face-to-face and online semi-structured interviews with professionals in the private healthcare sector. Semi-structured interviews allow participants to express their experiences and perspectives on topics the researcher may not have anticipated, making flexibility essential (Rubin & Rubin, 2012). This adaptability proved effective in uncovering how professionals perceive deviance and the strategies they use to address it. To design the interview questions, I consulted GMC guidelines and internal hospital policies to identify potential gaps and limitations in the existing frameworks. I also drew upon media scandals, court cases, and the content of platforms like "What Do They Know," a UK-based website that publishes Freedom of Information (FOI) requests and responses submitted to public authorities (WhatDoTheyKnow, n.d.), to understand which issues gain public visibility. This process provided insight into how thresholds for acceptable behaviour have shifted within the healthcare sector.

The following section will provide a justification for the sample and describe the data collection process. Table 1 presents a comprehensive breakdown of the interviewees' areas of expertise.

3.4 Methods of Data Collection

In-depth qualitative interviewing is a naturalistic research method where researchers engage with individuals who have knowledge or experience related to the topic of interest. By conducting these interviews, researchers can gain detailed insights into the experiences, motivations, and opinions of others beyond their own perspectives (Rubin & Rubin, 2012). In qualitative research, it is common practice to seek out individuals with substantial experience and expertise in the field. These individuals—often those with long professional histories or active engagement in the topic—are considered key informants, individuals selected for their specialised knowledge relevant to the study, who can offer deep and nuanced understandings (Flick, 2018; Cunliffe & Alcadipani, 2016; Mikecz, 2012).

Given this context, selecting a sample with direct experience of the issues under investigation was necessary. I adopted purposive sampling, a non-probability technique used to select participants based on their relevance to the research topic (Kumar, 2019), to identify individuals in the private healthcare sector with the capacity to provide in-depth, relevant knowledge. I conducted nineteen semi-structured interviews with professionals in the sector between December 2022 and May 2023 (see Table 1, page 75). Although I initially identified around 90 potential participants on LinkedIn during the early planning stages, this figure reflected the scope of outreach rather than a formal interview target. My original goal was to conduct between 20 and 25 interviews based on what is typically sufficient for achieving thematic saturation in qualitative research. However, given the access barriers associated with reaching senior professionals in private healthcare, including non-responsiveness and institutional constraints, the final sample was revised to 19 interviews. Despite the lower number, the interviews conducted provided rich and meaningful data for the purposes of this study. The final sample included purposively selected participants, and three individuals

recruited through snowball sampling, where existing participants refer others who may be eligible or willing to participate.

I began by identifying a research area based on two criteria: 1) a high concentration of private hospitals, and 2) accessibility within a two-hour train journey from Colchester to facilitate face-to-face interviews. As a result, Greater London and Essex were selected as the initial field sites. Using Google Maps, I compiled a list of hospitals in these areas and visited their websites to gather the names of board members and administrators. However, most websites did not provide contact details. This situation led me to LinkedIn.

LinkedIn, a professional networking platform, has been increasingly used in research to recruit hard-to-reach participants (Andrews, 2012; King et al., 2014; Yuan et al., 2014). Several studies also highlight how healthcare professionals use social media for recruitment and engagement (Brooks et al., 2019; Malyavko et al., 2021). Given my sample's seniority and institutional authority, LinkedIn seemed to be a promising tool for individuals in senior or leadership positions.

Most of the identified individuals had LinkedIn profiles and followed their hospitals' pages. While LinkedIn Premium allowed me to send direct messages, the limit of 15 messages per month quickly proved insufficient. I then sent personalised connection requests explaining my research. Despite this effort, only one person agreed to participate, while two explicitly declined, citing concerns about breaching employment contracts. This is consistent with Stokes et al. (2019), who found LinkedIn less effective than Facebook for recruiting healthcare professionals. Not being able to find the number of participants I wanted prompted me to reconsider my recruitment methods and explore more direct communication channels.

After these setbacks with LinkedIn recruitment, I shifted my strategy to email outreach. I found a publicly available spreadsheet, the "Register of Accountable Officers 2022," from the Care Quality Commission. This document included individuals' names and email addresses at public and private hospitals. When emails were not directly available, I used known institutional email formats to construct addresses (James, 2006). I also used Rocket Reach, a tool for identifying email formats. Ultimately, I expanded the research area to include all of England, which allowed me to broaden the participant pool. As a result, I began conducting interviews online in addition to the originally planned face-to-face format.

I revisited LinkedIn to search large hospital group pages and filter staff using keywords like Medical Director, Hospital Director, CEO, and board member. While LinkedIn use is not strongly associated with age or gender, it is more common among highly educated, higher-income individuals (Blank & Lutz, 2017), which matched my participant pool. Similar patterns were also observed in Stokes et al.'s (2019) study.

In total, I compiled a list of 600 potential participants and sent approximately 1,700 emails. Most participants were recruited purposively and contacted through email. The recruitment email included a project overview and information sheet (see Appendix A, p. 247). However, email firewalls and enterprise spam filters, which block unfamiliar bulk messages at the organisational server level, posed significant barriers. For example, 110 emails were flagged as spam, and 20 were returned undelivered. I attempted to resolve this by contacting IT staff via LinkedIn, but with little success.

In addition, 50 of the email addresses proved invalid, leading to delivery failures. In these instances, I used LinkedIn as a supplementary outreach tool. I attempted to contact three times per potential participant, alternating between email and LinkedIn. If there was no response or explicit refusal, I did not pursue further communication. Given the senior roles of the

participants—board members and senior administrators—recruitment was particularly challenging, resulting in a relatively small final sample. This reflects observations by Cochrane (1998) and Monahan and Fisher (2015), who note that individuals in senior or influential roles are often more reluctant to participate in research.

While most participants were recruited purposively, three were recruited through snowball sampling, where existing participants refer others who may be eligible or willing to take part. One board member and two hospital managers shared my study with their subordinates, who agreed to participate. However, two of these three interviews yielded limited insight, possibly due to participants' perceived obligation to participate. I conducted 12 online and seven face-to-face interviews. Participants included five board members, four hospital directors, three medical directors, two directors of clinical services, one president of quality, and one head of clinical training. All face-to-face interviews (except one) were held in hospitals or head offices in London. While in-person interviews are traditionally viewed as the gold standard for qualitative interviewing (Novick, 2008), online interviews allowed me to expand geographically and overcome travel limitations (Salmons, 2009).

Interviewee Number	Position in Hospital	Date, Type of Interview, Duration
1.1	Hospital Director	20 December 2022, Face to Face, one hour (Recorded)
1.2	Hospital Director	14 February 2023, Online, 1 hour 06 minutes (Recorded)
1.3	Director of Clinical Services	22 February 2023, Online, 24 minutes (Recorded)
1.4	Hospital Director	2 March 2023, Online, 40 minutes (Recorded)
2.1	Board Member of the Hospital	22 December 2022, Online, 20 minutes (Not Recorded)
2.2	Director of Clinical Services	6 January 2023, Online, 41 minutes (Recorded)
2.3	Group Medical Director	26 January 2023, Face to Face, 50 minutes (Recorded)
3.1	Divisional Vice President of Quality	10 January 2023, Online, 35 minutes (Recorded)
3.2	Board Member of the Hospital	12 January 2023, Face to Face, one hour 10 minutes (Not Recorded)
3.3	Board Member of the Hospital	12 January 2023, Face to Face, one hour (Not Recorded)
3.4	Chief Operating Officer	10 February 2023, Face to Face, 56 minutes (Not Recorded)
3.5	Head of Education and Clinical	27 February 2023, Face to Face, 54

	Training	minutes (Recorded)
3.6	Medical Director	1 March 2023, Online, 20 minutes (Not Recorded)
4.1	Hospital Director	8 February,2023, Online, 36 minutes (Recorded)
5.1	Board Member of the Hospital	16 February 2023, Online, 40 minutes (Recorded)
6.1	Board Member of the Hospital	6 March 2023, Online, 38 minutes (Not Recorded)
7.1	Medical Director	14 March 2023, Online, 50 minutes (Recorded)
8.1	Hospital Director	31 March 2023, Online, 33 minutes (Recorded)
8.2	Executive Medical Director	11 May 2023, Online, 35 minutes (Not Recorded)

Table 1: Detailed Participant and Interview Table

3.5 Methods of Data Analysis

Given the exploratory nature of this research, there was considerable overlap between data collection and analysis. After completing interviews with hospital board members, hospital directors, and medical directors, I began analysing the data using NVivo software. Thematic analysis was employed to identify key patterns, categories, and themes relevant to the research questions. All data were anonymised at the transcription stage so that the analysis was conducted on anonymised material to ensure confidentiality.

Thematic analysis is a qualitative method that identifies and interprets meaningful patterns within a dataset (Boyatzis, 1998; Braun & Clarke, 2006). It is especially suited to exploratory

research and can accommodate both inductive and deductive approaches. Although there are different iterations of thematic analysis (Fereday & Muir-Cochrane, 2006), most stem from a shared foundation that distinguishes between these two main variants.

Data can take many forms in qualitative studies, including interview transcripts, field notes, policy documents, photographs, and videos (Joffe & Yardley, 2004; Guest et al., 2011). This research used thematic analysis to explore interview data, providing insight into how participants understood and responded to clinical and behavioural deviance among doctors in private hospitals. Braun and Clarke (2006) suggest that thematic analysis is particularly valuable for early-career researchers, offering accessible, transferable skills applicable across multiple qualitative analysis forms. Unlike theory-driven methods such as Conversation Analysis or Interpretive Phenomenological Analysis, thematic analysis can be applied independently of any specific epistemological framework. Its flexibility—allowing inductive, deductive, or combined approaches—makes it well-suited to exploratory work. Themes were derived inductively from the data. My own perspective as a researcher influenced the interpretation process, which is in line with reflexive thematic analysis. As themes emerged, I looked for divergences and commonalities across responses, enabling deeper analytical reflection (Nelken, 2000).

NVivo software served as an organisational tool, helping to structure and visualise codes and themes. I manually developed codes by reviewing the interview transcripts line by line, then applied those codes within NVivo for systematic organisation and retrieval. While NVivo helped manage the data, I carried out all coding decisions and theme development without relying on any automated coding functions. Silver and Lewins (2014) note that Computer-Assisted Qualitative Data Analysis Software (CAQDAS) tools like NVivo offer well-organised digital filing systems, aiding the secure handling of large datasets. However, such tools do not

interpret or generate meaning themselves and cannot replace the analyst's role in drawing thematic insights.

While some interviews were audio-recorded and subsequently transcribed, others were documented through detailed note-taking due to various contextual considerations. I transcribed the interview with the support of AssemblyAI, an automatic speech recognition platform that converts audio recordings into text. The use of this tool significantly reduced the time required to produce accurate transcripts. After generating the initial transcripts, I conducted a second round of quality checks by listening to the recordings while reading the transcripts. During this process, I corrected errors due to mishearing, background noise, or software inaccuracies to ensure fidelity to participants' intended meaning.

3.6 Ethics And Limitations of The Research

This study underwent a comprehensive ethical evaluation and received approval from the Faculty of Social Sciences Ethics Sub-Committee at the University of Essex. Following this, participant recruitment was initiated via LinkedIn and email.

The use of email and LinkedIn aligns with current research trends in leveraging digital platforms for professional outreach. As noted by Stokes et al. (2019) and Jones et al. (2020), LinkedIn is a widely accepted tool for recruitment, offering efficient access to targeted professional populations through its advanced search filters, large user base, and ability to connect with individuals in specific occupational roles rapidly. However, it also raises concerns about privacy and perceived intrusiveness when researchers initiate unsolicited contact. Caers and Castelyns (2010) caution that while LinkedIn functions in a professional domain, its use may still result in discomfort or bias, particularly if users do not explicitly consent to be contacted. In response, I ensured all outreach messages clearly explained the purpose of the

research, the voluntary nature of participation, and the inclusion of a comprehensive information sheet (Appendix A, page 253).

Once participants expressed interest, they were sent a consent form (Appendix B, p.250) along with further study details. The consent form explained the aims of the research, requested permission to audio-record the interview, and stated that participants could decline to answer any question or withdraw at any time. While most signed the consent form, six participants gave oral consent. Additionally, seven participants declined audio recording; in these cases, I took detailed notes during the interviews. Once the interviews were completed, I began the process of transcription and anonymisation.

To facilitate accurate and ethical data handling, I personally transcribed all recorded interviews using Assembly AI and then verified the transcripts manually. Anonymisation took place during the transcription stage, which is in line with ethical research standards recommended by the British Sociological Association (BSA, 2017). Names and identifying details were removed to ensure confidentiality, and pseudonym codes such as “1.1” or “2.2” were used. In this format, the first digit refers to the hospital group. The second digit indicates the order in which the participant was interviewed within that group. This system allowed for contextual reference without compromising confidentiality. All data were stored securely on a password-protected personal device and shared only with my supervisory team, in accordance with data protection principles outlined by the Information Commissioner’s Office (ICO, 2021).

Despite the depth and richness of the interviews, the sample size of 19 must be interpreted with caution. The participants represent a small fraction of the 600 individuals contacted. Access was limited to individuals with publicly available profiles, and several others declined or withdrew due to the need for managerial approval, highlighting institutional barriers to participation. This reluctance may be understood through the lens of organisational loyalty and

risk aversion. Umphress and Bingham (2011) and Caprar et al. (2022) explain that when employees strongly identify with their organisations, they may prioritise institutional loyalty over transparency. This can sometimes lead to unethical pro-organisational behaviour. Chen et al. (2016) describe this tension as a conflict between defending the organisation and adhering to broader societal values. Such dynamics—particularly the tension between organisational loyalty, fear of managerial scrutiny, and concern for job security—likely influenced both participant willingness and the candour of interview responses.

Moreover, in qualitative research, social desirability bias (SD bias) can heavily impact the authenticity of participant responses, leading them to present themselves or their behaviours in a socially acceptable light, often distorting the true nature of their attitudes or actions. This bias tends to emerge when participants respond to sensitive topics in ways that they perceive to be morally or culturally favourable, rather than offering genuine insights (Bergen & Labonté, 2019). In studies of ethical decision-making or behaviours that may be socially stigmatised, such as issues surrounding deviance or moral judgments, participants may underreport undesirable actions or exaggerate their alignment with social norms, thus leading to distorted conclusions (Chung & Monroe, 2003). The impact of SD bias is particularly problematic when self-reported data is central to the research, as it undermines the validity of the findings. For example, in the study by Chung and Monroe (2003), higher SD bias was found in ethical dilemmas, where participants were more likely to present an idealised version of their actions and attitudes, rather than reflecting their true behaviours.

The effect of SD bias is particularly pronounced in areas where there are culturally accepted standards or sensitive issues. This bias can also impact the interpretation of research findings, leading to overestimates of ethical behaviour or underestimates of unethical actions. Consequently, researchers must be mindful of these biases when designing studies and

interpreting results, and strategies such as ensuring privacy, establishing rapport, and utilising indirect questioning techniques can help mitigate the effects of SD bias (Bergen & Labonté, 2019). Awareness of SD bias, while difficult to eliminate, is crucial for improving the accuracy and integrity of qualitative research.

While valuable, the perceptions captured in my research may be subjective and influenced by personal biases, particularly social desirability bias. Participants, including patients, healthcare professionals, and administrators, might provide responses that align with socially accepted views or professional expectations, rather than reflecting their true thoughts on medical deviance. For instance, healthcare professionals may downplay deviant behaviours to maintain their professional image. This bias could result in overestimating the level of satisfaction with how medical deviance is managed or underreporting the extent of deviant behaviour within the sector.

However, acknowledging this limitation is crucial because it allows for a more nuanced interpretation of the findings. While the data may not always reflect entirely objective or unfiltered opinions, it still provides valuable insights into how medical deviance is perceived within the context of private healthcare. These perceptions are significant because they shape the responses of healthcare institutions, regulators, and policymakers, ultimately influencing the practices and policies that govern the sector. Ultimately, these perceptions, despite being subjective, are critical for understanding the complex dynamics of medical deviance, the role of healthcare professionals, and the expectations of the public. They provide a starting point for further exploration into the extent to which these perceptions align with actual practices and how they shape policy reform and accountability in the private healthcare sector.

3.7 The Role of Reflexivity in Shaping the Research Narrative

Reflexivity is a critical aspect of qualitative research. It allows researchers to consciously reflect on their positionality—that is, their social and professional identity and how it shapes their interactions, assumptions, and interpretations. It also involves examining their biases and their potential influence on the research process (Berger, 2015). In this study, reflexivity played a vital role in addressing two significant challenges: (1) reaching and interviewing elite participants and (2) navigating the dynamics of power in the field. By critically engaging with these challenges, I was able to mitigate their impact and ensure the validity and rigour of my research.

Elites, defined as individuals in positions of power or authority (Hornby et al., 1983), often present unique challenges in terms of access and engagement due to their protective barriers and high levels of control over their time. In criminological literature, the term "the powerful" is often used to describe elites or experts, a concept also explored in other social sciences. However, within criminology, various groups may be seen as powerful, including policymakers, scientists, criminal justice professionals, social movements, white-collar criminals, and occupational deviants. Essentially, this term refers to individuals involved in harm, crime, and crime control. From a professional or institutional standpoint, this could encompass white-collar criminals, those responsible for actions or omissions that lead to environmental damage, financial and economic crimes, human rights violations, social justice breaches, abuse of power, unethical conduct, and biases, among other issues (Petintseva et al., 2020). The process of accessing elite participants posed several obstacles, particularly given my position as an early-career researcher outside the healthcare sector. My lack of a direct connection to the healthcare sector amplified these challenges. Unlike researchers with

established networks or institutional support, I had to rely on creative recruitment strategies to establish contact with participants.

As a young researcher in her mid-twenties, I was keenly aware of the potential age-related biases and perceptions of inexperience I might face when reaching out to senior healthcare professionals in their forties and fifties. I adopted a highly professional demeanour in all my communications to overcome this. I paid close attention to the tone of my emails, ensuring they conveyed both my respect for the participants' expertise and the importance of their contribution to my research. I presented myself formally for face-to-face interviews, dressing in business attire and applying light makeup to convey professionalism. These efforts were intended to counteract any assumptions of inexperience or lack of credibility based on my appearance.

The recruitment process also demanded persistence and adaptability. With limited success through LinkedIn and direct emails due to professional barriers such as enterprise-level spam filters, I had to refine my approach continuously. For instance, guessing email addresses using the hospital-specific email formats I identified in the Care Quality Commission's publicly available Accountable Officer Excel list was a time-intensive but effective strategy. While this approach demonstrated ingenuity, it also required me to confront the ethical dilemmas of persistence in contacting potential participants. I had to remain mindful of not overstepping professional boundaries while maintaining the determination to achieve my recruitment goals.

Interviewing elites presented a unique set of power dynamics that required careful negotiation. While Brinkmann and Kvale (2005) argue that the interviewer holds a certain degree of control over the interview process, this balance shifts significantly when interviewing individuals in positions of authority. In my interactions, the participants' status as decision-makers and leaders within their organisations created an inherent power imbalance. This imbalance was

particularly pronounced given my position as a junior researcher with limited professional standing in their field.

To navigate these dynamics, I made a conscious effort to prepare thoroughly for each interview. This included researching the participants' professional backgrounds, hospital roles, and their organisation's public-facing policies. By demonstrating a strong understanding of the context and the specific challenges faced by private hospitals, I aimed to establish credibility and reduce the power gap. Furthermore, I adopted an empathetic and respectful approach during interviews, creating a conversational environment that encouraged openness and trust.

One of the challenges I encountered was the tendency of some participants to present institutional or organisational viewpoints rather than personal perspectives. As Harvey (2010) notes, elites often feel a responsibility to represent their organisations and may hesitate to share personal opinions that could be perceived as critical or controversial. In such cases, I employed follow-up questions to gently probe for more personal insights, framing them in a way that allowed participants to share their views without feeling exposed or vulnerable.

My identity as a non-native speaker conducting research in a predominantly English-speaking professional setting also influenced the research process. Being an international researcher placed me in a disadvantaged position, as my speech patterns and accent may have led some participants to question my level of professionalism. I was particularly conscious of this when interviewing elites who were highly articulate and accustomed to formal communication. To address this, I consciously slowed my speech and focused on clear pronunciation during interviews. While this approach improved clarity, it also served to project confidence and professionalism.

Additionally, my outsider status—as someone external to the healthcare field and as an international researcher—introduced challenges and opportunities. As an international researcher, I was sometimes perceived as unfamiliar with local professional norms, which may have influenced how participants engaged with me. However, this status also allowed me to approach the topic with fewer assumptions, encouraging a more open and exploratory healthcare sector analysis. While this lack of insider knowledge initially created barriers to understanding the nuanced dynamics of the healthcare sector, it also allowed me to approach the topic with fresh eyes, unencumbered by preconceptions that might influence an insider's analysis. Throughout the research process, I remained mindful of this dual positionality and actively sought to balance my outsider perspective with insights gained from participants.

The reflexive process extended beyond data collection to the analysis phase, where I critically examined my assumptions and potential biases. For example, during thematic analysis, I was cautious not to overinterpret the data to fit preconceived notions about deviance in healthcare. Regularly revisiting the raw data and seeking feedback from my supervisory board ensured that my interpretations remained grounded in the participants' responses.

Additionally, I maintained a reflexive journal—a log of reflections, decisions, and researcher thoughts maintained throughout the study—documenting my thoughts, observations, and decisions. This journal helped me identify patterns in my own behaviour. For example, I noticed a tendency to steer interviews toward certain topics or to favour particular types of responses. By engaging in ongoing self-reflection, I was able to maintain a critical awareness of how my positionality and actions influenced the research outcomes.

Despite the challenges, the reflexive approach allowed me to navigate complex dynamics and achieve meaningful engagement with participants. The insights gained from elite interviews provided valuable perspectives on the perceptions and management of deviance in private

hospitals, even if the sample size was smaller than anticipated. However, I acknowledge that my positionality may have influenced the willingness of participants to engage fully or the depth of their responses. For example, the age and professional status differences between the participants and me may have led some to adopt a more guarded or formal tone during interviews.

Looking back, I recognise the importance of reflexivity not only as a methodological tool but also as a personal practice that fosters growth and adaptability as a researcher. By acknowledging and addressing the challenges inherent in this study, I was able to produce findings that are both rigorous and reflective of the complex realities of healthcare management.

3.8 Conclusion

This chapter has outlined the qualitative methodological framework and research process employed to investigate how clinical and behavioural deviance among doctors is perceived and addressed within the UK's private hospital sector. It reaffirmed the relevance of adopting a critical criminological perspective, particularly in examining the organisational and cultural conditions that shape institutional responses to deviance.

The chapter detailed how purposive and snowball sampling, coupled with innovative digital recruitment strategies, enabled access to 19 senior healthcare professionals despite notable barriers to entry. Reflexivity remained a central pillar throughout the research, particularly in navigating power asymmetries during elite interviews and accounting for the researcher's positionality.

Thematic analysis, guided by grounded theory techniques and supported by NVivo and AssemblyAI, provided a flexible yet systematic framework for coding and interpretation.

While the study faced limitations, such as a small sample size and institutional access restrictions, the findings offer rare empirical insight into an underexamined area of criminological inquiry.

By juxtaposing organisational practice with formal policy documents such as the GMC's Good Medical Practice, the study highlighted key disjunctures between normative expectations and real-world enforcement of standards. The chapter underscores the ethical and analytical rigour underpinning the research process and lays the foundation for the chapters that follow, which will explore these findings in greater conceptual and thematic depth.

4 CHAPTER 4 - OPERATIONAL PRIORITIES IN HEALTHCARE

4.1 Introduction

This chapter examines how operational priorities and managerial expectations shape doctors' behaviours, roles, and relationships within UK private healthcare. It explores how factors such as professional conduct, financial performance, and training frameworks influence hospital culture and define interactions between doctors and management.

A central concern is the tension between profitability and the regulation of deviance. Guided by the research questions—how private healthcare perceives and addresses doctors' deviant behaviours—the chapter analyses how hospital policies, professional hierarchies, and governance mechanisms shape institutional responses.

It also considers the impact of external pressures, including recruitment challenges, NHS competition, and reputational concerns, on decision-making. In doing so, the chapter offers insight into how private healthcare balances commercial interests with professional standards and patient safety in regulating medical conduct.

4.2 Doctors' Training

During the interviews with participants, a unanimous agreement emerged regarding the professional capabilities training and ethical and clinical training required for doctors. All participants concurred that doctors should have completed comprehensive training[3] during

[3] The journey to becoming a doctor typically commences by enrolling directly into medical school following secondary school or college, with the standard medical degree lasting five years. Alternatively, an alternative path involving a foundation year is available for individuals lacking a sufficient science background or facing disadvantaged circumstances. Moreover, accelerated graduate degree programs, lasting four years (plus an additional year if intercalated), offer another avenue for aspiring doctors.

After completing medical school, individuals undergo a two-year foundation program aimed at acquiring practical work experience and training. During this period, participants can explore various medical specialities before making a definitive choice for specialisation in the second year. Specialising in general practice (G.P.) typically requires three years of training, while other specialities demand a duration of five to eight years post-medical school, with paediatrics normally necessitating an additional ten years of training (NHS, 2024a). Furthermore, the General Medical Council (GMC) plays a pivotal role in approving curricula and assessments for the

their medical school education and under the National Health Service (NHS). Before proceeding with the analysis and clarifying the participants' responses, briefly providing information on doctors' training in the UK is useful.

According to the UK Foundation Programme Curriculum (2021), the training curriculum can be categorised under two primary headings: Clinical Skills and Professional Capabilities. Clinical skills predominantly concentrate on the doctor's clinical proficiency, while professional capabilities encompass the doctor's skills and behaviours that either do not directly pertain to the clinical field or have indirect relevance. In this study, I use the term ethical training to refer broadly to education or guidance related to ethical issues in medical practice. Although the term is not formally defined in this context, it encompasses responsibilities typically included under the umbrella of professional capabilities, such as communication with patients and colleagues, continuous professional development, and adherence to professional values. I chose to use ethical training rather than professional capabilities to emphasise the ethical dimension more directly, particularly in areas where doctors' behavioural deviations may arise. Training in these aspects is therefore understood to have a direct influence on doctors' conduct. Participants were queried about training within this context. According to their shared answer, doctors employed in private hospitals are expected to complete their 5- to 8-year professional training before their employment in the private hospital. In addition to formal education and training, participants stated that the hospitals where participants work provide further training to enhance doctors' professional competence. While participants agreed that hospitals offer doctors clinical, behavioural, and economic training, their understanding of the specific training formats provided by hospitals varied, resulting in divergent responses.

Foundation Programme, as well as overseeing 65 specialities and 31 sub-specialities designed by royal colleges and faculties (GMC, 2024d).

A significant number of participants (12 out of 19) view the dissemination of hospital policies through email and follow-up reminders as an educational intervention. Hospital Directors (1.1, 4.1) acknowledged that the extensive policy documents outlining expectations related to behavioural, professional, and legal standards play a crucial role in informing doctors. These documents cover essential topics such as probity, patient engagement, and diversity. One Medical Director (1.2) explained how these policies also serve as a form of ethical education, particularly for doctors who may not have received comprehensive training on ethical matters during their time in the NHS. Moreover, doctors transitioning to private hospitals receive specific training on pricing, a practice not typically provided by the NHS. The Director of Clinical Services (2.2) underscored the importance of this pricing policy training, noting that the hospital only covers training related to pricing, further distinguishing it from NHS practices.

Participants also cited online training as a prevalent method, often preferred after hospital documents are delivered via email or printed. The Hospital Director's (1.4) statement corroborated this sentiment: "It [training] comes in several different forms…but it is not, for the most part, face-to-face. It is generally done online..." (Hospital Director, 1.4).

Participants emphasised that such training is not tailored to individual hospitals but is part of the broader mandatory annual appraisal[4] requirements for doctors. This training predominantly addresses risk management areas such as fire safety and fall prevention, reflecting standard organisational training practices. It does not encompass essential clinical skills or profession-specific development for both clinical and non-clinical staff, as observed by the NHS (2022), which private hospital directors assume is completed during the doctors' prior medical training. Nevertheless, participants indicated that even certain private institutions that offer online

[4] A medical appraisal is an annual meeting between a doctor and a colleague trained as an appraiser. This process involves facilitated self-reflection, supported by information gathered across the full scope of the doctor's work. The evidence collected is crucial in demonstrating the doctor's fitness to practice in line with GMC standards, regardless of their area of specialisation (BMA,2024).

training in the medical field, like Medex[5], provide mandatory training and might incorporate modules or courses on professional ethics, which doctors can undertake if they wish. While these platforms support compliance and upskilling, their effectiveness in addressing complex issues like clinical or behavioural deviance remains limited.

Although participants referred to mandatory training, this type of training typically focuses on general compliance or procedural requirements and does not align with the professional capabilities central to this research. I include this point here to highlight a gap between what is currently provided and the kind of training that might more directly address deviance among doctors.

While most participants discussed the dissemination of hospital policies via email and the availability of compulsory online training, one hospital group diverged from this general trend by offering face-to-face training sessions. Head of education and clinical training (3.5), who is the sole head of education and clinical training within the sample and is employed by Hospital Group 3. These hospital groups refer to private healthcare companies that operate multiple hospitals under a single organisational structure; participants may have worked in different hospitals but within the same corporate group. Emphasised that training in the healthcare sector does not adhere to a singular fixed approach. As a clinician, she underscored the necessity of staying updated on new techniques and knowledge.

> An organisation will always have different types of training because training is not just formal courses... We have Julia candle training robots. We have people coming with

[5] These online training platforms, like Medex, specialise in training within the health and social care sector. Their e-learning platform offers a wide range of training, from skills for care-endorsed courses, including the Care Certificate, manual handling training, and various clinical courses. These online platforms are designed to reduce training time, track seminar sessions, provide personalised support, and ensure compatibility with all modern devices. The courses offer 24/7 access, comprehensive training reports, consistent quality across organisations, and compliance with Care Quality Commission standards (CQC) (see Regulatory Bodies and Political Reforms, page 19).
Platforms such as Medex offer a wide range of online training options, including mandatory and specialist courses, which illustrate the growing reliance on flexible, third-party providers to deliver professional development in the healthcare sector (Medex Group, 2025).

> actors, and they have a go. They are meant to tell people bad news, and they have to disclose something that went wrong. (Head of Education and Clinical Training, 3.5)

This example underscores the diversity of training approaches used within private hospitals, particularly those that blend technical skill development with experiential learning aimed at improving communication, accountability, and the handling of adverse events.

4.3 Hierarchy and Power Dynamics in Hospitals

This section critically examines how rigid hierarchical structures within hospitals can undermine teamwork and open communication, highlighting how private healthcare institutions attempt to mitigate these risks by encouraging staff to speak up (see Riley & Manias, 2005; Gillespie et al., 2008; Higgins & MacIntosh, 2010; Schwappach & Richard, 2018)**.** Healthcare organisations commonly adopt a hierarchical management structure characterised by a top-down chain of command from the top to the bottom (Essex et al., 2023). Consequently, participants strived to manage and regulate hierarchical relationships and mitigate excessive hierarchy within hospitals to minimise the potential damage caused by strict hierarchy. In this regard, participants unanimously underscored the importance of speaking up, which helps empower employees in a lower position than doctors to share problems they witnessed or experienced.

Participants provided concrete examples of how the speaking-up strategy was applied in practice. Participants from different positions (1.1 Hospital Director and Medical Director 2.3) mentioned consistently encouraging staff to voice any concerns or safety issues concerns encountered. Speak-up policies allow individuals to report any troubling incidents to a designated speak-up champion anonymously. A Board Member (3.3) emphasised the importance of fostering an environment where everyone feels empowered to speak up. He recounted an incident where a porter noticed something amiss during surgery, prompting the participant to halt the procedure and conduct a thorough check, ultimately preventing a

potentially disastrous error related to incorrect patient information. Additionally, he referenced the Paterson Inquiry (see Section the Impact of the Harold Shipman and Ian Paterson Cases on the UK Healthcare System, p. 20) as a compelling example of how unchecked hierarchies can adversely affect an organisation, highlighting how a doctor's prolonged harmful actions went unchallenged due to the failure of hospital staff to speak up.

Participants discussed how entrenched hierarchical patterns within the medical profession have contributed to a culture in which problematic behaviours are normalised or go unchallenged. Several interviewees (6) noted the difficulty of managing these dynamics, especially when they are rooted in long-standing professional traditions and status hierarchies. A Hospital Director (1.2) mentioned the ongoing challenge of addressing poor behaviours that have been historically accepted within the healthcare system. Group Medical Director (2.3) noted that the historical acceptance of deviant behaviour in the medical field had emboldened doctors, who may believe they can evade consequences due to their professional status. This was echoed by the Hospital Director (1.2), who described how some doctors act with a sense of entitlement akin to being gods. Similarly, the Medical Director (3.1) confirmed the prevalence of arrogance among doctors, attributing it to their leadership roles in their respective fields. While she did not necessarily view arrogance as inherently harmful, she acknowledged that it could affect workplace relationships within the healthcare setting.

Despite variations in individual experiences and observations, participants unanimously agreed that hierarchical structures persist in medical culture and continue to influence workplace dynamics. One Hospital Director (1.2) stressed that professional rank strongly shaped relationships among staff, especially highlighting the power imbalances between surgeons, consultants, and nurses. She attributed these dynamics to traditional medical training methods, which often rely on authority-based instruction (see Hepple,2001; Logghe et al., 2018). She recounted examples of junior doctors being subjected to autocratic and fear-inducing behaviour

by senior doctors. In one case, a senior doctor threatened a junior colleague's future career—behaviour that ultimately resulted in the senior doctor's dismissal for inappropriate conduct, including the mistreatment of female doctors (see Jenkis,2020).

While hierarchies exist even among doctors, the disparity is more pronounced between doctors and nurses, prompting a discussion about gender dynamics within the hierarchical structure of the medical field. A Hospital Director (1.2) reflected on the ways entrenched hierarchical structures within medical culture intersect with gender, noting, "...it is pretty interesting to see the gender split around accepting some of that behaviour…." Her account, along with those of other female participants, challenges the idea that medical hierarchies can be understood purely in terms of professional rank. For instance, nursing has historically been a female-dominated profession (Oakhill et al., 2005; Clow et al., 2014), and this gendered history complicates any interpretation of the doctor-nurse hierarchy as solely positional. Viewing these dynamics only through job title risks obscuring how gender shapes staff relationships and workplace interactions. Four female participants who had begun their careers in nursing echoed these perspectives, suggesting that gender remains a key axis in understanding hierarchical relations in clinical settings. Several participants (10)—particularly female interviewees—reflected on the persistence of sexist structures in medicine, noting that although these dynamics are less overt than in the past, they remain visible in subtle but impactful ways. This ongoing presence of historical gender hierarchies was particularly evident in one hospital director's account.

> … It is always men who have either reported me or done something that I think is behind my back or maligned me or bullied me… I think male doctors, historically, nurses [were]their handmaidens; we would do everything they said, and I think some of them still think that is the case. For me, I am a hospital director, I am a nurse, I am his boss… (Hospital Director, 8.1).

The case reported by Gallagher and Roberts[6] (2023) illustrates how fear and rigid hierarchies established during medical training can create environments in which sexual harassment is tolerated or goes unchallenged. Members of Parliament are set to investigate allegations that female surgeons within the NHS have been subjected to sexual harassment and assault, including incidents reported to have occurred during surgeries. A significant study revealed that female trainees have been subjected to abuse by senior male colleagues, raising concerns about workplace safety and accountability in the NHS.

Steve Brine, chair of the Health and Social Care Committee, described the revelations as shocking, emphasising that the NHS must ensure hospitals are safe environments for all staff and hold those accountable. The committee plans to address these issues as part of its future work on NHS leadership. The incidents include women being groped beneath their scrubs, having male surgeons rub against them, and experiencing inappropriate propositions or assaults. Some women reported being offered career advancements in exchange for sexual favours, and others have been raped. Such behaviours were condemned as "*atrocious*" by the British Medical Association, while the Royal College of Surgeons of England acknowledged the widespread nature of the issue, calling it a "*source of great embarrassment*" for the profession. Retired surgeon Dr Liz O'Riordan shared her experiences of harassment during her career, stating that many trainees feel unable to report incidents due to fears of career repercussions (Harwood-Baynes,2023).

Given the history of gendered power imbalances between doctors and nurses, hospital administrations may seek to mitigate hierarchical structures by encouraging nurses to speak up

[6] A 2023 study by Gallagher and Roberts, it was found that 30% of female surgeons in the NHS have experienced sexual assault, with many incidents occurring during surgeries. The study also highlighted other forms of harassment, such as unwanted physical advances and inappropriate comments. Nearly 90% of respondents reported witnessing misconduct among colleagues(Gallagher and Roberts,2023).

and by more actively monitoring doctors' actions. A Hospital Director (1.2) highlighted that nurses are expected to report poor practice and behaviour, indicating a system of accountability within their organisation. A Board Member (3.2) described management directives aimed at empowering nurses to monitor doctors, leveraging their extensive experience and familiarity with procedures.

While private hospitals are taking steps to encourage speaking up and improve reporting rates, the UK government is also making efforts to strengthen the NHS in this regard. The UK government has unveiled bold plans to regulate NHS managers for the first time, aiming to dismantle a "*culture of cover-up*" and bolster accountability in the health service (Department of Health and Social Care, 2024). Prompted by scandals at trusts like Morecambe Bay[7] and East Kent[8], the proposals include lifetime bans for managers who silence whistleblowers or engage in misconduct, ensuring such individuals cannot simply move between NHS roles. At

[7] The Morecambe Bay scandal refers to a series of serious failings in maternity care at Furness General Hospital, part of the University Hospitals of Morecambe Bay NHS Foundation Trust, in Cumbria, England. The scandal came to public attention after a significant number of preventable deaths of mothers and babies occurred between 2004 and 2013 due to substandard care, poor clinical practices, and a dysfunctional culture within the maternity unit. At least 11 babies and one mother died as a result of poor care, and several other babies suffered serious harm.

The hospital's maternity unit faced a range of issues, including failures in monitoring fatal health, inadequate responses to medical emergencies, and suboptimal postnatal care. The unit also suffered from a lack of effective teamwork between midwives, obstetricians, and other healthcare professionals. A particularly problematic dynamic involved midwives who were described as having a "them and us" attitude, creating barriers to effective collaboration with doctors and other staff members.

A culture within the unit that overly emphasized achieving "normal births" led to an unsafe resistance to medical interventions, even when such interventions were necessary. This focus on "normal birth" compromised patient safety and led to tragic outcomes. Moreover, complaints and concerns raised by families were often ignored or inadequately investigated by the trust and regulatory bodies overseeing the hospital, such as the Care Quality Commission (CQC) (Kirkup, 2015).

[8] Between 2009 and 2020, multiple incidents of substandard care resulted in at least 45 baby deaths that could have been avoided if proper care had been provided. Numerous other babies were left with life-altering injuries. The problems within the trust were found to include a lack of adherence to clinical guidelines, poor decision-making, and a failure to recognize and appropriately escalate medical concerns during labour and delivery.

A significant issue was the toxic culture within the maternity units, where staff members often felt unable to raise concerns or speak up about unsafe practices. Midwives and doctors reported a lack of effective teamwork and collaboration, which contributed to poor patient outcomes. Furthermore, the review found that mothers and families who experienced poor care were frequently treated with a lack of compassion, and their concerns were dismissed or ignored (Kirkup,2022).

the heart of these plans is a statutory duty of candour, which would legally require managers to address patient safety concerns transparently. A 12-week public consultation has been launched to gather views on proposed reforms to NHS management and regulation, including the introduction of barring mechanisms and full statutory registration for healthcare leaders. While the primary aim is strengthening accountability rather than assigning blame, responses have revealed diverging perspectives. Health leaders, such as Amanda Pritchard[9], have emphasised the need to support managers in meeting high standards, whereas patient advocates have welcomed the initiative as a step toward greater transparency. Overall, the consultation signals a decisive effort to restore trust, safeguard whistleblowers, and foster a culture of openness critical to delivering safe care (Gregory, 2024).

Some participants (3) noted improvements in hierarchical dynamics over time, attributing this to the increasing humility and respectfulness of newer generations of surgeons and consultants. This change in attitude has shifted focus toward recognising the importance of teamwork and mutual respect in modern medical practice. Participants viewed the change positively, as it fostered collaboration and reduced stress among healthcare workers. However, participants stated that changes in professional education have also resulted in a generation gap between doctors and their patients. While younger doctors may adopt a more casual and informal approach to patient interaction, older patients may expect a more traditional, authoritative demeanour from their doctors. Although potential misunderstandings arise from these differences, such as a doctor saying that the patient was as healthy as a butcher's dog, which the patient did not take well, participants perceive the overall shift towards decreased hierarchy and increased teamwork as beneficial. A Medical Director (2.3) underscored the importance

[9] Amanda Pritchard is a prominent British healthcare leader who served as the Chief Executive Officer (CEO) of NHS England from August 2021 until her resignation at the end of March 2025. She was the first woman to hold this position in the organisation's history (Hospital Times,2021; O'Dowd, 2025).

of teamwork among medical professionals, highlighting that healthcare knowledge is too complex to be mastered and practised by a single individual.

> I am a paediatrician, which is probably one of the least hierarchical professions, and everybody has absolute respect for their nursing colleagues or whatever, because people respect each other. We have different parts of knowledge that we work better on, and we work best as equals. (Medical Director, 2.3)

Consequently, healthcare professionals often depend on each other's expertise and collaborate to deliver optimal care (Rawlinson et al., 2021). The participant accounts and the existing historical-structural literature offer a broadly consistent picture of how medical hierarchies are embedded in professional culture (Lyden et al., 2010; Higgins & MacIntosh, 2010; Schwappach & Richard, 2018). Sources (Pringle, 1998; Roberts, 2001) converge around the observation that authority and power have been deliberately concentrated in certain groups—often senior male physicians—leaving nurses, junior staff, and female clinicians at a disadvantage when it comes to speaking up or contesting deviant behaviours. There is also an emphasis on a long-standing "authority gradient," where subordinates hesitate to question or challenge their superiors. This similarity is especially evident in discussions of how fear of retribution contributes to a culture of silence, where intimidation and bullying can persist largely unreported (Okuyama et al.,2014).

Within this convergence, the participant data shows tangible consequences of hierarchical structures in day-to-day hospital operations. Nurses and junior doctors, for instance, describe feeling unable to intervene when a senior colleague acts in a way that might jeopardise patient safety or violate professional norms (Weller & Long, 2019). Specific experiences, such as staff being unable to initiate stop procedures or facing challenges when trying to hold senior physicians accountable for inappropriate behaviour, illustrate the immediate obstacles encountered within rigid medical hierarchies.

A closely related area of overlap emerges around gender dynamics. Participant testimonies about sexual harassment and the marginalisation of female professionals align with studies on how male-dominated medical specialities, particularly surgery, have long fostered environments where women and nurses face unjust power imbalances. In parallel, the literature cites historical barriers that limited women's access to medical education and high-status roles, noting that these exclusions shaped an ethos in which male physicians typically wield unquestioned authority (Pringle,1998). The participant data reinforces the persistence of these attitudes, with female hospital directors recalling incidents where sexist behaviour or coercive tactics by senior male colleagues still occur despite policy initiatives intended to create more inclusive workplaces. In essence, the participant data provides immediate, experience-based insights into the personal and organisational cost of living within hierarchical systems, along with specific steps being taken to mitigate their impact.

4.4 The Influence of Profit and Competition on Healthcare Practices

One of the prominent findings was the competition between the NHS and private hospitals. The opinion that each participant unanimously agreed with and defended was the acknowledgement of this competition as a significant factor influencing the dynamics within the private healthcare sector. More than half of the participants emphasised that private sector hospitals are comparable to NHS hospitals and should not be considered inferior. For example, a Hospital Director (1.2) stated, "…This is a hospital with the same ethical, moral, and clinical standards as any hospital in the land in the NHS."

Six participants emphasized that the private sector was on par with the NHS regarding service quality, ethics, patient safety, and controlling deviant behaviour, with some even suggesting that the private sector, particularly private hospitals, and hospital groups, surpasses the NHS in these aspects. When we look closely at the areas claimed by the participants, their first

statement was that private hospital management is more comfortable due to its smaller size than NHS hospitals.

A Hospital Director (1.1) emphasised less pressure in the private sector, making it easier to focus on patient care rather than solely managing the hospital's operations. Concurrently, participants generally agreed that managing a private hospital facilitates easier regulation and management of deviant behaviour. One of the reasons for this convenience is the size of the hospitals. Board Member (3.3) highlighted the administrative pressures on the NHS and suggested that deviant behaviour might be easier to conceal within the NHS due to its size and complexity. Similarly, a Hospital Director (4.1) noted that the closer relationship between management and doctors in the private sector, due to smaller hospital sizes, allows for greater scrutiny, which helps control deviant behaviour. Further, a Medical Director (7.1) claimed to have observed more deviant behaviour in the NHS than in the private sector.

The other reason is the convenience of practising privileges (PP) rights (further information in Chapter 6). The Medical Director (7.1) suggested that doctors in the private sector tend to be more cautious because they understand that breaching rules could result in the loss of their PP and, consequently, their source of income. The Director of Clinical Services (2.2) explained that terminating a contract with a misbehaving doctor is much simpler in the private sector compared to the NHS.

Consequently, several participants asserted that the private sector has a more robust system that meets higher standards. However, not every comment made by participants favoured private practice over the NHS. One Hospital Director (1.2), who had previously worked in the NHS, acknowledged that while the NHS was not without flaws, it had a more stringent system of control in place during her time there. She also noted that private hospitals, in contrast, had a poor management reputation in the past.

While most participants expressed positive opinions about the private health sector and their respective institutions, a few (3) noted their dissatisfaction with how both the NHS and the private healthcare sector are portrayed in the media. Participants noted that although similar problems occur within the NHS, the media tends to focus more heavily on incidents that take place in private hospitals. Several interviewees expressed frustration at what they perceived as unfair media scrutiny, suggesting that the private sector is often held to a higher public standard. At the same time, participants acknowledged that media coverage of the private sector is not wholly negative and occasionally reflects positive developments as well.

For example, a BBC article highlighted safety concerns at Spire Healthcare, one of the UK's largest private healthcare providers, following several patient deaths, including NHS-funded patients (Plaha, 2024). Nafisa Khan, a patient undergoing a routine operation in a Spire hospital without intensive care facilities, died after delays in transferring her to an NHS hospital for critical care. Spire later admitted failures in recognising the severity of her condition. The subsequent BBC Panorama investigation–revealed systemic issues, such as inadequate communication about private hospital capabilities and reliance on NHS ambulance services for emergencies, leading to fatal delays. For example, three deaths at Spire Norwich Hospital involved long waits for ambulance transfers. In one case, a 14-hour delay occurred before transferring a critical patient just one mile to an NHS hospital.

Spire Healthcare has faced criticism for its reliance on resident doctors working up to 168 hours per week, raising concerns about burnout and patient safety. Testimonies from doctors reveal worries about the impact of these working conditions on patient care. Spire claims it has updated its working practices and emphasises that patient safety remains its priority (Plaha, 2024).

The article also revisits Spire's past scandals, including rogue surgeon Ian Paterson (see Section the Impact of the Harold Shipman and Ian Paterson Cases on the UK Healthcare

System, p 20) and complaints about another surgeon, Michael Walsh[10], highlighting historical failings in patient safety. Despite these incidents, Spire maintains that 98% of its hospitals are rated "good" or "outstanding" and asserts it is committed to improving patient safety and addressing ambulance delays. The Department of Health has acknowledged steps taken since the Paterson Inquiry to strengthen patient protections in independent healthcare settings (Plaha, 2024).

In another example, the Joyce Parker Hospital in Coventry, run by private healthcare giant Cygnet Health Care, has once again come under scrutiny after admitting adult patients to its facility just weeks after shutting its children's services amid abuse allegations. Earlier this year, the Care Quality Commission (CQC) uncovered damning evidence of staff physically abusing child patients, including CCTV footage showing children being dragged while restrained. Following this, the hospital closed its children's unit in September, only to reopen as a facility for male adults, with the NHS already placing vulnerable patients there despite the unresolved issues. This is not the first time the hospital has "recycled" its services: in 2020, it reopened for children's mental health care after closing its women's eating disorder unit due to a critical CQC report. Critics, including Deborah Coles from the charity INQUEST[11], have

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[10] Michael Walsh, a consultant orthopaedic surgeon based in Leeds, UK, specialized in shoulder surgeries. He practiced at Spire Healthcare from 1993 until his suspension in 2018 following concerns about the standard and appropriateness of his treatments (Minton Morrill, n.d.).
Investigations revealed that Walsh had performed unnecessary or poorly executed surgeries, leading to patient harm. As a result, Spire Healthcare dismissed him and referred the matter to the General Medical Council (GMC) (Campbell, 2020).
In a 2023 hearing before the Medical Practitioners Tribunal Service (MPTS), Walsh admitted to performing procedures that were not clinically indicated and acknowledged benefiting financially from these actions. He applied for voluntary erasure from the medical register, which the tribunal accepted, resulting in his removal from practice (Leonard, 2023).
Patients affected by Walsh's actions have pursued medical negligence claims, with legal firms such as Thompsons Solicitors and Simpson Millar representing individuals who received substandard care (Thompsons Law, n.d.;Emsley,2020).
This case has raised broader concerns about patient safety and oversight within private healthcare settings. Spire Healthcare has faced criticism for its handling of the situation and was fined £20,000 in 2021 for delaying informing patients about Walsh's malpractice (Leonard, 2023).

[11] INQUEST is a UK-based charity, founded in 1981, that provides independent expertise on deaths involving the state. It is the only organisation offering specialist support to bereaved families, legal professionals, the media,

called for urgent reform to address these recurring issues, which highlight a dangerous loophole in private healthcare oversight (Thomas, 2024). Meanwhile, recent NHS data revealed Cygnet Health Care received £4.3 million for out-of-area mental health placements over the past year, raising concerns about the reliance on private providers with troubling histories. Despite mounting criticism, the Department of Health and Social Care declined to comment on the hospital's latest rebranding (Thomas, 2024).

In response to the private sector hospital criticisms and scandals in the media, the Executive Medical Director (8.2) emphasised that private healthcare does not threaten the NHS as the media presents. On the contrary, he claimed that the NHS does not have adequate facilities to care for all the patients; therefore, the private sector does not take business away from the NHS, as the media claims. Patients are the ones who choose the private sector. He accused the media of printing stories that people want to read and added that people want to read that private healthcare is a fraud, while the NHS is the hero. He emphasised that most of the beds in his hospital group are occupied by NHS patients since they cannot find an empty bed in the NHS.

For example, participant (8.2) said gynaecology is one of the areas where the NHS falls short. The article "*Gynaecology patients going private to avoid NHS waiting lists*" (Karpel, 2024) highlights the growing trend of women turning to private healthcare to avoid long NHS waiting lists for gynaecological treatment, often enduring severe pain while waiting for vital care.

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and policymakers in cases of deaths in custody, detention, mental health settings, or involving multi-agency failures. Grounded in daily casework, INQUEST employs an integrated approach combining direct support, policy advocacy, media engagement, and systemic analysis. Central to its mission is the empowerment of bereaved people and the pursuit of truth, accountability, and reform.

The charity prioritises access to justice, institutional transparency, the elimination of racism and discrimination, and accountability for state and corporate failings. INQUEST campaigns for non-means-tested legal funding for families, improved inquest processes, and systemic transformation to prevent future deaths. Committed to social justice, it ensures that the voices of affected families inform policy and public discourse, challenging the systemic inequalities underlying many deaths in state care (INQUEST,n.d).

Waiting lists for gynaecology appointments have more than doubled since February 2020, with some women reporting they feel forced to seek private options for faster access to treatment.

Claire, a 40-year-old librarian, spent over £10,000 on private surgery for endometriosis after facing a three-year NHS wait, highlighting the financial burden of private care (Karpel, 2024). Similarly, Amy, who was 40, paid £2,000 for private consultations to expedite an NHS referral (Karpel, 2024). To address the 7.5 million treatment backlog, the UK government plans to expand the private sector's role in NHS care by 20%, funding an additional one million appointments and operations annually with a £2.5 billion boost, raising private healthcare funding to £16 billion. While Labour leader Keir Starmer defends this move as patient-focused, critics like Dr Tony O'Sullivan argue that the private sector acts as a "parasite", diverting NHS funding and staff while profiting from public healthcare needs and advocating for direct NHS investment instead (Campbell,2025).

Conversely, David Hare, chief executive of the Independent Healthcare Providers Network, praised the agreement as a recognition of the private sector's integral role in the NHS's long-term recovery and capacity expansion. The debate underscores the tension between public and private sector roles in addressing healthcare challenges in England (Campbell,2025).

Although not all participants mentioned a problem with media coverage (only 3), those who did agree, these participants expressed confusion over why the private sector is often targeted in the media and instead suggested that it is an underlying resentment toward the private sector and a bias that results in it being portrayed as inferior to the NHS. Participants defended the private sector, asserting it is not responsible for the NHS's challenges and should not be scapegoated.

However, while participants rejected media criticism, they also acknowledged the economic factors that set the private industry apart in this race. One participant said: "I suppose things are financially driven, aren't they, in the private sector, which differs from the NHS." (Medical

Director, 1.3). Another participant said: “This is private health care... A reasonable cost for that consultant, obviously, you know, you are paying a bit more because you go private and you are going to pay for that...” (Medical Director, 3.6)

The Chief Operating Officer and Medical Director (3.4, 3.6) from hospital group 3 described their hospital as being at the top of the private sector. Both believed that patients should choose their hospital to access the expert team in the field and that this expertise came at a reasonable cost. They also felt the reputation of top consultants and their affiliation with the hospital highlighted the quality of care and expertise available to patients. Further, they both emphasised the private sector’s relentless pursuit of higher standards and its financially driven approach, which they suggested influenced the dynamics between hospital management and doctors. When we look at how this relationship is affected by financial factors, it becomes apparent that hospital management is selective about which consultants they allow to work in the hospital, preferring those who can contribute to business growth and revenue generation.

For example, a Chief Operating Officer (3.4) said that the hospital management team regularly meets with the hospital group’s top 50 consultants since these doctors are the top performers by revenue. This effect on decision-making underscores the influence of financial considerations on management decision-making within private healthcare institutions. Four participants mentioned that doctors may receive less severe or no punishment for mistakes or deviant behaviours, depending on their financial contributions to the hospital. This practice suggests a connection between economic factors and disciplinary actions in healthcare settings, which will be explored further in Chapter 6.

4.5 Supporting The Doctor: The Role Of Hospital Management

Doctors are often expected to demonstrate empathy towards their patients, but the impact of this expectation on their own emotional well-being is rarely recognised. To address this oversight, this paper explores how the emotional labour involved in expressing empathy affects

physicians personally and influences their capacity to handle challenging situations. While medical professionalism prioritises patient welfare, it is equally important to consider the well-being of doctors (Kerasidou and Horn, 2016). Participants' experiences in management have highlighted the importance of supporting doctors, prompting them to develop their own methods of providing support.

Before examining how participants support doctors at the local and organisational levels within hospitals, it is crucial to first consider doctor support groups outside the hospital and their modes of operation. This approach helps to understand the extent to which participants perceive themselves as supporting doctors.

NHS Practitioner Health is a confidential mental health and addiction service available for doctors and dentists in the UK, offering psychological therapies, peer support, and assistance with issues such as burnout, depression, and anxiety. The British Medical Association Wellbeing Support Services provides 24/7 confidential counselling and peer support for doctors, medical students, and their families, with access to therapists and trained volunteers. The Royal College of General Practitioners offers resources and advice tailored to the needs of general practitioners, as well as workshops and programs focusing on resilience, mental health, and managing workloads. The Doctors' Support Network is a peer-support network aimed at reducing stigma and encouraging openness about mental health among doctors and medical students experiencing difficulties. Samaritans operate a 24/7 helpline that provides a safe space for anyone in distress, including healthcare professionals, to discuss emotional challenges. Many local GP support networks, established by health boards and clinical commissioning groups, offer mentoring, coaching, and stress management resources to support GP well-being. Practitioner support programs in some regions provide targeted initiatives such as peer support groups and workshops on coping strategies and self-care. Mind Charity delivers mental health support and resources for healthcare workers, including online tools, counselling

services, and crisis support. Medical Defence Unions (e.g., MDU, MPS) offer advice and guidance on medico-legal issues, helping to alleviate stress related to complaints or investigations. These groups collectively work to address the mental health and well-being of GPs, encouraging them to seek help early and overcome barriers like stigma and concerns about confidentiality (GPonline, 2024).

When we look at the participants, for many participants (8), supporting doctors involves considering the ups and downs of their private lives since they might witness doctors' private lives. A Board Member (3.3) explained how he supported his employees by paying attention to changes in doctors' behaviours and recognising signs that something may be wrong in their personal lives. Similarly, another Board Member (6.1) emphasised the significance of addressing issues in doctors' private lives as the first step in resolving any concerns. He stated that understanding the context of a doctor's personal situation is essential for providing effective support, noting that engaging in conversations positively impacts the doctor and helps moderate their behaviours.

> … he [the doctor] was very grateful that I had taken the trouble to ask him what was happening in his life at the time, and that he suddenly had all these incidents and complaints, and it was a very constructive conversation. So, I think patterns of behaviour, such as sitting down and talking to the person, are probably critical elements to understanding whether it is deliberate or just a lapse in behaviour. (Board Member, 6.1)

In addition to supporting doctors, management particularly emphasised the need to prevent or minimise any damage doctors may suffer due to investigations or errors. A Group Medical Director (2.3) highlighted the daunting and challenging experience for a doctor undergoing investigation. She stressed that while a doctor may have had good intentions, mistakes can occur, making it crucial to understand the doctor's perspective. She advocated for

investigations to be conducted promptly to mitigate any potential harm to all parties involved, including the doctor. Similarly, another board member affirmed this sentiment, emphasising the manager's responsibility to protect doctors, even from themselves.

> Meanwhile, handling the doctor compassionately and supportively because, again, it is innocent until proven guilty, or you do not know the whole picture…The second thing you must sort out is protecting the doctor from others and themselves, because sometimes the doctor can find themselves overly remorseful… You have to make sure that the person [doctor] is not at suicide risk, particularly if a patient has had harm. (Board Member, 3.3)

Campbell's (2024) news article is a form of the participants' statements as seen in the media. The Medical Protection Society found that lengthy NHS disciplinary proceedings are severely affecting doctors' mental health, with some experiencing suicidal thoughts. Of the 61 doctors surveyed, 75% reported anxiety, stress, and depression, while 88% felt angry and frustrated. Many described the process as "brutal," "humiliating," and like a "witch-hunt", with four out of five believing they were treated as "guilty until proven innocent." Some doctors were suspended for months or years, even when later cleared of wrongdoing. One was barred from surgery for the entire process, and another reported being stripped of their office space and belongings. Alarmingly, half of the doctors surveyed faced allegations after raising patient safety concerns, leading experts to warn that NHS trusts may be using disciplinary measures to silence whistleblowers. The Medical Protection Society supports 450 doctors annually facing allegations and warns that prolonged investigations create a culture of fear, undermining patient safety. Although the news article does not cover only the private hospital's situation, participants are on the same page as the Medical Protection Society.

Both participants quoted above (2.3 and 3.3) agreed that hospitals should provide support in cases where a doctor has good intentions but makes a mistake. The group medical director

emphasised that genuine errors could happen, acknowledging the fallibility of individuals. Conversely, the board member highlighted the importance of not dismissing individuals for making mistakes in the field, suggesting that such a strict approach would have led to his own absence.

A Hospital Director (1.1) of a relatively small hospital within a large private hospital group stated that he lacked medical experience but possessed extensive management experience. Unlike other participants, he adopted a method that diverged from the consensus. He focused on making the efforts and successes of his doctors visible to the rest of the hospital, aiming to motivate them. Despite his non-medical background, he prioritised effective communication and preferred face-to-face interactions. Over his two-year tenure managing the hospital, he attempted to boost doctors' motivation by publicly expressing satisfaction with their work and making their efforts visible through symbolic gestures such as coupons. Patients can nominate a doctor, nurse or other healthcare professional as an employee of the month, and the hospital director rewards them with a gift or a voucher.

There was a doctor-centred approach to supporting doctors in some cases and a hospital-centred approach in others. A Hospital Director's account (Participant 8.1) supported this current situation. She has had a nursing career for more than twenty years, so even though she is a hospital manager right now, she feels like she belongs to the group of nurses rather than doctors. She was more outspoken and direct than other participants when discussing hospital management's preferential treatment of doctors, stating that, as a nurse, she had experienced systemic unfairness for years. She acknowledged the high demand for healthcare professionals—especially doctors—which, in her view, incentivised hospitals to retain doctors by offering them strong institutional support. However, her remarks also revealed frustration: despite recognising this labour market pressure, she expressed concern that doctors were able to retain their positions, even after engaging in inappropriate or harmful behaviour. This

comment reflects broader tensions around power and accountability in private healthcare settings, where institutional loyalty to doctors may undermine efforts to address professional misconduct. Hospital Director (8.1) stated that "…they [doctors] just move somewhere else, and because people [hospital director] are so desperate, it is really difficult to recruit. People [managers] will just accept them."

In addition to supporting the doctor, there were also participants who thought that this would benefit the hospital. A Board Member (3.3) touched upon keeping doctors in the organisation by showing support. He stated that they provided some sort of compassion and support because "the salvaged doctor" would never leave the organisation until the doctor's contract was terminated.

A newspaper article explains the reason for the shortage of doctors in this field and demonstrates the efforts of the private sector to recruit doctors from the NHS. According to The Guardian, David Rowland, the director of the Centre for Health and the Public Interest, an independent thinktank, said:

> There is only one finite pool of medical professionals in the UK, the vast majority of whom are employed directly by the NHS. Recruitment referral fees of this kind are likely to form part of an overall strategy employed by private hospital companies to pull medical professionals away from working in the NHS and towards the private sector (Marsh, 2023).

Another article exposes the significant financial burden that private locum agencies impose on the NHS, which is estimated to be spending £500 million annually to cover staffing shortages amid a recruitment crisis, framing the situation as "private hospitals rip off the NHS" (Dilworth, 2024). Agencies profit from hiring out doctors at high fees, with some directors earning over £1 million a year. The rise in agency costs has been fuelled by the chronic shortage of healthcare workers, with NHS trusts often forced to exceed capped rates to ensure coverage.

For example, ID Medical Group posted profits of £7.8 million in 2023, up from £3 million in 2021, with one director earning over £1.1 million that year. Another agency, Cook Recruitment Group, reported a six-fold increase in operating profits between 2021 and 2024, while Acacium Group, the largest UK locum provider, recorded £1.4 billion in revenue in 2023, half from UK operations. These agencies are incentivising recruitment with rewards like luxury holidays, high-value vouchers, and Rolex watches.

Critics, including Health Secretary Wes Streeting, have decried the "eye-watering sums" spent on temporary staff, pledging to curtail such spending to address the NHS's 113,000 staffing vacancies. This situation highlights the intense competition between the private sector and the NHS to attract and retain doctors—a dynamic that shapes how private hospitals respond to, manage, and potentially overlook clinical or behavioural deviance among high-value medical staff.

As a solution to the monopolisation in doctor education and the limited pool of doctors seen in the literature, the UK Government recently announced the allocation of 350 additional medical school places across England, backed by over £2.4 billion in funding, as part of efforts to address doctor shortages in underserved areas (GOV.UK, 2024). This expansion aligns with the NHS Long Term Workforce Plan, which aims to double medical school places to 15,000 annually by 2031. However, medical professionals have raised concerns regarding the NHS's capacity to train and employ these additional doctors effectively (Colivicchi, 2024). The British Medical Association has emphasised the need for further investment to guarantee employment opportunities for all medical graduates within the NHS. Additionally, challenges such as insufficient GP training resources and the slow increase in GP training positions remain problematic, with some prospective GPs being turned away. GP trainers argue that increasing medical student numbers alone will not resolve these issues, citing the need to improve working conditions to retain junior doctors after qualification, as well as the importance of expanding

the number of trainers and placements to maintain the quality of medical education (Colivicchi, 2024). While private hospitals try to pursue more doctors, the NHS has difficulty maintaining the doctors under the NHS umbrella (Sauerteig et al.,2019).

4.6 Conclusion

This chapter has explored how organisational culture in private hospitals and management's expectations for doctors' behaviour may influence deviant behaviours among the latter, particularly in private hospitals. Unlike some NHS settings, where ongoing training and reinforcement of professional conduct are common, private hospitals often rely solely on doctors' prior education and experience. The emphasis is placed on doctors conforming to professional standards without additional educational support, relying instead on hospital policies outlined in their employment contracts.

Communication dynamics among healthcare professionals, especially between doctors and nurses, are closely monitored in private hospitals. Efforts are made to mitigate hierarchical structures that may hinder effective teamwork, as recognised in previous literature and supported by my findings. Private hospitals prioritise maintaining a functional hierarchy that prioritises patients' welfare and safeguards the institution's reputation. Consequently, deviant behaviours, such as arrogance among surgeons, are closely monitored and addressed to ensure seamless operations.

Given the profit-oriented nature of private hospitals, doctors are expected to contribute to the institution's financial success by attracting patients and generating revenue. Hospital management closely monitors doctors who significantly contribute to economic gains, sometimes applying lenient disciplinary measures in cases of deviant behaviour to retain valuable personnel.

Supporting doctors is crucial for enhancing patient care quality and fostering a conducive work environment. Addressing doctors' well-being not only improves service delivery but also

mitigates staff turnover. However, challenges arise when hospitals face doctor shortages, potentially compromising their recruitment standards. Nonetheless, hospitals typically offer support to doctors who prove beneficial to their operational and financial objectives.

Overall, this chapter highlights the complex interplay between organisational expectations, professional conduct, and economic imperatives within private healthcare settings. While prioritising patient care and maintaining a harmonious work environment are key objectives, hospitals must navigate challenges associated with doctor recruitment, support, and retention to ensure sustainable operations.

5 CHAPTER -5 MONITORING AND ASSESSING DEVIANCE

5.1 Introduction

This chapter examines how private healthcare institutions perceive and respond to doctors' deviant behaviours, directly addressing the central research questions: How is deviance perceived in private healthcare, and how is it addressed?

The first section explores how hospitals define and identify deviance, particularly distinguishing between professional errors and intentional misconduct. It focuses on how participants interpret recurring patterns of behaviour, breaches of professional standards, and non-compliance with hospital policies as indicators of deviance.

The second section analyses how institutions monitor and manage these behaviours. It examines the tools and processes used for oversight, including performance data, patient feedback, complaint systems, annual appraisals, and information-sharing between institutions. These mechanisms are central to identifying concerns and determining appropriate responses.

The third section addresses how institutions navigate ambiguous or grey area cases, where the distinction between error and misconduct is unclear. It considers how professional judgement, institutional memory, and external guidance (such as GMC and CQC standards) shape decision-making in these complex scenarios.

The fourth section turns to the broader organisational context. It investigates how financial pressures, organisational hierarchies, and reputational concerns influence how deviance is managed and how these factors can sometimes compete with ethical and clinical priorities.

Finally, the chapter highlights the role of patient safety as a foundational concern underpinning institutional responses to deviance. It considers how safeguarding concerns, the risk to patient

wellbeing, and public accountability shape both preventive measures and institutional interventions.

By tracing these interconnected themes, the chapter provides insight into how private healthcare institutions conceptualise, monitor, and respond to deviance, revealing the tensions, priorities, and values embedded in institutional governance.

5.2 Conceptualising Medical Deviance and the Factors That Shape It

This section begins by exploring how participants identified and responded to early signs of deviance among doctors. Many participants—particularly board members, hospital managers, and medical directors—held senior roles that placed them in close proximity to doctors' day-to-day work. Several (17) were also practising or former doctors/nurses themselves, which gave them additional insight into professional norms and workplace conduct.

First, failing to meet the established medical standards was one type of doctor behaviour that caught participants' attention and was perceived as a deviation. Indirectly, participants (1.2, 1.4, 3.3, 3.5) agreed that not adhering to the written General Medical Council (GMC) guidelines was also considered a deviation since the GMC is the regulatory body that provides and updates the highest professional standards. One participant, who was a Head of Education and Clinical Training (3.5) considered breaking governance rules around any type of management as deviance as well. Participant 1.4 emphasised that deviations from expected conduct could occur across various aspects of hospital governance, ranging from clinical practice to interpersonal behaviour. However, he also clarified that such deviations do not necessarily constitute criminal behaviour or negligence. As one Board Member (3.3) explained, deviation "Is moving away from what is either defined or expected in terms of behaviour [and] practice." This definition captures how participants often understood deviance:

as a departure from established professional norms, whether formally codified or culturally expected within the hospital environment.

After discussing deviance in general terms, several participants provided more specific examples of behaviours they considered professionally inappropriate. These examples ranged from clinical neglect to breaches of organisational policy. One Hospital Director (1.1) described deviant behaviour as including violations of patient confidentiality, a lack of transparency with patients, and failing to dedicate adequate attention and time during consultations—actions that, in her view, fall short of the profession's highest standards. As the Director of Clinical Services (1.3) put it, "The issue was not just clinical performance but a lack of honesty and disregard for institutional rules." Similarly, a Board Member (2.2) pointed to procedural noncompliance as a form of deviance, offering the example of doctors who routinely failed to sign drug charts correctly, despite a requirement to sign in five specific places. He characterised these as "little deviations from policy." These examples reflect participants' understanding that deviance is not limited to major clinical errors but can also include everyday behaviours that gradually erode professional and organisational standards.

A Medical Director (7.1) described an incident involving an older doctor over 65 who consistently failed to follow modern clinical practices. The participant explained that this behaviour was not merely a matter of generational difference or reluctance to adapt, but was viewed as a form of clinical deviance, since the doctor's outdated methods posed a risk to patient safety and fell short of current professional standards. He recalled warning the doctor that continued support from the hospital would not be possible unless he either retired or updated his practice to align with contemporary expectations. Medical Director (7.1) said to the doctor, "… You have to either stop doing what you are doing or learn and reintroduce the practice with a new technique or with a modern technique…."

In the final illustration, a Hospital Director (8.1) noted that a doctor's religious beliefs interfered with their medical practice, which is against the hospital policy and the GMC.[12] Therefore, the Hospital Director (8.1) warned the doctor by saying, "So, we have had it where our doctor might have been a Muslim and said to that patient, no, you need to pray more…".

As the examples illustrate, while participants often described deviance broadly as going beyond the guidelines, this serves as an umbrella concept. When examined more closely, the behaviours considered deviant vary significantly and are assessed on a case-by-case basis.

In addition to failing to adhere to modern and best professional standards in the medical field, participants also consider knowingly causing harm to a patient as deviance. Failure to address early warning signs may allow a doctor's behaviour to escalate, increasing the risk of serious harm to patients. However, in the following examples, the doctors take risks, knowing their actions might hurt the patient. The participants discussing this issue expressed their regret for the patients affected by it while also conveying anger towards their colleagues for stepping outside the bounds of professional ethics and endangering the profession's reputation. A Hospital Director (1.2) encountered a situation where a doctor at their hospital deliberately jeopardised a patient's life during surgery. A teenage patient arrived at the hospital with a complaint about protruding ears. The doctor who admitted the patient discovered that the boy had undergone severe heart surgery and was still on blood thinners. Although performing non-emergency surgeries is generally not recommended after major heart surgery, the doctor proceeded with the plastic surgery. The hospital director said, "Obviously, he [the doctor] got paid a handsome fee for doing this particular surgery, and from what I understood, he essentially took it on to help fund an extended summer holiday." After the procedure, the

[12] According to GMC (2024) Good Medical Practice a doctor must refrain from expressing their personal beliefs—whether political, religious, or moral—in a manner that takes advantage of patients' vulnerability or may reasonably cause them discomfort. It is essential to adhere to GMC detailed guidance on personal beliefs and medical practice.

patient returned to the hospital's ER with bleeding from both ears. Due to the patient's use of blood thinners, which neither the other doctors nor the hospital management were aware of, they faced significant challenges in stopping the bleeding. Following this incident, the doctor was investigated and subsequently dismissed.

Similarly, a Hospital Director (8.1) mentioned being suspicious of doctors abusing their prescribed medications, which is common in the healthcare sector (Tamburello, 2015; Al-Worafi, 2020). One of the doctors has been prescribing medication for a ward that does not need that kind of medication. The participant became suspicious, reviewed the prescriptions, and recognised that the medication was susceptible to misuse due to its psychoactive properties and potential for patient abuse.

In this particular case, I have chosen not to disclose the participant's number or role in order to protect both their anonymity and their personal relationship with the individual involved. The participant, a colleague and friend of Justin Stebbing[13], described how Stebbing had made inappropriate clinical decisions that were not in the best interests of his patients. Justin Stebbing forced his patients to inappropriate, highly aggressive treatments, and my participant expressed his sadness at this situation and said that he was startled at how his friend showed such a deviation from the GMC guidelines and put his patients in danger.

In addition, participants tend to see doctors' repeated mistakes as deviance. Although they cannot provide a precise classification method, the participants claim they can easily distinguish this, thanks to their extensive experience in the sector. In this context, keeping

[13] According to the news article in The Standard newspaper (Lydall, 2021), the Medical Practitioners Tribunal Service (MPTS) suspended Dr. Justin Stebbing for misconduct. Dr. Stebbing, a highly respected oncology consultant known for his innovative clinical practice and cancer research, faced allegations of failing to provide adequate care to 12 patients over three years. The accusations centred around inappropriate treatment of advanced cancer patients, exaggerating treatment benefits, and prescribing ineffective care, according to colleagues. Unfortunately, the majority of these patients (11 out of 12) passed away shortly after receiving the treatment directed by Dr. Stebbing, with some dying within days. Initially, Dr. Stebbing denied all complaints, but later admitted to 30 of the 36 charges during the panel's deliberations. He was ultimately found guilty of an additional three charges (Wellesley and Tumilty, 2022).

communication open with other staff is essential to determine if the behaviour is recurring. It is also important to identify any patterns in the complaints received about the doctor and to use the doctor's numerical data. Even though they do not have an exact method, the aspects they pay attention to include the frequency of the behaviour. They define a deviation as a doctor repeatedly exhibiting the same behaviour despite being warned, showing no improvement, or failing to pay attention to this behaviour.

Participants also drew clear distinctions between honest errors and deviant actions. Across the interviews, there was a strong consensus that deviance involved knowingly departing from established medical standards, intentionally or recklessly harming patients, or engaging in repeated patterns of inappropriate conduct. In contrast, isolated mistakes or misjudgements were not typically viewed as deviant unless they formed part of a broader, recognisable pattern. These distinctions served as a foundation for how concerns about doctors' behaviour were interpreted and managed.

Stage of the process	Typical practice in UK hospitals	Why subjectivity creeps in	Concrete mitigations
Initial triage of an incident	A manager (often the clinical lead for the service) decides whether the event is *error*, *mistake* or *potentially deviant* before a formal investigation is opened. Many Trusts now use the NHS "Just Culture" Guide or the older Incident Decision Tree (IDT) to structure that call.	Personal familiarity with the doctor ("halo" or "horn" effect) and professional norms that presume benevolent intent can steer the first judgement.	Require the triage form to be completed by two reviewers—one from the doctor's own specialty and one external—and filed before any discussion with the doctor begins.
Fact-finding / evidence-gathering	Root-cause analysis (RCA) teams collect notes, EMR data, device logs and witness statements. PSIRF (rolled out 2023–24) encourages system-focused, learning-centred reviews rather than blame-centred ones (NHS,2022c)	Selection bias: what documents are pulled, which colleagues are interviewed, and how questions are framed all colour perceptions of intent. Hindsight bias means reviewers judge identical acts more harshly if the patient outcome was poor (Banham-Hall and Stevens, 2019).	Adopt PSIRF's *Learning Response Toolkit* checklists; anonymise case summaries for the first discussion meeting so reviewers do not know *who* was involved; include a human-factors specialist on every RCA panel.
Culpability decision	Many Trusts use the five-question NHS *Just Culture* algorithm (deliberate harm? health impairment? foresight? substitution? mitigating factors?) to recommend "support / remediation", "system fix", or "disciplinary" Improvement Cymru Academy (n.d.).	Algorithm outputs can still be overridden by managerial discretion; studies show gender, race and hierarchy influence which incidents are escalated.	Make the algorithm output *public within the investigation file*; any override must be signed by the medical director and justified in writing. Require an external lay member on the panel for high-harm cases.

Table 2: How intent is assessed in practice

As shown in the table above, the systems predominantly used by the NHS in England are highlighted. These systems aim to be as objective as possible when determining whether a behaviour constitutes deviance, seeking to minimise subjectivity. Nonetheless, the table also illustrates the shortcomings of these systems. In contrast, when examining private hospitals, participants did not mention the use of these systems (which will be discussed in Chapter 7).

Participant 2.2 explained that her threshold for tolerating such behaviour was lower than that of her colleagues, particularly when a breach involved deliberate non-adherence to hospital policies or protocols. In such instances, she would confront the doctor and issue a verbal warning. She also added that if a pattern of behaviour emerged, the hospital or the GMC would initiate a formal investigation. Similarly, the Director of Clinical Services (1.3) described issuing a verbal warning to a doctor for poor clinical performance and inappropriate behaviour. Although he did not elaborate on the nature of the behaviour, he noted that the doctor continued to act in the same way. As a result, the hospital management decided to retrain the individual in an attempt to improve performance. "We tried to retrain him. We tried to speak to him again… We had warned and told him the required standard, but he still did not change." In this case, the retraining served not only as a corrective measure but also as a way to reinforce hospital standards and expectations for clinical practice (see Chapter 4).

Subsequently, they terminated the doctor's employment due to the absence of any observed improvement in behaviour. The participant did not clarify how long the doctor had been given to change or what criteria were used to assess improvement. A Chief Operating Officer (3.4) explained that a similar process is followed in their organisation: when repeated misbehaviour is observed, they initiate a conversation with the doctor. If no meaningful change occurs, the doctor's practising privileges are suspended. Additionally, they emphasised the importance of

internal reporting mechanisms or, in other words, of “speaking up”, which was explained in Chapter 4. They noted that in identifying these patterns, the clarity of reports from other colleagues is crucial. In particular, they argued that the more precisely they can see a pattern emerging from colleagues’ reports, the faster they can act against the doctor. A Board Member, for example (6.1), stated:” So, if something is brought to my attention, I will always look at the track record of incidents and complaints relating to that individual to see if there is a pattern.”

The same participant also expressed that they observed these recurring patterns predominantly manifesting in areas of bullying and harassment. They also conveyed the situation from a perspective that focused on the doctor’s character and attributed this (deviance) to the doctor’s personality, stating that the doctor quickly “bubbles over” or gets irritated due to their inability to tolerate the stress around them. It is observed that the participant attributes the doctor’s anger to the doctor’s character and the adverse events that go wrong with the doctor’s other colleagues or in the work environment. However, a Medical Director (3.6) paid more attention to these and stated that such situations – bullying and harassment – could result in sacking. When a pattern is identified, the participants asserted that they take immediate action. If such occurrences are regular, it leads to an investigation, and as a result, the doctor may lose their practising privileges. In severe cases, they may sever their ties with the hospital altogether. They may refer the doctor to the GMC as a last resort. Group Medical Director (2.3), for example, stated, “Non-trivial is the sort of stuff that repeats patterns of behaviours, significant, poor behaviour in people.”

Another point that participants tend to use to distinguish between error and deviation is how the doctor reacts after being warned. Despite holding different positions in healthcare (1.4, 2.3, 3.1, 3.2, 3.3, 7.1), all participants agreed that an apologetic stance by the doctor, combined with a sincere acknowledgement of errors and a commitment to avoid repeating them, significantly improves the decision-making process. The critical point emphasised was the

importance of doctors being self-reflective. One anecdote described how a doctor's visible remorse and tears demonstrated their capacity for introspection. Participants stressed that doctors should acknowledge when they have overstepped boundaries and offer an appropriate apology when faced with a complaint.

> So, if their [doctors'] reflection is thorough and respectful of what they have done, and they can almost immediately tell you why, they will never let that happen again. Great! That is learning because we can all make genuine mistakes. (Board Member 3.2)

> So, reflection and remorse are key attributes of a good clinician. So, you can see from that that a good clinician is not somebody who makes no mistakes, because I would like to find someone who is not making any mistakes. (Group Medical Director, 2.3)

Board Members of Hospital Group 3 (3.2 and 3.3) echoed these sentiments, accentuating the significance of being remorseful and insightful, mainly when defensiveness indicates a deficiency in comprehending their errors. They provided examples to illustrate how behaviours such as throwing instruments in the operating room or refusing to compromise can signal that a doctor does not fully appreciate the consequences of their actions. Additionally, Board Member (3.3) illustrated, by way of example, an incident where a nurse inadvertently administered a dose of medication intended for 24 hours within a single hour. The nurse, understandably distraught, exhibited visible distress, prompting hospital management to assuage her emotions. As Board Member (3.3) outlined, this reaction is a typical response in such circumstances. As seen above, participants list constructive reactions in such situations as crying, feeling regretful, and realising and accepting what the healthcare professional did as wrong. In contrast, participants considered defensive, dismissive, or aggressive reactions from doctors, particularly when confronted about concerns, as unacceptable. Such behaviours, they argued, warranted formal intervention.

Three participants (2.2, 2.3, 3.6) who hold similar roles are typically the first to handle complaints about doctors. They described a shared approach to initial assessment and escalation, often making similar judgments about whether a case warrants further investigation or disciplinary action. They noted that if a doctor in their hospital shows insufficient remorse and fails to recognise the harmful impact of their behaviour on team dynamics—demonstrating a lack of accountability or self-awareness—the hospital will follow established protocols. They also compared a doctor expressing genuine contrition with statements like "I apologise, I see my error, your concern is justified," and one deflecting responsibility with comments like" I am not at fault, others are to blame."

Additionally, if the doctor attempted to conceal their actions, cover them up, gaslight others, or become verbally aggressive rather than addressing the issue, this was considered a serious red flag. The participants indicated that management would become suspicious of the doctor in such cases, believing these behaviours reflect poorly on the doctor's character. Furthermore, participants indicated that doctors are likely to be warned that if they repeat the same mistake, the consequences will significantly escalate and could lead to their firing. (Chapter 6).

A few participants (4) implicitly agreed with the concept of the "ripple effect"—the idea that one deviant act or event can have far-reaching consequences, influencing others' behaviours, attitudes, or the broader organisational culture—even if they did not express this view explicitly. Hospital Directors (1.1, 1.4) acknowledged that there will always be small, overlooked situations and indicated these minor actions could accumulate and escalate into more significant problems. Hospital Director (1.1) noted that "There are always things going on, and it can be minimal, but it can ripple out," highlighting how even minor issues can escalate. Similarly, Hospital Director (1.4) observed that "It is the smaller bits that do not come immediately to mind but are probably the ones that will cause us bigger problems at some point," emphasising the long-term risks of seemingly insignificant behaviours.

The Hospital Director (1.4) cited note-keeping as an example of this situation. They mentioned the necessity for doctors to take notes and report on their general work regularly but acknowledged the possibility of neglecting this duty. Doctors could sometimes claim they were in a hurry and forgot to write it down when they were warned about it. Another example was that forgetting to take a temperature measurement once may not pose a problem, but if repeated many times, it could become an issue. These were considered minor incidents, but if they accumulate and escalate, they could be considered deviations from the norm. A Group Medical Director (2.3) expressed this situation as follows. "You pick up on the small things, so they do not become big things."

A small portion (3) of the participants had another concern regarding this matter. According to a Board Member (3.3), when a doctor is observed doing something wrong, the likelihood of them having done other things wrong is relatively high. He described a scenario where a concern was raised about a doctor's behaviour, such as not washing hands before a procedure. However, it was discovered upon investigation that this is just one of many issues observed with the doctor's conduct. These ranged from minor concerns — poor notetaking and tardiness — to more serious behaviours, such as unprofessional conduct or suspected intoxication. While some may consider these issues minor, the participant emphasised that they could indicate more significant problems. He underscored the importance of addressing seemingly minor issues, noting that they can signal deeper concerns about professionalism and competence. As Board Member (3.3) put it, "A small thing… is a marker of something that might be bigger… You always look and keep [track] because one thing adds to another, adds to another, adds to another."

5.3 Collecting Data on Doctors' Performance

When asked how they initially addressed concerns about inappropriate behaviour, nearly half (9) described adopting a monitoring strategy; this form of monitoring did not involve detailed

surveillance but rather heightened attentiveness to behaviours that were clearly conspicuous, ethically questionable, or outside accepted clinical standards. In addition to direct observation and informal monitoring, participants emphasised the growing importance of systematically using quantitative data to evaluate doctors' performance. Collecting outcome-based metrics, such as complication rates or patient readmissions, was described as a way to identify patterns that may signal clinical concerns or deviations from expected standards. Nearly all participants stated that they relied on patient-related outcome data, such as how many patients returned to the hospital after surgery. One Hospital Director (1.2) noted that this practice was common across both the private sector and the NHS. A group medical director (2.3) illustrated this point by saying, "Say you are a surgeon with a high complication rate." In such cases, poor outcomes may suggest that a doctor's clinical practice is problematic, prompting further scrutiny or intervention.

Moreover, they added that a high complication rate is concerning and requires attention. A Group Medical Director (3.1) described the system used to monitor and collect data on the high complication rates in their hospital. They mentioned the hospital's clinical audit program, which enables them to have activity reports with a live dashboard. This system allows management to see doctors' performance when searching by name, enhancing observation within the institution. The program covers various aspects, including the number of patients a doctor sees, complaints, incidents, patient-reported outcomes, and whether a patient returned to the operating room. A similar system was observed in other hospital groups as well. Participants (1.3, 2.1) stated that they monitor the postoperative course of patients following discharge from the operating room, specifically focusing on whether the patient returns to the operating room within 28 days with post-operative complications.

A patient loss post-treatment is recorded as an accident in the system, assigned an accident number, and added to the doctor's file.

> So, we know how many incidents each consultant has had and what other themes they relate to, or if someone had a big pile of people getting clots after surgery or had a big pile of bad behaviours, I would know what I was dealing with. (Director of Clinical Services, 1.3)

In addition to tracking quantitative indicators, such as complication rates or the number of surgeries performed annually, participants also highlighted the importance of internal documentation for monitoring doctors. As Hospital Director (1.1) noted, "I wrote a note, and I put it in the consultant's file." A participant (1.3) discussed addressing a doctor's failure to meet required standards by reminding them of the expected standard and noting the incident in their file, which affected their practising privileges. This documentation ensured that all incidents in which the doctor was involved were known when their performance was assessed in the future. Another observation, or rather an evaluation method, is the annual appraisal process through which doctors reflect on their professional development with a qualified colleague. All participants mentioned it, and it was seen in every hospital, including the NHS, indicating it was very important.

Many participants, including Board Member (2.1), highlighted annual appraisals as a key tool for monitoring doctors' behaviour: "So, behaviour is one area, so we monitor that through a lot of soft measures as well as appraisals and review." A Hospital Director (1.2) discussed management's role in reviewing and signing off on a doctor's appraisal. As part of this process, the hospital reviewed several aspects of the doctor's practice. They examined the number of surgeries performed, the doctor's performance history both within the NHS and at a local independent hospital, and any complaints that had been filed. They also considered the volume of patients the doctor had treated and whether the doctor had been involved in any serious incidents. Group Medical Director (2.3) said that while reviewing a doctor's appraisal, they considered whether any incidents had occurred, or concerns had been raised. These points were

raised by all of this study's participants and were reported as being a regular practice in the hospitals where they worked.

Although the focus is always on the annual appraisal, a Medical Director (3.6) stated they also pay attention to doctors' social media accounts. However, he was the only participant who stated that they paid attention to this. Although there are some regulations regarding social media sharing in GMC's guidelines, it cannot be said that this is the primary concern of hospitals. However, an executive Medical Director (8.2) noted how he ended a doctor's contract with the hospital due to a WhatsApp video and his comment. He said that doctors were rude to NHS patients and implied that private patients were more important than NHS patients. Although this discussion happened on a WhatsApp group, the medical director ended his contract because he was disrespectful.

A Director of Clinical Services (2.2) emphasised the common practice of collecting patient feedback and complaints across hospitals. They highlighted that all hospitals have systems in place for gathering patient feedback and complaints, and their hospital operates a similar system. Patients can provide feedback via email, phone calls, and occasionally through written letters. They mentioned instances where patients directly contacted them to express dissatisfaction with a doctor's actions or treatment options offered. Conversely, patients also commend the excellent service the hospital provides. Additionally, they noted that patient surveys are routinely conducted, and the data obtained from these surveys are evaluated. They emphasised the importance of monitoring instances where a doctor's name is mentioned explicitly in surveys or complaint forms.

A Group Medical Director (2.3), who was part of the same hospital group, mentioned the process of gathering specific feedback about doctors through patient surveys. They expressed satisfaction when positive feedback about doctors was received, but acknowledged instances of negative feedback and assured that they would take steps to address them. When a patient

leaves negative feedback, the hospital contacts them via phone to gather further information and offer assistance, noting that negative feedback is often related to car parking and advertising. They inform patients about the hospital's complaint mechanism and listen to their complaints attentively.

A Board Member (3.2) stressed that the collected data are analysed hospital by hospital and even within hospitals, and they are further examined at the ward level. Furthermore, participants (3.2 and 4.1) noted that while many hospitals attempt to gather additional information from patients who file complaints, what sets their hospital management apart is their commitment to actively following up on those complaints and using them to inform internal reviews or interventions. Participant (3.2) encouraged the chief executive and chief nurse to engage directly with patients on behalf of the hospital in these situations. Engaging with patients directly is not an excessive measure but rather a way to demonstrate to the patient how seriously their complaint is being taken. If the patient perceives that their complaint is not being taken seriously, encountering the chief executive or chief nurse can prompt them to share their experience with family members or acquaintances, highlighting the importance of addressing patient concerns effectively.

Despite the presence of a comprehensive feedback and complaint collection system, participants commonly expressed difficulty in assessing the reliability and usability of patient complaints. One factor that was seen to undermine reliability was the perception that some patients may submit complaints in pursuit of financial compensation.

At the same time, participants reported that certain complaints were given more weight than others. A Chief Operating Officer (3.4) stated that complaints were taken especially seriously when they specifically named a doctor. Moreover, if similar complaints were received from multiple patients or corroborated by colleagues within the hospital system, they were considered particularly credible and subject to further investigation.

Participants (1.2, 3.1, 6.1, 7.1) highlighted how the country's high inflation rate and resulting belt-tightening policies have begun to shape the nature of patient complaints. They observed a significant increase in the number of complaints, which they attributed, in part, to a lack of public understanding about the structure and costs of private healthcare services. For example, some patients who underwent surgery four or five years ago are now expressing dissatisfaction and seeking to reclaim the costs. Others appear unaware that services such as blood tests or follow-up consultations may incur additional fees beyond the initial procedure. Participants also noted that the volume of complaints has increased alongside the growing number of patients visiting private hospitals. As the Director of Clinical Services (1.3) observed, "Sometimes you feel as if patients are complaining to get money back," suggesting that some complaints may be financially motivated rather than rooted in genuine clinical concerns.

A Head of Education and Clinical Training (3.5) reflected on her experience managing complaints in the NHS, noting that a significant portion of complaints were often related to concerns about preventing harm to another patient or instances of clinical neglect rather than economic reasons in private hospitals. Examples include cases where patients' relatives were not properly cared for, such as not being fed or left unattended in bed without assistance in the NHS. Families understandably become emotionally upset in such situations due to a perceived lack of care. However, in the private sector, complaints tend to revolve more around dissatisfaction with services and seeking financial compensation, reflecting a growing trend of a "claim culture." For instance, one patient demanded feedback on the consultation and compensation for perceived stress caused by the interaction.

5.4 Challenges in Deciding on Deviant Behaviour

This section will cover the complexities of evaluating and addressing deviant behaviour among doctors within private healthcare settings. It explores the various factors influencing decision-making processes and highlights the challenges hospital management faces in distinguishing

between errors and deviant actions. While ensuring patient safety and upholding professional standards are paramount, grey areas often emerge due to subjective interpretations, varying perspectives, and the unique dynamics of the medical community.

One of the key themes discussed is bias and uncertainty. This subsection examines how biases and personal relationships within the medical community can influence decision-making. It discusses the "closed shop" effect**,** wherein decision-makers are often fellow doctors, creating an insular environment that may discourage external scrutiny and foster a culture of favouritism or protectionism within the profession. The section also highlights how social ties within the medical community, such as friendships and professional networks, can blur the lines between objective and subjective evaluations. Additionally, the subsection addresses the difficulties in assessing behaviours that fall into ambiguous or grey areas, where it can be challenging to distinguish between errors and deliberate deviations.

The second theme, Adhering to Regulatory Bodies, focuses on the role of guidelines provided by regulatory bodies such as the General Medical Council (GMC). It explores participants' views on the adequacy and limitations of these guidelines and how they are interpreted in practice when dealing with complex cases. While some participants find the GMC guidelines sufficient, others highlight their broad nature and lack of specificity, making them open to interpretation. This subsection also examines how hospitals supplement GMC guidelines with their internal standards and other regulatory frameworks to create a more rigorous decision-making process.

The third theme, Serving the Business Best, addresses how hospitals' financial interests and reputational considerations can impact decision-making. This subsection explores how the desire for profit and the need to attract high-quality consultants can lead to variations in how deviant behaviour is addressed. It highlights historical examples, such as the Paterson case (see Section the Impact of the Harold Shipman and Ian Paterson Cases on the UK Healthcare

System,p 20), to illustrate how hospitals may tolerate deviance if it does not threaten their financial gains or reputation. The subsection also discusses participants' views on the importance of balancing business interests with ethical and professional standards.

Finally, the section examines health risks as a key consideration in decision-making. This subsection highlights participants' views on the threshold for intervention, focusing on cases where there is potential or actual harm to patients. It emphasises that patient safety is a core priority and that even the possibility of harm is sufficient to warrant intervention. The subsection also addresses the importance of considering both physical and psychological harm, reflecting participants' broader understanding of patient well-being.

5.4.1 Favouritism and Grey Areas in the Field

As highlighted at the beginning of this chapter, distinguishing between error and deviation depends on the doctor's practice, which should be up-to-date and aligned with professional guidelines, ensuring no intentional harm to the patient. An action is considered an error if it occurs singularly, and a deviation if deliberately repeated. This distinction introduces ambiguity within the domain, shedding light on the impact of grey areas on participants' decision-making processes. Many participants, regardless of gender or position, expressed confusion regarding grey areas. The grey areas mentioned by the participants here (see Chapter 2, Deviant Actions in Grey Areas) can be divided into two sections based on the literature. Firstly, the internal grey area refers to situations where participants challenge their own moral boundaries and find themselves in conflict-of-interest scenarios. Secondly, the external grey area involves situations characterised by ambiguous guidelines, a lack of external support, and new practices that do not fit within the existing regulatory framework. Firstly, when we examine the examples in which participants are internally challenged, they refer to their own moral boundaries as a point of reference.

As the Group Medical Director (2.3) put it, “They [behaviours] are often a big grey. They are grey because it is a grey world. So, I think they are reasonable, and they try to keep up and bring more things in and do stuff.” The participant posited that this matter’s crux lies in personal preference: “How would one wish to be treated in a similar circumstance?” The response to this query is inherently subjective, varying from individual to individual, thus rendering it typically ambiguous.

A Hospital Director (1.2) is disturbed because a doctor working within the hospital has engaged in an action that the director themselves would not have done. The participant gave an example of an orthopaedic doctor who forced his patient to buy a device for a specific spinal surgery, and how she could not decide about the situation. The doctor used their patient as a mediator to request a particular spinal device not available at the private hospital, but only in comprehensive hospitals. With the doctor’s guidance, the patient repeatedly approached the hospital administration, emphasising that acquiring this device was crucial for their treatment. The participant mentioned contacting the doctor and asking whether the doctor’s actions were appropriate. This example illustrates where boundaries can become blurred. While the doctor’s conduct was not explicitly evaluated as ethical or unethical in this case, the participant emphasised that situations sometimes perceived as deviant can lead to progress in the field, noting that “it can be somebody’s passion or drive to change what is currently happening” (Hospital Director, 1.2).

They highlighted the difficulty in assessing doctors’ behaviours, emphasising that such actions are not necessarily seen as strictly black or white but sometimes fall into a grey zone. While underscoring that there is no absolute truth in the medical profession, participants also noted the evolving nature of what is considered correct, particularly with advances in technology and shifting standards of practice over time. These uncertainties, arising from external factors, are

confusing the participants and making it more difficult for them to make decisions regarding the actions of the doctors.

In the ambiguity of blurred boundaries, a Director of Clinical Services (2.2) delineated a hypothetical dialogue she might engage in with a doctor. Should a patient levy an accusation against the doctor, alleging a lack of empathy, the doctor might conceivably mount a defence, asserting that they were perfectly courteous. In response, the participant would inquire whether the doctor demonstrated genuine concern and furnished adequate support to the patient. Supporting her stance, the participant underscored the perceptible nuances inherent in such situations.

Another Hospital Director (1.4) expressed a desire to elucidate the grey areas within the field more directly, citing the example of a doctor consistently arriving 15 minutes late each day. According to the participant, when a doctor justified their tardiness by citing traffic congestion, he acknowledged feeling compelled to accept the explanation, given the difficulty in personally verifying its truthfulness. He reflected on the inherent complexity in categorising doctors' actions, noting that such decisions often fall into ambiguous territory: "That is where you get into that grey area of what is measurable and frequent poor behaviour and what is occasional, not too bad behaviour, but still not desirable either" (Hospital Director, 1.4).

Participants, due to insufficient external support and external factors, relied on their accumulated years of experience to form judgments in order to narrow down the grey area when navigating clinical or behavioural conduct. For instance, participants (2.3 and 3.1) described using common sense and professional judgement to assess doctors' behaviour, stating that with enough experience, deviation becomes easier to identify. These decisions were often made collaboratively, with experienced teams reviewing the situation together to determine whether a doctor's behaviour crossed professional boundaries without overstepping

into micromanagement or unjustified interference. Participants stated that they collected as much evidence as possible to understand the doctor's action and its impact, for example, by getting the details of the complaint from the patient in writing and giving them a broader perspective. Further, the prevalence of doctors who consistently demonstrate professionalism, politeness, and compassion towards patients makes deviations from established norms more readily identifiable. As the Divisional Vice President of Quality (3.1) explained, evaluating behaviour often involves drawing on one's own professional judgement: "I think with it you have to bring your own experience and make sure when we are looking at the doctor's behaviours or any issues or concerns…" Similarly, the Group Medical Director (2.3) emphasised the nuanced nature of these assessments, stating, "It is not that we sit there with a rule book and say, well, you have broken rule twenty-three. It does not work like that."

As previously noted, participants unanimously agreed that a doctor's response to their mistakes played a key role in how their behaviour was assessed and managed. However, several participants also raised concerns about the potential influence of favouritism in this process. A small group—four participants, all of whom had transitioned into leadership roles from nursing—shared the view that favouritism could affect decision-making around doctor accountability. A Hospital Director (1.4), for instance, observed that doctors are often judged by fellow doctors, which, in his view, creates a "Closed Shop" dynamic that risks undermining objectivity.

> … it does feel a little bit like a closed shop, and it feels like no one from the outside who is not from a medical background is looking and saying, wait a minute, that does not look reasonable to me. (Hospital Director, 1.4)

Another similar example arose from participants who held the role of Group Medical Director and Hospital Director (2.3 and 8.1). They explained that doctors within the same community

often socialise together, engaging in weekend golf outings, fostering close friendships, and even sharing the same classroom in medical school. This close-knit social circle extends beyond leisure activities, with members readily offering assistance to one another in need. She contended that doctors rely on each other, support one another through challenging situations, and alleviate each other's difficulties. Consequently, objective decision-making may sometimes be eclipsed by personal connections. The participants further underscored ongoing efforts to address and mitigate such occurrences. Participants (2.3 and 8.2) highlighted the importance of promoting transparency. During an investigation, measures are implemented to guarantee that the person responsible for investigating the doctor comes from a distinct hospital.

A Hospital Director (8.1) with a nursing background offered extensive commentary on this issue, drawing from firsthand experiences of challenges stemming from the closed community dynamics among doctors, which often extend to favouritism. According to her assertion, when a doctor is referred to the GMC, the referred doctor typically seeks support from an acquaintance or schoolmate within the GMC. This acquaintance then submits a written testimonial in favour of the doctor implicated in the complaint, advocating for their continued practice. She contends that the investigation processes for nurses and doctors differ significantly, with nurses subjected to more rigorous scrutiny than their doctor counterparts. When faced with complaints, one participant alleged that doctors are often shielded from comprehensive investigation, with testimonies from colleagues serving to protect them—practices she attributed to entrenched gender norms within the medical profession (see Chapter 4). Hospital Director (8.1) remarked that "They are [doctors] protected, and it used to be like. I have been a nurse for 20 years; it was like an old boys' network within the GMC and doctors. I believe that still exists." This perception of professional protection was echoed by the Group Medical Director (2.3), who stated, "I do not think they [doctors] are always honest with each

other about what they have done to get themselves reported to the GMC or investigated." Together, these comments point to a culture of professional solidarity that may obstruct transparency and accountability. In addition to the issue of peer protection, participants raised concerns about how deviance itself is defined, suggesting further complexity in holding doctors accountable.

5.4.2 Adhering to Regulatory Bodies

While participants do resort to years of experience to decide on the grey areas mentioned above, it is also a matter of professional practice to consult the GMC guidelines. It is possible to approach participants' views on *Good Medical Practice* (GMC, 2023) in two groups. First, I will present the statements of participants who consider the *Good Medical Practice* guide entirely sufficient. Then, I will include the opinions of participants who argue that the guide is insufficient and needs further development.

This first group, which supports the sufficiency of the GMC guidelines, constitutes one-third of the participants. They claimed that the GMC guidelines is quite comprehensive and that there is a counterpart in the GMC guidelines for errors or deviant behaviours encountered by doctors in their practice. According to participants, the GMC sets out apparent and various expectations it covers, from interacting with patients to doctors' financial interests and so on. A Hospital Director (1.2), despite not having a medical background and serving solely as an administrator, stated that he firmly believes the General Medical Council (GMC) guidance is sufficient for evaluating doctors' conduct. Other participants shared this perspective, indicating that hospital management decisions are often grounded in the principles outlined by the GMC. For instance, the Group Medical Director (2.3) remarked, "I have not been able to find any line in good medical practice that it does not fit what they [doctors] have done," suggesting a strong alignment between the GMC's expectations and actual incidents encountered in practice.

Similarly, Board Member (6.1) affirmed, “I think they are quite good. I think the GMC guidance is pretty clear,” reinforcing the notion that institutional reliance on GMC standards is both practical and well-founded.

Participants (3.1,3.6,6.1) stated that they also used the CQC[14] (Care Quality Commission) in addition to the GMC guidelines and supported both with their hospital standards. The expectations of CQC from hospitals were clear, covering everything from how patients were cared for to how patient complaints were handled. Organisations fill this gap by using other guidelines as well. For instance, if there was an issue related to consent and the leading guide did not fully address it, they could find a separate and more detailed guide for that specific topic by referring to other specific guides about confidentiality, children and young people, or interests and beliefs on GMC and CQC websites. Also, the hospitals had their own internal competencies and specific rules for each unit. Participants were confident that the hospitals had enough guidelines and regulations. Although the hospitals’ internal regulations were viewed as sufficient, participants also utilised the GMC guidelines to aim for a much more rigorous framework.

Unlike other participants who confirmed that GMC guidelines were sufficient, the Hospital Director (2.1) explained that their approach involves creating additional standards beyond those set by the GMC. He characterised the GMC as both a union and a self-regulatory body for doctors, suggesting that it lacks sufficient independence to enforce accountability. As a result, he placed greater emphasis on Care Quality Commission (CQC) regulations and internal hospital policies to guide performance expectations and ensure oversight.

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[14] The Care Quality Commission (CQC) serves as the independent regulatory body overseeing health and adult social care in England. Its core mission is to ensure that these services deliver care that is not only safe and effective but also compassionate and of high quality. This is achieved through a systematic process of monitoring, inspecting, and regulating care providers. Furthermore, the CQC is responsible for publishing comprehensive reports on their findings, thus ensuring transparency and accountability. In instances of substandard care, the CQC is empowered to take corrective actions to enforce improvements, thereby safeguarding public health and well-being. This regulatory framework is pivotal in maintaining and enhancing the standards of healthcare and social services in England (CQC,2024c).

A Board Member (6.1) mentioned that GMC's primary focus was on "integrity and honesty" rather than clinical performance. He supported this argument by highlighting cases from GMC hearings, noting that the main issues during these hearings were usually related to doctors lying or misbehaving. The cases related to clinical performance were almost non-existent. Therefore, he believed that if the GMC focused more on clinical performance, it would achieve much better outcomes.

Participant (6.1) supported his argument by providing an example of how the GMC intervened and provided support in an incident he experienced. He described a situation involving a responsible officer who needed to report concerns about a doctor to the hospital. When the participant contacted the GMC for consultation regarding the issue, it emerged that the doctor had failed to notify the GMC that he was employed at that hospital. Consequently, the GMC initiated an investigation to determine why the doctor had failed to inform them.

An Executive Medical Director (8.2), while expressing general support for the role of the GMC in maintaining professional standards, also criticised the organisation for its lack of responsiveness to change. He remarked that "…the GMC standards for doctors [have] not changed very much in the last five to ten years," suggesting that the guidance may no longer reflect the evolving realities of medical practice.

Nevertheless, he argued that it is necessary to explain which standards a doctor has violated in order to investigate them; for this, the GMC has clearly defined professional standards. However, he later mentioned an incident within the hospital where the GMC and the hospital did not reach the same conclusion. A visiting consultant, who was not salaried but received work from the organisation, faced complaints from vulnerable women alleging that he manipulated them during therapy sessions by making them believe he was in love with them. The organisation investigated these complaints, but due to the lack of a GMC framework and a responsible officer, the organisation took on the investigation internally. Despite finding

nothing to support these claims for a year and a half, the responsible officer revoked the visiting consultant's privileges due to concerns about his practice. The decision was based on the belief that the consultant was practising therapy without appropriate training. However, the GMC did not find any wrongdoing. Participants considered the situation as a grey area regarding the consultant's practice and the organisation's decision-making process. It also shows that although hospitals rely on GMC Guidelines to provide a more explicit framework, sometimes the GMC and hospital decision-making processes cannot be on the same page.

When we look at the other participants, instead of wholeheartedly agreeing that GMC is effective, like the participants mentioned in the previous section, they talked about its effectiveness and missing parts. The participants (1.3, 2.2, 3.1, 3.5, 8.1) indicated that the guidelines were not stringent enough, were overly broad, and lacked sufficient specificity. While acknowledging that the guidelines cannot account for every accident or deviation, the participants emphasised the need for the GMC to be more comprehensive. Since the guidelines are broad, which makes them open for interpretation, and therefore do not address the grey areas specifically, they argued that the guide should also be "simpler and more explicit." However, they also acknowledged that even if the guidelines were more straightforward, they would still be open to interpretation, and uncertainty could not be entirely eliminated. A Hospital Director (8.1) echoed other participants' views, expressing concern that the broad nature of GMC guidelines could allow doctors to interpret or manipulate them to their advantage. Despite this, participants generally agreed that the guidance is sufficient to address a wide range of professional conduct issues. As Hospital Director (2.2) noted, "Because their guidance is pretty broad, it does leave a fair bit of room for grey areas, and it surprised me." Similarly, the Head of Education and Clinical Training (3.5) observed, "…There is a wide gap between what one person could read or observe…and another one could observe it," underscoring the subjectivity involved in interpreting professional standards. On the other

hand, the board members (3.2 and 3.3) of Hospital Group 3 expressed that the adequacy of the guide depends on how closely it is followed, emphasising that understanding its spirit is the critical aspect.

> … If you take that line, they are probably adequate. All right. If you do not take that line, in other words, if you do not adhere to them and to the spirit of what they are saying, not just the words but the spirit of the words, then they probably are not adequate, in my view… (Board Member,3.3)

The participant underscored the insufficiency of merely interpreting the written text literally, asserting the reader's need to discern the underlying intent and formulate their interpretations. They sought to elucidate this notion through a hypothetical scenario. Consider a solicitor advocating for Dr A. While the GMC guide may espouse the axiom "it is what it is", the solicitor will contend that this phrase harbours interpretative ambiguity. Herein lies their contention with the GMC. Even if the GMC permits interpretive latitude at this juncture, it should advocate for comprehending the guide's benevolent intentions and ethos. Hence, the guide harbours grey areas and occasionally lacunae. Enumerating and encompassing every eventuality within a professional guide is undeniably challenging. Therefore, the participant argued that rather than superficially adhering to the rules, professionals should focus on understanding the underlying intent. As the Head of Education and Clinical Training (3.5) stated, "If you have got good written guidance around something, then you have fewer potential interpretation issues," emphasising the value of clarity in reducing ambiguity and misinterpretation. He (7.1) noted that GMC guidelines, focused on good medical practice, formed the primary reference point for discussions around professional conduct. He believed that while the GMC had generally captured the essence of good medical practice, there was room for improvement in the domains they covered and their focus. He thought the GMC did well in supporting patients but felt that its stance towards doctors had shifted over the years.

While it used to be more neutral or supportive, he now perceives it as slightly biased against doctors when handling complaints. So, although he acknowledged the GMC's role in providing guidelines, he felt it was not as pro-doctor as it used to be, say, 20 or 30 years ago. He suggested consulting GMC standards for guidance on how to evaluate and respond to clinical or behavioural concerns. He referred to "good medical practice" and the "practising privileges document," indicating that the latter likely takes precedence as it reflects the principles of good medical practice.

Many participants mentioned that when the GMC guide proved insufficient or failed to provide a complete answer to their questions, they reached out to other hospitals for information exchange. These could be other branches within their hospital group or other private hospitals where the doctor might be working. This situation is called dual practice. [15]

Participants (1.1, 1.3, 1.4) indicated that when a complaint is received about a doctor, information exchange occurs between the doctor's workplaces if the dual practice is present. They resorted to inter-branch communication when making decisions about deviant behaviours, if relevant. They noted that, as part of a hospital group with multiple branches, they regularly exchanged information about doctors' performance and conduct across sites in ambiguous or uncertain situations, and they consulted other branches to determine if they had encountered similar cases before and what decisions were made. This communication allowed them to shape their internal procedures accordingly. A Director of Clinical Service (1.3) had

[15] Dual practice, the practice of working in both public and private healthcare sectors, has been prevalent in most healthcare systems globally (World Health Organisation, 2000). The likelihood of dual practice varies considerably based on a physician's specialty and level of experience. Medical and surgical specialties, which have direct patient interactions, are more prone to dual practice compared to support specialties like pathology or radiology (Koelewijn et al., 2014). Therefore, fields such as cardiology, dermatology, orthopaedics, and obstetrics and gynaecology see higher rates of dual practice. Building a good reputation and attracting private patients takes time, often making dual practice more common among older physicians (González, 2004; Morris et al., 2008). For example, nearly all public hospital doctors also engage in private practice in Austria and Ireland. In the UK, about 60% of doctors practice privately, with income caps for full-time public doctors set at 10% of their public income, while part-time doctors face no such limitations (Morris et al., 2008).

a particular consultant with behavioural and clinical issues; the participant had met him and documented it on several occasions. Although the doctor was aware of his shortcomings, he failed to make any changes to his behaviour. As a result, the participant terminated his contract and prioritising patient safety, informed the other institutions where the doctor was employed. As Hospital Director (1.1) explained, "... they would have to report to us if there had been any complaints about their work or any part of their practice of the trust. And we have to do the same here," highlighting the reciprocal responsibility among institutions to share information regarding professional conduct. They discovered that a consultant had inappropriately touched a patient and informed their sister hospital. At the end of the conversation, they removed the doctor's practising privileges (PP).

A Chief Operating Officer (3.4) emphasised that if necessary, and the doctor also works in the NHS, information could be exchanged with the NHS as well as other private hospitals.

> So, if we have concerns about a consultant, we will speak to someone at our corporate body who is linked with their equivalent in the NHS. Moreover, we can find out if there are also concerns in the NHS so that we can flag their behaviour to them, and they can flag their behaviour to us. (Chief Operating Officer, 3.4)

Participants (3.4 and 4.1) explained that they would also consult with a doctor's previous or current employer when concerns arose, typically the NHS. They noted that most doctors working in the private sector also hold roles within the NHS, making the NHS their primary employer. As a result, the private sector maintains regular contact with NHS institutions when investigating or verifying a doctor's professional background. If they were concerned about a consultant's performance, mainly if the outcomes were poor, they flagged this to the NHS to ensure no further issues needed investigating. Whether the NHS confirms or denies the concerns, if the private sector had any doubts, they proceeded with their own investigation

after informing the NHS. This ensured that both sides shared information and nothing was overlooked. Regarding this issue, a Board Member (6.1), who also held the position of responsible officer in the hospital, provided the following explanation.

He explained that as a responsible officer (RO), there was a duty to inform other responsible officers in all hospitals where a doctor with severe concerns about conduct or capability worked. He emphasised that this duty to inform was mandatory. For instance, if he had informed the NHS of a concern and they decided to terminate the doctor's employment, he would have expected the NHS to notify him of their decision, whether he had taken similar action or not. Conversely, if he had already terminated the doctor's employment and informed the NHS of the reasons, he would have expected the NHS to inform him of their subsequent actions. He clarified that this process ensured adequate information transfer between the parties involved.

Another way of exchanging information between institutions is via a responsible officer.[16] (RO). Participants (3.1,3.3,3.4,8.2), whether from the same hospital group or not, indicated that, besides information exchange among hospitals or branches within a hospital group, another source for obtaining information about participating doctors was the RO. Participants noted that they contacted the doctor's Responsible Officer (RO) when seeking further information about a participating doctor's conduct. As Chief Operating Officer (3.4) explained, "We have a relationship with a responsible officer, share information, guard a doctor's practice and behaviour, deviance…" indicating the collaborative oversight efforts in maintaining

[16] Responsible officer (RO) is a bridge position that connects GMC and hospital and who should oversee local clinical governance within RO's healthcare organisation, focusing on the conduct and performance of doctors. RO's role involves assessing doctors' fitness to practice and coordinating with the GMC regarding relevant procedures. While RO provides recommendations, the ultimate decision on doctor revalidation lies with the GMC, serving as the regulator.

RO also collaborates with the GMC on individual fitness to practice cases, particularly when national sanctions are deemed necessary. Understanding the local context is crucial, as is promptly addressing minor issues. Additionally, RO ensures the organisation implements effective systems for evaluating doctors' performance and conduct. This localized approach, coupled with closer collaboration with the GMC, aims to ensure fairness to doctors and enhance patient safety (NHS,2011)

professional standards.

A Board Member and Executive Medical Director (3.3,8.2) expressed great satisfaction with the GMC's RO's support and emphasised its value. He highlighted the importance of informing the RO whenever decisions were made regarding a doctor, as the GMC would report any patient harm resulting from the doctor's behaviour. Consequently, the responsible officer would contact the doctor's other workplaces to check for similar incidents.

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The board member (3.3) then provided a hypothetical example: if a doctor exhibiting deviant behaviours decided to leave the institution and start afresh, possibly in a new city or abroad, the doctor might not inform the responsible officer. In such a case, the responsible officer would not have a record of the doctor's conduct. However, if the employee had informed the GMC, a record would be accessible wherever the doctor is. This record would serve as an apparent reference for potential employers.

Participants (3.3 and 8.2) and the RO regularly meet with a GMC link person to discuss various incidents, including those that may initially seem minor. They value open, informal communication, allowing for early-stage discussions about a doctor's conduct before initiating any formal investigation. During these meetings, the GMC representative records names and workplaces and later contacts the link persons at those workplaces to gather further details.

This preliminary process serves as a precursor to formal reporting to the GMC. If similar incidents are identified in other cases based on GMC's records, appropriate actions are taken promptly. This method enables early identification and resolution of potential issues, ensuring

comprehensive oversight and timely intervention. Participants appreciate the opportunity to assess whether an issue meets GMC's threshold before escalating it, providing a supportive mechanism for addressing concerns efficiently. This proactive approach is particularly beneficial, as formal GMC investigations are significant undertakings for any doctor.

Some participants (3) noted that despite encountering negative situations in these reports, the doctor could still be hired. They explained that if the doctor demonstrated a remorseful attitude and the GMC investigation resulted in a decision of "no action to take," the doctor could be deemed eligible for employment. A Board Member (3.3) indicated that even if they found a record of a previous accident or deviant behaviour in a doctor's file, they might still hire the doctor. They added that the record would at least inform them of the areas where the doctor needs to be monitored and controlled. By paying attention to these specific areas, board members believed they could proactively avoid potential issues with a doctor's conduct. As the Director of Clinical Services (1.3) put it, "[Doctors] might be as good as gold there [other hospitals] and terrible here or vice versa," highlighting the context-dependent nature of professional behaviour across institutions.

Participants explained that if the GMC representative (RO) discovers minor issues occurring elsewhere, participants would then contact the RO and suggest referring the individual to the GMC. However, they noted that if the representative finds more severe issues at another location, they might instruct him to report the individual to the GMC. They emphasised that this is a significantly different scenario, as it usually implies that the person will almost certainly face some form of court appearance with the GMC. They added that being instructed to report someone is a significant step and has happened very occasionally, underscoring the seriousness of such a directive. While the participants generally reported satisfaction with communication between institutions, a few (3) emphasised that this communication was insufficient and required improvement. One Board Member (5.1) noted, "I do not think health

care is as good as it should be in sharing information between institutions," underscoring the perceived gaps in inter-organisational collaboration and transparency. Three participants (1.3, 5.1, 6.1) noted that, despite the communication between institutions, sometimes they lacked information about the decisions and actions taken by the other institution after informing them about a doctor.

Board Member (5.1) mentioned that while they might have known that Mr A, or Surgeon A, had a higher return to theatre rate, the system still had gaps in ensuring that all other places where he worked were informed about his performance at their institution. He expressed concern that better information sharing between healthcare institutions still needed to be done, a point he had repeatedly raised with the board.

A Director of Clinical Services (1.3) confirmed the statement and added that they had no information about the doctor's fate. They mentioned that after informing the other hospital where the doctor worked, they were unaware of the decision made by that hospital and that hospitals were not obligated to make the same decision. As mentioned above, a hospital may hire a doctor who has not left a previous hospital on good terms, nor are they required to decide on the same strategy as a previous employer.

5.4.3 Serving the Business Best

Participant (6.1), who is an RO in his hospital, explained that when there were severe issues, such as substance abuse or sexually inappropriate behaviour, there was a duty to inform other responsible officers and the GMC. He rarely had to do this and could recall only two occasions: one related to a doctor's capability and the other to substance abuse. He suspended the doctors' practising privileges in those situations pending further information. One doctor never had his privileges reinstated and has not returned. He spoke to the doctor's RO, which highlighted a

lapse in communication since the doctor should have informed the responsible officer, but he did not.

The participant found that case interesting because it revealed that the doctor had not informed the GMC that he had worked at his hospital. He was not aware of the doctor's drunk driving conviction until later. This case exemplified a breakdown in the system, though it was not due to a failure by the GMC or the RO, but instead, the doctor's failure to disclose his employment details accurately. The GMC was quite interested in this issue once it came to light. He pointed out that the system fails when a doctor does not inform their NHS trust or the GMC about their work in a private hospital, leaving him without crucial information unless provided directly by the doctor.

He explained that all doctors had a responsible officer responsible for oversight and regularly confirmed the doctor's fitness to practice. Additionally, all doctors were subject to an annual appraisal. However, he pointed out that, like any review system, its effectiveness was only as good as the information available and considered during the review.

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they [Paterson's colleagues] feel that it was not appropriate to say it because financially, this person was earning the hospital much money?"

Participants stated that the worsening of events was due to the hospital's money earned through Paterson. It would be wrong to say that no disciplinary action was taken, but these disciplinary actions were probably not as strict as they could have been. If we were to view the hospital as a sports team, the hospital's financial situation and the fact that the doctor was a big player influenced this decision. "Paterson was deemed untouchable because he generated much money for the two private hospitals where he worked. So, he was deemed untouchable from a financial point of view because he was too valuable to them to undermine. (Medical Director, 7.1)" A Medical Director (7.1) stressed the importance of hospital management remaining vigilant and attentive to potential conflicts of interest (see Kelman & Hamilton, 1989; Gioia, 1992; Zey, 1999; Monahan & Quinn, 2006; Wright et al., 2022).

He noted that, although such cases were not frequent, he had encountered them several times during his career. The Executive Medical Director (8.2) shared an instance where he terminated a doctor's contract due to a message in a WhatsApp group.

> …I dismissed him even with pressure from other people in the company, saying he was a big owner. I dismissed him even though many of his colleagues at the site said, Do not do this. Please rethink it because he was popular. I dismissed him because I was not happy with the ethical things that he had done… (Executive Medical Director,8.2)

He revealed that his colleagues at the hospital exerted pressure on him and attempted to change his decision. It is observed that this exact mechanism is at play in other hospitals and was present in the Paterson case.

A small minority of participants, three individuals, who were interestingly all working at different hospitals within the same hospital group (3), discussed the concept of reputation,

which other participants did not. Board Member (3.3) stated that doctors who do not adhere to the spirit of the GMC guidelines would not benefit the hospital. At the same time, the other two participants (3.4 and 3.6) directly addressed this issue.

Both the Chief Operating Officer (3.4) and the Medical Director (3.6) emphasise the crucial role of reputation in healthcare. The Chief Operating Officer highlights that poor outcomes and working with questionable consultants can tarnish the hospital's reputation, driving away high-quality consultants. Similarly, the Medical Director points out the importance of a doctor's reputation outside the hospital, implying that external perceptions significantly impact internal operations. Together, they underline that maintaining a good reputation is essential for attracting and retaining top talent and ensuring the best patient care.

5.4.4 Health Risk of Patient

Health risk emerged as a critical and non-negotiable threshold for intervention, with all participants agreeing that any action compromising patient safety—whether physical or psychological—requires management action. The central consideration is whether harm has occurred or there is a possibility of harm, even if no actual harm materialises. As the Hospital Director (1.4) explained, intervention is necessary "even when actual harm has not yet occurred, as the potential for harm alone justifies action." Minor issues, such as a doctor being ten minutes late to a non-urgent appointment, may cause frustration but do not endanger patient safety, whereas any behaviour with the potential to cause harm prompts immediate intervention. As the Director of Clinical Services (2.2) put it, "I think the easiest threshold to determine when it is severe is when it begins to affect patient safety."

Participants also highlighted that safety encompasses both physical and psychological dimensions. As one Group Medical Director (2.3) stated, "I would say that anything that makes me worried that patient safety or colleague safety [is] impacted is serious." Chief Operating

Officer (3.4) echoed this, emphasising that any degree of damage, “whether emotional or physical, will not be tolerated.” Hospital Director (4.1) similarly noted, “I guess if somebody has been harmed in a situation, be that physically or psychologically …” and another Hospital Director (8.1) stressed that intervention is essential “When it is [doctor’s actions] impacting on the well-being of the patient.” Team distresses itself was considered a key signal for management to act: if a team is sufficiently concerned to report an incident, it is taken as an indicator that harm—physical or psychological—may be occurring.

While instances of direct patient harm were described as rare, they were seen as “spectacularly wrong” when they occurred, despite robust safety measures. One Hospital Director (1.4) recalled a case where a doctor administered anaesthesia to the wrong eye during cataract surgery, even though the area was marked with large black markers. Although no harm came to the patient, and the doctor was distressed and remorseful, the case illustrated how basic procedures can still fail.

In contrast, other incidents involved apparent negligence and financial motivation. A Hospital Director (1.2) described dismissing a doctor who performed non-essential cosmetic surgery on a 19-year-old patient still on blood thinners just two weeks after major cardiac surgery. The doctor had instructed the patient to conceal his recent surgery, leading to severe complications. As Board Member (3.2) explained, “So, if it is where patients have come to harm, then you would not, I think, pretty much universally for a doctor, you would almost certainly suspend them.”

The ethical complexities of cosmetic surgery were also discussed in relation to younger patients. Participant 1.2, reflecting as both a hospital administrator and a parent, expressed unease at adolescents undergoing aesthetic procedures, noting that peer bullying sometimes influenced requests. She described a multidisciplinary team process, including psychological

assessment, used to determine necessity. However, a recent case involving a ten-year-old patient undergoing pinoplasty raised safeguarding concerns when the mother pushed for additional cosmetic procedures. While the surgery followed CQC-required procedures, it appeared more aligned with parental preference than the child's needs, prompting the hospital to stop such surgeries. The case generated debate over whether the operating doctor acted ethically despite following formal processes, highlighting the importance of team-based ethical decision-making. Participants agreed that while personal beliefs inevitably shape leadership decisions, these must be balanced against professional standards.

Complaints related to cosmetic surgeries further underscored the risks, particularly when patient expectations diverged from outcomes. One participant cited complications such as allergic reactions to materials, implant infections, and ruptures. Although rare, these risks reinforced the broader consensus that all decisions—especially in elective procedures—must be guided by a primary commitment to patient safety and well-being.

5.5 Conclusion

This chapter provided insight into how private hospital management defines deviance and how their systems monitor and assess doctors' behaviours and performances. Participants' perceptions and definitions of deviant behaviour revolve around three central motifs: ensuring that doctors meet the best modern standards, avoiding intentional harm to patients, and avoiding the repetition of deviance.

A common characteristic among these motifs is that participants evaluate doctors' actions as either a deviation or an error; such a distinction is based on the doctor's intent. While the second category (intentional harm) is easier to verify, the first (meeting standards) and third (repetitiveness) categories involve interpretative and investigative efforts to understand the doctor's intent. Despite claiming to identify what constitutes a mistake easily, participants

struggle to differentiate between error and deviance. They look for the fundamental difference in the doctor's intent and the development of the action, determining whether it was a spontaneous error or a planned and structured deviation. Errors are characterised by momentary lapses and unplanned actions without malicious intent, while deviance involves repeated actions despite warnings, suggesting a deliberate pattern.

The core issue is that these evaluations rely heavily on the participants' discretion. Hospital observation, data collection, and annual appraisal systems help monitor doctors' actions and clinical performance, potentially reducing the margin for error and deviance. However, these data collection processes remain vulnerable to human intervention since participants might interpret the doctor's intention. One aspect that opens these processes to human influence is the doctor's regretful attitude after an error or deviant behaviour. Acknowledging the mistake and expressing remorse is viewed positively and can reduce the likelihood of severe penalties. Another factor is the perceived favouritism within the medical community, where doctors support each other even in cases of deviance, favouritism or a culture of sticking together. Finally, participants face confusion when encountering situations that do not fit neatly into predefined categories of deviance or error. They may struggle with small-scale, ongoing issues that fall outside or do not fully align with their definitions, leading to ambiguity regarding appropriate sanctions. Moreover, it seems much is dealt with informally and thus does not get into official records.

Participants turn to GMC guidelines to clarify these grey areas. However, the guidelines do not resolve all ambiguities or cover every scenario. Consequently, some participants interpret the guidelines based on their judgments and experiences. Although continued communication between hospitals is beneficial, the desired level of collaboration to track deviant doctors is not always achieved. This lack of cooperation can complicate monitoring and allow deviant doctors to continue practising or find new employment.

There may be more tolerance for deviance regarding conflicts of interest, particularly concerning the hospital's revenue and reputation. Historical examples, such as the Paterson case, suggest that hospitals may tolerate deviance if it does not threaten their financial gains or reputation. However, this tolerance likely exists below a threshold where the deviance does not pose a significant reputational risk.

6 CHAPTER 6- BALANCING LENIENCY AND PUNISHMENT

This chapter investigates how private healthcare institutions balance leniency and punishment when addressing doctors' deviant behaviours. It explores the nuanced decision-making processes involved in sanctioning deviant behaviours, focusing on the internal and external measures used to address such actions. This discussion aligns closely with the research questions: how does private healthcare perceive doctors' deviant behaviours, and how does it address them? By examining the factors influencing institutional responses, the chapter illuminates the ethical, professional, and practical considerations shaping the management of deviant behaviours.

The chapter is structured into three main sections. The first section, Mitigating Circumstances, examines the factors private hospitals use to explain or justify doctors' deviant behaviours, including professional tension, doctors' arrogance and trust, and personal life problems. These mitigating factors often result in informal resolutions rather than formal sanctions.

The second section, Sanctions, explores the range of actions taken against doctors, from informal warnings and restrictions on practising privileges to formal investigations and contract terminations. This section also examines the practice of suspending and withdrawing doctors' practising privileges, a mechanism unique to the private sector.

The final section, GMC Referrals, discusses cases where misconduct leads to formal investigations by the General Medical Council (GMC). This section highlights the criteria for referrals, the GMC's processes, and the outcomes of such investigations, which can include warnings, suspensions, or erasure from the medical register.

Through this analysis, the chapter underscores the delicate balance hospitals must maintain between protecting institutional interests, safeguarding patient safety, and ensuring professional accountability.

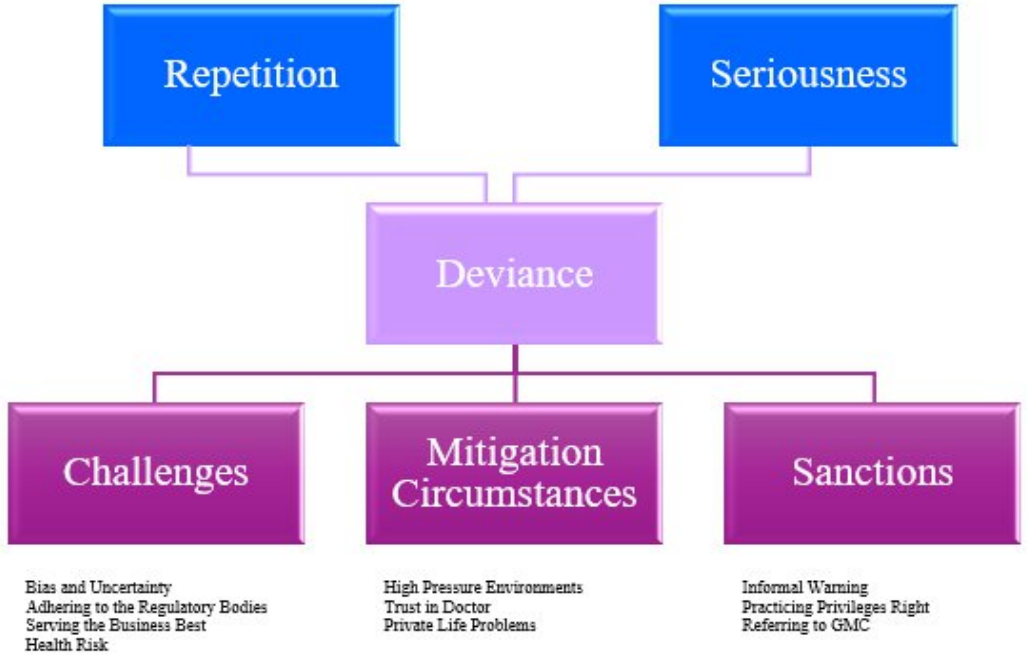

Figure 2: Framework of Assessing and Addressing Deviance in Private Healthcare

6.1 Mitigating Circumstances

Participants identified various mitigating factors when assessing deviant behaviour among doctors, and this part will address those mitigating factors. Stressful, high-pressure environments, particularly in operating rooms, were frequently cited as explanations for actions like shouting or throwing instruments. Such incidents were often resolved informally, reflecting a level of tolerance where stress-induced behaviours are seen as understandable rather than requiring formal intervention. This aligns with literature that highlights the impact of authority and hierarchy in medical settings.

Another factor was the belief that doctors' specialised training and responsibilities justify a certain level of confidence or arrogance. While some participants saw this as a minor issue, others emphasised the risks of unquestioning trust in doctors, which can enable deviant

behaviour and compromise patient safety. Historical cases like the Paterson Inquiry (see Section the Impact of the Harold Shipman and Ian Paterson Cases on the UK Healthcare System, p. 20) illustrate the harm that can result from excessive deference to medical authority. Additionally, personal life issues were noted as potential causes of deviant behaviour. Participants emphasised understanding the reasons behind a doctor's actions, rather than focusing solely on punitive measures, when issues like divorce or family strain were involved. This perspective aligns with research linking emotional distress and personal challenges to deviant behaviour.

6.1.1 High-Pressure Environments and Deviant Behaviours in Hospitals

Stress and tension in the hospital, particularly in the operating room, were cited by half of the participants (10 participants) to explain and sometimes justify doctors' deviant behaviours. Medical Directors (3.6 and 7.1) and Hospital Directors (1.1 and 1.4) listed several inappropriate behaviours occurring within the hospital, particularly in the operating room. These included shouting at staff, throwing instruments, being dismissive, and displaying rudeness. Such behaviours were described as widespread, often attributed to the high-pressure nature of the work environment, especially within enclosed spaces like operating theatres (see (Lyden et al., 2010). They described how the operating room team changes into their scrubs and heads to the operating room in the morning, spends the entire day working in a windowless space, only interacting with each other, and then returns home after long hours. This illustrates how confined and high-pressure the operating room environment can be. Medical Director (3.6) explained that such an environment often leads to abrupt communication styles: "So sometimes it is just that consultants are busy. It would be [to command other health workers] get this, get that…" This form of behaviour, while not overtly aggressive, reflects the urgency and informality that can characterise intraoperative interactions.

Similarly, Hospital Director (1.4) acknowledged that the theatre environment can heighten stress and contribute to borderline unacceptable behaviours: “More likely, you will get some slightly unacceptable behaviour, and it might place in the theatre… a slightly more pressured environment…” These accounts underscore how the enclosed, fast-paced nature of operating rooms may contribute to the normalisation of minor behavioural deviations, particularly when staff are under pressure.

The Hospital Director (1.1) described an incident in the operating room where Surgeon B interrupted Surgeon A’s surgery to complain about delays. The operating room manager reported this to the hospital administrator. Participant (1.1) then warned Surgeon B, explaining that such concerns should be addressed after the surgery and, if repeated, would involve the theatre manager. Surgeon B acknowledged the mistake and apologised, but the surgeon pointed out the stressful environment as well. The participant later asked the theatre manager to monitor Surgeon A’s punctuality. This process was handled informally with no official records. Another almost identical incident occurred in hospital group 2. Group Medical Director (2.3) mentioned that due to the prolonged duration of a surgery, another surgeon barged into the operating room and started arguing with the surgeon performing the procedure.

While expressing that they do not want such incidents in the hospital, participants stated that if they (2.2 and 3.4) see a doctor shouting, it is usually because something is not going right, or the staff are slow in preparing the necessary conditions. They emphasised that these doctors are not harmful and do not enjoy yelling at others. Chief Operating Officer (3.4) mentioned that a doctor was furious and shouted at the operating room staff. The reason was that the operating room temperature was unsuitable for the surgery, and the doctor requested it to be fixed for a week.

Also, a Director of Clinical Services (2.2) had a similar mentality and mentioned a similar case of a doctor who called the pathology lab and was rude to the staff. This complaint was brought

to their attention by the pathology line manager. Upon asking the doctor about the incident, they learned that the lab had been late in sending a result. There was a similar pattern in another incident shared by the same participant in which a surgeon threw several instruments onto the floor and shouted at the staff during a procedure in the operating room. As a result, one of the scrub team members entered a report into the hospital's incident reporting system. However, the doctor defended himself by saying several things had gone wrong and that he was not ready. Participant accepted this explanation and said, "So, there were some extenuating circumstances..."

In some cases, incidents are not limited to staff shouting at each other but can turn physical. The Director of Clinical Services (1.3) described an incident in the operating room where a doctor pushed the nurse by the shoulders instead of asking the nurse to move aside. As a result, the doctor was compelled to apologise to the nurse. The participant stated that performing surgery is challenging and understood that the doctor was just trying to do their job. They added that, while this incident was not the worst possible outcome, they do not want such events to occur within the hospital.

Following a conflict in the operating room, they informally cautioned a doctor through conversation and compelled the doctor to apologise to the staff. This way, the doctor avoids an investigation, and the hospital protects the doctor through the process, ensuring they can continue working. The findings from the hospital participants align with the literature on hierarchical power dynamics and authority gradients in surgical environments. The rigid hierarchy in operating rooms, as discussed by Riley & Manias (2005) and Gillespie et al. (2008), manifests in behaviours where senior physicians exert dominance over staff, often in high-pressure situations. The literature highlights how authority and deference create a culture where intimidation, dismissiveness, and even deviant behaviours are tolerated due to the hierarchical structure (see Higgins & MacIntosh, 2010; Schwappach & Richard, 2018). This

is evident in the reported incidents where surgeons shouted at staff, threw instruments, or acted aggressively, often justifying their actions as responses to stress or inefficiencies in the operating room. Additionally, Schwappach and Richard (2018) discuss how junior staff hesitate to challenge senior physicians due to fear of professional repercussions, a dynamic reflected in how conflicts were handled informally rather than through formal disciplinary measures to protect the doctors.

However, the findings also suggest a degree of normalisation of deviant behaviour that extends beyond what is emphasised in the existing literature. Previous studies have primarily focused on systemic contributors to unsafe practices, such as poor communication, procedural shortcuts, and passive non-compliance under pressure (Prielipp et al., 2010; Wright et al., 2022). In contrast, hospital participants in this study described more overt behaviours—such as shouting, throwing instruments, or even engaging in physical altercations—as understandable emotional reactions to a high-pressure environment rather than as professional violations warranting formal intervention. This indicates a more permissive institutional stance toward visible and disruptive conduct than is typically acknowledged in the literature. The notion that mitigating circumstances justify such behaviour indicates a cultural acceptance of stress-induced misconduct, reinforcing institutional tolerance rather than active mitigation. While the literature discusses hierarchical complacency leading to safety compromises, these findings highlight how private hospitals may actively shield doctors from consequences, ensuring that operations continue without disruption—a potentially critical distinction between public and private healthcare settings.

6.1.2 The Perceived Right to Arrogance: Trust and Medical Authority

Another mitigating circumstance participants use to interpret doctors' behaviours is the belief that doctors have the right to be arrogant and sometimes even rude. As noted by eight participants, this view stems from considering doctors' lengthy and challenging training

process and the trust placed in their decisions and actions due to the knowledge acquired from this training (Dibben and Lena, 2003; van der Schee et al., 2007). For example, Board Member (2.1) highlighted the necessity of extensive training to become a doctor and noted that doctors perform an incredible and unique task of cutting open a human body, requiring a different mindset and degree of confidence. A Divisional Vice President of Quality (3.1) agreed that while arrogance is not widespread among doctors, it is more frequently observed in leading surgeons and certain high-status specialities, such as orthopaedics. She noted that these individuals are often "the top, top of their game," suggesting that their exceptional expertise and elevated status within the medical field may contribute to the development—or tolerance—of such attitudes.

Some participants did not view arrogance as deviance but as a minor inappropriate behaviour requiring low-level management and intervention. However, some participants disapproved of this approach. They found doctor arrogance or the complete trust in doctors disturbing. A Hospital Director (8.1) described an issue she experienced when working as a nurse. A doctor did not correctly explain medications to patients and nurses. This was a significant issue because patients and healthcare providers must understand the medication given. The participant and other nurses noticed that the medication prescribed by the doctor was not compatible with the patient's mental and physical condition. When nurses questioned this, the doctor emphasised that he was in charge there and ordered the nurses to do as he said. The participant found this very challenging because of a power imbalance, and she could not act. This example also brings the nurse–doctor conflict discussed in Chapter 4 back into focus. At the same time, other incidents shared by participants reflect the historical roots of tolerance for inappropriate behaviour by doctors.

Hospital Director (1.2) emphasised that believing in doctors was constructed historically, and the tolerance of doctors' behaviours has historically established itself. She stated that doctors

still display this behaviour and find this courage today because of the tolerance shown to doctors throughout history. This historical tolerance was reflected in another hospital at a more individual level. The participant expressed discomfort with reducing this historically accepted behaviour to a personal level. The Hospital Director (1.4) complained about the phrase "she always does that" in the hospital setting. They noted that such statements normalise doctors' deviant behaviours.

The Hospital Director (1.1) confirmed that such an approach could contribute to the normalisation of doctors' deviant behaviours, drawing a parallel with the Paterson Inquiry. He highlighted how one of the key reasons suspicions around Paterson's actions persisted for so long was that staff believed he was the expert and, therefore, either did not—or felt they could not—intervene. As the participant reflected, "He [Paterson] is the expert; he knows what he is doing…"

The interview data suggesting that doctors have the right to be arrogant or that certain forms of arrogance are tolerated due to extensive training and high-stakes decision-making aligns with a longstanding discourse on the perceived hierarchy of medical professionals. Much of the literature on doctor–nurse conflicts and medical arrogance highlights precisely this dynamic: health professionals and hospital staff often acquiesce to a physician's behaviours or opinions because of the inherent power imbalance, trust in their expertise, and the historical esteem in which the role of the doctor is held (Johnson et al., 2010). The comments from board members and hospital directors who view some doctors' dismissiveness or overconfidence as a minor concern requiring only limited intervention reflect earlier findings that these behaviours are often not deemed sufficiently egregious to warrant formal corrective action (Milyavsky et al., 2017). This parallels prior literature describing a culture of leniency: a sense that physicians' advanced education, life-or-death responsibilities, and specialised skill sets justify, or at least partially explain, arrogance or occasional incivility (Cleary et al., 2015).

However, the data indicating that some staff members find doctors' behaviour disturbing—and that unquestioning trust in medical decisions can enable deviance—speaks to the vulnerabilities created by this historical tolerance. Existing studies on derailing doctors likewise show that unchecked overconfidence can lead to compromised patient safety and a hostile work environment (Joffe et al., 2022). Nurses or other subordinates may feel unable to intervene, thereby raising the risk of systemic errors (Lee et al.,2021). Notably, the hospital director's remark that "He [Paterson] is the expert; he knows what he is doing" demonstrates the power imbalance that the literature consistently pinpoints as a barrier to speaking up (Johnson et al., 2010). Thus, although several participants rationalised or minimised arrogance—citing specialised training or the idea that "they are at the top of their game"—the incident involving a doctor prescribing incompatible medication underscores the detrimental consequences when staff do not feel they can challenge potentially harmful decisions.

Furthermore, the references to the Paterson Inquiry illustrate the real risk of harm that arises when professionals defer uncritically to a doctor's perceived authority (Hospital Director, 1.1). Studies on medical misbehaviour regularly reveal the harmful role of organisational cultures in which deviant or disrespectful physician behaviours are regarded as immutable personal quirks rather than structural issues requiring consistent oversight (Cleary et al., 2015; Milyavsky et al., 2017). The interviewee's critiques of phrases such as "she always does that" attest to the normalisation of arrogance, where staff have not only come to expect it but, at times, see it as an acceptable part of medical culture. In this regard, the interview accounts coincide with literature that identifies a need for active management strategies to recalibrate these norms; without systematic approaches and accountability, reverence for doctors' expertise can be used to rationalise poor conduct (Joffe et al., 2022).

Hospitals, as complex organisational structures, often operate under immense pressure. Stressful environments, long hours, and the emotional toll of patient care can contribute to

lapses in professional conduct. It is understandable that emotional distress or overwhelming stress can lead to temporary deviations from typical behaviour. This is where leniency becomes a tool for understanding and addressing the root causes of these actions. However, there is a fine line between empathy for the doctor's situation and the need for maintaining professional boundaries that safeguard patient well-being. One of the key challenges is determining where to draw the line between humanising doctors and maintaining strict accountability. The suggestion of a "hierarchy of value" comes into play here: Should hospitals prioritise the emotional well-being of medical professionals over the strict enforcement of professional standards? Or is patient safety always the paramount concern, with mitigating circumstances offering only limited justification for deviant actions?

If we think of this as a triangle, hospital management is trying to strike a balance between patient safety, the mental health of doctors, and professional standards. As we observed in the previous section, the frequency of the behaviour and, as will be seen in later sections, the damage caused by the action during punishment, are two fundamental elements in this sought-after balance. As the frequency of the behaviour and the harm caused to the patient increase, it becomes evident that the hospital moves further away from humanising the doctor.

In sum, the experiences recounted by participants echo the literature's central themes regarding the cultural and historical underpinnings of physician arrogance and its often under-managed status within hospitals. While some participants appear to support or tolerate such behaviours, consistent with long-standing hierarchies, others emphasise the risk of unquestioning trust leading to potentially unethical or medically unsound practices. Thus, these interview data reinforce the academic consensus that professional arrogance is not merely an individual failing; it is facilitated by longstanding structural and cultural factors that afford medical

practitioners' considerable leeway to behave in ways that would be deemed unacceptable in other professional contexts.

6.1.3 Doctors' Private Life Problems

Finally, an approach observed in a small group of participants (4 individuals) but not commonly among the majority involves explaining doctors' behaviours by considering their personal lives. Participants in different positions (2.3, 3.3, 3.4, 6.1) emphasised that doctors' behaviours could also stem from issues in their personal lives. They stated that when they hear a negative comment or complaint about a doctor, they ask the doctor if everything is all right in their personal life. They emphasised that if you catch one mistake from a doctor, many others might be behind it, often stemming from personal life issues.

In their view, a good person who was always an excellent clinician suddenly started to seem to deteriorate and gradually began to cut corners or misbehave. Therefore, they emphasised that management's attitude should not always be "Oh look, I have found something wrong" but should also investigate the reasons behind this behaviour.

Board Member (6.1) highlighted an incident in which a doctor kicked an object in the operating room—a behaviour the participant described as highly uncharacteristic of that doctor's usual conduct. Concerned by this shift, they followed up with a conversation to better understand what had changed. As they recounted, "…What is happening? You are not a bad boy. You were not on my radar until recently, and then you have been on it multiple times…" (Board Member, 6.1). As a result of the conversation with the doctor, they discovered that the doctor was going through a contentious divorce. Therefore, they argued that it is essential to understand the background circumstances before placing blame.

Both the empirical data and the literature highlight the impact of personal life struggles on medical deviance, particularly regarding emotional distress, burnout, and subsequent behavioural changes. The empirical findings suggest that some doctors' misconduct stems

from personal difficulties rather than inherent personality flaws, aligning with the literature's emphasis on psychosocial stress as a contributing factor to deviance (Ghodse, 2005; Howe, 2015). Participants in the study noted that when a previously well-regarded doctor begins exhibiting erratic behaviour, it may indicate underlying personal issues, such as divorce or family strain. This perspective is echoed in the literature, which identifies relationship breakdowns, emotional turmoil, and burnout as significant risk factors that compromise clinical judgment, decision-making, and interpersonal interactions (Ly et al., 2015; Marshal et al., 2021). Both sources emphasise that unresolved personal stress can lead to withdrawn, irritable, or reckless behaviours, potentially jeopardising patient care and team cohesion.

6.2 Sanctions

The previous section examined the extenuating circumstances provided by the hospitals in response to doctors' errors or deviant behaviours. Hospitals shaped these explanations to favour retaining the doctors within the hospital. However, hospitals might choose to protect themselves after doctors' deviant behaviours and shift the responsibility directly onto the doctors rather than attributing it to personal life issues or stressful work environments. This chapter will highlight how this shift happens, the official steps, and the sanctions.

6.2.1 Informal Warning

An informal warning usually follows the mitigating factors outlined above. When a hospital investigates a doctor's mistake or misconduct, the usual first step is to issue an informal warning. After softening the action by referring to the reasons above, the informal warning comes into play when the hospital believes the doctor's behaviour requires action but not a significant sanction.

Before delving into the participants' insights, presenting a clearer picture of what is meant by giving an informal warning is crucial. This term refers to instances where, as a result of the

doctor's actions, the hospital administration opts to informally caution the doctor without conducting a formal investigation and recording it in the doctor's file or sometimes not even deeming a conversation necessary.

Informal warnings were prevalent among participants, being observed in all 19 interviews. Although they provided insight into when informal warnings were issued, the imprecise definition and limits of deviant actions (see Chapter 5) meant that no clear boundary existed. This resulted in partial agreement on which behaviours warranted an informal warning. Participants (1.1, 1.3, and 3.1) described instances when they used informal warnings. For example, if there was a complaint about a doctor's attitude or behaviour from a patient or hospital staff member, a verbal warning was issued. This approach aimed to resolve issues before they escalated into formal patient or staff complaints. However, informal warnings were deemed inappropriate in severe cases, such as when a doctor's actions endangered a patient's life. For example, a Divisional Vice President of Quality (3.1) mentioned that serious complaints about a doctor's performance and behaviour were referred to the hospital's decision-making body. Thus, informal verbal warnings were typically reserved for low-level complaints to address issues pre-emptively. The participants said that they prefer informal warnings because of how terrifying and exhausting an investigation can be for a doctor.

While the participants I mentioned above acted according to the nature and essence of the movement, a group of participants preferred to focus on the doctor's attitude and character while applying an informal warning. In contrast to other participants who focused primarily on the deviant actions themselves, medical directors (2.3, 3.6, 8.1) highlighted that the nature of the sanction would vary depending on the doctor's attitude. Medical Director (3.6) mentioned that when doctors clearly show remorse and regret, they are given only a verbal warning. Another Medical Director (2.3) stated that this approach is sufficient, and most responsible doctors respond well to it and subsequently pay more attention to their behaviour.

For example, the Hospital Director (8.1) stated that the decision to warn a doctor formally depends on how well you know the doctor. They mentioned that a doctor at their hospital had made a mistake, but they believed this doctor was a good person and did not make mistakes with malicious intent. The doctor leaves everything for the last minute, rushes it, and makes errors. Therefore, they have become accustomed to issuing informal warnings to this doctor.

Despite the prevalence of informal warnings, they were not always delivered in person. Participant (8.1) shared that another common method involves issuing warnings via phone conversations. She noted that the private sector tends to avoid email communication, as emails create written records, whereas phone calls do not, making the latter preferable for informal discussions. In one instance, she warned a doctor over the phone and then followed up by documenting the conversation in an email, copying relevant hospital staff. While the phone conversation itself was informal, the written follow-up served to ensure accountability without initiating formal disciplinary action.

While many warnings are issued in person or by phone, some participants, at least in some circumstances, prefer to use email. For example, the Hospital Director (1.2) mentioned preferring written communication for informal warnings. In a previously mentioned example (Chapter 5), the doctor required a patient to obtain a special kit exclusive to the private hospital. The hospital did not want to procure this kit, so the participant had to warn the doctor. They indicated that, while the warning was informal, the doctor was given caution via email.

Director of Clinical Services (2.2) noted that the England Health Board had warned the hospital after discovering that doctors at the private hospital were directing patients to NHS hospitals for necessary blood and stool tests. While this allowed patients to avoid private testing fees, it placed additional strain on the NHS. In response, the participant stated that a written warning was sent via email to all doctors in the hospital. This approach aligned with common practice among participants, who often relied on email to formally communicate expectations

and address emerging concerns. The vast majority of the participants (16) showed a willingness to understand the reasons behind the doctor's behaviour. They noted that when a complaint arises regarding a doctor's behaviour or clinical performance, the medical director first speaks with the doctor to understand the underlying cause. When participants learn of a doctor's inappropriate behaviour, they want to understand the reason behind it to see if there is a reasonable explanation. The desire of participants to understand doctors' actions—and their efforts to justify or mitigate such behaviour—often stemmed from contextual factors such as the operating room environment, the doctor's personal life, and the high level of trust placed in the medical profession. For instance, Hospital Director (1.4) reflected on how clinical outcomes can sometimes be interpreted generously in light of patient or procedural complexity: *"*...So, it could be your patient cohort is just a little bit less healthy than anybody else's, and therefore, you are more likely to have people go back to the theatre." Participants indicated that understanding the doctor is beneficial in two ways. Firstly, a head of education and clinical training (3.5) noted that an action plan can be developed by conversing with the doctor. Some doctors need to improve communication, emotional intelligence, and understanding of hospital rules and policies. They stated that doctors had not acted improperly or exhibited negative behaviour towards others in most cases but had come to work with the right intentions. Therefore, they emphasised that communicating with the doctor before launching an investigation is more sensible.

Secondly, a Group Medical Director (2.3) mentioned that they can avoid initiating an investigation if they have sufficient knowledge about the doctor. Participants (2.3, 3.1) noted that if doctors' practising privileges were suspended in an inquiry, they might not receive payment from the private hospital. Consequently, if there was uncertainty about the process, the preference was to avoid burdening the doctor.

6.2.2 Practising Privileges in Private Hospitals: Granting, Restriction, and Suspension

Restricting and suspending practising privileges is a disciplinary mechanism specific to the private sector that holds doctors accountable and responds to their actions. However, before going any further in this discussion, it is necessary to explain what practising privilege is for a comprehensive understanding.

Practising Privileges (PP) at private hospitals grant medical practitioners permissions categorised into various levels based on their scope of practice within the hospital setting. These categories range from consultation in the outpatient department to more advanced procedures such as anaesthetic services or diagnostic imaging procedures. Medical practitioners must provide evidence of adequate training, competency, and experience for the procedures they wish to undertake under their PP. Regular reviews every two years ensure compliance with the agreed scope of practice, participation in annual appraisals, and adherence to policies and regulations. Maintaining PP requires evidence of insurance, GMC registration, and participation in mandatory training. (Graham, 2015).

Restriction means placing specific limitations on the medical practitioner's practice. They may still be allowed to practice within certain conditions or boundaries, such as not performing specific procedures or working under supervision.

Suspension is a temporary halt to the medical practitioner's ability to practice. During a suspension, the practitioner cannot perform clinical duties until the suspension is lifted following an investigation or a specified period.

Withdrawal permanently removes the medical practitioner's practice privileges. Unlike a suspension, which is temporary, withdrawal means the practitioner will no longer be allowed to practice at the facility or under the organisation's jurisdiction (Graham, 2015; Guthrie, 2019). To earn PP rights, doctors must apply and undergo a long and arduous process.

Participants (1.1, 1.4, 3.4) noted that each private hospital has a policy for granting practising privileges to suitable doctors. To obtain these privileges, doctors must complete numerous documents[17] and procedures. Hospitals require evidence of the doctor's indemnity and professional insurance. A significant criterion is whether there have been prior complaints against the doctor.

The process involves verifying that the GMC documentation is current and that the doctor can provide a reference. Upon completing all documentation, the hospital interviews the doctor. If the doctor is successful, the hospital's medical advisory committee will review the application. This committee includes representatives from each speciality, and the application is reviewed explicitly by the representative from the relevant speciality.

After the representative's approval, the application is sent back to the committee. Securing these privileges involves a lengthy application process, typically taking about two to three months. Although applications are submitted directly to the private hospital where the doctor wishes to work, the procedure and required documents are consistent across hospitals. According to Graham (2015) and Guthrie (2019), medical practitioners must comply with GMC guidance, maintain confidentiality, and be open and honest in patient communication and handling of complaints. Practice privileges of a medical practitioner may be restricted,

[17] To establish proof of identity and professional qualifications, the standard dataset includes a recent photograph, basic demographic and identity information, and, if applicable, a work permit and Information Commissioner's Office registration or exemption. Additionally, evidence of compliance with relevant mandatory training, a CV detailing any gaps in employment history, and two references are required, along with the name of the designated body and Responsible Officer. Medical Practitioners must also provide a current Disclosure and Barring Service certification, renewed at an enhanced level every three years, and satisfactory evidence of conduct in previous employment. Maintaining current registration with the General Medical Council, including entry on the specialist register and any other relevant professional registrations, is essential. A valid certificate of adequate insurance or medical indemnity cover must also be provided with details of previous or pending claims. Practitioners must disclose all locations where they hold practising privileges or work as a doctor, and evidence of participation in annual whole practice appraisal, including appraisal summaries and personal development plans, is required. If these are insufficient, relevant information from whole practice appraisals may be considered, and at least one whole practice appraisal may be mandatory before applying for Practising Privileges in the UK. Additional documentation should include a description of the scope of practice, the volume of work in each practice area, participation in quality improvement activities, and outcome data shared in registries. Finally, the immediacy of availability for attendance, including minimum availability, travel distance requirements, and back-up arrangements for known non-availability, appropriate to the level of care delivered, should be documented (Guthrie,2019).

suspended, or withdrawn by the CEO if concerns arise regarding their conduct or performance. If issues related to patient welfare, clinical practice, misconduct, or non-compliance with GMC (2023) are identified, the CEO will recommend that the board take appropriate action. The board will also consider referring the matter to the GMC. Depending on the outcome of the investigation, the suspension may be temporary or lead to permanent withdrawal of the PP. The practitioner must report any restrictions or suspensions during their next appraisal and include them in their revalidation folder. In certain situations, the CEO may issue a warning, which will be recorded in the doctor's file and considered in future issues. Additionally, clinical partners may notify other healthcare providers and relevant regulatory bodies about suspending or withdrawing PP.

Participants (1.1, 2.2, 3.1, 3.4, 8.2) thought private hospitals could be considered fortunate because they can restrict or suspend doctors' practising privileges, which helps overcome any problems with doctors. Therefore, a small minority of participants (three individuals) consider the ability to withdraw practising privileges as a form of freedom or luxury. However, the majority view is that initiating an investigation and dismissing a doctor as one of the most severe consequences a doctor can face. Director of Clinical Services (2.2) stated that "So, we have the luxury almost of being able to say to consultants that we have to… We do not want you to be here anymore."

The participants noted that restricting or suspending the doctor's rights could encourage the doctor to reflect on their actions and ultimately understand their mistakes. For example, if it were determined that a doctor did not perform well in the operating room but had no issues in the outpatient setting, the Divisional Vice President of Quality could still permit the doctor to work at the hospital by restricting their activities solely to outpatient care. This approach would enable the doctor to continue working at the hospital while addressing the specific concerns

related to their performance, as mentioned. However, they emphasised that the contract would be terminated if there was no improvement and the doctor still lacked insight into their errors.

Nevertheless, before going into restricting and then suspending, the participants issued an informal warning and tried to solve the problem at the local level and wait for a change. The Group Medical Director (2.3) explained that when disciplinary action against a doctor was deemed necessary, the hospital aimed to apply the least restrictive intervention. Emphasising the importance of proportionality in response, he cautioned against overly punitive measures: "…So, the worst thing you could say is, okay, they just stopped doing everything. We exclude them from the world, and we stopped doing everything…" This statement highlights a reluctance to isolate or fully exclude doctors unless absolutely necessary, underscoring the hospital's preference for measured, supportive strategies wherever possible.

Therefore, a divisional vice president of quality (3.1) shared that they follow a policy referred to as the "sponge policy" within the hospital, aiming to initially evaluate and resolve concerns internally. The local decision group, composed of highly skilled professionals, considers all factors during an investigation. In cases where a doctor works at multiple hospitals, the investigation may be transferred from the local group to the corporate group. When the local group wishes to suspend a doctor, the final decision must be approved by the corporate-level management. Once a case progresses beyond the local institution to the corporate decision-making group, the likelihood of serious consequences increases, often resulting in the suspension of practising privileges and, in some cases, referral to the GMC for further investigation.

Participants (2.3, 3.1, 4.1) emphasised that decision-making at the local level was already complex and challenging, even before cases escalated to corporate management. In revoking a doctor's practising privileges and considering the subsequent actions, many questions must

be addressed, which could sometimes be confusing. They discussed whether it was sufficient to partially revoke the doctor's privileges or necessary to halt all of the doctor's operations. Following this, they must decide whether to keep the doctor employed at the hospital. After reaching this stage, they also deliberate on whether it was necessary to report the doctor to the GMC, which will be covered in this chapter.

Board Member (6.1) emphasised the importance of documenting all events and procedures following the granting of practising privileges, in order to have a clear record that could support future decisions about renewing, modifying, or revoking those privileges if concerns arise. When a decision is made against a doctor, the doctor might seek legal advice. Therefore, they emphasised the importance of documenting decisions and complaints to protect themselves. Moreover, in cases where decisions need to be made based on a doctor's behaviour, they arrange a meeting with the doctor as promptly as possible, ideally with a colleague present, to ensure objectivity. They emphasised that having two people involved helps maintain objectivity and helps with decision-making.

Participants' reasons and stories for restricting or suspending doctors' PP varied. The common thread in these narratives is that the doctors deviated from GMC guidelines and hospital protocols. However, the circumstances surrounding these deviations differ. Also, the doctor does not need to exhibit deviant behaviour to lose their PP. Participants (all of them) emphasised that if they were dissatisfied with the doctor's performance or conduct, they could revoke practising privileges just as quickly as they were granted.

Chief Operating Officer (3.4) described a situation where they suspended a doctor's practising privileges. After the doctor began working within the hospital group, it was observed that the outcomes of their cases were not satisfactory and did not meet the hospital's expectations. Consequently, the decision was made to suspend the doctor's PP and investigate. Following

the investigation, it was concluded that no serious issues were found, and the doctor was returned to his work.

In another case, a Medical Director (7.1) mentioned that a few years ago, a doctor was investigated for inappropriately admitting patients, over-investigating while on the ward, and using intravenous antibiotics when oral antibiotics would have been the standard according to the antibiotic policy. The investigation confirmed that the allegations were accurate. The doctor was advised and provided a written document outlining the correct policies. Initially, the doctor complied well with the rules, but deviations from the guidelines were later observed, prompting another warning. The doctor's practising privileges were suspended following a third meeting, during which the same issues were addressed. Subsequently, the doctor voluntarily resigned. As one medical director (7.1) noted, the hospital has, in similar situations, "relinquished practising privileges on consultants who believe, we believe, have transgressed ethical clinical standards".

Executive Medical Director (8.2) explained that the suspension of a doctor's practising privileges was due to an allegation involving a sex worker who came to the hospital as a patient and claimed that a junior doctor at the hospital had engaged in sex for money. The participant considered this a moral issue and investigated if the doctor was involved in her case, and it turned out he was not. Moreover, the doctor denied the claims. Approximately six months later, another complaint was received about the same doctor. The allegation was that the doctor had begun a romantic relationship with a female patient and that they had started living together. At this point, the participant did not go for investigation and directly suspended the doctor's PP since a similar complaint had occurred. After the suspension, the investigation was started, and it was discovered that while the doctor did have a relationship with a patient, the patient was not under the doctor's care at the time of the relationship. She had not been a patient when the relationship began. It was revealed that the woman pursued the complaint as a form of

retaliation following the end of their relationship. Consequently, the doctor's privileges were reinstated.

As previously discussed, hospitals can restrict or suspend the PP granted to doctors. At a higher level, a doctor's behaviours may lead to the termination of the doctor's contract, also referred to as withdrawing practising privileges. More than half of the participants agreed that terminating a doctor's contract and withdrawing all practising privileges is far less common than restricting or suspending privileges. They have rarely encountered such situations throughout their careers. For instance, a Hospital Director (1.2) who has held senior positions for at least 15 years, with six years in the private sector, mentioned that despite this extensive experience, they have only dismissed two doctors.

Participants stated that although there are various reasons why doctors may lose their practising privileges, these generally fall into two categories: knowingly endangering a patient or persisting in deviant behaviour, as discussed in previous sections. As previously mentioned (Chapter 5, page 42), a Hospital Director (1.2) encountered a situation where a doctor at their hospital deliberately jeopardised a patient's life during plastic surgery. Another doctor was dismissed for behavioural reasons, specifically for using their position unprofessionally to bypass standard treatment procedures to secure special treatment for a family member.

Another significant aspect of withdrawing a doctor's PP, as previously discussed in Chapter 5, is recognising a pattern. Participants' (1.3, 3.4, 3.6) experiences illustrated how this factor influences the decision to terminate a doctor's employment. Participants stated that identifying a problematic behaviour pattern often led to immediate action, including potential dismissal. When such patterns were detected and occurred regularly, they did trigger a serious investigation, which might result in the doctor losing their practising privileges.

A Director of Clinical Services (1.3) mentioned warning a doctor about their clinical performance and behaviour (Chapter 5, page 44), but the doctor continued to exhibit the same

pattern. As a result, the participants indicated that they initially retrained the doctor. Subsequently, they terminated the doctor's employment due to the absence of observed positive change on the doctor's part.

Repeating a problematic pattern can lead to sanctions within the same hospital and job loss at other hospitals. Chief Operating Officer (3.4) reported that after receiving a complaint from a patient about an unnecessary procedure during a gynaecological examination, the hospital group initiated an investigation. Observing a pattern of behaviour from the doctor across Hospital Group 3, including this recent incident, Hospital Group 3 and its affiliated sister hospital were informed. As both hospitals shared similar views on the doctors' behaviour, the doctors were dismissed from their positions, which showed the importance of information exchange between institutions. As seen above, while the withdrawal of practising privileges is typically driven by severe issues such as endangering patient safety or exhibiting problematic patterns, there was an exceptional case in my study. Executive Medical Director (8.2) (Chapter 5, page 48) described an instance where a doctor was dismissed for crudely commenting about NHS patients in a video shared on a hospital WhatsApp group.

6.2.3 GMC Referral

In addition to the above restrictive actions, a doctor can be referred to the General Medical Council (GMC). Before delving into participants' responses, understanding how the GMC conducts investigations and how it makes decisions will render the rest of the chapter more comprehensible. The GMC receives several thousand concerns annually, closing approximately 80% without investigating, as these do not meet thresholds or fall outside its investigatory remit. Immediate closures are typical, though some may take longer if complex. In cases where no follow-up is heard from the GMC, one can assume the concern was closed.

A few cases not warranting investigation are shared with the individual and their responsible officer for consideration during ongoing appraisal and revalidation. Prior notice is given if

additional information from an employer or a responsible officer is necessary before decision-making. An investigation is initiated if the GMC believes the concern, if substantiated, necessitates restricting medical practice. Such scenarios include misconduct, poor performance, criminal convictions, physical or mental health issues impacting medical practice, determinations by other regulatory bodies, or insufficient English proficiency (GMC, 2024a).

If the GMC decides to investigate a concern raised about a doctor, it does not indicate a preliminary decision. Many investigations conclude without action, with only the most serious concerns leading to suspension or removal from the medical register. When GMC start an investigation, it will contact a doctor's employer for pertinent information. GMC can conclude your case with no further action, issue a warning, agree on undertakings with the doctor to address a problem with the doctor's practice, and refer the doctor's case to the MPTS—the MPTS for an interim orders tribunal hearing. Although part of the GMC, it operates independently and reports directly to Parliament. The GMC, in 2021, referred fewer than 300 of the 350,000 registered doctors to a medical practitioners' tribunal hearing. If the MPTS determines that a doctor is unfit to practice, it can suspend or remove the doctor from the medical register or impose conditions on their registration. Additionally, the MPTS can issue a warning if a doctor has significantly deviated from the guidelines outlined in Good Medical Practice, even if their fitness to practice is not impaired (GMC, 2024b).

Only cases where there is a realistic prospect of proving significant impairment are referred. This decision is based on a two-part test: first, the seriousness of the allegations, and second, the likelihood that those allegations can be substantiated. Considerations include whether the doctor's failings are capable of being remedied, whether they have already been addressed, and the likelihood of those failings being repeated. Misconduct examples include sexual assault, violence, severe clinical concerns, and unlawful discrimination.

Case examiners may invite doctors to comply with undertakings if it is sufficient to protect patients without tribunal hearings. Impairments can arise from misconduct, deficient performance, criminal convictions, health issues, or other regulatory determinations. Medical practitioners' tribunals can take no action, agree to undertakings, impose conditions, suspend, or erase a doctor from the register. Even without a finding of impairment, significant departures from standards may still warrant warnings (GMC, 2024c).

As outlined earlier, the GMC uses a multi-step evaluation process, after which the MPTS takes over to conduct its own detailed assessment. This extended, multi-phase approach often results in prolonged investigation timelines. Furthermore, as stated by the GMC, if cases do not meet the established threshold, no action is taken in response to these complaints. Consequently, participants prefer to resolve issues internally within the institution. Participants (2.1 and 3.4) decide on these matters in conjunction with the Medical Advisory Committee, reporting doctors to the GMC only when deemed necessary. Participants consider referring to the GMC as a last resort and mentioned that it rarely occurs during their professional careers, thus limiting their experience with such cases. Some participants (1.4,2.3,3.6) emphasised that they had never witnessed such situations firsthand and never referred a doctor to the GMC. They witnessed it because if they did, patients sometimes approach the GMC directly.[18] Consequently, limited participant experience is reflected in the chapter with fewer examples.

When one looks at the reasons why participants refer doctors to the GMC, one comes across the reasons mentioned earlier: poor medical practice, repetition, and drug abuse. Hospital Director (1.1) and Chief Operating Officer (3.4) reported doctors at their hospitals to the GMC due to poor medical practice. In both cases, the doctors' Practice Privileges (PP) were

[18] Although GMC allows patients to refer doctors directly, it first directs patients to local channels during this process. When you enter the website, you will see the titles Raise a concern about your GP, Raise a concern about your treatment at a hospital or local service, Concern about your private care. These titles also include links to where to complain if you have a complaint about the place providing the service. If you want to continue with GMC, the system that GMC calls the "concern tool" decides whether your complaint is at the GMC level (GMC,2024a).

suspended during the investigation. Both participants expressed satisfaction with the GMC's performance in this process and noted their keen involvement in the matter.

As previously discussed, repeated mistakes or misbehaviours are also considered a threat to patient safety. The Director of Clinical Services (2.2) and Medical Director (3.6) emphasised that repeated instances of inappropriate behaviour by doctors could trigger a serious investigation. This investigation could ultimately result in the doctor losing their job and potentially being referred to the GMC.

Another reason for referral that emerged from interviews with participants was related to the use of medication by doctors. This includes both the treatment of patients with medications and the use of drugs by doctors themselves, which may fall into the category of drug abuse. The Hospital Director (8.1) (see chapter 5, page 116) mentioned being suspicious of a doctor abusing the medications they prescribed and, therefore, referred him directly. Also, A Head of Education and Clinical Training (3.5) said that a doctor involved in the theft would only draw up half the prescribed amount of a drug, discard it in a sharps bin (used for disposing of medical waste), and later retrieve the drug from the bin when no one was around. Over time, the doctor's behaviour became erratic and showed signs of addiction. Eventually, surveillance cameras caught them in the act. This led to an investigation and trial by the regulatory authorities, where the doctor was struck off and referred to the GMC.

The Executive Medical Director (8.2) provided two examples related to medication abuse. In the first case, a doctor attempted to persuade and encourage an adolescent patient to take their medication by consuming the medication in front of the patient. Participant 8.2 found this behaviour very concerning and initiated an investigation. The investigation revealed that the doctor exhibited irregular behaviour in other areas, leading to a referral to the GMC.

In the second case, a locum doctor wrote unnecessary prescriptions, raising concerns about their professional conduct. Prescriptions for drugs that could be abused lead to another

immediate referral. He added, “These examples illustrate severe misconduct in the medical field.”

The participants do not know what the GMC has decided on the above examples. However, in some cases, even when a GMC investigation does not yield conclusive results, participants still refer situations they find suspicious to the GMC for further assessment. Also, participants chose to refer a doctor to the GMC due to patient safety concerns. Although GMC generally does not take any action against the doctor, in the cases it does, doctors will get a record in their folders that is accessible regardless of where the doctors practice. This allows employers to review the doctor’s file and understand the context of the situation. Even if the GMC did not impose sanctions, employers could monitor the doctor closely and address deficiencies. Revisiting the example provided by the Medical Director (7.1) under the section “Practising Privileges Right”, the doctor was repeatedly warned for improper antibiotic administration. Following these warnings, the doctor’s practising privileges were suspended. Subsequently, the doctor voluntarily withdrew his practising privileges from that hospital. As one Medical Director (7.1) explained, “he withdrew his practising privileges voluntarily to avoid further investigation and possible referral to the GMC”. Subsequently, the doctor voluntarily withdrew his practising privileges from that hospital.

The participant stated that this voluntary withdrawal raised even more suspicion, which prompted them to refer the doctor to the GMC and inform the responsible officer about the situation.

Executive Medical Director (8.2) recounted an incident involving a visiting consultant who faced multiple complaints from vulnerable women, alleging that he manipulated them during therapy, leading them to believe he was in love with them. Although these incidents were historic, the speaker’s organisation decided to investigate since the first complaint came from a woman outside their care who lacked a GMC framework. Despite the GMC finding no

wrongdoing after a year and a half, the participant decided to revoke the consultant's visiting privileges due to concerns about his practice. The speaker felt that the consultant was acting as a therapist without proper training, despite the consultant's argument that he was merely offering support. This decision reflects the speaker's discomfort with the consultant's approach, even though the GMC did not find fault.

In the most striking and powerful example from the participants regarding the referral to GMC, the participant talked not about his own experience but about his friend's experience. The participant provided an anecdote about a friend who, due to confidentiality reasons, is not identified by participant number. The participant, a colleague and friend of Dr. Justin Stebbing (see Chapter 5, page 118), described how Dr. Stebbing made incorrect decisions regarding patient care.

Participants in this study reported limited experience with referring doctors to the GMC, often lacking detailed knowledge of the outcomes of such referrals. While internal measures and local actions are prioritised, they follow a multi-stage investigation process when cases escalate to the GMC. If deemed severe enough, cases may be escalated to the MPTS, which has the authority to impose sanctions ranging from warnings to suspension or even erasure of a doctor's registration.

Although this study did not directly examine the outcomes of GMC referrals, MPTS hearings serve as a formal regulatory mechanism addressing misconduct. Outcomes vary based on the severity and context of the doctor's actions. For example:

Warnings may be issued for behaviour that falls short of professional standards but does not impair fitness to practice.

Suspensions are applied when doctors need time to reflect and remediate their actions while protecting public safety.

Erasure is reserved for severe or repeated misconduct incompatible with professional standards, ensuring patient safety and public confidence. These decisions underscore the importance of clear evidence, insight, and remediation in assessing a doctor's fitness to practice.

For example, between 2017 and 2022, the General Medical Council (GMC) censured 24 doctors in the UK for improperly accessing and using patient information, highlighting the critical importance of maintaining patient confidentiality. These cases were among 194 incidents of alleged confidentiality violations reported during that period. The GMC emphasised that breaches of patient trust are taken very seriously, and such misconduct can lead to disciplinary actions, including warnings or removal from the medical register. This underscores the necessity for healthcare professionals to adhere strictly to data protection protocols to preserve the integrity of the doctor-patient relationship (Campbell, 2023).

Further research could explore the interplay between private hospitals and formal regulatory bodies like the GMC and MPTS. Understanding these dynamics is crucial for developing robust systems that balance professional accountability with opportunities for remediation and return to practice, where appropriate.

6.3 Conclusion

This chapter has explored the processes by which doctors' deviant behaviours are assessed and sanctioned within private healthcare institutions, focusing on internal measures and formal regulatory actions. It discussed three key mitigating factors: professional tension, arrogance, and trust due to the demands of the profession, as well as the impact of personal lives on performance. These factors often lead to leniency and informal warnings rather than referrals to the GMC. However, as misconduct escalates, stricter measures like limiting or suspending medical privileges are applied. The chapter also highlighted cases leading to formal referrals

to the GMC and insights from MPTS (The Medical Practitioners Tribunal Service) hearings, showcasing sanctions from warnings to erasure.

The findings indicate that doctors' misconduct or errors are initially approached with tolerance, taking into account mitigating circumstances. By issuing informal warnings, hospital management claims to provide the doctor with sufficient time to correct their behaviour without initiating a local-level investigation.

If the doctor's behaviour does not improve, another local measure, the limitation of practising privilege rights, is applied. If the hospital believes it cannot resolve the issue locally, it refers the case to the GMC.

For a referral to be considered by the GMC, it must meet the GMC's threshold; otherwise, the case is closed. When accepted, the GMC has a multi-stage investigation process and, if deemed severe enough, escalates the case to the MPTS. Even in cases that reach this final stage, there remains a possibility that the doctor will face no sanctions. Additionally, if the MPTS erases the doctor's registration, thereby preventing them from practising, the doctor retains the right to request re-registration and return to the profession later.

The results indicate that doctors' deviant behaviour can be tolerated for extended periods depending on hospital management. As long as the doctor provides economic value to the hospital (see Chapter 5), they may benefit from the "mitigating circumstances" umbrella, or they may only receive a suspension instead of losing their practising privileges (PPs), allowing them to continue working and seeing patients. When it comes to the GMC, although participants benefit from the RO system, there are perceived gaps once a doctor is referred to the GMC. Even if the hospital escalates the issue to the GMC because it could not be resolved locally, the GMC may close the complaint without investigation if it does not meet its threshold.

An important point here is that, by the time a doctor is referred to the GMC, they have already gone through the hospital's mitigating circumstances and PP processes. No findings in this study suggest that doctors are referred to the GMC for their first error or deviant behaviour. Despite this, the GMC may still choose not to investigate the referral. Furthermore, the GMC has the right not to inform hospitals if a referral is closed, which indirectly encourages hospitals to resolve issues locally while reducing the GMC's workload.

In the cases used in my thesis, participants encountered similar hearings at the MPTS for incidents reported by hospitals to the GMC. As seen in these cases, outcomes can vary widely. The key point, however, is that there is always a potential for deviant doctors to return to practice. Although doctors' return to the profession may seem beneficial to public welfare due to the time and scarcity of medical professionals, the potential long-term negative impacts on patients and colleagues must also be carefully considered.

In conclusion, this chapter examined how private healthcare institutions address doctors' deviant behaviours, focusing on internal measures and formal regulatory actions. Mitigating factors like professional tension and personal challenges often lead to informal warnings rather than referrals to the GMC. When local actions fail, cases may be escalated, though GMC thresholds and review processes often allow deviant doctors to remain in practice or later reapply after removal by the MPTS.

However, as only select private hospitals participated, with varied experience in managing such cases, further research is needed across more diverse settings to fully assess how these behaviours are managed for patient safety and professional integrity.

7 CHAPTER 7-CONCLUSION

7.1 Introduction

This research has presented and discussed the exploratory findings, as this study focuses on understanding medical deviance with minimal existing empirical groundwork about private hospitals and organisational research studies on medical deviance. This research has pursued two primary goals, starting with an analysis of the concept of medical deviance.

1) Investigating the institutional perception of clinical and behavioural deviance in private hospital management systems.
2) The analysis of the local and interinstitutional addressing and sanctioning practices.

The research draws on different theoretical perspectives: first, it starts from Sutherland's viewpoint on adopting an all-encompassing working definition of medical deviance by going through discussions on white-collar crime and occupational crime. Second, it has considered the privatisation of healthcare literature to understand the position of private healthcare in the UK. Lastly, it has focused on organisational culture and occupational crime literature to comprehend how organisational culture might shape the perception of deviance and how to address it. In terms of methodology, this study adopted a qualitative approach consisting of semi-structured interviews with 19 members of private hospitals' top management: board members, hospital managers and executive managers. The research facilitated an in-depth understanding of experts' perspectives and experiences regarding medical deviance.

In this study, I have framed medical deviance as a comprehensive umbrella term covering a broad cluster of acts (medicine abuse, yelling at staff, throwing operation tools, skipping necessary procedures, etc.) that vary from less harmful to extreme, affecting hospital dynamics and patient health and safety. In contrast, organisational bodies in the UK do not define it.

Instead, the GMC's Good Medical Practice guidelines outline and explain the behaviours that doctors are expected to follow. Non-compliance with or deviation from these guidelines can indirectly be considered medical deviance. In other words, medical deviance can be positioned as behaviours that fall outside the scope of Good Medical Practice guidelines. Chapter 2 has offered an overview of the theoretical framework- differential association and neutralisation techniques- under which I conducted this study. First, it provides a brief outline of the differential association theory and neutralisation techniques, and then it focuses on the conceptual toolbox with specific attention to the medical field. Second, it has reviewed the literature in the field of medical deviance, focussing on the organisational structure and culture. Furthermore, in line with the central theoretical perspective of this study, chapter 2 briefly reviews the privatisation of healthcare in the UK.

Chapter 3 details the method adopted, the data collection techniques used for purposive sampling, issues of access, coding and data-analysing strategies, the reflexivity process, and, finally, the ethics and limitations of this study. Chapter 3 outlines the research methodology employed in this study, emphasising its exploratory, qualitative approach to examining the perceptions and management of clinical and behavioural deviance by doctors in private hospitals within the UK healthcare system. The chapter details the use of semi-structured interviews with hospital board members, directors, and medical professionals, supported by thematic analysis to identify patterns and themes. It highlights the challenges of accessing elite participants and the strategies used for recruitment, including purposive and snowball sampling. The chapter also reflects on ethical considerations, such as maintaining participant confidentiality, obtaining consent, and addressing power dynamics during interviews. By adopting a critical criminological perspective, the study investigates the intersection of economic priorities, organisational culture, and regulatory frameworks in shaping how private

hospitals perceive and address deviant behaviours, while acknowledging the limitations inherent in its methodology and sample size.

Drawing on the collected interview data, three empirical chapters have tackled the research questions as follows. Chapter 4 engaged with organisational culture in private hospitals and management's expectations for doctors' behaviours. Drawing specifically on 19 interviews with private hospitals' management, this chapter helped provide a detailed view of private hospitals' organisational practices and dynamics and understand if it differs from the NHS and, if it does, how. The data aligns with the literature relevant literature and shows that (e.g. Beecher & Todd, 1954; Simmons et al, 2011; Rosenstein, 2011; Barach & Phelps, 2013; de Leon et al., 2014; Cochran & Elder, 2015; Berman-Kishony & Shvarts, 2015; Reid, 2014) the structure may influence deviant behaviours among the latter. As my research also demonstrates, economic concerns and interests of the hospitals might lead a doctor to cut corners (see Prielipp et al., 2010).

Chapter 5 focuses on how private healthcare institutions perceive, monitor, and address deviant behaviours among doctors, emphasising the distinction between errors and intentional deviations. It examines the tools and systems used for identifying and managing such behaviours, including patient feedback, performance data, and appraisal processes, while highlighting the challenges posed by grey areas and subjective discretion in decision-making. The chapter explores the influence of organisational priorities, such as financial incentives and hospital reputation, on how deviance is managed. Additionally, it underscores the critical role of patient safety in shaping institutional responses, emphasising the complex balance between economic, ethical, and regulatory considerations. It highlighted that doctors' deviant behaviours are assessed internally through professional standards, intent, and patterns of conduct. Participants consider 'deviance' to be a concept that is so powerful that participants

choose to use misbehaviour or disruptive behaviours, rather than 'deviance', to define the behaviours that I describe as deviance. However, there was no agreement on the concept's name, and the behaviours under the concept overlapped. Therefore, this research argues that regulatory bodies should establish a clear operational definition of medical deviance, explicitly addressing the seriousness of wrongdoing. This would help streamline the management of such behaviours in private hospitals and create a more organised and consistent body of literature. Hospitals rely on observational and appraisal systems to monitor doctors' behaviours, yet these processes are highly discretionary. While formal mechanisms within private hospitals exist, informal tolerance practices, such as leniency for profit-making doctors and tolerance of their individual circumstances, play a critical role in managing deviance, resulting in a limited number of cases being referred to the GMC (see Chapter 6 for more detail). Also, as my thesis demonstrated, the normalisation of deviance is another critical point that hinders the investigation of doctors' deviant behaviours since the action has already been accepted as normal (see also Banja, 2010; Simmons et al., 2011; Prielipp et al., 2010; Barach & Phelps, 2013; Wright, 2013; King, 2016; Price & Williams, 2018). Hospitals employ local remedies such as appointing speak-up champions and establishing clear communication structures to address this. Additionally, efforts to balance hierarchical power dynamics aim to further shape perceptions of and responses to doctors' actions. These measures, focused on sustaining teamwork and safeguarding the institution's reputation, align with findings in the literature (this is in line with previous literature; see e.g. Higgins & MacIntosh, 2010; Porto & Lauve, 2006; de Leon et al., 2014; Berman-Kishony & Shvarts, 2015; Grade et al., 2019; Sacks et al., 2015; Frasier et al., 2020; Laschinger et al., 2016).

Chapter 6 analyses and explains the private hospital sanctioning system against deviant doctors. The private sector's profit-oriented nature of private hospital often intersects with tolerance attitudes towards medical deviance, mainly where high-performing doctors contribute

significantly to the hospital's financial goals. As emerging from the interviews, private hospitals tend to apply lenient measures, such as informal warnings, to doctors' misbehaviour, with formal sanctions being reserved for their repeated or escalating misconduct. This leniency reflects economic considerations and operational pragmatism, highlighting the influence of financial success on tolerance levels for certain behaviours. However, as interviewees reported, private hospitals turn to internal measures, such as limiting doctors' practising privileges, when their deviance escalates before referring cases to the GMC.

Lastly, this discussion suggests that neutralisation techniques play a critical role in how private hospitals in the UK manage medical deviance, allowing them to reconcile financial priorities with ethical and professional obligations. Management frequently employs strategies such as distorting facts, denying harm, appealing to higher goals, and shifting responsibility to mitigate the impact of deviant behaviours while maintaining institutional profitability. For instance, hospitals justify leniency towards high-revenue doctors by emphasising their good intentions or the complexity of medical decision-making, making accountability more ambiguous. Additionally, regulatory bodies and legal systems often reinforce these dynamics by prioritising the retention of medical professionals over punitive measures, further enabling hospitals to distance themselves from responsibility.

Moreover, this discussion highlights how hospital management strategically frames deviance to align with economic goals, using techniques such as evidentiary solipsism—asserting exclusive authority over defining misconduct—and the displacement of responsibility, portraying doctors as independent contractors rather than institutional actors. These mechanisms not only obscure accountability but also contribute to the normalisation of deviant practices within private healthcare. By integrating insights from organisational criminology, this study underscores how the pursuit of financial stability shapes responses to deviance,

ultimately reinforcing a system where economic imperatives take precedence over transparent ethical governance.

Although the private sector may be thought to be stricter than the national health system in detecting and punishing medical deviance (e.g. due to the, generally speaking, smaller size of hospitals, less staff, and the heightened care provided to patients), this study demonstrates that in fact the opposite is true: private hospitals tend to deal with doctors' misconduct internally and rather leniently. Therefore, it can be argued that the number of cases reported to the GMC may be lower than the actual number of cases that should be reported. This situation indicates that doctors who should otherwise face disciplinary action manage to evade such consequences and continue practising, thereby gaining access to an environment where they are likely to perpetuate similar deviant behaviours. This shortfall poses significant risks to patient safety and professional ethics, highlighting the need for regulatory bodies to enhance the effectiveness of their oversight and reporting mechanisms.

7.2 Discussion

This study makes a significant contribution by introducing a new framework for understanding medical deviance, focusing on the interplay between economic interests and neutralisation techniques within private hospitals in the UK. Adopting an institutional perspective supported by original empirical data provides unique insights into how these institutions manage deviant behaviours while navigating the tension between operational demands and ethical priorities.

Drawing on 19 semi-structured interviews, the research explores how private hospitals reconcile the competing imperatives of patient care and economic gain. It examines their strategies for monitoring deviance and balancing leniency with punishment when addressing such behaviours. The findings reveal that private hospitals frequently employ neutralisation techniques to manage these conflicts, aligning their responses with institutional and economic

priorities rather than transparent accountability. Actions range from issuing warnings to imposing restrictions, suspensions, or withdrawals of practising privileges and, in more severe cases, referrals to the General Medical Council (GMC). However, the organisational context often influences these decisions, emphasising informal discretion and regulatory thresholds over uniform ethical standards.

Also, by incorporating a criminological approach, the study highlights the limitations of a purely medical perspective in explaining the systematic protection of doctors. This critical lens offers a deeper understanding of how structural and economic factors shape the responses to deviance in private healthcare, contributing to criminology scholarship by addressing the inherent conflicts in decision-making within these institutions. While some participants framed deviance in terms of individual misconduct, this study argues that an overreliance on a medical or individualistic perspective, focused on 'bad actors', obscures deeper systemic issues. Instead, the findings support a shift toward recognising how institutional processes, organisational culture, and governance structures contribute to the persistence or concealment of deviance. The criminological approach to healthcare has not been fully developed in the criminology literature. This is at least in part because, according to Sutherland (1949), physicians were viewed as inherently more honest than other professions. This perception was echoed by contemporaries such as Parsons (1951), Reiss (1961), and Hodge et al. (1964), who emphasised the ethical standards and social prestige of doctors, leading to their exclusion from early discussions of white-collar crime. These assumptions created a perception of the medical field as inherently virtuous, limiting the scope of research into deviance within healthcare for a long time and hindering the application of organisational crime theories to this domain. This exclusion reflects the broader context of the UK healthcare system, which, prior to the 1980s, was characterised by its nonprofit orientation, with economic profit largely absent as a motivator for organisational behaviour.

In contrast, the privatised healthcare system in the United States has provided fertile ground for exploring the intersection of economic imperatives and deviance. Burgess (1981), for instance, examined financial crimes committed by physicians, shedding light on how profit-driven systems can foster deviant behaviours. In this context, the primary concern has often been physicians misappropriating funds from hospitals or public systems, with less attention paid to broader organisational complicity in deviance. The US experience highlights the role of privatisation and profit motives in shaping deviant behaviours, providing a useful comparative lens for understanding the evolving dynamics in the UK healthcare system.

The structural differences between the US and UK healthcare systems delayed the application of organisational deviance frameworks in the UK. However, significant events such as the Stafford Hospital Scandal—a crisis linked to budget cuts within the NHS from 2005 to 2009—have brought the issue of deviance into sharper focus. The increasing privatisation of UK hospitals (Goodair, 2024) and an emphasis on economic profitability have created new opportunities for examining how financial and organisational pressures shape responses to deviant behaviours. These shifts have also underscored the normalisation of deviant behaviours for financial or other organisational gains (Kelman & Hamilton, 1989; Gioia, 1992; Wright et al., 2022; Entwistle & Doering, 2024), an issue that has been previously overlooked within the UK's public healthcare model.

This research focuses on perceptions and responses to clinical and behavioural deviance among doctors within private UK healthcare settings, specifically examining how hospital management understands and addresses these actions. Deviant behaviour like communication gaps and team dynamics (Awad et al., 2005; Sevdalis et al., 2007; Porath et al., 2015; Riskin et al., 2015;), other disruptive behaviours like rudeness (Rosenstein & Naylor, 2012; Van Norman, 2015; Villafranca et al, 2017) and medical errors (Wiegmann et al., 2007; Coats & Burd, 2009; Haynes et al., 2009) among healthcare providers poses significant risks to patient

safety (Makary et al., 2006; Belyansky et al., 2011) and institutional reputation (Reuber and Fischer, 2010; Jabeen et al., 2018; Senyapar, 2024) making it a critical area of study.

While public healthcare has frameworks for addressing deviance, there is limited research on how private healthcare organisations respond to such challenges. Existing studies often focus on the perspectives of doctors and nurses (Gillespie et al., 2009; Higgins & MacIntosh, 2010; Leung et al., 2012; Walrath et al., 2013; Wright, 2013; Cochran & Elder, 2015) without any distinction between the private sector and public sector and studies are medically based rather than criminology. By contrast, this research incorporates insights from participants in managerial roles, such as board members, hospital directors, and medical directors, and in the private healthcare sector.

As said above, the literature on medical deviance has predominantly focused on the behaviours of doctors and nurses (see Gillespie et al., 2009; Higgins & MacIntosh, 2010; Leung et al., 2012; Walrath et al., 2013; Wright, 2013; Cochran & Elder, 2015), leaving the managerial perspective largely underexplored. This oversight is significant because, as Ashforth and Anand (2003) argue, leaders play a critical role in the institutionalisation of deviance by "rewarding, condoning, ignoring, or otherwise facilitating" unethical behaviours (pp. 6–7). Their influence over organisational norms and practices makes the managerial perspective essential to understanding how deviance becomes normalised within institutions. Building on this, Entwistle and Doering (2024) emphasise the necessity of focusing on management to gain a more comprehensive understanding of organisational wrongdoing.

This lack of attention to management is particularly relevant in the context of private hospitals, where the prioritisation of economic profitability creates unique pressures. The normalisation of deviant behaviours by companies prioritising financial gain is not new in the criminology literature (Ashforth and Anand, 2003; Earle et al., 2010). However, this study offers a fresh

perspective by revealing how leadership dynamics within UK private hospitals shape institutional responses to doctors' deviant behaviour—an area that has received limited scholarly attention. As Ashforth and Anand (2003) describe, leaders significantly influence the conditions under which deviant behaviours are rewarded or overlooked, thereby facilitating their institutionalisation. This study demonstrates how the pressures of economic goals compel management to employ neutralisation techniques to reconcile profitability with the societal and professional expectations inherent in healthcare systems.

From the perspective of institutional corruption, Lessig (2013) argues that corruption arises when ongoing, strategically applied pressures—often legal or socially acceptable—gradually erode an institution's ability to fulfil its intended purpose. This form of corruption diverts the institution from its intended purpose or weakens its ability to fulfil its objectives. Additionally, the corruption erodes public trust in the institution or its intrinsic trustworthiness, ultimately compromising its legitimacy and overall function. Lessig conceptualises institutional corruption in consequentialist terms, defining it by the impact that corrupt behaviours have on an institution's effectiveness rather than the legality or morality of these behaviours. One way institutional corruption manifests is by diverting an institution from its primary function, potentially rendering it incapable of fulfilling its role.

However, Lessig does not assume that all institutions necessarily have a well-defined purpose. Corruption, in this sense, can only exist if an institution's function can be assessed relative to a specific goal—if no such goal exists, the concept of corruption would not apply. Miller (2010) further argues that an act or practice qualifies as institutional corruption if it negatively impacts the institution's collective purpose, disrupts its shared processes, or degrades the integrity of individuals within it. Additionally, for it to be considered corruption, the individual involved must have intended, anticipated, or had the ability to prevent their contribution to these harmful

effects. When looking at hospitals, the term “hospital” generally refers to an institution established to receive, care for, and treat individuals requiring medical, surgical, or dental attention. It is typically defined as a nonprofit facility, meaning it is not operated for private financial gain (Finch, 1994).

Returning to the concept of institutional corruption, it is important to note that it can manifest not only through overt wrongdoing but also through more subtle mechanisms that gradually weaken an institution’s ability to fulfil its core purpose. Rather than completely obstructing its function, this form of corruption introduces barriers that make it more difficult for the institution to operate effectively or maintain public trust. In this way, institutional corruption erodes both the institution’s credibility and its trustworthiness, further diminishing its ability to serve its intended role (Lessig, 2013).

Although hospitals are specifically established for patient care, and this purpose is observed in participant statements, the fact that the hospital is private opens the door to another debate. The private nature of a hospital, meaning that it operates with the goal of economic profit, can also make it more difficult for the hospital to fulfil its primary purpose of providing patient care and may hinder its normal and effective operation.

Lessig (2013) suggests that certain institutions, such as public health systems, rely on public trust to effectively fulfil their functions. When external influences undermine confidence in their recommendations, the institution’s credibility is compromised. As a result, any factor that diminishes the public’s trust in its guidance and decision-making can be considered a form of institutional corruption, as it hinders the institution’s ability to achieve its intended purpose.

In this context, private hospital management can be evaluated as a source of institutional misalignment. While management is technically part of the hospital institution, its objectives

may diverge from the hospital's broader mission. In such cases, management may function as a quasi-independent entity, similar to how the pharmaceutical sector operates, potentially undermining the hospital's collective purpose. The conflict of interest between the hospital's foundational mission and the objectives of management is inevitable. An example of this conflict is hospital management's tendency to focus more on and provide greater support to higher-earning doctors.

However, the support provided in this context and even the impression of a partnership can be misleading. Grey (2009) explains this through the effects of neoliberal policies on workplace health and safety regulations. He emphasises that workplace regulations suggest that both employer and employee share equal responsibility, while in practice, the employee ultimately bears the greater burden. Since workers are in a more vulnerable position in the workplace, they are at greater risk in the event of an accident or violation and must take extra precautions to protect themselves.

Tombs and Whyte (2007:139) describe this phenomenon as a "de facto corporate veil," which effectively shields both company owners and senior executives from personal responsibility for safety-related offences. The de facto corporate veil refers to a situation where, in practice, corporations and their senior officials are shielded from personal liability, even when legal or ethical accountability should apply. This concept, described by Tombs and Whyte, suggests that corporate structures and regulatory frameworks create a form of indirect protection for executives and owners, making it difficult to hold individuals responsible for corporate wrongdoing, particularly in cases of safety violations, workplace negligence, or institutional misconduct.

Returning to the initial point of conflict between the hospital as an institution and the objectives of its management board, this situation exemplifies the tension between institutional purpose

and administrative interests. A broader societal context highlights this contrast. For instance, the NHS in the United Kingdom has shaped public perceptions of healthcare through its principles of free and accessible care for all, emphasising equity over profitability. Also, the profession's ethical rules say, "First, do no harm" (Leung et al., 2012). As my interviews revealed, these foundational principles directly oppose private hospitals' profit-driven motives, creating a moral and operational dilemma for private hospital administrators. To navigate this dilemma, expanded neutralisation techniques proposed by Kaptein and van Helvoort (2019) can be integrated with the concept "prioritising the bottom line" from Entwistle and Doering (2024).

Although the term "bottom line" originally refers to the net profit or loss in financial reports, it has come to signify an intense focus on a single critical priority at the expense of other considerations (Mesdaghinia et al., 2019, p. 492). This focus is subtly evident in private hospitals, where revenue-generating doctors are often prioritised. For instance, regular meetings are held with doctors who generate more profit, and leniency is displayed in disciplinary measures against them. While this prioritisation of focus can lead to increased efficiency, Greenbaum et al. (2021) warn that it may result in an overemphasis on a narrow range of performance metrics, often neglecting broader patient care. In cases where prioritisation indirectly encourages deviant behaviours, private hospitals deny the deviance outright or, when untenable, shift responsibility.

One technique commonly employed by individuals to deny deviance is the distortion of facts (Kaptein & van Helvoort, 2019). This approach is particularly effective in medicine, where knowledge is inherently complex and often indeterminate. Kaptein and van Helvoort (2019) describe this phenomenon as "there is no truth," though in healthcare, a more fitting adaptation might be "there is no single truth." For instance, management may justify a doctor's clinical

decisions by emphasising the existence of multiple valid treatment options for the same condition. While this argument is plausible and reflects the evolving nature of medical science, it also limits patients' ability to critically engage with or challenge such decisions due to their lack of specialised knowledge. This dynamic fosters an implicit reliance on the doctor's expertise and intentions, which, while often necessary, can sometimes obscure errors or biases.

As highlighted in the literature, the medical profession has established a monopoly within education (Hepple, 2001; Logghe et al., 2018), which appears to extend into research and professional regulation as well. In this highly specialised domain, doctors' behaviours are predominantly evaluated and regulated by their peers, creating a system of internal oversight. While this peer-regulated structure ensures that those with the requisite expertise assess complex clinical matters, it also raises concerns about insularity. The profession's control over both knowledge production and evaluation can limit external scrutiny, reinforcing a closed-loop system in which alternative perspectives—whether from patients, interdisciplinary fields, or broader societal discourse—struggle to gain traction. This self-regulatory framework, while essential in safeguarding medical expertise, thus also presents a paradox: it preserves professional autonomy and scientific rigour while simultaneously reducing accountability to non-experts, leaving the legitimacy of medical decision-making largely unquestioned.

In addition to distorting facts, private hospitals can also deny the consequences of deviant behaviours. My participants stated that when patients file complaints or demand refunds, management can deflect accountability by arguing that complications could not be directly linked to earlier procedures, particularly if significant time has passed. Williamson (2015) refers to this as the "fallacy of measurability," where outcomes that cannot be quantified are dismissed as non-existent or unworthy of consideration. Furthermore, some participants of my study claimed that rising living costs have led to increased complaints motivated solely by

financial concerns. They claimed patients only try to take money from the hospital's pocket (see e.g. page 126). This line of defence, which reduces patient grievances to financial immorality, parallels tactics seen in broader comparisons between private hospitals and the NHS. Private hospitals often respond to criticisms, such as claims of prioritising profit or providing insufficient care, by highlighting perceived shortcomings within the NHS, such as long waiting lists or delays in treatment. However, these issues are often linked to systemic challenges, such as chronic underfunding, rather than inherent inadequacies in the NHS itself. By positioning themselves as a superior alternative, private hospitals capitalise on these public frustrations to bolster their own reputation. Participants of my study emphasised that patients often choose private hospitals due to excessively long waiting times in the NHS (see e.g. page 102). They also highlighted that patients opt for private hospitals because of the perceived higher quality of services provided. However, previous studies (Goodair and Reeves, 2024) and participants' statements in this study reveal a different perspective: private hospitals tend to select healthier patients, thereby reducing the likelihood of dealing with high-risk complications like post-surgical infections, multi-organ failure, or the need for prolonged critical care interventions. Additionally, these hospitals are not always equipped to handle more complex cases, underscoring limitations in their capacity to provide comprehensive care.

Another prominent neutralisation strategy involves emphasising the intentions of doctors, which also has a part in distorting the facts. Participants in this study often justified questionable behaviours by doctors by asserting that doctors acted with good intentions, suggesting that such actions were not deliberate misconduct. However, determining intent remains inherently complex and subjective. Leape (1994) defines error as an "unintended act,"but proving whether an act was genuinely unintentional is fraught with difficulty. Jesilow et al. (1985) highlight the inherent challenges in establishing intent, pointing to physicians' reluctance to criticise their peers and the vagueness of treatment guidelines as barriers to

accountability. Consequently, decisions on intent often rely on intuition rather than systematic evaluation, blurring the lines between error and deviance.

Management often positions itself as the ultimate authority in determining medical deviance and assessing a doctor's intent. Kaptein and van Helvoort (2019) describe this as "denying one's impotence," where management asserts its unique ability to interpret events and redefine deviance to align with institutional interests. Similarly, Nelson and Lambert (2001) discuss "evidentiary solipsism," a behaviour where individuals frame themselves as uniquely capable of discerning the "true" meaning of events, thus enabling them to manipulate narratives around deviant behaviours. Participants consistently emphasised their moral integrity, claiming they always acted ethically in addressing deviance, even under external pressures. However, this assertion often masks the influence of financial considerations, with revenue generation subtly underpinning these evaluations.

As illustrated in Chapter 5 of this thesis, management frequently assesses deviant behaviour using a framework based on four key criteria: frequency, seriousness, expression of regret, and intent. Initially, the frequency of the deviant act is assessed, with isolated incidents more likely to be classified as errors. If a pattern of recurrence emerges, the seriousness of the act and its impact on patient outcomes become the focus. Moreover, the systems used to assess actions by doctors, as displayed in Table 2: How intent is assessed in practice, are predominantly employed within the NHS. Participants provided no information regarding these systems. However, two principal concerns have emerged. The first relates to data sharing delays. While independent hospitals now submit outcome data to PHIN, only 82% provide incident data of publishable quality. Furthermore, these submissions primarily pertain to clinical harm rather than behavioural deviance (Independent Healthcare Providers Network, 2024).

The second issue involves the absence of a single national enforcement mechanism. An NHS Trust that disregards the PSIRF framework fails NHS England oversight reviews. By contrast, a private provider must still meet the CQC's fundamental standards, but enforcement is more protracted and typically focuses on broader ratings—such as "safe" and "well led"—rather than a specific framework breach.

Within the NHS, compliance with the Patient Safety Incident Response Framework (PSIRF) is contractually mandated rather than simply recommended. Service Condition 33 of the 2024/25 NHS Standard Contract requires all providers of NHS-funded care to maintain a PSIRF-compliant incident response policy and plan, rendering non-compliance a breach of contract (NHS, 2023). Delivery is monitored through NHS England's annual operational planning process and the NHS Oversight Framework. A trust that fails to implement PSIRF may face escalatory measures, including recovery support interventions and potential financial penalties, under this national oversight system (NHS England, 2022c; NHS England, 2024b).

In contrast, independent hospitals are regulated by the Care Quality Commission's statutory fundamental standards. CQC inspectors assess compliance with regulations on safe care and treatment (Regulation 12) and good governance (Regulation 17) without legally enforcing PSIRF or any equivalent framework (CQC, 2023; CQC, 2024b). Although CQC reports increasingly reference PSIRF implementation—such as Queensway Hospital's 2025 report, which noted the hospital's progress with PSIRF while rating its safety domain as "Good" (CQC, 2025)—enforcement still relies on general quality ratings and subsequent warning notices or re-inspections. Consequently, a private provider neglecting PSIRF must still meet fundamental standards, but the regulatory process is slower and framed around overall service quality rather than a specific framework breach. In contrast, an NHS trust faces immediate contractual and performance-related sanctions for similar non-compliance.

Finally, management examines the doctor's expression of regret, often interpreting genuine remorse as a mitigating factor. However, despite these layers of evaluation, financial considerations remain the underlying determinant in many cases, and it is one of the key elements of addressing deviance.

While economic considerations drive the reluctance to penalise doctors within private hospitals, examining this issue at the level of regulatory bodies reveals a different underlying reason: "the appeal to higher goals", which is another neutralisation technique of Kaptein and van Helvoort's (2019). Jesilow et al. (1985, 1986) have argued that the legal system is often reluctant to penalise physicians, a claim further supported by a news article from Kirk (2017). The Evening Standard reports (Lydall,2021) that Dr. Mohammed Shamji, a highly-regarded British surgeon, was found guilty of groping two female colleagues. Despite the seriousness of the offences, the court spared him jail time, citing his exceptional medical skills and contributions to the field as key factors in the decision. The judge argued that incarcerating Dr. Shamji would result in a significant loss to society due to his medical expertise. This decision has drawn criticism for seemingly placing professional competence above accountability for misconduct, raising concerns about how power, status, and reputation can influence the outcomes of legal and disciplinary actions involving deviant behaviour.

In this context, the legal system and regulatory bodies often operate under the assumption that, despite instances of misconduct, a doctor may still serve the broader interests of public health. As a result, even when a private hospital refers a doctor to the GMC for investigation, there is a higher likelihood of a favourable decision allowing the doctor to continue practising, as stated by some participants (page 130). This view is further supported by anecdotal evidence and media reports (Kirk, 2017), which highlight cases in which regulatory decisions appear to

prioritise the retention of medical professionals over imposing stricter sanctions for misconduct.

As my research also demonstrates, when deviance poses a significant risk to the hospital's reputation or finances, management shifts from redefining deviance to outright denial of responsibility. For example, they may argue that deviant doctors are independent contractors who merely rent hospital facilities, thereby distancing the institution from accountability. Management's attitude aligns with Entwistle and Doering's (2024) concepts of "diffusion and displacement of responsibility" and Kaptein and van Helvoort's (2019) "blaming circumstances." Such strategies highlight the power dynamics in private healthcare, where institutions influence how deviance is defined and addressed.

The lack of clarity surrounding the concept of medical deviance also contributes to hospital management's ability to deny responsibility. Moreover, there is a significant gap in the literature regarding how regulatory bodies conceptualise and address medical deviance, the balance between public and institutional interests, and the roles of various stakeholders. Additionally, existing literature tends to focus primarily on the actions of doctors, drawing attention away from the broader systemic and organisational dimensions of medical deviance. This narrow focus further complicates efforts to establish a comprehensive understanding and effectively regulate such behaviours. As discussed in the literature review (Chapter 2), academic research on medical deviance has been relatively limited. With the intensification of debates surrounding the incompetent physician, initiated in the 1960s (Derbyshire, 1965), and medical deviance—or "disruptive behaviour" as it is often termed in medical literature—this issue has primarily been studied within medical scholarship. It is possible to argue that this focus has led to two significant disadvantages in the literature.

As discussed in the literature review (chapter 2), the medical field predominantly employs the terms “disruptive behaviour” and “disruptive doctor.” This terminology focuses on deviant behaviours and their causes rather than on systemic and organisational factors. Jesilow’s use of the term *medical deviance* concentrates solely on financial crimes within the medical field, labelling them as *medical deviance* while excluding behaviours categorised as *disruptive behaviour*. However, the activities highlighted by Jesilow, which are entirely profit-driven, could be more appropriately considered crimes within the context of theft rather than deviance.

Therefore, Jesilow’s term “medical deviance” should be retained. However, its content should be revised to encompass a broader scope, with the financial activities he highlighted being evaluated under the crime category. In light of the literature and the findings of this study, I propose the following definition of medical deviance. Medical deviance can be understood as a spectrum of behaviours that, while not severe enough to fall under criminal law, are psychologically or physically disruptive to patients and colleagues at a low to moderate level. A behaviour that qualifies as medical deviance must involve the misuse of the trust inherent in being a physician or healthcare worker for personal gains, such as maintaining favourable relationships with hospital management, seeking psychological or physical gratification, or pursuing financial benefit. This misconduct occurs through actions that deviate from the guidelines and rules established by the hospital, management, or other governing bodies, there by representing a breach of ethical or institutional standards.

7.3 reported satisfaction **Policy Considerations and Outcomes**

To develop effective policies addressing medical deviance, significant restructuring of GMC and CQC guidelines is needed, beginning with a review to clarify the boundaries and content of medical deviance. This redefinition should include harmful practices normalised at the hospital level that are not currently perceived as deviant. The GMC's Guidance on Reporting Alleged or Suspected Criminal Conduct to the Police (2015) categorises offences like theft, sexual misconduct, and drug offences, providing distinctions between crime and deviance. However, differentiating between professional and non-professional crimes would reduce confusion, highlighting the need for clearer conceptual frameworks.

Introducing distinct terms such as medical deviance and medical crime could improve clarity and support proportional punitive practices aligned with the severity of the act. While GMC and CQC guidelines are broadly comprehensive, participants' opinions in Chapter 5 reveal variability in their interpretation, aligning with criticisms by Entwistle and Doering (2023). Their study highlights limitations in the regulatory framework, such as prioritising compliance with administrative processes over evaluating patient care outcomes, as exemplified by the Stafford Hospital scandal (mentioned on page 18).

The CQC's framework, based on five key domains—safe, effective, caring, responsive, and well-led—assesses compliance with fundamental standards but often emphasises formal structures rather than substantive care outcomes. These concerns are echoed in the Review's Interim Report on the Operational Effectiveness of the CQC (UK Government, 2024a), which identified shortcomings such as inefficiencies, technological issues, loss of credibility, and ambiguity in rating methodologies. These deficiencies reduce the CQC's capacity to identify underperformance and drive improvements in care delivery.

Reforms should address these issues by enhancing process evaluations, fostering sector expertise, and ensuring regulatory frameworks engage directly with patient care realities. This would strengthen regulatory bodies' credibility and provide valuable insights for addressing deviance in healthcare across the public and private sectors.

7.4 Recommendations for Future Research

While conducting this study, several themes emerged that suggest compelling directions for future research in healthcare deviance. Central to this endeavour is exploring how doctors' deviant behaviours are perceived and managed, particularly within regulatory, ethical, and cultural contexts in private healthcare. A multidimensional approach could foster mechanisms that better protect patients, institutions, and the public.

One significant limitation of this study is its focus on private hospitals, excluding NHS institutions. Future research could explore similar themes in NHS settings to enable direct comparisons, as illustrated by the Stafford Hospital case (mentioned on page 18). Management priorities, financial objectives, and governance structures in the NHS have been linked to systemic failures and unethical practices (Entwistle & Doering, 2024). Such studies would illuminate differences in organisational deviance across public and private sectors and inform targeted interventions.

A key distinction in the literature and findings is the concept of intent, which remains challenging to measure. Participants in this study often linked intent to personal values, placing responsibility on individual behaviour. Future research should investigate how intent is understood by various stakeholders to refine training, ethical guidelines, and management strategies. Therefore, future research should pursue a multi-layered agenda that deepens empirical understanding of how intent is judged. First, large-scale vignette experiments should be run across both NHS and independent hospitals, presenting identical clinical scenarios to

review panels that either apply the Just Culture algorithm or rely on informal deliberation; the resulting data would reveal whether algorithmic guidance produces more consistent and equitable intent classifications. Complementing this prospective work, retrospective bias audits of completed PSIRF and serious-incident files ought to examine whether factors such as a doctor's gender, ethnicity, or the length and quality of the manager–doctor relationship, together with panel composition, systematically predict culpability findings once harm severity and behavioural frequency are held constant. A third line of inquiry should employ randomised controlled trials to test the effectiveness of cognitive-bias training for reviewers, comparing modules that target specific distortions—halo and horn effects, outcome bias, and affinity bias—to establish which interventions most improve inter-rater reliability. Finally, these scholarly efforts would be greatly facilitated if NHS England mandated that every PSIRF (and equivalent independent-sector) report contains an "intent assessment appendix" documenting the Just Culture algorithm responses and any managerial overrides; such a standardised dataset would not only enable the empirical projects outlined above but also furnish a national benchmark for the quality of decision-making in incident investigations.

Although deviance is often viewed negatively, its positive aspects warrant exploration. Technological advancements continually redefine medical practices, transforming initially deviant behaviours into accepted norms. Positive deviance approaches, as seen in studies like Gabbay et al. (2013) and Foster et al. (2022), highlight the potential of studying "outliers" to uncover context-specific best practices, fostering resilience and adaptability in healthcare systems.

Additionally, this research critiques the media's portrayal of private healthcare institutions. While the NHS represents values like equality and solidarity (Webster, 2002; Gorsky, 2008), private hospitals are often perceived as contradicting these principles, raising tensions around profit-driven motives. The "your money or your life" dilemma, humorously exemplified by

Jack Benny[19]'s indecision, underscores the power dynamics in healthcare. This authority can provoke public frustration, often directed at institutions rather than individual physicians. By examining these dynamics, future studies could address public perceptions and their implications for healthcare governance.

[19] Jack Benny (born Benjamin Kubelsky on February 14, 1894, in Chicago; died December 27, 1974, in Beverly Hills, California) was a legendary American entertainer renowned for his impeccable comedic timing and subtle style. A skilled violinist by training, he began performing in vaudeville from 1912, where the violin became a comedic prop rather than a serious instrument. His career turned pivotal in 1932 with his debut on radio, gaining widespread popularity through The Jack Benny Program, which aired for 23 years and later transitioned to television, where he remained a fixture until 1965 (Britannica, 2025).

8 BIBLIOGRAPHY

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APPENDIX A- INFORMATION SHEET

PARTICIPANT INFORMATION SHEET FOR BOARD MEMBERS, MANAGERS, DIRECTOR OF CLINICAL SERVICES, CHIEF EXECUTIVES AND DIRECTOR OF QUALITY/SAFETY/GOVERNANCE/RISK OF HOSPITALS AND GPS

MEDICAL DEVIANCE IN THE PRIVATE HEALTHCARE SECTOR IN THE UK

Dear Sir/Madam

My name is Esin DAMAR, and I am a PhD candidate in the Department of Sociology at the University of Essex. I would like to inform you about my PhD project and invite you to participate in the research. Please take your time to read the following information carefully before deciding.

Purpose of the study

This study aims to understand

1. How private healthcare perceives medical deviance.
2. How private healthcare responds to medical deviance.

Importance of the study

This study is important because

1. The General Medical Council prescribes specific rules that doctors have to obey while performing their profession, whose breach may impact patients' trust in the healthcare system. We can build a better doctor-patient relationship if these behaviours are understood and prevented.
2. The UK health policy has been changing towards a gradual privatisation of the healthcare sector. Understanding how medical deviance has been tackled in the private healthcare sector will likely inform future efforts in the sector.

Why should you take a part?

a) You will contribute to defining best practices in the medical profession regarding ethical standards. Such practices could already be in place in your organisation and help other practices/hospitals to improve their internal detection and prevention systems or otherwise support your organisation whilst improving or enriching its internal toolset and mechanisms in the area.

   In addition, you can ensure that society receives a better-quality health service, and you can help maintain a high quality service in hospitals and GPs.

Other information about the research

1. You have been chosen because of your private board members, managers, director of clinical services, chief executives and director of quality/safety/governance/risk of hospitals and GPs role.

2. The expected number of interviews with board members, managers, director of clinical services, chief executives and quality/safety/governance/risk director of hospitals/GPs are between 20 and 25.

3. The interview will take from approximately 30 minutes to 1 hour.

4. Interviews can be held face-to-face or online, according to your preferences.

5. Participation in the research is entirely voluntary. If you decide to participate in the study, a consent form will be sent, which you would need to sign (electronic or handwritten) and send back to me via e-mail. If you change your mind after participating in the research, you are free to withdraw from the study without giving

any reason.

6. This study will anonymise any sensitive information and your personal information (name, workplace, and others).

7. I would like to record the interview to be able to analyse it later. If you'd rather not be recorded, you can specify that in the consent form.

8. Interviews' audio files and transcripts will be stored on University's storage system Box and my personal computer, which requires a password to access it. This study will collect electronic data. The data can be accessed by PhD candidate Esin Damar and the supervisors: Professor Anna Sergi and Doctor Anna Di Ronco.

If you have any concerns about any aspect of the study or a complaint, in first instance, please contact my supervisors, Professor Anna Sergi and Doctor Anna Di Ronco, using the contact details below. If you are still concerned, you think your complaint has not been addressed to your satisfaction, or you feel that you cannot approach the abovementioned academics, please contact the departmental Director of Research in the department, Doctor Isabel Crowhurst (icrow@essex.ac.uk). If you are still unsatisfied, please contact the University's Research Governance and Planning Manager, Sarah Manning-Press (e-mail sarahm@essex.ac.uk). Please include the ERAMS reference ETH2122-1637.

APPENDIX- B CONSENT FORM

PARTICIPANT INFORMATION SHEET FOR BOARD MEMBERS, MANAGERS, DIRECTOR OF CLINICAL SERVICES, CHIEF EXECUTIVES AND DIRECTOR OF QUALITY/SAFETY/GOVERNANCE/RISK OF HOSPITALS AND GPS

Title of the Project: Medical deviance in the private healthcare sector in the UK

Research Team: Esin Damar

Please initial box

1. **I confirm that I** have read and understand the Information Sheet dated …… for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw from the project at any time without giving any reason and without penalty. I understand that any data collected up to the point of my withdrawal will be destroyed
3. *Example of a risk statement:* I understand that due to the nature of the interview I may feel discomfortable or frustrated.
4. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained.
5. I understand that my fully anonymised data will be used for PhD dissertation
6. I understand that the data collected about me will be used to support other research in the future and may be shared anonymously with other researchers.
7. I give permission for the de-identified (anonymised) transcripts and audio/video recordings.
8. I agree to take part in the above study.

Participant Name: Date: Participant Signature:

Researcher Name: Esin Damar Date: Researcher Signature:

APPENDIX- C INTERVIEW QUESTIONS

1. How do you describe a good or ideal doctor-patient relationship?
2. How do you define deviance in the medical sector?
3. What do you think about the sufficiency and efficiency of ethical standards in the medical profession, like GMC guidelines?
4. What kind of deviance that doctors display from the ethical standards of the medical profession comes to your mind first?
5. How frequently do you encounter deviance that doctors display from the ethical standards of the medical profession?
6. How do you decide whether something is deviance from the ethical standards of the medical profession?
7. How do you decide whether a rule break is a mistake or whether doctors do it deliberately?
8. How do you monitor doctors' performance to ensure they follow professional rules?
9. When do you consider deviance that doctors display from the ethical standards of the medical profession a severe issue?
10. What are the steps after realizing that a doctor shows deviance?
11. How do you collect patients' feedback about their experiences/complaints with doctors?
12. Does the hospital have any training program providing ethical information for doctors? If it does, could you share the details, like the training content?
13. Does imposing a disciplinary action on a doctor create an economic pressure on you if that doctor is one of the highest earning employees of the hospital?