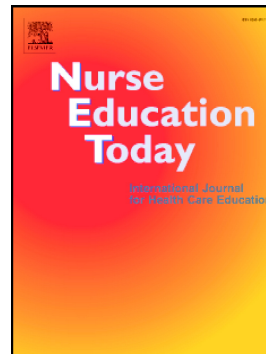


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Yet another healthcare tragedy has been uncovered in the UK. Less than three weeks ago as we write, the Gosport Independent Panel (hereafter referred to as the Panel), chaired by the Right Reverend James Jones KBE, published its report into several hundred deaths at the Gosport War Memorial Hospital (GWMH), (Gosport Independent Panel, 2018). Following concerns raised by relatives, journalists, a small group of nursing staff, a police investigation and in 2010, a General Medical Council Hearing into the prescribing doctor's practice, the panel examined over 2000 deaths at GWMH between 1987 and 2001. It concluded that the lives of as many as 450 older people had been "shortened while in hospital" (p.vii) as a consequence of the prescription and administration of opiates, often given in combination with other powerful sedatives in the absence of any demonstrated clinical need. It is thought that "there were probably at least another 200 patients similarly affected but whose clinical notes were not found" (2.101:27)¹. Search through the entire Gosport Panel Report for any mention of 'informed consent' from either patients and/or families for such a life-shortening pharmacological approach. You will find none.

To date criminal changes have not been pressed, but on the report's publication the UK Health Secretary, Jeremy Hunt confirmed that the findings would be examined by the police to see whether criminal prosecution was warranted.

Much of the significant media coverage to date has focussed on the prescribing medical officer, Dr Jane Barton. With the exception of work by Darbyshire & Ion

¹ We use the same identifying notation as is found in the actual Panel Report (Gosport Independent Panel, 2018), (section:page number)

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(Darbyshire and Ion, 2018), there has been relatively little discussion of the role of nursing at GWMH. Here we examine that role in this most awful story and specifically consider the implications for nurse education.

As with the last great UK healthcare scandal at Mid Staffordshire NHS Trust (Francis, 2013), much will be written about how this most recent tragedy could have occurred. Inevitably there will be close examination of the character and possible intentions of the key players in the story. There will also be talk of funding shortages, training needs, system failure and a mythical golden past when healthcare was delivered by selfless doctors and their obedient angels. We touch on some of these where relevant, but maintain that this case is ultimately about heinous derelictions of professional responsibilities at both clinical and managerial levels and the toxic, command and control systems that spawn and enable them. We concur with the Panel that the failures at Gosport occurred against a backdrop of clear clinical guidance on the use of opiates and in a professional climate where both the regulatory framework and nurses' responsibilities and obligations were broadly identical to those in existence today. In short, although the events in Gosport may have occurred nearly two decades ago, they remain highly relevant for today's health care professions and do not rely on either a counsel of perfection, or 20/20 hindsight. They are not 'historical issues', they are contemporary and should be understood as such.

Gosport in context

Before beginning this examination, it is important to emphasise again that while undoubtedly one of the most shocking, Gosport is just the most recent in a long line of tragic healthcare failures, preceded by other scandals going back as far as the 'endemic maltreatment' at Ely Hospital in late 1960s (Howe, 1969). Mid Staffordshire may stand out for many, but the Francis Report (Francis, 2013) was published in the same timeframe as failings uncovered at the Vale of Leven Hospital (MacLean and Government, 2014), Winterbourne View (Department of Health, 2012), Morecambe Bay (Kirkup, 2015) and Abertawe Bro Morgannwg University Health Board (Andrews and Butler, 2014). Readers tempted to see this as an exclusively UK issue, will find little comfort in the work of Hindle et al (Don Hindle, Jeffrey Braithwaite, Jo Travaglia and Rick Ledema, 2006); (Reader and Gillespie, 2013); (Darbyshire and McKenna, 2013); Groves et al ((Groves et al., 2017)); or Malmedal et al ((Malmedal et al., 2014), who along with others, have mapped varying degrees of failure, neglect, abuse and contempt across many countries and specialities.

The Panel's findings and their educational implications

The Panel's four primary findings in Section 12.11 of the report make for bleak and disturbing reading. The neologism, 'clusterfuck' could have been coined specifically for Gosport alone, given the multiple failures at every conceivable level. We will deal with three of the findings, leaving the fourth to others as it addresses failures on the part of professional regulators, local politicians, the

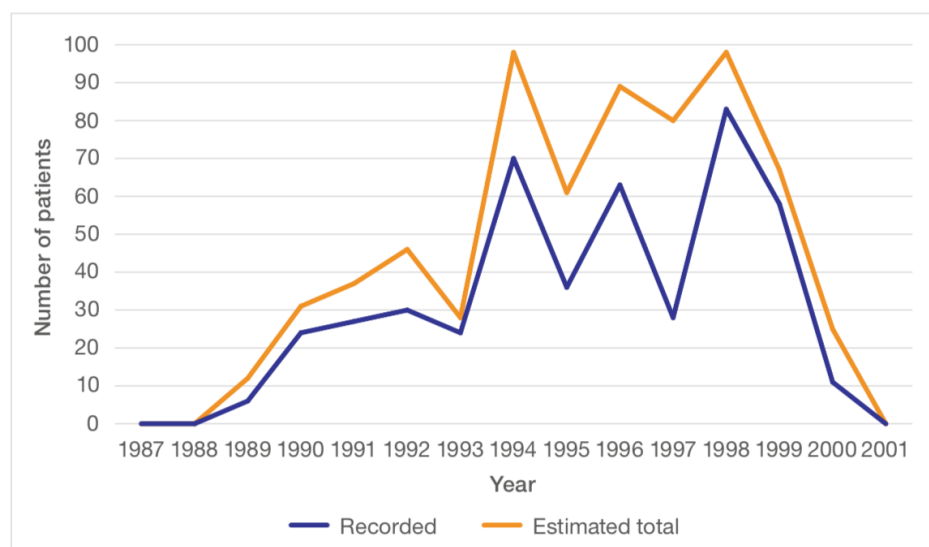
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police and other statutory bodies. These are important matters, but our interest here is primarily related to those charged with direct responsibility for patient care and the nurses who managed them.

1. “There was an institutionalised regime of prescribing and administering “dangerous doses” of a hazardous combination of medication not clinically indicated or justified, with patients and relatives powerless in their relationship with professional staff”. (2.11:316)

The report maps how over a period of years from 1987-2001 there was an increase in the use of diamorphine without clinical indication which coincided with an overall increase in death rates in the wards affected. This trend was reversed when this prescribing regime ended (see figure 2, 2.102:27)

Figure 2: Opioid use without appropriate clinical indication, 1987 to 2001, numbers per year



These drugs were frequently prescribed and administered in the absence of any clear or documented clinical indication and often to patients who were admitted for respite care or rehabilitation - not as part of any negotiated and agreed ‘end

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of life care' strategy or because the patients were in extreme pain. The prescribing policy gave nurses authority to administer "PRN" medications across a very wide dose range (in some cases between 20mg and 200mg of diamorphine), which resulted in administration of 'inappropriately' high starting doses and escalating or continuous opioid use. The outcome was that very few of those patients subjected to this regime survived for more than a few days after its initiation (2.123:33). While prescribing in this case was clearly the domain of the medical officer, the administration of medication and the monitoring of any untoward effects was the responsibility of registered nurses.

How then do we explain the administration of such potent cocktails of medication in the absence of any clear indication of their clinical need, often at the sole discretion of the registered nurse(s), in the absence of written guidance, with no clear indications of genuine informed consent and at doses that any RN should have known were dangerous and potentially lethal? There are a number of arguments that might be presented to account for these actions. First, it might be suggested that the intentions of these registrants were malign and that they intended harm - this is a matter for others to determine and until such time as they do, we firmly exclude it as a possibility.

It is, however, possible that the administering nurses were unaware of the potential and / or actual consequences of their practices. The Panel gave this idea short shrift, stating that:

“...the records also show that nurses in the hospital administered the drugs and continued to do so for many years, *although the link with the pattern of deaths would have been apparent to them.* (our italics)

(Gosport Independent Panel, 2018), 3.13:45)

It may also be that they held the prescribing medical officer in such high regard, or feared her or held her to be infalible, to the extent that they either could or would not challenge her. This perceived ‘authority gradient’ is highly possible and is indeed a prominent feature of so many other inquiries and studies, (Cosby, 2010; Cosby and Croskerry, 2004; St Pierre et al., 2012; Walrath et al., 2015) from as far back as first reports of ‘The Doctor-Nurse Game’ (Stein, 1967).

Perhaps they believed that any outcomes resulting from giving these drugs were the responsibility of the prescriber alone, rather than both the prescriber and administerer. None of these explanations are, however, acceptable and all fail to grasp the simple fact that registered nurses are accountable for their actions and omissions. They are mandated to have the patient as their prime focus of professional concern, not their colleagues, other disciplines, or their organisation. This accountability means that as RNs we are answerable for what we do or fail to do. It is a cornerstone of our claim to professionalism. It may be convenient to imagine that as registrants we can opt out of, or choose if and when to accept this heavy responsibility, but this is simply not the case. The NMC Code ((NMC, 2015) for nurses and midwives could not be any more direct or unambiguous: the standards and principles that an RN must uphold in his or her practice are “not negotiable or discretionary”.

2. “There was a disregard for human life and a culture of shortening the lives of a large number of patients”. (p.vii)

We simply do not know where or how to begin to address such a finding. What educational preparation or intervention would ‘prevent’ an RN from having such a disregard for human life? What level of education or ‘positive culture’ would be required to counter the prevalence of an ethos where the “shortening of patients’ lives” was this commonplace and routine? We absolutely refute any suggestion that those employed at GWMH were fundamentally flawed, ‘evil’ or different in essence from ourselves. GWMH, like all inquiries before it, has been much more about ‘wicked problems’ than ‘wicked people’ (Burns et al., 2012). While this ‘othering’ (Roberts and Schiavenato, 2017) of failure is tempting, in that it makes a case for ‘monsters’ in our midst, it does little to highlight the real problems - namely that ordinary nurses, ostensibly just like you and just like us, willingly participated in actions which prematurely ended patients’ lives in the absence of any clinical reason to do so and that organisations, regulators and systems designed to protect patients did nothing of the kind.

We cannot over-emphasise that we are not breaching ‘Godwin’s Law’ https://en.wikipedia.org/wiki/Godwin%27s_law by arguing that Gosport *is at all comparable* with the Nazi crimes against humanity, but we are suggesting that the ‘disregard for human life’ might be explained by a failure to truly think about what was happening and to see the administration of powerful, unwarranted medication as a simply another task to be completed, under the direction of a ‘more senior’ medical colleague and without question. Such collusion has a long and dark history. In their detailed accounts and discussion of nursing in Nazi

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Germany, Benedict and Shields ((Benedict and Shields, 2014) and (O'Donnell et al., 2009) explore this question of how 'ordinary nurses' could possibly go along with and indeed enthusiastically participate in programs of genocide and mass extermination, while claiming that they were 'only following orders' or that they 'had no choice' (Benedict and Shields, 2014), p.28).

Here we turn for a possible explanation to work by Roberts and Ion ((Marc Roberts and Ion, 2014; M. Roberts and Ion, 2014; Roberts and Ion, 2015) published in the aftermath of the disaster of Mid Staffordshire. In their attempt to explain the dehumanising care that was reported by (Francis, 2013) they drew on the work of the political scientist Hannah Arendt, who tried to understand participation in the holocaust - most famously at the trial of the prominent Nazi, Adolf Eichmann, in Jerusalem in 1961 (Arendt, 2006; Roberts and Ion, 2015). In her controversial analysis she argued that it was Eichmann's failure to think - for Arendt 'thinking' was a key element of what it means to be human, to engage emotionally or to truly reflect upon his actions which allowed him to play a major role in the genocide while maintaining an apparently clear conscience.

Lessons for nursing and health professional education

What then can we as nurse educators learn from this most egregious of calamities at GWMH? Before plunging into the abyss, we highlight the one light in the darkness of GWMH, the small group of nurses and their Royal College of Nursing representative who raised concerns about prescribing at the hospital in 1991. Although their concerns were dismissed and they were ultimately seen as

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“trouble makers” (4.57:91) who faced the possibility of being “sacked or moved” (4.57:91), their commitment to the elderly, vulnerable people whose care they were charged with and their nursing professionalism are commendable. These nurses:

“gave the hospital the opportunity to rectify the practice. In choosing not to do so, the opportunity was lost, deaths resulted and, 22 years later, it became necessary to establish this Panel in order to discover the truth of what happened”. (1.24:7)

Thereafter the GWMH story is unremittingly bleak.

Are we preparing and enabling nurses to ‘speak out’ and ‘do something’?

Is contemporary nursing education successfully equipping and enabling nursing students to be the new graduates who can and will challenge and question peers, colleagues and those in positions of power at their future hospitals and health services? We ask in some trepidation as we fear that history teaches us that the answer is ‘no’. We also wonder whether nursing education itself still provides a safe haven for some educators who enjoy wielding power and control over ‘their’ students by attempting to micromanage every aspect of their education. If such nurse educators are still ‘out there’, they are mirror images of what new graduates may encounter in clinical practice and are equally complicit in this problem.

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This seems an insultingly trivial example, but it may be indicative of the deeper, more 'wicked problem' (Hyde, 2016) of 'Why don't nurses speak out' when they see or encounter something wrong? Consider the mini furore now taking place regarding some nurses being forbidden to have or drink from water bottles in wards. It seems almost unbelievable that in 2018 this is even an 'issue', but it is (Darbyshire, 2018). Nurses are being told or 'ordered' by senior nurses and others in power that their water bottles and / or drinking in the ward is 'not allowed'. The 'reasons' given are usually ludicrous, ranging from infection hazards, through making the place look untidy to 'it's policy'. Yet qualified RNs seem unable or unwilling to challenge, question or defy such arbitrary diktats. Put bluntly, if they cannot challenge or resist such a farcical and trivial 'order' from those in power, for fear of all of the usual disapprovals and sanctions highlighted in almost every 'scandal report' and whistleblowing case, what chance is there that they will question, challenge or refuse to 'follow orders' that will potentially harm, injure or even kill patients? They are, in effect, being 'softened up' and conditioned by hierarchical, command and control Stalinist fear factories to accept orders and instructions without question, for fear, as the Panel report makes clear, of causing "upset" (1.7:4) or being seen as "troublemakers" (4.57:91). It is difficult to imagine a more dangerous lesson to learn.

This is not far-fetched 'whataboutery' but a concrete example of the complex social, interactional and organisational milieu that a student or graduate RN will enter (Ehrich, 2006; Szymczak, 2016; Tarrant et al., 2017; Waring et al., 2016). What would happen were your students to decide to question, challenge or defy

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senior or authority figures in this way? Would such clinical placements suddenly vanish? Would your Head of School receive angry communications from the DoN asking what was happening with your once wonderful (compliant) students and their 'attitude problems' or 'unprofessional behaviour'?

3. "When the relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions". (2.11:316)

How does this finding square with professional and ethical guidance (International Council of Nurses, 2012; NMC, 2015), that is scarcely 'new', which requires us to work in partnership with families and carers, to advocate on their behalf and to promote their health, well-being and safety? The failure to do this at GWMH has occurred numerous times previously in other settings and is a particular feature of defensive professional cultures which seek to rebut and deflect complaints and criticism rather than examine, investigate and learn from them (Dekker, 2016). This raises a vital question for RNs, students, nurse educators, clinicians and managers/leaders and that is, 'where is your centre of gravity' and where do your primary responsibilities lie? Enough humbug about 'patient-focused care', forward-facing hospitals and the like. If your first responsibility is to yourself, your colleagues and your organisation, with patients and relatives coming a poor fourth, then you have no right to be registered as, or to call yourself a health professional or health service manager. If your default position is 'reputation management' rather than patient safety and wellbeing, you are a significant part of the problem.

Is 'more education' an answer?

Let us now tackle the inevitable calls for 'more education' that will surely follow the Panel's Report. For some, education will always be 'A Good Thing' and thus more of it can only ever be better. We disagree that education per se will prevent the next GWMH scandal. What exactly would education look like that would ensure that a qualified RN will 'have regard for human life', will prioritise patients and their wellbeing, will discuss care openly with patients and families, will monitor patients for any deleterious signs or symptoms that may arise from their medications, will keep accurate clinical and nursing notes and records regarding care, will have an approach to nursing and patient care that is *not* "task oriented", "custodial" and "perfunctory" (3.31:49) and who will *not* euthanise their patients? To suggest 'more education' as any kind of answer, begs the question; 'What kind of qualified RNs are we currently graduating? To our knowledge, every university and every nurse education programme already swears that their nurse graduates are ready to take their place as members of the profession and that they are ready to accept the registrant's responsibilities inherent and expressed in the current NMC Code of Practice.

Education for whom?

There is often an unspoken assumption in many reports into 'poor practice' that the focus of education should be on the clinicians and front-line staff, who can be better educated (and managed) into 'doing the right thing', who can be 'trained' to speak out more, to 'say something', who can be both policed and 'policied' into improving safety and quality. Perhaps if they could be sent on yet another

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communication or leadership course, all would be well. This is a perverse misunderstanding of the context of social control that undergirds so many scandal and poor care reports. As Tarrant et al note:

“Interpreting challenges in exercise of voice as simply problems of communication is insufficient (...) understanding how to support those who seek to intervene in potentially inappropriate or unsafe behaviour in healthcare requires an understanding of social control.” (Tarrant et al., 2017), p.9).

Perhaps a useful rule of thumb would be that for every educational or professional development programme deemed necessary for nursing students and clinicians, there should be three mandated for hospital managers, regulatory body leaders, senior medical staff, deans and heads of schools and directors of nursing. Let's start to change the attitudes and behaviours of those who already occupy influential leadership positions and who often determine or control a 'cultural climate'. A good place to start would be for all those in leadership positions to ask whether their policies, processes and management style would withstand the kind of scrutiny seen at Mid Staffordshire or GWMH.

Preparing nurses not to keep playing the 'doctor-nurse game'?

How we educate and prepare our RNs (and other health professionals) surely has to change. We highlight one phenomena in particular, the noxious, demeaning and now unmistakably lethal 'Doctor-Nurse Game' and its attendant dysfunctional communication; between junior and senior nurses, nurses and

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doctors and even junior doctors and consultants - in short, the danger anywhere that a silencing and intimidating 'authority gradient' (Cosby and Croskerry, 2004; Walrath et al., 2015) exists, as it assuredly and unfortunately does.

Hopefully, the days of 'ethics teaching' as many of us remember it are numbered. Ion et al, (2018) have argued that at the very least our ethics teaching needs to be reinvigorated and applied. The demands of and pressures on today's corporatised health services and the features of so many of the 'scandal' reports from the last 50 years show that no significant 'lessons have been learned' and that little of import that will protect patients in everyday clinical practice has changed. As long as 15 years ago, (Walshe, 2003) concluded his review of NHS Inquiries with the observation that: "It is far from clear that the NHS is learning all it can from failures, or making the most of the opportunities for improvement that they offer" (p.25). Nothing has changed and there is almost no doubt at all that the next GWMH report is being prepared somewhere, as we write this.

Instead of more lectures by hand-knitted ethicists reciting trilogies of 'ethical principles' that students must somehow memorise and enact in practice, perhaps we need sessions led by investigators themselves who have seen such lethal failures 'up close', by investigative journalists who know the panoplies and litanies of lies and deception that underlie so much of corporate, hospital, health service and political life and by families and relatives who have spent so many years of their lives searching for crumbs of an answer from 'the official channels'.

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Then, we teach students about powerful politeness and constructive challenging, about what Graham called over 30 years ago, 'Principled organizational dissent' (Graham, 1986). We teach how, when, and why to challenge, question and confront. By this we mean that it is not sufficient to teach students what their professional responsibilities are, but also to help them enact these. A useful start would be for nursing and medical educators to model and exemplify some of these behaviours and characteristics. How often do our students see how their teachers and professors manage disagreements or potential conflicts and differences of opinion? How do faculty react and resolve issues when they are questioned or challenged by colleagues or by students? If an educator's, consultant's or senior nurse's reaction to a question or challenge, either overt or barely contained, is akin to "How dare you, I've been nursing since before you were born", or "I'm a doctor, who do you think you are? If you want to question me, then go to medical school and get a proper qualification", then we have no right at all to expect our students and new graduates to be clinical canon fodder in a fight for higher standards of patient safety.

Some imagine that questioning other professionals or challenging those in authority is a call for rudeness or abrasive unprofessionalism. Quite the contrary. We seek a professional world where health professionals routinely question and challenge each other civilly and directly, from a reasonable evidentiary base, as a professional courtesy as well as a professional obligation and where we actually expect this from colleagues, not recoil from it in indignation. If you are the kind of nurse, educator, dean, doctor or other professional who deems such questions or challenges from students or

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colleagues to be a form of insult, disloyalty, insubordination or questioning of authority and who reacts with indignation, petulance, anger, retribution or worse, then either change your attitudes and behaviour, or get out of healthcare or health professional education now, for you are part of this seemingly intractable problem that is costing patients their lives. We simply cannot afford to have you around any more. You are far too dangerous to keep.

In an ideal world and one that we should be creating now, not in eons, doctors and nurses would be sharing educational and practice experiences that model and mandate the kind of cooperation and communication that we so desperately need to see in practice. It is not enough surely for the nurses and doctors of the future to be educated in the same rooms or spaces, revolutionary as that may seem in some quarters. They need to learn and interact together as colleagues who will both share responsibilities for patient care and safety if this charade of the 'doctor-nurse game' is ever to be put behind us. We cannot accept another 50 years of 'The Doctor-Nurse Game' as being just an inevitable aspect of 'how the world is'. If this 'world' is failing our nurses, doctors and health professionals and killing and harming patients, then it has to be dismantled and destroyed.

Now.

Professional development and anticipatory prescribing

There is one educational recommendation for nurses that will surely meet with universal agreement. The panel noted that:

“It has also borne in mind that nursing staff should not have been put in the position of being the sole arbiters of when to start continuous opioids and what doses to employ, particularly in the absence of adequate training. (3.25:48)

This is almost impossible to fathom. Yes, nurses should not be ‘put in this position’ but these are not hapless cyphers, these are qualified, registered nurses. Their job as registrant RNs is not to allow themselves to be ‘put in any positions’ that conflict with their professional responsibilities. Their job is to challenge and question these ‘positions’ and to refuse to adopt any actions or inactions that may cause patients harm or death. There is no problem per se with the ‘anticipatory prescribing’ described in the Panel’s report (Gosport, 2018) and nurses’ valuable role in this (Wilson et al., 2014; Wilson and Seymour, 2017). There is a huge problem with nurses taking on roles and responsibilities for which they are woefully unprepared. The most experienced and well educated of palliative care nurses or nurse practitioners would surely balk at being expected to take on the responsibility for determining, starting, increasing and deciding on opiate cocktail doses for elderly people with no educational preparation. This is incredibly skilled work demanding high level knowledge of drugs, drug interactions and administration, the physiology of older people, skilled patient assessment, titration, negotiation with relatives, drug side effects and more. For nurses to undertake this without any specialist preparation and education beggars belief. Yet the Panel noted that, in relation to *any* form of professional development, they were:

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“... unable to find records of training in clinical and other expected learning programmes. It is therefore unclear how the nursing staff at the hospital were supported in keeping up to date with contemporary practice and expectations for the care they were expected to deliver.”

(3.23:48)

We are reminded here of the aphoristic conversation between a hospital's CFO and a CEO:

CFO: 'What happens if we spend a lot of money on staff development and education and they leave?'

CEO: 'What if we don't and they stay?'

Conclusion

For any nurse and for those of us in nursing education, it is almost painful to read the GWMH Panel Report and to see how badly nursing at both clinical and management levels failed patients, families and those nursing colleagues who initially alerted hospital managers. It is no comfort that numerous others involved in health, legal and regulatory services failed comprehensively also. It is wholly unrealistic to imagine that there is an educational 'fix' for the long-standing and endemic problems of our hierarchical hospitals, health services and Schools of Nursing. We cannot wait patiently until the the patriarchy is dismantled, until society changes, until 'adequate resources' fall from the sky, until all inequality is banished, until all cultures become positive or until all health professionals begin to be kind and civil towards one another. We have to leave a legacy in nursing that sees our profession in a better condition than it

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was when it was entrusted to us. We in nursing education can and must do something:

- We can stop tolerating and perpetuating the insidious Doctor-Nurse Game
- We can demand and help arrange that nursing, medical and other health professional students have meaningful, interactive learning experiences where they learn how to engage and work together as valued colleagues, not as demi-gods and underlings.
- We can demand that nurse educators and programs stop infantilising and oppressing students via empires of rules, regulations and other technologies of micromanagement and social control.
- We can ask and expect the same from our clinical colleagues.
- We can work specifically with clinical colleagues to model, demonstrate, enable and teach students when, why and how to question, challenge and confront collegially, constructively and responsibly.
- We can do everything we can to dismantle and destroy the 'authority gradients' that are so harmful to patient safety.
- We can help our students align their 'centre of gravity, not with their own self-interest or that of their colleagues or organisations, but with patients, families and communities.
- As educators, we must lead by example, by speaking out, by fostering, encouraging and welcoming questioning and challenging and by continuing to do so for as long as it takes. In doing so, we model true professionalism and accountability.

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Nursing education cannot wash its hands of the GWMH issues, think that these are a 'service problem' and imagine that someone else will tackle them. It will be exceptionally difficult, but we have to try.

END

4888 words

ACCEPTED MANUSCRIPT

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