Is There a Surge in Sanctions? Our Reflection on Nurses Being Struck Off

Executive Summary

Recent reports suggest that the number of UK nurses being struck off the register by the Nursing and Midwifery Council (NMC) has risen sharply. Media headlines and professional commentary have described this as a 'surge' in sanctions (the Telegraph 2024), sparking questions about whether nursing practice is deteriorating, regulation has become harsher, or systemic pressures are manifesting at the individual level.

This is our reflective analysis of these trends. and compare nurses' experience with that of doctors, to highlight the role of professional power, representation, and procedural design in shaping outcomes. Finally, we consider the implications for safety, trust, and professional culture, in the UK and internationally.

Introduction

The decision to strike a professional off a register is one of the most severe sanctions regulators can impose. For nurses, whose professional identity is closely tied to trust, compassion, and reliability, the impact of such cases reverberates far beyond the individuals involved.

Headlines suggesting a rise in nurses being struck off and media reports prompted our recent poll and led to us questioning: are more nurses failing to meet standards of practice? Or is the regulatory environment itself shifting in response to systemic pressures, public expectations, and cultural change? Our reflection seeks to explore those questions, with a particular focus on the UK, while drawing lessons for the wider international community.

The landscape: what the data shows

In 2023/24, 214 nurses and midwives were struck off the Nursing and Midwifery Council (NMC) register, a figure almost double the number from two years earlier (Medical Negligence Assist 2024). The NMC regulates over 800,000 nurses and midwives, meaning that while the percentage struck off remains small (0.027%), the rise is visible (NMC 2023) RCNi's Nursing Standard cautions against reading this as a straightforward increase in misconduct. It suggests changes in reporting, regulatory transparency, and employer referral expectations are significant drivers (RCNi, 2024). Allegations most often relate to clinical errors, failure to escalate deterioration, poor record-keeping, dishonesty, or breaches of professional boundaries — many linked to high-pressure practice environments rather than intentional harm (GMC 2024).

Drivers and Contributory Factors

- Regulatory transparency: Cases are more visible than in the past, creating a perception of increase even when proportions remain low.

- Systemic strain: Staffing shortages, workload intensity, and rising patient acuity contribute to errors that escalate to regulatory concern.
- Cultural change: Both patients and staff are more willing to raise complaints, reflecting a wider emphasis on accountability.
- Threshold shifts: Evolving expectations in professional standards, particularly around documentation and escalation, mean behaviours once addressed locally may now prompt NMC involvement.
- Mandatory employer referrals: Recent regulatory changes have clarified employers' duties to refer staff where fitness to practise may be impaired. NHS trusts and independent providers are now expected to report cases even if local action has been taken. This has widened the reporting pipeline and increased case volume (NMC 2023).

Comparative Lens: Nurses and Doctors

A comparison with doctors helps illuminate the distinct dynamics of nursing regulation:

- Proportion: Around 100 doctors were erased by the General Medical Council (GMC) in 2023/24, out of 350,000 registrants which is a rate broadly similar to nurses.[5] Nature of cases: Nursing cases often stem from everyday practice failures under pressure, whereas doctor cases more often involve criminal behaviour, prescribing breaches, or gross negligence.
- Regulatory structures: The NMC both investigates and adjudicates, while the GMC refers cases to the independent Medical Practitioners Tribunal Service (MPTS). This separation provides doctors with greater procedural safeguards.
- Representation: Doctors typically benefit from strong legal advocacy via defence unions; nurses' access to representation is more variable.
- Visibility: Nursing cases are more numerous and lower-profile; doctor cases are fewer but attract intense media coverage when they occur.

Reflection: Nurses are often sanctioned for errors symptomatic of systemic failure, while doctors' cases tend to involve higher-impact misconduct. This highlights inequities in how professional accountability is experienced.

Professional Power and Perceived Fairness

Within the nursing profession, there is a longstanding perception that nurses are held to stricter regulatory and ethical standards than doctors, particularly in areas such as honesty, documentation, and lower-level criminal convictions (RCNi, 2024; The Guardian, 2023; Royal College of Nursing, 2023). While doctors often benefit from extensive legal advocacy and the procedural separation of investigation and adjudication through the GMC and MPTS, nurses experience a more direct NMC process, often with less consistent access to representation (RCNi, 2024; GMC, 2023; NMC, 2024).

This structural difference feeds a sense of inequity. Recent media reporting has highlighted cases in which doctors convicted of serious criminal offences have been allowed to return to practice after relatively short suspensions, while nurses in comparable or less serious situations have been struck off (The Guardian, 2023). Many nurses interpret this as evidence of differential thresholds and professional power dynamics between the two groups.

For nursing teams, this perceived imbalance compounds existing pressures. It reinforces a sense that their profession is more vulnerable to punitive action and that regulatory outcomes reflect broader hierarchies within healthcare (RCNi, 2024).

Conclusion

The apparent 'surge' in nurses being struck off in the UK is not simply a story of declining professionalism. It reflects a complex interplay of systemic strain, cultural change, mandatory employer referrals, regulatory transparency, and professional vulnerability. Comparisons with doctors show that while sanction rates are proportionally similar, the types of cases, thresholds for escalation, and access to advocacy differ markedly. Nurses remain more exposed to systemic failings being judged as individual misconduct.

For the nursing profession, for regulators, and for healthcare leaders internationally, the lesson is clear: maintain accountability but resist equating error with misconduct. In doing so, we protect not only patients but also the integrity and resilience of the workforce.

References

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