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Iatrogenic injustice: an institutional ethnography of Fitness to Practise hearings

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ABSTRACT

The public has an important role to play in the regulation of health and social care, including raising concerns about harms caused by health and social care professionals to improve the safety and quality of services. There is little evidence about the experiences of members of the public who engage in regulatory processes and raise concerns with regulators. We conducted an institutional ethnography of the experiences of public witnesses (patients, service-users or family members of patients and service-users) in Fitness to Practise hearings held in the UK 2021–2023. We found public witnesses' experiences of these processes were onerous and, often, disappointing. We argue that these negative experiences arose from the ruling relations of the regulatory powers. Witnesses were required to perform certain kinds of work to fulfil their role. The adversarial form of justice exercised by regulatory bodies entailed the systematic doubting of witnesses' testimonies; producing epistemic injustice. Witnesses were at risk of being made more vulnerable, in the sense of being exposed to further harm, through and by the Fitness to Practise processes. Troubling tensions were evident between witnesses' experiences of Fitness to Practise and what they expected from institutions ostensibly concerned with upholding professional standards of practice and conduct to protect the public. We interpret the exercise of power observed by the regulators over public witnesses as iatrogenic injustice; harm caused by interactions between the public and institutions of health and social care. There are important implications for reduced public trust in health and social care systems and regulatory processes.

1. Introduction

The public has an important role to play in health and social care regulation. In the tripartite model of responsive regulation, the public moderates between regulator and regulated. This approach can empower public interest groups, enhance the legitimacy of regulators and prevent regulatory capture and corruption (Ayres and Braithwaite, 1992; Bouwman et al., 2015). Responsive regulation offers more democratic, participatory regulation than professional self-regulation or managerialism (Horowitz, 2013). Greater involvement of the public in professional health and care regulation has been a trend across many countries since the 1990s, especially in light of high-profile medical scandals that cast doubt on self-regulation (Carney et al., 2016), and aligns with the move for greater engagement of the public more generally in health and social care. However, little is known about how individual members of the public fare when they contribute towards professional regulation. This article provides an empirically-grounded theorisation of public experiences of raising concerns with health and social care regulators.

Institutional ethnography was used to investigate the relations between regulators and the public in Fitness to Practise proceedings held between 2021-23. Fitness to Practise (FtP) is the process UK regulators use to deal with concerns about their registrants, sometimes called professional misconduct or disciplinary processes (Stobbs, 2022). Similar mechanisms elsewhere, such as medical boards in the US, hold professionals to account and are important in upholding public interest

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and trust (Horowitz, 2013). The public raise the majority of concerns with regulators. FtP hearings are held for a minority of cases: which constitute the most serious concerns in terms of public protection and trust in the profession, about a specific registrant or registrants. This difference, between concerns raised and cases heard, has been interpreted as a shortfall in the commitment by regulators to take complainants seriously by O'Donovan and Madden (2018) in their analysis of complaints to the Irish Medical Council. Hearings involve evidence being heard by a committee of professional and lay members, with legal expertise included by a legally qualified chair or through support of a legal advisor. Registrants may be self-represented (thus, in some types of cases, cross-examining witnesses themselves) or represented, for example by legal counsel. Case-presenters (typically legal counsel) present the regulator's case against the registrant, which is contingent on evidence such as witness statements and other findings (including by the criminal court, if relevant). Witnesses may be patients, service-users or family members and friends as well as colleagues of the registrant and other professionals. This article focuses on the former group of *public witnesses* who raise concerns and give evidence as a result of harm they have experienced as patients or service-users or whose family members or friends have been harmed.

Normative assumptions of responsive regulation are that trust and cooperation is found between regulator and regulated, and of an enhanced role for the public, that leads to increased transparency, preventative measures, systemic reforms, and in the case of healthcare, improved patient safety (Carney et al., 2016; Healy and Braithwaite, 2006). Our findings problematise these norms by showing that regulators' powers led to onerous costs and disappointing consequences for public witnesses, experienced as wrongs. We offer the concept of iatrogenic injustice to account for these wrongs, which include but are not limited to epistemic injustice. The public's role in FtP is essential in allowing regulators to discharge their function to protect the public and their evidence can be critical to understanding what happened, yet they bear unfair costs when fulfilling this role.

2. Harm and the public

The public can experience harm from health and social care services related to errors, deliberate misconduct, institutional failure and injustices. Medical harm, thought to be widespread (Mayor et al., 2017), is categorised by England's national reporting and learning system as low, moderate, severe or death (NHS England, 2019; NHS National Patient Safety Agency, 2004). Harm related to medical management of illness or injury, including side-effects of treatments, is known as 'clinical iatrogenesis' (Illich, 1976). Patient safety is an approach taken across health systems to address such harm by measuring, monitoring and improving healthcare (Dixon-Woods et al., 2014). Patient safety principles include transparency, with a 'no blame' culture understood to be important in identifying how systems, the design of technology and the environment might make errors more likely (Vincent et al., 2020). In practice, patient safety serves as a form of regulation (Waring, 2007) with a role for patients and the public to identify and report adverse events (Vincent and Coulter, 2002; Ocloo and Fulop, 2012).

The public can also be harmed through institutional failures as revealed in high-profile cases such as that in the UK at the Mid--Staffordshire Foundation Trust Public Inquiry (2013). Broader experiences of harm, abuse and neglect indicate that defining harm in fact or extent is not as straightforward as patient safety measures might suggest. For example, objective assessment of injuries might not account for subjective experiences and the longer-term impact of harm. Further, the focus on clinical iatrogenesis can obscure non-clinical outcomes that a patient might experience as harmful, for example, injustices such as disrespect (Beach, 2024). Harm can therefore encompass forms of social and cultural iatrogenesis (Illich, 1976). These harms arise from the expropriation of health by the healthcare system: the wresting of the means to secure health away from lay people. Harm can be caused by rendering people dependent on the health and care system, and therefore disempowered to deal with their own vulnerabilities and suffering.

Addressing harm to the public must also encompass how individuals are treated by organisations and regulators in the aftermath of incidents (Ocloo, 2010). Accountability and fair organisational cultures are needed to consider not only different categories of human action (human error, negligence, recklessness and intentional rule violation) but also how systems determine facts, what constitutes culpability and how they deliver redress. Methods to promote public involvement in organisational regulation across different countries include proactively seeking information from patients and family members about services (e.g., through surveys and interviews) and consulting with patients and family members after adverse events (Wiig et al., 2020), yet evidence shows these efforts have not consistently led to improved involvement or outcomes. A study of Dutch healthcare complaints processes found most participants felt their complaint had not led to improvements in healthcare quality (Bouwman et al., 2015, 2016) and UK research showed quality improvement processes were impeded by how complaints were handled (van Dael et al., 2022). Difficulties engaging with organisational regulatory processes identified by Wiig et al. (2020) include the emotional burden for patients and family members. Dissatisfaction with both process and outcome was expressed by complainants to the Australian Health Practitioner Regulatory Agency (Biggar et al., 2020) with differences found between what complainants and professional regulators wanted (Carney et al., 2017).

Evidence indicates that engaging in FtP proceedings can be stressful and harmful for registrants facing allegations (General Medical Council, 2013; Finn et al., 2022). A cross-sectional survey of doctors with recent or current complaints against them found they were more likely to report depression, anxiety, and thoughts of self-harm and suicidal ideation compared to doctors without complaints (Bourne et al., 2015). An interview study of registrants who had completed the FtP process reported negative psychological impacts due to feelings of uncertainty and powerlessness associated with the process (Maben et al., 2021). 'Adversial' and 'disrepectful' treatment of nurses undergoing FtP was reported in the Nursing and Midwifery Council Independent Culture Review (2024 p.17).

Little is known about public witnesses' experiences despite the central role they play, although research commissioned by two UK regulators indicates the process can be stressful (General Medical Council, 2014; Finn et al., 2022). Related work in the criminal justice system shows that victims of crime can be re-traumatised by the adversarial trial environment, particularly during cross-examination (Ellison and Munro, 2017). There is evidence that testifying in court has been re-traumatising for harmed members of the public (Beckene et al., 2020) and a trauma-informed approach to prosecution, including cross-examination of victims, may mitigate these adverse consequences (Werner, 2021). To address this gap in knowledge, we set out to address the research questions: how do public witnesses experience FtP hearings and how do those experiences arise?

3. Methodology

Institutional ethnography, an approach to investigating everyday institutional practices and relations (Smith, 1987, 2005; Smith and Griffith, 2022) guided our empirical work and analysis. This approach incorporated standpoint theory: gaining knowledge of regulators from the standpoint of public witnesses. Drawing on Smith's concept of ruling relations and following Ahmed's (2021) phenomenological work on complaint (which showed how complaining reveals institutional power), we analysed how witnesses' everyday activities were coordinated by regulators. Whilst each witness had a unique experience, by taking the standpoint of public witnesses, we traced the common organisational practices of regulation observable in FtP hearings, in the texts associated with and produced by those hearings, and in witnesses' accounts of raising concerns with regulators.

4. Research setting and methods

The regulatory landscape of health and social care in the UK is complex and piecemeal. Ten statutory regulators of health and social work professionals are overseen by the Professional Standards Authority (PSA), with a further three statutory professional regulators for social care in Scotland, Wales and Northern Ireland. Each regulator sets its own professional standards, holds its own register of practitioners and process for dealing with concerns. Six regulators were involved in the wider study of which this article reports one part (see (Wallace et al.) for other reports).

Twenty-two FtP hearings, 10 in person and 12 online, held in public by nine professional regulators of health and social care professionals across England and Scotland were observed between November 2021 and March 2023. Observations were supplemented by 56 documents and 12 interviews. Ethical approval was granted by the Health and Education Research Ethics and Governance Committee at Manchester Metropolitan University (EthOS reference number 35942). Ethnographers attended hearings in the same way as members of the public; granted permission to attend according to certain restrictions (leaving when private matters were heard) and on certain conditions (for example agreeing not to publish information on social media during the hearing). Hearings where public witnesses who had been harmed were expected to give evidence were identified by regulators (who had advance knowledge of which witnesses were to be called) and by GH and FR reviewing publicly available hearing notices and allegations. Regulators and research participants have been anonymised. Ethnography included time spent in and around the hearings, for example in physical and online waiting rooms. The methodological principles of conducting ethnography were consistent across the in-person and online hearings; participation in the social world of the online hearing involved gathering *enacted* data (for example ethnographers noted their participation in the online format, including logging in, waiting, uncertainty about anonymity, feelings of exposure when our initials were displayed on screen and other experiences shared with participants) and *extant* data (collation of determinations that were produced regardless of their presence) (Salmons, 2022).

A total of 81 full days of hearings were observed by at least one of GH, FR, SR or AM (see Table 1). Hearings were scheduled for multiple days, 7 were observed in their entirety (bar private sessions) and the remainder were observed in part, primarily due to logistical constraints. Each researcher took contemporaneous fieldnotes totalling thousands of words. Fifty-one documents were collated: allegations, determinations (setting out the decision in respect of the registration of the registrant) and case law. After hearings and appeal periods had concluded, regulators forwarded invitations to participants to be interviewed by the research team. Of 36 invitations, six were accepted including one public witness. The remaining five were panel members (3) and colleague witnesses (2). Six additional public witnesses were recruited via social media (a short video was shared on Twitter during November and December 2022) and from a survey of members of the public who had complained to 8 regulators during 2021–2022. Eleven interviews with 12 people were conducted by GH and AM via MS Teams (one interview was with two people). See Table 2. All interviewees provided written informed consent. Interviews lasted between 40 and 139 min, resulting in a total of 664 min of audio data. Recorded interviews were transcribed verbatim and contemporaneous notes were made of one interview that was not recorded. Three interviewees provided supporting documents (n = 5) including letters written to regulators and records of their experiences.

Analysis involved reflexivity during fieldwork, comparison of fieldwork with interview data, and a process of research co-production (summarised in Fig. 1). During fieldwork, the two lead ethnographers, GH and FR, met regularly to map the ruling relations, identify features of hearings that were analytically important and relevant theoretical framings including Fricker's (2007) concept of epistemic injustice. A narrative summary of each hearing was produced to synthesise the vast number of fieldnotes under a series of headings that covered contextual information for the hearings, presence of harm, and witness work to allow comparison across different cases. The use of narrative summaries allowed for an appreciation of the unique experiences and complexities of each case, whilst the headings allowed us to identify common process, and informed the 'indexing' of interview data to link interviews with observations and texts (Rankin, 2017). Co-production (Slattery et al., 2020) involved 6 workshops discussing findings with project advisory groups, public members, regulators and professionals to inform project recommendations (reported on in full (Wallace et al.)). Important insights from co-production with the public were the differences between witnesses' expectations of hearings and what they experienced, and how they interpreted the role of regulators as part of the wider health and social care system.

Table 1
Summary of hearing observations.

	Hearing number	Regulator	Format of hearing	Number of days observed
	H1	R1	Remote	2
	H2	R2	In person	1
	H3	R2	In person	1
	H4	R2	In person	1
	H5	R2	In person	1
	H6	R3	Remote	1
	H7	R2	In person	1
	H8	R4	Remote	8
	H9	R5	Remote	7
	H10	R1	Remote	15
	H11	R6	Remote	5
	H12	R4	Remote	4
	H13	R7	Remote	5
	H14	R7	In person	8
	H15	R8	Remote	5
	H16	R9	In person	2
	H17	R9	In person	1
	H18	R3	In person	1
	H19	R9	Remote	2
	H20	R8	In person	2
	H21	R1	Remote	5
	H22	R6	Remote	3
Total	22	9	10 in-person 12 remote	81

Table 2
Interviewees details.

Participant code/regulator	Role	Hearing Observed	Recruitment source
14/7	Panel member - professional	Hearing 14	Regulator
22/9	Harmed public witness. Not called as witness at hearing.	Not observed	Survey
07/6	Public witness, was prepared for hearing but not called at last minute	Hearing 11	Regulator
12/7	Chair/panel member	Hearing 13	Regulator
08/10	Public witness referred to regulator but no hearing	Not observed	Social media
09/10	Public witness referred to regulator but no hearing	Not observed	Social media
13/7	Panel member	Hearing 14	Regulator
10/5	Colleague witness	Hearing 9	Regulator
11/5	Colleague witness	Hearing 9	Regulator
17/2	Public witness, referred but no hearing	Not observed	Social media
18/02	Public witness, referred but no hearing	Not observed	Social media
16/02	Public witness, referred but no hearing	Not observed	Social media

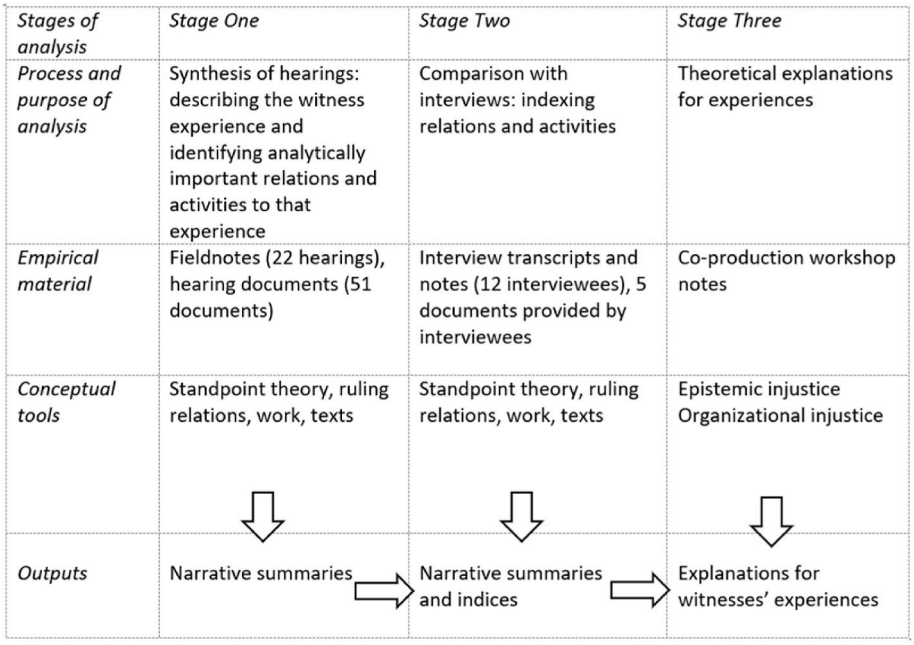

Fig. 1. Schematic of data analysis.

5. Findings

5.1. Summary of hearings

Twenty-one hearings were concerned with allegations about a registrant, one was an application to be restored to the regulator's register following a previous disciplinary proceeding (see Table 3). Twenty hearings were concerned with allegations that primarily focused on harm (actual or potential) to a public witness, two hearings were primarily concerned with allegations of misconduct towards colleagues (rather than patients or service-users) but with subsequent potential for harm for public witnesses. The allegations were: breaching sexual or professional boundaries (8 hearings), inadequate provision of care (7), inadequate or falsified record-keeping (4), verbal or physical abuse (3), financial exploitation (2), dishonesty (2) and breaching confidentiality (2). Some hearings included multiple allegations across these categories. The outcomes for registrants were: warning (or reprimand/admonishment) (5 registrants), suspension (5), removal from the register (4), case dismissed (3), conditions of practise imposed (1), and no sanctions (1). Two cases were adjourned and not concluded during the period of the study. The hearing about restoration to the register resulted in the registrant being permitted to return to practice.

5.2. Public witnesses' experiences

We report here on common findings about public witnesses' experiences of hearings, which were generally onerous and, at times, distressing. Interviewees, including those who raised concerns with regulators without progressing to a full hearing, expressed disappointment with FtP processes. There was a mismatch between what people expected from the health and social care institutions and professionals that were ostensibly there to care for them and their experiences of harm; this mismatch was compounded when they raised concerns about that harm with regulators. We show below how these experiences were shaped by witnesses' interactions with regulators.

5.3. Ruling relations during hearings: unfamiliar processes and rules

Hearings were formal occasions which required witnesses to perform a series of tasks according to explicit rules and implicit social norms. Witnesses were required to attend hearings to answer questions about their statements, and to do so, found they had to manage their emotional responses. Witnesses' movements, speech and interactions during the hearings were rigidly controlled. The unfamiliarity of proceedings put witnesses at a social disadvantage, regardless of their professional backgrounds. This disadvantage added to the cognitive and emotional demands of witnesses, demands exacerbated by engaging with certain people as a consequence of their participation.

Witnesses' entry to the hearing, whether a physical room or online meeting, was controlled by a hearings clerk or officer. All witnesses were required to take an oath or make an affirmation before confirming their witness statement was correct; an experience which underlined the formality of the proceedings and one which was unfamiliar to witnesses although routine to members of the committee. When in person, witnesses had to sit in a specific seat, relinquish any memory aids (notes or devices) and refer only to the 'bundle' of evidence provided for them. When participating remotely, they had to keep their camera on, ensure they were in a private space and uninterrupted. The formal dress code of the committee and legal counsel (business wear and a tacit requirement to wear jackets) emphasised the power differential of social differences if witnesses were more informally dressed.

The pace of witnesses' speech during cross-examination was tightly controlled, to allow notetaking. Consequently, witnesses were often interrupted; asked to stop or slow down. Witnesses were only allowed to respond to questions and not to move onto a new or tangential subject, or offer their interpretation of events or contextualise information. For example, during Hearing 13, Patient A was cross-examined about the timing of her actions after she left the registrant's practice following treatment which resulted in physical harm. Patient A was offered the chance to 'correct herself' (GH fieldnotes) in relation to what appeared to be an inconsistency in her reporting, after the barrister questioned how Patient A was able to drive (Box 1).

Patient A's account of her post-treatment pain was juxtaposed by the barrister's questions about the time she spent driving. Patient A started to explain she had driven from the registrant's practice and stopped to buy pain medication but was interrupted and asked to respond only to the question about driving. The witness appeared frustrated by being unable to explain her actions and worked to maintain her composure. Later, she offered to provide phone records to qualify the timing of her actions; this offer was not permissible. The presentation of alternative

Table 3
Summary of hearings.

Hearing number	Regulator	Summary of allegations	Findings in relation to harm of public witness	Outcome for registrant
H1	R1	Did not provide adequate care to public witnesses or take appropriate actions	Public witnesses were exposed to serious risk of harm, and this was an aggravating factor when considering sanctions	Warning
H2	R2	Financial exploitation of public witness	Distress was caused and profession brought into disrepute	Removal from register
H3	R2	Breached confidentiality, dishonest conduct in relation to medication	No physical harm (harm in a 'narrow sense') but that distress was caused and this was aggravating factor in considering sanctions	Suspension
H4*	R2	Inadequate care and poor professional performance	Previous misconduct had been remedied	Restoration to register granted
H5	R2	Sexually motivated harassment of a colleague	Potential for harm to come to public witnesses	Suspension
H6	R3	Falsified records	No risk of harm to public witness	Suspension
H7	R2	Inappropriate and sexually motivated conduct towards a public witness	Facts not proven, no harm found	Case dismissed
H8	R4	Inappropriate conduct, failure of respect and dignity, breach of sexual boundaries with public witness	Public witness suffered actual direct harm, and this was an aggravating factor in considering sanctions	Suspension
H9	R5	Failed to perform certain procedures, did not maintain accurate records, did not give appropriate advice to public witness	Public witness was put at unwarranted risk of harm	Warning
H10	R1	Failed to maintain appropriate professional boundaries, put health and safety of public witness at unacceptable risk	Public witness was put at unwarranted risk of harm	Removal from register
H11	R6	Verbal and physical abuse of public witness	Facts not proven, no harm found	Case dismissed
H12	R4	Failed to: inform public witness of risk of procedure, obtain informed consent to procedure, carry out procedure appropriately	Public witness suffered actual physical harm (potentially life-threatening)	Warning
H13	R7	Inadequate care and record-keeping	Public witness exposed to potential harm	Warning
H14	R7	Inadequate monitoring of public witness, failure of record keeping, failed to ensure public witness was provided with pain relief for duration of procedure	Distress to public witness caused by registrant	Fitness to practise not found to have been impaired
H15	R8	Transgression of professional and sexual boundaries with public witness	Public witness was exposed to significant unwarranted harm	Suspension
H16	R9	Dishonest actions towards employer, administered incorrect medication to public witness	No actual harm to public witnesses occurred but they were put at risk of harm	Removal from register
H17	R9	Breach of professional boundaries with public witness	Public witness was exposed to significant risk of harm	Removal from register
H18	R3	Inadequate advice and misleading statements to public witness	Case dismissed - no findings given	Case dismissed
H19	R9	Failed to ensure appropriate care was provided to public witness	No actual harm caused but that registrant had placed public witnesses at risk of harm	Conditions to practise imposed
H20	R8	Inappropriate conduct, transgression of professional and sexual boundaries with public witness	No actual harm had been caused to the public witness	Warning
H21	R1	Verbal abuse of colleagues and failure of record keeping	Case not concluded - no findings available	Interim suspension order: case adjourned
H22	R6	Inappropriate behaviour, verbal abuse of colleagues and public witness	Case not concluded - no findings available	Case adjourned

*restoration hearing.

scenarios to witnesses' accounts was a common feature of cross-examinations; witnesses were not permitted to elaborate on their statements, only to respond to questions.

Public witnesses were further disadvantaged during hearings by unfamiliar material as well as unfamiliar processes, adding to their intellectual and cognitive work. During Hearing 13, Patient A was questioned closely about her statement and other evidence (Box 2).

This witness, like others observed, was disadvantaged by the reference to unfamiliar paperwork and processes, as she worked to respond to factual questions.

Witnesses appeared emotionally affected at times, visibly working to compose themselves. In such cases, the Chair offered breaks and acknowledged the stressful nature of hearings. For example, Patient A in Hearing 8 became visibly upset. The allegations in this case related to the witness being subjected to an intimate examination by the registrant

Box 1
GH fieldnotes

PA (Patient A) I think it was in 15 min.

RB (Registrant's Barrister) well you said 5 min.

PA yes I did.

RB that is the document you provided.

PA I was in constant pain when I left.

RB I just want to go back to what you said before.

PA the pain was getting worse and worse.

RB did you make an error in your account can you help us there.

PA I can't really remember the exact time frame.

RB if you meant 15 min that is not what you said.

PA it happened so quick.

RB can I suggest that if you were in such agony you wouldn't have driven for another 25 min.

PA I didn't drive for 25 min.

RB do you agree.

PA no I don't agree I phoned my friend to see what I should do ….

Box 2
GH fieldnotes

RB (Registrant's Barrister) asks Patient A to 'turn to page 171'.

Patient A: I don't have those pages.

RB is referring to the documentation from the A&E department Patient A had attended but Patient A only has her evidence so she cannot see what the barrister is referring to. There is some debate amongst the Committee about which documents Patient A has and can have. The Chair asks Patient A how easy it is for her to download some additional documents. Patient A replies she has another device there. 'I want you to have time to do that I am going to suggest that we take until 11.30 to allow that to happen' Chair. Legal Advisor - A&E staff not being called as witnesses – hearsay. 11.41 by *the time we start again.*

RB continues with questions: 'When the pain got worse you decided to phone reception … 30 mins later … in your statement you state [you were in] absolute agony … '

Patient A: ' … are we back at the other document now … have to go back into that … '

The Chair reassures: 'Take your time … we well understand how difficult it is … '

RB: … Eighth page …

Patient A: 'the email you sent to council … ?'

Chair: 'The very first complaint you made to [the regulator].

Finally Patient A can find it …

without being offered a chaperone. Allegations that the examination was sexually motivated were not proven but serious failings were found in the registrant's conduct, in part because of the registrant's failure to recognise the patient's vulnerability. Patient A was identified as vulnerable by the Committee and was offered special measures during the hearing, namely she would not have to see the registrant whilst giving evidence and was offered breaks. Although face-to-face interaction with the registrant was avoided, the witness was still brought into relation with the registrant and hence the memory of the events she described as 'violating'.

Extreme emotional strain was observed and reported in Hearing 17 by a witness giving evidence about the treatment of his son (the patient) who had died. This witness gave evidence in person, however the patient's mother arranged to give evidence remotely due to her distress at her bereavement and the FtP process. Father and mother were separated but in communication about the hearing. During the hearing, the father refused to call his son by the pseudonym 'Patient A' and broke convention by using his name, stating:

> ' … he was not just a figure, he was a person' (GH fieldnotes).

He explained how difficult taking part in the hearing was:

> ' … every time I touch this process it is a very difficult process for me and his mother, because he has passed away. But I am here … ' (GH fieldnotes).

Following cross-examination, he asked the panel:

' … please be on his mother's side … if I were to tell her about this [experience today] she would refuse to attend' (GH fieldnotes).

In addition to the emotional distress caused by participating in the hearing this witness was required to engage in interpersonal work beyond the hearing, in this case with his son's mother.

Being a public witness was onerous and daunting, as described by one panel member:

'But I just do think the whole process is, I mean, terrifying, really, to anybody, when you've got a whole load of strangers, whether it's via video or in person. You've never done this before; everybody else has done it before, but you're the only person who doesn't deal with that kind of environment on a day-to-day basis … ' (participant 13/7).

Maintaining presence and composure required significant work on the part of witnesses. This work was coordinated and constrained by the rules of hearings, in an environment which put witnesses at a disadvantage compared to the highly-prepared and experienced professionals conducting adversarial cross-examinations. The work of participating in hearings was undertaken following and because of events that had harmed witnesses, in a process akin to a form of 'second assault' by prompting the witness to re-experience those original events (Werner, 2021).

5.4. Ruling relations and the everyday world of the witness

The work involved for witnesses to participate in FtP proceedings was not paid or undertaken in the context of an employee-employer relationship but work nonetheless in that their actions required purpose, time, bodily effort, and resources (Smith and Griffith, 2022). This work was the consequence of the relationship witnesses entered into with regulators when they first raised concerns, and continued before, during and after hearings, as witnesses sought to make sense of outcomes.

Before hearings, witnesses were required to use intellectual and language resources, navigate the referral process and provide written evidence of their concerns. One witness explained how she first approached her local authority, then the Care Quality Commission before finally being directed to the professional's regulator (participant 07/9). The witness had to write an account of her concerns about her mother's care which involved developing 'regulatory literacy' (O'Donovan and Madden, 2018). Evidence and details of historic events had to be provided by referring to records of previous complaints lodged with the registrant's employer and reviewing family WhatsApp messages. Post hearing, this witness had to make sense of the determination document; the anonymisation of her mother (referred to as Patient B) made it difficult to understand how concerns had been evaluated.

Witnesses had to mobilise material resources and support from others. Attending hearings involved arranging time off work or away from family, sometimes overnight, and making travel plans. The use of technology to facilitate remote hearings brought its own work. One public witness explained how, not familiar with the hearing's software platform and having responsibility to feed farm animals, they needed to arrange for a family member to stay with them for the duration of the hearing to provide technical and practical support (participant 07/9). The witness was then told on the day of the hearing (Hearing 19) they would not be called to give evidence.

Witnesses had to endure unspecified periods of waiting. The time spent waiting for a hearing to be scheduled (usually many months) contrasted with the relatively short notice given to some witnesses to be available for a hearing, leaving them feeling strangely unprepared despite the protracted wait. Waiting involved uncertainty, anticipation, and potentially dread of the hearing. A lack of information and delays resulted in what one interviewee described as a 'horrible' experience:

'You get these huge delays. You send your submissions in and there's huge delays on every communication. You're talking about months between communications, even. So there's no real dialogue, and there's no real will or effort to understand what it is that you've submitted or are complaining about … You know, as a complainant, you're completely shut out of the system. And … It's horrible. Really horrible' (participant 16/02).

Hearings could be adjourned for several months. The registrant in Hearing 17 appealed (unsuccessfully) against the outcome, resulting in a further wait for a conclusion.

Witnesses' work culminated over lengthy periods and uncertain timelines, with the work of FtP often following engagement in other (often unsatisfactory) complaints processes, and involvement of family and friends in providing practical and emotional support. The work that witnesses performed was instrumental to the regulator's investigation and subsequent hearing. This work was ruled by regulators, with witnesses subject to powers and procedures which appeared non-negotiable.

5.5. Ruling relations beyond the individual witness

Relations between regulators and witnesses extended beyond the localised experiences of hearings. We identified features of the FtP process that were problematic for witnesses collectively, regardless of their individual circumstances and specific interactions with committees. Being a witness meant being exposed to epistemic injustice and being made vulnerable. These experiences provoked disappointment in witnesses; they described feeling let down not just by regulators but by the wider system of health and social care.

Public witnesses' interactions with regulators led to epistemic injustices; injustices done to people in their capacity to know and convey knowledge (Fricker, 2007). Patients are understood to be particularly vulnerable to epistemic injustice due to the asymmetries of power and knowledge inherent in the relations between patients and healthcare professionals (Kidd and Carel, 2017). Cross-examinations involved casting doubt on witnesses' abilities to provide a reliable account, and on their understanding of events. For example, Hearing 20 involved a public witness who had raised concerns about a registrant in relation to words and actions alleged by the regulator to be:

'inappropriate and/or a transgression of professional boundaries and […] a transgression of sexual boundaries' (Hearing 20 determination).

During cross-examination, the registrant's representative referred to the witness's health as impairing her ability to recall events accurately. Casting doubt on this witness's credibility was a form of testimonial injustice; a way of discrediting her ability to know something due to a prejudice about her medical condition. Raising doubts about witnesses' credibility was a common feature of the hearings observed and such doubts were recorded in determinations.

Hermeneutical injustice, a lack of credibility that a person has made sense of their own experiences, was also observed. The witness in Hearing 20 stated that the registrant had made unprofessional and unwelcome comments. The registrant did not dispute that he had made those comments but disputed 'the meaning behind them' (Hearing 20 determination). The word 'fit' was one example; interpreted as meaning either healthy or sexually attractive. In the context of other actions by and comments of the registrant, the witness interpreted the word as having a sexual meaning. However, the registrant's representative put it that:

'Patient A [had] paint…[ed] the Registrant's behaviour with an undercurrent of something sexual, when in fact there was no such undercurrent' (Hearing 20 determination)

The registrant was alleged by the witness to have spoken about a 'degenerate sexual fantasy' (Hearing 20 determination). The Committee disregarded this allegation, finding the witness's evidence not credible:

> 'Whilst the Committee found Patient A to be a witness attempting to tell the truth, and broadly credible, in this particular it found that credibility to be limited. Patient A had swiftly translated what she had heard or purported to hear from the Registrant in to a "degenerate sexual fantasy." Even taken at its highest the Committee could not agree. It therefore considered Patient A had embellished her understanding of what had been said and had inadvertently started from the point of view that her [redacted] had been the subject of denigrating comments, rather than dispassionately judging what had actually been said to her. Her understanding was influenced by personal conflicts within her own family' (Hearing 20 determination).

The onerous nature of cross-examination can be explained, in part, by the sense of injustice resulting from being discredited in this way. When a panel member was asked why they thought cross-examination was stressful, they answered:

> 'Partly because people think they are not being believed and people think they are not telling the truth … If you press them it's as if you are accusing them of not telling the truth but they may be 100 % certain that they are right. Can be very frustrating to be accused of not telling the truth" (participant 14/7)

This frustration is explained by Fricker (2007) as arising from the injustice of being doubted to be able to know something. Being rational and able to know something is part of our shared humanity, so the social meaning of being doubted in a capacity as 'knower' means being discounted as somehow less than fully human. Cross-examination is a deliberate process of testing witnesses' evidence, challenging their interpretation and potentially discrediting them to deliver adversarial justice; the system of justice which allows a judgement about truth to be made from two opposing accounts of events. Doubting a witness is inherent to FtP, and this results in epistemic injustice.

Epistemic injustice and experiences of vulnerability were compounded by established techniques of cross-examination. Witnesses were made vulnerable in the sense of being made open to social and emotional harm (Fineman, 2019) through the recall of certain events during cross-examination, the presentation of alternative accounts to those provided by witnesses, and at times from breaching boundaries of witnesses' privacy, whether intentionally or accidently. This vulnerability was in addition to the asymmetries inherent in healthcare where patients inhabit positions of relative dependence with less power and knowledge than providers of healthcare and affected witnesses beyond the constraints of the hearing itself.

The lengthy cross-examination of the public witness in Hearing 17, for example, involved disclosure of details of his relationship with his deceased son. The registrant's representative put certain accounts to the witness of that relationship, such as:

> ' … he was unhappy about living with you and he didn't have a good relationship with you … ' [GH fieldnotes].

Details that might usually remain private or indeed unarticulated were entered into the record including the witness's thoughts and feelings about his son's death, his actions towards his son during his life, and his reflections on those actions. This witness was left open to emotional and social harm through intrusive and distressing questioning. This vulnerability might be experienced by any or all witnesses exposed to questioning of their private life, going beyond 'narrow' understandings of vulnerability that regulators seek to address through special measures during a hearing (Sorbie and Garippa, 2024).

For some witnesses, engaging in FtP resulted in disillusionment and anger. Expectations that regulators would provide 'answers' in the form of clarity and truth about events were disappointed (interview 16). Disillusionment emerged when comparing their motivations for raising concerns with their experiences of engaging with regulators. One public witness explained:

> ' … I think any one of the people that you interview who have been harmed or got losses or whatever, will say that the only reason that they want to report something is to try to avoid it happening to other people …. That's all we ever want.' (participant 17/9).

Whilst this witness said he could potentially forgive a healthcare error, he could not excuse his negative experience of the subsequent investigation:

> ' ….people get harmed, people die, but as families, we accept that. We do accept that that is going to happen sometimes in hospitals. What we can't forgive is how you treat people afterwards, the cover-up, the lack of scrutiny and the lack of learning.' (participant 17/9)

Both outcome and process were unsatisfactory for some witnesses, exacting an emotional toil by causing feelings of anger and distrust. These feelings shaped their ongoing interactions with services; their experience of the regulatory process had longer-term impacts on their perception of the wider health and social care system.

5.6. *The problematic of the witness*

In sum, our findings showed that public witnesses embodied a *problematic*; there was a conflict between their authorised status as members of the public due protection by regulators and their experiential status as witnesses subject to discrediting and doubt. Witnesses' evidence was critical to the regulator's case and the target of challenge by the registrant (or their representative). This conflict, between how the public witness was construed by regulators and their experience during hearings, surfaced during cross-examination. Being witness to, harmed by and complaining about registrants' actions which were disputed appeared to be an uncomfortable, insecure and distressing position. Public witnesses occupied multiple roles; they were (putatively) witnesses to events, but also, in many cases the complainant (they had raised the concern about the registrant), and the person harmed by the (alleged) events. However, they had little power to assert these different roles, nor to recount their own experiences. The costs of being public witnesses, which we found included performing arduous work and being made vulnerable to distress, appear particularly unjust in light of their experiences of harm and their role in serving a public good.

6. Discussion

Institutional ethnography allowed us to trace how regulators exerted powers over public witnesses (the ruling relations) which led to onerous costs and disappointing consequences; experienced by public witnesses as wrongs. We interpret these wrongs as a collective injustice and offer the concept of iatrogenic injustice by way of explanation.

We define iatrogenic injustice as the injustice done to someone harmed through their interactions with health and social care who is then unfairly exposed to further harm as they seek to raise concerns with professional regulators about that harm. Building on Ocloo (2010), we consider iatrogenic injustice as an extension of the concept of social iatrogenesis to include the harm caused to public witnesses who are rendered dependent on regulators to address their concerns, yet fail to achieve satisfaction through that process. We include people harmed themselves and those who raise concerns about other harmed people (e.g., family members). The dimensions of these injustices for public witnesses include: unfair and unexpected costs and burdens of participating in regulatory processes; epistemic injustices; the elision of their rights to be protected by regulators as members of the public whilst participating as witnesses; and the de-centring of their experiences of harm in pursuit of regulatory action.

We add to previous research that has identified emotional burdens, costs to regulators and epistemic injustices arising from involvement in regulation (Wiig et al., 2020). We offer new knowledge about the costs

to witnesses and the wider burden they assume as they enter the professional regulatory space because of their experiences of harm. Whereas epistemic injustice has previously been identified as a potential concern relating to the input of patients and family members in organisational regulation, our findings show how epistemic injustice is an inherent component of adversarial processes of FtP, enacted through cross-examination; public witnesses are subjected to systematic doubting. Through the construction of the concept of iatrogenic injustice, we can account for some of the mismatches reported elsewhere between public expectations of regulatory processes, and their experiences (e.g., Biggar et al., 2020; Carney et al., 2017).

The concept of iatrogenic injustice problematises the notion of participatory regulation, challenging the tripartite model of responsive regulation. Through empirical study of public participation, we have found that such participation causes witnesses to assume certain roles which place them in a different relationship with regulators than that of the wider general public. Whilst acting at witnesses, their statements (and therefore their knowledge of events) are subject to challenge and doubt. Previous work by O'Donovan and Madden (2018) analysed how individuals were disempowered through interactions with professional regulators; we show how the public is collectively disempowered by being made vulnerable by the FtP process. As witnesses, people are placed into a different category of 'the public' than they are when they are considered as part of the general public requiring protection. People become separated through their role as witnesses from the broader public, which regulators seek to protect, resulting in the elision of their rights to be protected by regulators as members of the public.

Our study showed that regulation was not *responsive* to public witnesses. Regulators were necessarily focused on registrants' actions, as they sought to fulfil their duties. The consequences for public witnesses were that their experiences were instrumentalised to make judgements about registrants, rather than to address harms experienced by witnesses. The wrongs witnesses experienced were compounded by their motivations; they sought to contribute towards the collective good by raising concerns with regulators and realise improvements for other people. To be harmed by regulators whilst fulfilling their expected role in regulatory processes seems profoundly unfair.

6.1. Strengths and limitations

This study offers new insights and empirical data from the standpoint of public witnesses into their experiences of FtP. A rich dataset was drawn from different kinds of allegations, harms and witness experiences, although limited by restricted access to discussions held in private and our inability to recruit witnesses as interviewees before or during hearings. However, our conclusions are consistent with similar studies, offering assurance that our findings are valid. This work analyses witnesses' experiences as distinct from other hearing participants whose experiences will also be important in considering wider institutional dynamics and injustice, and offers insight into professional regulation rather than broader regulatory practices.

6.2. Implications

Witnesses' experiences of FtP could be improved, for example through better and more timely communication from regulators and a reduction in their 'witness work'. However, such improvements will not address the injustices that are inherent to the adversarial system of FtP, and that have serious implications in terms of the potential to reduce public trust in professional regulation and in the professions they regulate. A lack of trust in regulators can lead to disengagement with regulatory processes, a potentially grave concern given the central role afforded to the public in models of regulation. Further, there is potential for reduced trust and respect not only for regulators, but for the wider system of health and social care.

7. Conclusion

Our investigation of the experiences of public witnesses shows that, from their standpoint, FtP hearings are experienced as inherently unfair. Public witnesses expect to be believed and supported as individuals when they have been harmed during their interactions with health and social care professionals and services, and in their collective role as providing the counterbalance to the dynamic between regulators and regulated. As witnesses, they intend to perform a public duty in seeking to prevent further harm to others, yet we found that they are isolated as individuals in a system of professional regulation. They must bear the costs of being a public witness: for individuals the cost is to be exposed to harm, injustice and onerous work. Collectively, the potential cost is the undermining of public trust in the health and social system and regulatory processes.

CRediT authorship contribution statement

Gemma Hughes: Writing – original draft, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Francesca Ribenfors:** Writing – review & editing, Methodology, Investigation, Formal analysis, Data curation. **Sara Ryan:** Writing – review & editing, Supervision, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Louise M. Wallace:** Writing – review & editing, Supervision, Funding acquisition, Conceptualization. **Rosalind H. Searle:** Writing – review & editing, Funding acquisition, Conceptualization. **Arne Mueller:** Writing – review & editing, Investigation, Data curation. **Mari Greenfield:** Writing – review & editing, Formal analysis. **Annie Sorbie:** Writing – review & editing, Methodology.

Ethical approval

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Data availability

Anonymised data will be made available on reasonable request.

References

Ahmed, S., 2021. Complaint. Duke University Press, Durham.

Ayres, I., Braithwaite, J., 1992. Responsive Regulation Transcending the Deregulation Debate. Oxford University Press, Oxford.

Beach, M.C., 2024. Disrespect in health care: an epistemic injustice. J. Health Serv. Res. Policy 29 (1), 1–2. https://doi.org/10.1177/13558196231212851.

Beckene, T., Forrester-Jones, R., Murphy, G.H., 2020. Experiences of going to court: witnesses with intellectual disabilities and their carers speak up. J. Appl. Res. Intellect. Disabil. 33 (1), 67–78. https://doi.org/10.1111/jar.12334.

Biggar, S., Lobigs, L.M., Fletcher, M., 2020. How can we make health regulation more humane? A quality improvement approach to understanding complainant and

practitioner experiences. J Med Reg 106 (1), 7–15. https://doi.org/10.30770/2572-1852-106.1.7.
Bourne, T., Wynants, L., Peters, M., Van Audenhove, C., Timmerman, D., Van Calster, B., Jalmbrant, M., 2015. The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. BMJ Open 5 (1), e006687. https://doi.org/10.1136/bmjopen-2014-006687.
Bouwman, R., Bomhoff, M., de Jong, J.D., Robben, P., Friele, R., 2015. The public's voice about healthcare quality regulation policies. A population-based survey. BMC Health Serv. Res. 15, 325. https://doi.org/10.1186/s12913-015-0992-z.
Bouwman, R., Bomhoff, M., Robben, P., Friele, R., 2016. Patients' perspectives on the role of their complaints in the regulatory process. Health Expect. 19 (2), 483–496.
Carney, T., Beaupert, F., Chiarella, M., Bennett, B., Walton, M., Kelly, P.J., et al., 2016. Health complaints and regulatory reform: implications for vulnerable populations? J. Law Med. 23 (3), 650–661.
Carney, T., Walton, M., Chiarella, M., Kelly, P., 2017. Health complaints and practitioner regulation: justice, protection or prevention? Griffith Law Rev. 26 (1), 65–88.
Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., McCarthy, I., McKee, L., Minion, J., Ozieranski, P., Willars, J., Wilkie, P., West, M., 2014. Culture and behaviour in the english national health service: overview of lessons from a large multimethod study. BMJ Qual. Saf. 23, 106–115. https://doi.org/10.1136/bmjqs-2013-001947.
Ellison, L., Munro, V., 2017. Taking trauma seriously: critical reflections on the criminal justice process. Int. J. Evid. Proof 21 (3), 183–208. https://doi.org/10.1177/1365712716655168.
Fineman, M.A., 2019. Vulnerability in law and bioethics. J. Health Care Poor Underserved 30 (4s), 52–61. https://doi.org/10.1353/hpu.2019.0115.
Finn, G., Crampton, P., Kehoe, A., Balogun-Katung, A., Tiffin, P., Page, M., Buchanan, J., 2022. Experiences of GDC fitness to practise participants 2015 – 2021: a realist study. https://www.gdc-uk.org/docs/default-source/research/gdc—experiences-of-ftp_v5_accessibility.pdf?sfvrsn=fe11add5_8. (Accessed 20 March 2024).
Fricker, M., 2007. Epistemic Injustice: Power and the Ethics of Knowing. Oxford University Press, Oxford.
General Medical Council, 2013. Exploring the experience of doctors who have been through the GMC's complaints procedures. https://www.gmc-uk.org/-/media/gmc-site/about/gmc-doctors-ftp-experience-report.pdf. (Accessed 20 March 2024).
General Medical Council, 2014. Exploring the experience of public and patient complainants who have been through the GMC's fitness to practise procedures. https://www.gmc-uk.org/-/media/gmc-site/about/gmc-complainants-ftp-experience-report.pdf. (Accessed 20 March 2024).
Healy, J., Braithwaite, J., 2006. Designing safer health care through responsive regulation. Med J Aust. 184 (S10), S56–S59. https://doi.org/10.5694/j.1326-5377.2006.tb00364.x.
Horowitz, R., 2013. In the Public Interest Medical Licensing and the Disciplinary Process. Rutgers University Press, New Brunswick, N.J.
Illich, I., 1976. Limits to Medicine: Medical Nemesis, the Expropriation of Health, 1994 edition. Marion Boyars, London.
Kidd, I.J., Carel, H., 2017. Epistemic injustice in medicine and healthcare. In: Kidd, I.J., Medina, J., Pohlhaus, Jr G. (Eds.), The Routledge Handbook of Epistemic Injustice. Routledge, London, pp. 336–346.
Maben, J., Hoinville, L., Querstret, D., Taylor, C., Zasada, M., Abrams, R., 2021. Living life in limbo: experiences of healthcare professionals during the HCPC fitness to practice investigation process in the UK. BMC Health Serv. Res. 21 (1), 839. https://doi.org/10.1186/s12913-021-06785-7.
Mayor, S., Baines, E., Vincent, C., Lankshear, A., Edwards, A., Aylward, M., Hogan, H., Harper, P., Davies, J., Mamtora, A., Brockbank, E., Gray, J., 2017. Measuring harm and informing quality improvement in the Welsh NHS: the longitudinal Welsh national adverse events study. Health Serv. Deliv. Res. 5 (9). https://doi.org/10.3310/hsdr05090.
Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013. Report of the mid staffordshire NHS foundation trust public inquiry. https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry. (Accessed 20 March 2024).
NHS England, 2019. Degree of harm: FAQ. https://www.england.nhs.uk/wp-content/uploads/2019/10/NRLS_Degree_of_harm_FAQs_-_final_v1.1.pdf. (Accessed 20 March 2024).
NHS National Patient Safety Agency, 2004. Seven steps to patient safety: the full reference guide. https://www.publichealth.hscni.net/sites/default/files/directorates/files/Seven%20steps%20to%20safety.pdf. (Accessed 20 March 2024).
Nursing and Midwifery Council, 2024. Independent culture review. https://www.nmc.org.uk/globalassets/sitedocuments/independent-reviews/2024/nmc-independent-culture-review-july-2024.pdf. (Accessed 22 July 2024).
Ocloo, J.E., 2010. Harmed patients gaining voice: challenging dominant perspectives in the construction of medical harm and patient safety reforms. Soc. Sci. Med. 71, 510–516.
Ocloo, J.E., Fulop, N.J., 2012. Developing a 'critical' approach to patient and public involvement in patient safety in the NHS: learning lessons from other parts of the public sector? Health Expect. 15 (4), 424–432, 10.1111%2Fj.1369-7625.2011.00695.x.
O'Donovan, O., Madden, D., 2018. Why do medical professional regulators dismiss Most complaints from members of the public? Regulatory illiteracy, epistemic injustice, and symbolic power. J. bioeth. Inq. 15, 469–478. https://doi.org/10.1007/s11673-018-9869-2.
Rankin, J., 2017. Conducting analysis in institutional ethnography:guidance and cautions. Int. J. Qual. Methods 16 (1), 1609406917734472. https://doi.org/10.1177/1609406917734472.
Salmons, J., 2022. Doing Qualitative Research Online, second ed. SAGE, Los Angeles.
Slattery, P., Saeri, A.K., Bragge, P., 2020. Research co-design in health: a rapid overview of reviews. Health Res. Pol. Syst. 18 (1), 1–13. https://doi.org/10.1186/s12961-020-0528-9.
Smith, D.E., 1987. The Everyday World as Problematic: a Feminist Sociology. Northeastern University Press, Boston.
Smith, D.E., 2005. Institutional Ethnography : a Sociology for People. AltaMira Press Blue Ridge Summit.
Smith, D.E., Griffith, A.I., 2022. Simply Institutional Ethnography: Creating a Sociology for People. University of Toronto Press, Toronto.
Sorbie, A., Garippa, 2024. (Re)constructing 'witness vulnerability': an analysis of the legal and policy frameworks of the statutory regulators of social work and social care professionals in the UK. Br. J. Soc. Work. https://doi.org/10.1093/bjsw/bcae185. Bcae185.
Stobbs, M., 2022. What is fitness to practise? https://www.professionalstandards.org.uk/news-and-blog/blog/detail/blog/2022/07/14/what-is-fitness-to-practise. (Accessed 20 March 2024).
van Dael, J., Reader, T., Gillespie, A., Freise, L., Darzi, A., Mayer, E., 2022. Do national policies for complaint handling in English hospitals support quality improvement? Lessons from a case study. J. R. Soc. Med. 115 (10), 390–398. https://doi.org/10.1177/01410768221098247.
Vincent, C., Coulter, A., 2002. Patient safety: what about the patient? Qual. Saf. Health Care 11 (1), 76–80. https://doi.org/10.1136/qhc.11.1.76.
Vincent, C., Oikonomou, E., Carthey, J., Macrae, C., 2020. Redesigning safety regulation in the NHS. BMJ 368, m760. https://doi.org/10.1136/bmj.m760.
Waring, J., 2007. Adaptive regulation or governmentality: patient safety and the changing regulation of medicine. Sociol. Health Illness 29 (2), 163–179. https://doi.org/10.1111/j.1467-9566.2007.00527.x.
Werner, E.M., 2021. Avoiding the second assault: a guidebook for trauma-informed prosecutors. Lewis & Clark Law Review 573 25 (2).
Wiig, S., Rutz, S., Boyd, A., Churruca, K., Kleefstra, S., Haraldseid-Driftland, C., Braithwaite, J., O'Hara, J., van de Bovenkamp, H., 2020. What methods are used to promote patient and family involvement in healthcare regulation? A multiple case study across four countries. BMC Health Serv. Res. 20 (1), 616. https://doi.org/10.1186/s12913-020-05471-4.
Wallace, L.M., Ryan S., Searle, R.H., Hughes, G., Sorbie, A., Ryan-Blackwell, G., Haider, S., West, R. Witness to Harm-Holding to Account. Improving patient, family and colleague experiences of Fitness to Practise proceedings: A mixed methods study (NIHR 131322) *NIHR Journals* (in press).