A Typology of Dishonesty

Illustrations from the PSA Section 29 Database

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1. Introduction

Honesty seems everywhere prized and dishonesty is generally disapproved of and discouraged. Honesty and dishonesty are key concepts in appraisals of character and are related to core values such as trustworthiness, integrity, respect and hope:

> To be honest is to be real, genuine, and bone fide. To be dishonest is to be partly feigned, forged, fake, or fictitious. Honesty expresses both self-respect and respect for others. Dishonesty fully respects neither oneself nor others. Honesty imbues lives with openness, reliability and candour; it expresses a disposition to live in the light. Dishonesty seeks shade, cover, or concealment. It is a disposition to live partly in the dark (Bennett 1993 p.599).

Honesty is most particularly prized in professional life. Reports of professionals who have deviated from this moral norm have resulted in disappointment, a loss of trust and, in some instances, moral outrage. Few professions have been left untouched by reports of dishonesty. Politicians, for example, cheated on their expenses claiming more than they were entitled to. Members of the clergy covered up child abuse resulting in significant harm and, in some instances, loss of life. The police and media lied about the behaviour of fans at a football match resulting in decades of distress and mistrust. Findings from the Veracity Index 2015 (Ipsos MORI 2016) found that the five 'most trusted professions' were: doctors, teachers, judges, scientists and hairdressers and the five 'least trusted professions' were: business leaders, journalists, estate agents, government ministers and 'politicians generally'. It is interesting that doctors emerge as top of the poll - 89% trust to tell the truth – but unfortunately, for our purposes here, no other health and social professions are included in the poll.

Reports of dishonesty in relation to health and social care professions are many and various. Some of these reach the threshold for fitness to practise complaints and many do not. We analyse findings from an examination of the Professional Standards Authority (PSA) Section 29 fitness to practise database with a view to identifying a typology of dishonesty that builds on previous regulatory research activity which can be utilised in professional education, for example, the Policis report *Dishonest behaviour by health and care professionals*. A PSA (2013) report entitled *Candour, Disclosure and Openness* (PSA 2013) concluded that:

> The literature we reviewed suggests that while being candid is almost universally acknowledged as 'the right thing to do', health professionals and social workers still struggle, for a variety of reasons, to be as open as they might be when things have gone wrong.
>
> People are no doubt held back by the common human reactions to these sorts of situations – the bystander effect, reluctance to acknowledge error, feelings of guilt, and so on – but prevailing cultures in different professions may also exert and important influence. Doctors and nurses, for example, appear to have different attitudes and approaches to disclosure, indicating that any regulatory responses may need to be profession-specific to address the different cultures, while attempting to establish common expectations across the professions. (PSA 2013 p. 14)

In this report, commissioned by the Professional Standards Authority (PSA), we outline the scope of the project, discuss the ethical and professional arguments relating to honesty and dishonesty in professional life and provide illustrations that support a typology of dishonesty.

2. **A typology of dishonesty – scope of project**

The aim of the study was to develop a typology of cases of professional misconduct that include an allegation of dishonesty. This is intended to support the Authority's programme of work to understand the impact of regulation and to develop strategies to prevent or reduce incidence of professional misconduct in future. Drawing on case material available on the Professional Standards Authority's database of final fitness to practise hearings across the nine regulators, which the Authority oversee (the 'section 29' database). The research built on the findings in the University of Surrey's Research Report *Database Scoping for the Professional Standards Authority* 2015.

A preliminary typology identified three categories:

1. Dishonest acts occurring outside the workplace/working hours and not involving patients or service users
2. Dishonest acts occurring in the workplace/working hours, which may involve patients and service users and which are recognized as dishonest by the perpetrator and/or colleagues
3. Dishonest acts occurring in the workplace/working hours, which may involve patients and service users and where the dishonest act involved has been 'normalized' at either individual, team, organization or other level and therefore is not recognized as such.

This research aimed to examine a wider range of cases with a view to:

1. Developing the typology as necessary, further to the analysis of a wider range of cases
2. Identifying, if possible, the prevalence of particular kinds of dishonest act in each of the three categories
3. Identifying, if possible, any patterns relating to the environmental circumstances in which dishonest acts occur across the three categories
4. Identifying, if possible, any patterns relating to the professions involved in dishonest acts across the three categories
5. Identifying, if possible, any patterns relating to the personal circumstances of those committing dishonest acts, looking for example at evidence brought forward in mitigation
6. Considering whether the data suggests future preventative interventions, regulatory or otherwise, of different dishonest acts across the categories.

It was not possible to provide definitive answers to all of these research questions on the basis that the sample of 151 cases proved to be illustrative rather than representative. However, the typology has been extended to six types with illustrations from case examples and the discussion below does offer some insight into the key areas identified above.

3. Honesty and dishonesty in professional life – the ethical arguments

A seminal text on the topic of 'Lying: Moral Choice in Public and Private Life' (Bok 1978) begins with these questions:

> Should physicians lie to dying patients so as to delay the fear and anxiety which the truth might bring to them? Should professors exaggerate the excellence of their students on recommendations in order to give them a better chance in a tight job market? Should parents conceal from children the fact that they were adopted? Should social scientists send investigators masquerading as patients to physicians in order to learn about racial and sexual biases in diagnosis and treatment? Should government lawyers lie to Congressmen who might otherwise oppose a much-needed welfare bill? And should journalists lie to those from whom they seek information in order to expose corruption?

Bok (1978 p.xvi) goes on to say:

> We sense differences among such choices; but whether to lie, to equivocate, be silent, or tell the truth in any given situation is often a hard decision. Hard because duplicity can take so many forms, be present in such different degrees, and have such different purposes and results. Hard also because we know how questions of truth and lying inevitably pervade all that is said or left unspoken within our families, our communities, our working relationships. Lines seem most difficult to draw, and a consistent policy out of reach.

In health and social care situations it is also not always clear what the truth is, for example, when there is uncertainty regarding diagnosis, prognosis or best treatment options. In an early publication, entitled 'Why Doctors Don't Disclose Uncertainty' Jay Katz (1984 p.40) states:

> The importance that physicians have attributed throughout medical history to faith, hope and reassurance seems to demand that doctors be bearers of certainty and good news. Therefore, the idea of acknowledging to patients the limitations of medical knowledge and of doctors' capacities to relieve suffering is opposed by an ancient tradition.

The shift from medical paternalism to a more patient autonomy focused relationship is likely to make reticence about disclosing uncertainty less likely and this shift has significant ethical consequences. As Katz (1984 p.44) concluded four decades ago:

> Trust could be grounded in a mutual recognition of the capacities and incapacities of both parties for coping with human (professional and patient) vulnerabilities engendered by uncertainty…

In relation to professional regulation, lines do need to be drawn in matters of honesty and dishonesty and there should be an aspiration to consistency in decision-making.

So, too, there needs to be openness, transparency and fairness in responding to cases of professionals' dishonesty. Regulators' focus is, first and foremost, on patient and public protection and on the avoidance of harm. Honesty in professional life seems likely to protect patients and the public and to avoid harm whereas dishonesty undermines public protection resulting in harm. But always and everywhere?

As Bok and Katz suggest, practical and ethical aspects of truth-telling may not be so straightforward. In an exploration of truth-telling in professional life, Tuckett (2004 p.505) provides an overview of the reasons for and against truth-telling in clinical practice as below:

Reasons for truth-telling	**Reasons against truth-telling**
Autonomy – this relates to patients' self-determination. Receiving information about their care and treatment enables them to plan ahead and put their affairs in order.	**Autonomy** – it is compatible with autonomy that a patient may request that information is not shared with him/her, that is, that 'truth-telling can be forfeited.'
Physical benefit – evidence suggests that 'truthfully informed patients who trust those responsible for their care tend to co-operate and seek treatment'.	**Physical benefit** – withholding information from patients is sometimes justified on the grounds that patients are better off not knowing as truth-telling can result in pain and even death.
Psychological benefit – 'deceptive practices risk being discovered and mistrust results' when patients are not told the truth.	**Psychological benefit**- the view that truth-telling can result in distress, depression, anger and loss of hope. The reasons given for withholding the truth is framed as the prevention of harm to patients and to self.
Intrinsic good – truth-telling can be considered as an obligation and a duty and a value of intrinsic worth.	**Uncertainty principle** – A challenge in clinical practice relates to uncertainty of diagnosis and prognosis. The imperative to tell the truth in the light of uncertainty may seem impossible.

Respect for autonomy is a strong reason to disclose the truth regarding patients' care and treatment IF this is desired by the patient. Weighing benefits (principle of beneficence) and harms (principle of non-maleficence) is also an important part of ethical deliberation. Arguments to withhold bad news from patients are discussed by Beauchamp and Childress (2013 p.303-308). They present three arguments to support 'some measure of noncommunication'. The first they refer to as 'benevolent deception' which has a long history in medical practice and tradition and is based on consequentialist grounds – 'what you don't know can't hurt you and may help you'. There may be an idea that withholding information also contributes to the

maintenance of hope. The second, paternalistic argument is that many patients would find it difficult to fully understand complex information about their care and treatment and should be protected from this. The third argument is that some patients do not wish to know the truth about their diagnosis, treatment and prognosis.

Whilst all of these arguments can be challenged effectively, it remains the case that truth-telling in clinical practice is not straightforward. Health and social care professionals have to deliberate carefully, taking into account the importance of respect for patient/service user autonomy and weigh benefits and harms. It is not simply a case of 'to tell or not to tell?' but also how much information to give, when, where and by and to whom. A high level of communication skill and ethical competence is required to share complex and difficult communication well. A further consideration relates to issues of justice and non-discriminatory practice. Is it the case that some patients are given more or less information on the basis of age, class, gender, ethnicity or some other difference? And, when if ever, is this ethically justified?

Whereas many **dishonesty-focused fitness to practise cases** relate directly to clinical practice – for example, inadequate information about proposed treatments, deception, disclosure of error, lying and theft from patients – many do not. Weighing benefits and harms of dishonesty can be equally contentious when the dishonesty does not directly relate to patients. Dishonesty may be directed towards employers, colleagues, universities, regulators or the state as, for example, when registrants lie about qualifications, plagiarise academic work, do not disclose criminal convictions or cheat on their tax return. It has been suggested that the public may have a higher threshold for dishonesty in private life where a professional role is viewed as more technical. An example was given of a dentist charged with tax evasion. Even if no direct harm to patients or the public follows from dishonesty in private life, it can be argued that dishonesty or deception may cause harm to the reputation of, and trust in, the profession overall (Policis undated).

Honesty in professional life can then be supported by a range of ethical theories and approaches. In applying *the four principles' approach,* promoted by Beauchamp and Childress (2013), the principle of respect for autonomy presents a strong rationale for truth-telling. Weighing the benefits (principle of beneficence) and harms (principle of non-maleficence) also – generally – support honesty as does the principles of justice (2013). In *virtue ethics*, honesty is recognised as a professional virtue or moral disposition of the professional, which can be thought of as lying in a mean between vices of dishonesty (deficiency) and brutal/excessive honesty or indiscretion (excess). Honesty is closely related to virtues such as integrity and courage (Banks and Gallagher 2008). In *duty-based ethics*, honesty is emphasised as an obligation of professionals and has be balanced with other professional duties such as confidentiality and the duty of candour. Such duties are set out in professional codes [see Section 5 below]. *Care ethics* focuses on the value of relationships and on

attentiveness and awareness of responsibility in response to dependency (Collins 2015). Honesty plays an important role in maintaining relationships of care.

4. Dishonesty from a legal and regulatory perspective

The concept of dishonesty is central to many criminal offences involving the appropriation of property. It has been suggested that around one half of all indictable charges tried by the courts include some requirement of dishonesty (Ashworth and Horder 2013). Given that there is such reliance on the concept of 'dishonesty' in a large number of the database cases it is interesting to note that there is no complete statutory definition of what dishonesty means in the criminal law. As an example the Theft Act 1968 outlines in s2 (1) what is not regarded as dishonest and this includes where the defendant believes that he has the legal right to deprive the victim of the property, where the defendant believes that the victim would have consented if they had known of the circumstances and finally where the defendant believes that the owner of the property cannot be discovered by taking reasonable steps. There is an attempt to present what may be dishonest where s2 (2) Theft Act 1968 suggests that a defendant may still be dishonest notwithstanding their willingness to pay for the property which they have appropriated. It has been suggested that this lack of statutory definition is regrettable, given its importance in criminal law, (Ormerod 2007) but it has also been argued that one of the reasons for this lack of statutory definition is because as a concept it is afforded an 'incomplete social consensus' (Wells and Quick 2010).

Given this lack of clear statutory definition the common law has developed over time a test for dishonesty. The first and second stages of this test were laid down in the case of *R v Feely* (1973) QB 530. In this case the defendant 'borrowed' money from the safe of his employer in spite of a very clear warning that employees were not to borrow money in this way. The defendant was transferred before he could make good his borrowing and the Court of Appeal in that case held that the defendant should have been able to present his intention to repay (which would not be theft) and a further key question should have been whether a person who takes money in those circumstances was dishonest, given the clear indication from their employer that this course of action was prohibited.

This attempt at clarification was further developed by the Court of Appeal in the case of *R v Ghosh* (1982) QB 1053. In this case the defendant was a consultant anaesthetist who had been working as a locum for an NHS hospital. Mr Ghosh also had a very busy private practice. He then falsely claimed fees from the NHS for carrying out an abortion, which had in fact been carried out by someone else. He was charged with a related deception offence but claimed he was not dishonest because he claimed that the fees were in fact owed to him for his consultancy work. The trial judge directed the jury in objective terms, which was to decide whether the defendant's conduct was dishonest according to the standards of ordinary decent people rather than whether the defendant believed his conduct, was dishonest (a

subjective question). Mr Ghosh appealed and on reviewing the previous authorities the Court of Appeal noted the problems with both objective and subjective approaches.

LCJ Lane in the Court of Appeal explored the problems with the objective approach through a hypothetical example. The example relates to a man from a foreign country where public transport is free. This man then visits the UK and travels on a bus. He then gets off without paying. He never had any intention of paying. To ordinary decent people his conduct would be dishonest but from his own perspective he was clearly not dishonest, as in his own mind failing to pay on a public bus is not dishonest. LCJ Lane then considers the problems with the subjective question through the 'Robin Hood' example where Robin Hood would have known that robbing from the rich to pay the poor was dishonest to ordinary people but he would have considered himself to be morally justified in doing so. The concern here was that if a purely subjective test were adopted then all standards, but that of the accused themselves, would be ignored and no property would be safe. The compromise was the current two-stage test.

The jury must ask two questions:

1) Was the defendant's conduct dishonest according to the standards of the ordinary reasonable or decent person? (wholly objective)

If the answer to this question was yes then:

2) Did the defendant realize that the ordinary reasonable or decent person would regard his conduct as dishonest? (part subjective and part objective)

This is now the common law test for dishonesty, which is used in all proceedings where dishonesty is alleged. This test, although now 35 years old, is not without its critics. It has been argued that the appeal of the test is that it appears to strike an effective compromise between the objective and the subjective requirements but this compromise is not a 'stable' one (Halpin 1996). This lack of stability is due, in part, to the issue of dishonesty being left with the fact finder (the jury or magistrate) with often inadequate judicial direction and as famously argued 'A jury without stars or compass cannot be accused of bad navigation. The direction it takes may be deplorable but cannot be wrong.' (Griew 1985).

In spite of this criticism the test for dishonesty in a criminal trial is for the prosecution to prove dishonesty beyond reasonable doubt. In the s29 database the fitness to practise panels universally make reference to *R v Ghosh* (1982) QB 1053 in their reasons. The main difference being that these cases are proven, or not, to the civil standard and so the regulator has to prove that, on the balance of probabilities, the registrant was dishonest according to this test.

It is observed in most cases that when a registrant has been convicted of a criminal offence then this becomes a 'conviction case' and as such the *Ghosh* test is

automatically satisfied. The more difficult cases emerge where a registrant has not been convicted of a criminal offence but it is alleged their behaviour is dishonest within their professional practice.

To illustrate this dilemma in practice we refer to a case on the database, which is not atypical of the type considered. In this case it was alleged that the registrant had failed to provide good clinical care to a patient in that they failed to provide an adequate assessment and treatment plan, which was followed by the patient being discharged from Hospital A even though it was not in the patient's best interests. It was further alleged that the registrant then completed an application for a post at Hospital B and failed to mention that concerns had been raised about their clinical ability whilst at the Hospital A. It was further alleged that when they attended for interview at Hospital B they failed to disclose that concerns had been raised about their clinical ability at Hospital A. It was then alleged that this failure to disclose on both the form and at interview was dishonest.

Although the allegation of failing to provide good clinical care was found not proved the panel did find the failure to disclose that concerns were raised on both their application and at interview. In their reasons the Panel acknowledged that they were satisfied that the registrant's actions in failing to disclose this information met the requirement of the first limb of the *Ghosh* test (the objective test). The Panel also noted the personal circumstances of the registrant at the time (lack of paid employment), the evidence given on oath, which was potentially misleading (the dates of employment on the application form were incorrect) and that the registrant had not provided details of referees from Hospital A. These details, in the round, persuaded the Panel that the registrant knew that what he was doing was dishonest and they rejected an argument made by the defendant that he was unaware of the need to provide such crucial information (the subjective test). The panel therefore decided he was dishonest.

From a regulatory perspective the next question was whether the registrant's dishonest actions amounted to misconduct, which was serious and which impairs the registrant's fitness to practise. At this stage in this case the Panel referred to the regulator's Code of Practice, which, like other regulators, requires registrants to 'be open, honest and to act with integrity.' Mention was made of 'probity' in this instance and the Panel referred to dishonest conduct having the potential to damage the public's perception of the profession as a whole. Here reference was made to a range of regulatory judgments delivered by the Administrative Court, which included *Cohen v GMC* [2007] EWHC 581 (Admin); *Yeong v GMC* [2009] EWHC 1923 (Admin) and *CHRE v NMC and Grant* [2011] EWHC 927 (Admin). In *Grant* [2011] the Court stressed the importance of the earlier case of *Cohen* [2007] being read in full so that panels do not rely too heavily on the remediability of misconduct without considering the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.

In *Grant* [2011] the Court considered the factors set out by Dame Janet Smith in the Fifth Shipman Report (2004). These require a Panel to ask whether their determinations in respect of the registrant's misconduct show that his/her fitness to practise is impaired in the sense that the registrant has acted in the past or is liable to act in the future in a way which would suggest they may place a patient at unwarranted risk of harm and/or has acted in the past or is liable to act in the future in a way which would bring the profession into disrepute and/or has breached in the past or is liable to breach in the future one of the fundamental tenets of the profession and/or has in the past acted dishonestly and is likely to act dishonestly in the future. Here the Panel, like others, recognised that the dishonest misconduct in this case did bring the profession into disrepute and it undermined the fundamental tenet of probity. The Panel also recognised that consideration of a registrant's fitness to practise is often forward looking and here the ability to remediate misconduct was seen as crucial, whilst recognising the importance of public protection.

At this point the panel also considered the judgment of Mr Justice Sales in *Yeong v GMC* [2009] EWHC 1923 (Admin) and of Mrs Justice Cox in *Grant* [2011] EWHC 927 (Admin). In the former, reference was made to the importance of reducing the risk of recurrence and in the latter reference was made to the future risk of reoffending but also the importance of upholding public confidence in the profession as a result of the current misconduct. Therefore in this case the Panel found that the registrant's fitness to practise was impaired as a result of their dishonest misconduct.

Once misconduct (in this case dishonesty) and impairment have been established, panels move on to consider sanction. Whilst sanctions do differ across the regulators, it is clear that the process of finding a registrant dishonest, which amounts to misconduct and then considering whether this has impaired fitness to practise is now, a well-established formula for decision making across the regulators.

5. Honesty, dishonesty & professional codes

In a discussion of veracity in professional-patient relationships Beauchamp and Childress (2013 Chapter 8 p.302) point out that:

> Codes of medical ethics have traditionally ignored obligations and virtues of veracity. The Hippocratic Oath does not recommend veracity, nor does the Declaration of Geneva of the World Medical Association. The introduction to the original 1847 Code of Medical Ethics of the American Medical Association (AMA) offers flowery praise of veracity, as "a jewel of inestimable value in medical description and narrative", but the code itself does not mention an obligation or virtue of veracity, and thereby allows physicians virtually unlimited discretion about what to divulge to patients […] Despite this traditional neglect of veracity, the virtues of honesty, truthfulness and candour are among deservedly praised character traits of health professionals and researchers.

The ethical arguments discussed in Section 3 highlight some of the challenges regarding truth-telling in clinical practice. Imperatives to be honest, open, candid and trustworthy, now core prescriptions in professional codes, reveal little of the uncertainty and ambiguity of information-sharing in compare complex health and social contexts.

Good medical practice (General Medical Council 2013), for example, relates honesty to 'maintaining trust' and states 'Be honest and open and act with integrity'. Doctors are also charged with promoting 'a culture that allows all staff to raise concerns openly and safely' and with reporting concerns about colleagues. Doctors are also required to 'listen to patients, take account of their views, and respond honestly to their questions.' At the same time, they 'must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.'

Doctors must also 'be honest and objective when writing references, and when appraising or assessing the performance of colleagues' and 'must share all relevant information with colleagues…'. Doctors are also required to 'treat information about patients as confidential. This includes after a patient has died.' Doctors must also 'be open and honest with patients if things go wrong' and 'must respond promptly, fully and honestly to complaints and apologise when appropriate'. In addition to these imperatives a section of Good medical practice is dedicated to 'Act with honesty and integrity' (GMC p.21-22 see **Appendix 1**) and makes a connection between honesty and integrity, trust and trustworthiness.

The Health and Care Professions Council Code (HCPC 2016 **Appendix 2**) also emphasises openness and honesty when things go wrong, the requirement to direct service users to complaint processes and to 'be honest and trustworthy' in 'personal and professional life'. Similarly, the General Dental Council (GDC **Appendix 3**) requires members of the dental team to 'be honest and act with integrity' and not to bring the 'profession into disrepute'. Additional responsibilities are added regarding the need to ensure that 'any advertising, promotional material or other information that you produce is accurate and not misleading, and complies with the GDC's guidance on ethical advertising'. The Nursing and Midwifery Code (NMC **Appendix**

4) emphasises also duties relating to professionals' duty of candour. At a recent Royal College of Nursing conference, it was emphasised that nurses should 'avoid acts of dishonesty in their private lives to avoid being referred to the regulator'. The speaker, NMC barrister Ben Rich, is quoted as saying:

> Anything that smacks of dishonesty is taken very seriously whether or not it impacts on your ability to be a nurse […] honesty is the key concept. Any conviction for dishonesty is going to get you an impairment. In most cases you will get an impairment. In most cases you will get a year-long suspension.'

An example was given of a nurse who 'altered an annual parking permit to avoid the charges for another year' (Sprinks 2015).

It is understandable that a regulator will emphasise the importance of honesty and the potential consequences of dishonesty in professional life. It is also true that acts of dishonesty in personal life may impact on professional registration. There has been little previous academic research regarding types of dishonesty, particularly in relation to Fitness to Practise data. Types of dishonesty identified via an internet search include:

- Outright lie; subtle lie; exaggerated truth; and intellectual dishonesty (see http://www.evcforum.net/dm.php?action=msg&t=13639)
- Lying; slander; fraud; and stealing (see http://godfruits.tv/dishonesty-destroys-lives/)
- Types of academic dishonesty include: cheating, bribery, misrepresentation, conspiracy, fabrication; collusion; duplicate submission; improper computer/calculator use; improper internet use; disruptive behaviour; and plagiarism (see http://spcollege.libguides.com/c.php?g=254383&p=1695452)

There does not appear to have been any previous work focusing on types of dishonesty that arise from a search of the Section 29 PSA database. The examination of 151 cases led to a sixfold typology. The researchers selected 111 cases from the end of the database and systematically reviewed each case of dishonesty as it was listed. Following this it became clear that three of the regulators had significantly more examples – the Nursing and Midwifery Council (NMC), the General Medical Council (GMC) and the Health Care Professions Council (HCPC) - and it was decided to then search for 10 cases of dishonesty for each of the General Optical Council (GOC), the General Dental Council (GDC) and the General Pharmaceutical Council (GPhC). Finally we searched for any relevant dishonesty cases for the smaller regulators and located 7 cases across the Royal Pharmaceutical Society of Great Britain (RPSGB), Pharmaceutical Society of Northern Ireland (PSNI) and the General Chiropractor Council (GCC) and then finally located three further cases for the NMC, HCPC and four cases for the GMC to complete the focussed sample of 151 cases.

Overall, we examined the following dishonesty cases: 1 from the GCC; 10 from the GDC; 26 from the GMC; 16 from the GOC; 0 from the GOsC; 54 from the NMC; 5 from the RPSGB; 12 from the GPhC; 26 from the HCPC; and 1 from the PSNI.

6. Findings: A Typology of Dishonesty

6.1 **Introduction**

We identified six types of dishonesty and provide exemplars in relation to each type. We distinguish, where applicable, between examples of dishonesty in professional and private life. The types of dishonesty that we discuss in this section are those of:

- Dishonesty by omission - not disclosing - where the truth is withheld;
- Dishonesty by commission - lying - where a registrant tells an untruth;
- Impersonation - impersonating - assuming the identity of another person;
- Theft - stealing;
- Fraud - deceiving; and
- Academic dishonesty - cheating.

In the following sections, we introduce each in turn providing exemplars from private and professional domains. **Table 5** provides more detail of examples from each professional group from the 151 cases examined. The range of cases was then narrowed down to include those discussed below.

6.2 **Dishonesty by omission** - not disclosing - where the truth is withheld

This occurs where a registrant withholds, fails to disclose the truth or sets out to deceive a third party, for example, relating to complaints being investigated or previous convictions. The first example relates to the professional context and the second to the registrant's private life.

Exemplar 1 NMC Case – Caution Order for 42 months – Professional domain

The Registrant was a Nurse who failed to disclose that she was subject to a Fitness to Practise investigation by the NMC when she applied for a bank nurse position twice and a permanent nursing position. Attended for an interview for the permanent position and then worked as a staff nurse having secured that permanent position.

The Panel decided the Registrant's fitness was impaired due to her misconduct, as it was evidence of her clinical performance and its potential failings. Her failure to disclose this information was deemed to be dishonest because she signed disclaimers in connection with her employment claiming that she was not the subject of any such investigation. The Panel decided that a Caution order would be the appropriate sanction. This Caution would then sit on the register alerting potential employers to the previous misconduct. The PSA decided that although the penalty was not unduly lenient there were concerns that the Panel did not consider the indicative sanctions guidance and the case law concerning persistent dishonesty.

Exemplar 2 GMC Case – 2 Months Suspension- Private domain

The Registrant was a Surgeon charged with submitting a self-declaration form to his employer where he indicated that he was not aware of any police investigation being undertaken as a result of allegations against him.

He was later charged with three counts of fraud by false representation under the Fraud Act 2006 with four similar counts being taken into consideration. He did not inform the GMC of these charges. The Registrant also received a conditional caution for dishonestly making a false representation on seven separate occasions in order to make personal gain. The Registrant was later stopped when driving a motor vehicle while uninsured. For this offence the Registrant received 6 penalty points on his licence, a £200 fine and was reported to the DVLA for fraudulently displaying an excise licence. The Panel decided that the Registrant's fitness was impaired due to his misconduct, his caution and noted adverse health and subsequently suspended him for 2 months. His dishonest omission was non-professional in that it related to retention on the Register rather than relating to clinical practice. The Panel felt the Registrant's response to the allegation of dishonest failure to notify the GMC of charges against him was unacceptable and did amount to misconduct. Subsequently the PSA believed the duration of suspension to be lenient but not unduly lenient.

6.3 **Dishonesty by commission -** lying - where a registrant tells an untruth

This is the second type of dishonesty and involves the registrant telling an untruth, effectively lying regarding an issue in her/his private or professional life.

Exemplar 1 GMC Case - 12 months suspension followed by 18 months conditions of practise – *Professional* domain

The Registrant was a Consultant Anesthetist who submitted a job application to a NHS Trust with a CV which indicated he had co-authored 6 research publications. This was untrue. A short list for the job was drafted and did not include the Registrant however a decision was taken to discuss the publications with the Registrant. The Registrant then withdrew their application before the Trust could inform them that the rogue publications had been discovered. The Registrant eventually informed the GMC that the reason for these rogue publications on his CV were due to a transposing error which took place during the compilation of the CV.

The Panel wer not convinced, preferring more consistent, credible evidence from other witnesses. Later, during the Panel, it became apparent that the Registrant had been deliberately dishonest and had lied on oath about how the rogue publications came to be on his CV. In light of this the GMC asked for the Registrant to be erased from the register. The Registrant argued that suspension would be sufficient. The Panel decided that suspension for 12 months would be an appropriate sanction with a further review after this date. This was an example of dishonesty by commission in a professional domain. The PSA took the view that the sanction was lenient, as public confidence would be undermined by such actions on the part of the Registrant. That said, they concluded it was not unduly lenient.

Exemplar 2 GOC Case –141013 - Erasure from register - Private domain

The Registrant was an Optician who submitted a series of claims to an insurance company with a view to recovering costs incurred for private healthcare treatment for himself, his wife and his son. These claims were fraudulent in that the treatment never took place, or the duration of hospital stay was falsely extended (4 nights instead of 1) or the cost of the treatment received was significantly exaggerated (for example £25 per hour for chiropody treatment becoming £225).

The Panel decided that the 8 allegations against the Registrant were found proved. They were dishonest events in a non-professional domain. Given the extent of the dishonesty found the Panel decided the only proportionate penalty available to them was erasure. Given the sanction imposed the PSA took the view that no further action was required.

6.4 - **Dishonesty by impersonation** - impersonating - assuming the identity of another person

This occurs when a registrant assumes the identity of another person or encourages another person to assume the registrant's identity.

Exemplar 1 - NMC Case –Struck off the register - Professional domain

The Registrant was a Nurse who on three occasions impersonated a police officer. They were also found to be in possession in their car of items that could be used to impersonate a doctor. These items would appear to have been stolen by the Registrant from their place of work. The Panel heard evidence that an independent witness saw the Registrant dressed as a police officer on two occasions when they collected their child from school. Another witness indicated that the Registrant had indicated that they often wore a police jacket because it enabled them to drive faster and therefore get to places more quickly. When arrested the police found a flashing green light in the Registrant's car and a hand written sign saying 'Dr X'. The Registrant admitted all charges. This case demonstrates an example of impersonation within a professional domain because the Registrant was able to impersonate the Dr by stealing items from the work place and they were seen at work putting on a police jacket when leaving a shift.

The Panel viewed these offences as very serious and concluded that the profession would be undermined if the Registrant remained on the Register. On that basis the Registrant was struck off. On that basis the PSA had no further observations to make.

Exemplar 2 GMC Case - 9 months suspension - Private domain

The Registrant was a Doctor who was convicted of the offence of Conspiracy to defraud when he impersonated his brother in order to sit 6 of his brother's university examinations over a period of 2 years. The Registrant was sentenced to 6 months imprisonment, suspended for 24 months with a Community Order requirement of 40 hours of unpaid work.

The Panel took the view that the Registrant had clearly been dishonest, albeit in the non-professional domain, and therefore 9 months suspension was the appropriate sanction. Erasure was not deemed to be an appropriate sanction because the Registrant was remorseful and did demonstrate insight at the hearing. The PSA did not believe the sanction to be lenient. A further review meeting took place where a further 8 months suspension was put in place. This has since expired.

6.5 **Theft -** stealing

In the professional domain, this can involve theft of money, property from patients or the employing care organisation.

Exemplar 1 RPSGB Case - Restoration with conditions 9 months - Professional domain

The Registrant was a Pharmacist who was restored to the Register with a condition, which was due to be reviewed 6 months after the case was heard. The Registrant was removed from the Register after a criminal conviction of obtaining property by deception was issued. This deception related to claims the Registrant made for payments from the prescription pricing authority for which he was not entitled. The Registrant was dishonest in that he received overpayments, which were then later repaid.

The Panel removed him from the Register as a result of these dishonest claims but he has since been restored subject to a supervision condition, which was due to, be reviewed 6 months after. This dishonesty was made possible due to the pricing arrangements within the workplace and so is a case of Theft/Fraud within the professional domain. The PSA raised no concerns with the restoration on the Register some 4 years after the original erasure.

Exemplar 2 NMC Case – 9 months suspension – Private domain [with elements of professional]

The Registrant was a Nurse who stole drugs from his employer and then destroyed an incident report form, which related to a dispensing error of his colleague. Subsequently the Registrant engaged in dishonest behaviour in the non-professional domain when they were convicted of theft and two offences of failing to surrender to custody at the appointed time for other offences.

The Registrant received a 12-month community order with a supervision and drug rehabilitation requirement. Subsequently the Registrant received a further conditional discharge for possession of 2 class A drugs. The Panel took into account the duration of the Registrant's claim to have been clean of drugs but felt insufficient time had passed for a return to work. The Panel decided that 12 months suspension was the appropriate sanction. The PSA took the view that whilst this penalty was not unduly lenient the Panel should have asked for independent medical evidence to support the Registrant's claim that they were now clean. An attempt at remediation could have made the difference between suspension and erasure.

6.6 Fraud - deception

This is the fifth type of dishonesty and assumes different forms in professional life, for example, submitting false registration of citizenship documentation or signing for medication as if it was signed for by an appropriate registrant e.g. prescription sheets. In personal life fraud can occur where registrants claim for benefits they are not entitled to.

Exemplar 1 NMC Case – 12 months suspension – Professional domain

The Registrant was a Nurse who was convicted of theft and was sentenced to 12 weeks imprisonment, which was suspended for a period of 12 months with a Community Order, with two requirements, a period of supervision and 120 hours of unpaid work. As a Nurse Prescriber the Registrant stole a prescription pad from which she forged a script to obtain a scheduled drug and that forgery demonstrates an example of impersonation within a professional domain. The Registrant claimed the events were due to her health and stress but the Panel did not accept this and felt that the Registrant lacked insight into her failings.

The Panel took the view that the Registrant had been dishonest and therefore 12 months suspension was the appropriate sanction. The PSA took the view that the sanction was appropriate in spite of some concerns over omissions in evidence gathering from the Panel.

Exemplar 2 NMC Case- 5 years Caution Order - Private domain

The Registrant was a Nurse who was convicted of attempting to pervert the course of justice in that knowing her husband was facing proceedings for a sexual offence against a complainant did purchase an airline ticket for the complainant and forged a letter from the complainant stating that the allegations against the Registrant's husband were untrue and also tried to persuade the complainant to retract her allegations.

The Panel commented that as a conviction case in a non-professional domain there was no suggestion that the Registrant's clinical competence was in any way compromised. That said the Panel recognized the very serious nature of the case against the Registrant and given her dishonesty they found her practise impaired and ordered a 5 year Caution Order.

6.7 **Academic dishonesty –** cheating in an academic context.

This is the sixth type of dishonesty and covers a wide range of activities such as bribery, cheating, fabrication, duplicate submission, improper computer/calculator use and plagiarism.

Exemplar 1 GPhC Case - 6 months suspension – Professional domain

The Registrant was a Pharmacist who was at the time of detection undertaking a postgraduate course of study. The Registrant submitted an assignment, which had a 60% similarity index with a piece of work, that had been submitted the previous year by a junior colleague of the Registrant. Initially the Registrant denied any accusation of academic misconduct but later admitted that he had copied the work.

The Panel decided that in light of the offence it was in the public interest to suspend the Registrant for six months. The PSA felt the Penal could have examined why erasure was not considered given the flat denial of the Registrant, which demonstrated a lack of insight into this dishonest practice. It was dishonest within the professional domain because the Registrant would have secured financial gain from completing the postgraduate qualification.

Exemplar 2 – NMC Case- 12 months caution – Personal domain

The Registrant was a Nurse who was charged with, and they admitted, selling 2 essays on eBay. The Registrant had advertised both essays at a price of £2.99 each and had represented that both essays had obtained higher marks than the essays had actually achieved (assessment 1 had an advertised mark of 69% when it actually obtained 56% and assessment 2 had an advertised mark of 65% when it actually obtained 53%).

The Panel took the view that the falsified marks were evidence of dishonesty and the Registrant admitted this. The Panel therefore decided that the Registrant's fitness to practise was impaired by reason of this misconduct and as this misconduct was unlikely to cause direct or indirect patient harm they imposed a caution order for a period of 12 months. The PSA did not query the sanction but they did think the Regulator had failed to charge the most serious aspect of the case, which was the fact the essays were placed on eBay in the first place. It was felt this ran the risk of further student plagiarism. It was dishonest to falsify the marks and both the Panel and the PSA recognized this did bring the profession into disrepute. However, it was also dishonest to encourage/incite plagiarism in this context. It was dishonest within the non-professional domain because the Registrant would have secured financial gain and it was conducted outside of the work place.

Note following feedback session at PSA – an example was given where practitioners received substantial financial 'gifts' from a care-recipient. This may amount to dishonesty by omission (for example, where the gift was not declared and

accepted in breach of the organisation's gift policy). It could be categorised as dishonesty by commission where a registrant lies about receiving gifts. Where 'gifts' were obtained in coercive circumstances this may be categorised as dishonesty, for example, where a registrant uses manipulative strategies to obtain money from a care-recipient . Further examples could be explored in future research.

7. A worked example applying a deliberative framework: a resource for professional education?

Developing and maintaining ethical competence in registrants and students is an important component of preventative action in relation to dishonesty. Effective professional education makes an important contribution to the development of ethical competence. We propose the following as a possible framework for an educational intervention relating to the development of a dishonesty typology.

(i) Provide an overview of ethical competence - one perspective concludes that it encompasses five elements (Gallagher in Higgs et al 2013):

Ethical knowing - Understanding of the requirements of a professional role, of the rationale and ethical underpinning for professionalism and knowledge of theoretical/philosophical and empirical ethics;

Ethical seeing – It is essential that registrants' recognise the ethical features and implications of activities they are engaged in, both in personal and professional life. The recognition of actions and omissions as honest or dishonest is a first step in avoiding a fitness to practise complaint.

Ethical reflection – This goes further than recognition of an ethical issue and requires that registrants are able to think through situations they are involved in. This involves deliberation drawing on ethical arguments and the requirements of professional codes taking responsibility for the decisions arrived at.

Ethical action – This includes doing the right thing in often complex and uncertain circumstances. This also includes awareness of the impact of their actions and omissions on others, including patients, families, colleagues, students, the organisation and the reputation of the profession.

Ethical being – One common approach to professional ethics is virtue ethics. This is the idea that ethics is aspirational and that registrants are aware of their fallibility and aspire to betterment. This includes the development of virtues such as respectfulness, compassion, professional wisdom and, of course, honesty. Ethical being then involves an aspiration to betterment and to the development of good character. The acceptance of ethical being as an element requires also reflection on the relationship between conduct/action and character.

Following on from a discussion of ethical competence in professional practice, we propose deliberative framework that would enable registrants and students to interrogate and learn from cases from the Section 29 database.

(ii) HONESTY: A Deliberative Framework

The following is an example of a deliberative framework that can be applied to dishonesty cases from the PSA S29 or any regulator's database. We use the acronym HONEST as an aide memoire:

- **H**ighlight the type of dishonesty and domain of offence
- **O**rganisational issues that may have impacted on the offence?
- **N**egative or aggravating individual factors that contributed to offence? The Policis report 'stairway of significance' regarding aggravating factors is helpful here [see 'worked example' below].
- **E**xplanations offered as possible mitigation? The Policis 'stairway of decreasing significance' regarding mitigating factors is illuminative here. [see 'worked example' below].
- **S**anction applied – Is it fair? Too lenient? Too severe? PSA response? Is the sanction proportionate?
- **T**raining or professional education that may remedy?

(iii) A worked example

Any of the case examples discussed and referred to in this report could be used in sessions aiming to develop the ethical competence of registrants in relation to honesty and dishonesty.

We identified one case example for the purposes of illustrating the potential of the HONESTY framework to raise awareness of the elements and implications of dishonesty in professional practice.

> A registrant obtained a position in an NHS trust in 2001 using a counterfeit British passport and National Insurance card. This was not discovered until 2010 by which time the registrant had obtained indefinite leave to remain in the UK. She had recently moved to a new position and had made her manager aware of this dishonesty. The panel concluded that the dishonesty amounted to misconduct. A five year caution was imposed and, although it was agreed there was no likelihood of recurrence the episode undermines the good reputation of the profession. The registrant's current employer, who has known her for one month, spoke positively of his experience of her clinical competence and integrity. He said the registrant had made him aware of the dishonesty from the outset. She had also expressed remorse and shame regarding her dishonesty. The PSA thought the decision was lenient and questioned whether a 'conditions of practice' sanction requiring supervision would have been more appropriate.

Case analysis

- **H**ighlight the type of dishonesty and domain of offence – This is an example of fraud involving the forgery of a passport and national insurance card. The domain related directly to professional practice as the counterfeit documents were used to gain employment.

- **O**rganisational issues that may have impacted on the offence? – There do not appear to be contributory organisational factors although it may be questioned why the dishonesty took so long to come to light. The PSA also questioned the regulator's process in checking documentation that supports registration.

- **N**egative or aggravating individual factors that contributed to offence? – This is not clear from the vignette but the circumstances behind the registrant's decision to use counterfeit documents should be interrogated. Why did the registrant not disclose the dishonesty prior to it being discovered in 2010? In terms of aggravating factors detailed in the Policis report, those relating to insight, remorse, premeditation and betrayal of professional trust appear to be most pertinent to consider.

- **E**xplanations offered as possible mitigation? – Again, professionals and students may ask about the circumstances of this registrant's arrival in the UK and what led to her overstaying the initial 6 month visitor's visa? Might, for example, she have been eligible for the right to remain at an earlier stage? What reasons might be presented to support this? And also her decision not to disclose the dishonesty? Mitigating factors to consider could include 'no immediate/direct threat to patient safety', insight and remorse, and disclosure and transparency (see Policis 'stairway').

- **S**anction applied – Is it fair? Too lenient? Too severe? PSA response? – The PSA suggested that the 5 year caution was lenient but did not take action to change this. What do professionals and students think of the sanction in the light of the dishonesty of 10 years' standing? It is also important to raise the question of proportionality regarding the sanction.

- **T**raining or professional education that may remedy? – In this case, the registrant expressed remorse and shame and it seems that there had been no additional significant examples of dishonesty reported in relation to her practice. Might she, for example, gain from undertaking a course on professionalism or to have regular discussions requiring reflection on the importance of honesty in professional life.

(iv) Learning points and questions for further discussion

With a view to consolidating learning with regard to dishonesty participants could be asked to discuss the following question areas:

- Discuss your understanding of the meaning of 'honesty' and 'dishonesty'?

- Give 3 arguments that support honesty in professional practice – for individuals, organisations and the profession?
- Provide anonymised examples of honesty from own professional practice
- Identify six types of dishonesty that arise in professional practice?
- Identify the consequences of dishonesty in professional practice – for individuals, organisations and the profession?
- Provide anonymised examples of dishonesty from own experience
- Discuss aspects of professional practice that makes honesty challenging?
- How might these challenges be overcome?
- Identify the elements of your professional code that supports honesty
- Identify further areas of learning that will enable you to develop ethical competence in relation to honesty in your professional practice

8. Conclusions and recommendations

This report was commissioned by the Professional Standards Authority with the primary aim of developing a typology of dishonesty from the fitness to practise S29 database. An understanding of how dishonesty manifests in the health and social care professions by interrogating and providing illustrations of each type has educational potential. In the previous section, we have suggested a framework for the analysis of dishonesty cases, which is a possible resource for professional education. A consideration of the ethical and professional aspects of honesty demonstrates the importance of this value. Whilst there may be disagreement about the ethics of disclosing the truth to patients relating to diagnosis and prognosis, there is little uncertainty regarding its importance in supporting trust and confidence in the health and social care professions.

Some challenging questions do remain regarding the relationship between professionals' conduct and their character. If there is an episode of dishonesty in private life, what implications are there for professional practice?

This research set out to examine a wide range of cases with a view to:

1. Developing the typology as necessary, further to the analysis of a wider range of cases
2. Identifying, if possible, the prevalence of particular kinds of dishonest act in each of the three categories
3. Identifying, if possible, any patterns relating to the environmental circumstances in which dishonest acts occur across the three categories
4. Identifying, if possible, any patterns relating to the professions involved in dishonest acts across the three categories
5. Identifying, if possible, any patterns relating to the personal circumstances of those committing dishonest acts, looking for example at evidence brought forward in mitigation
6. Considering whether the data suggests future preventative interventions, regulatory or otherwise, of different dishonest acts across the categories.

We discuss our responses to each of the project aims below:

1. *Developing the typology as necessary, further to the analysis of a wider range of cases*

Section 6 of this report details our sixfold typology of dishonesty as: dishonesty by omission; dishonesty by commission; impersonation; theft, fraud; and academic misconduct/

2. Identifying, if possible, the prevalence of particular kinds of dishonest act in each of the three categories

Of the 151 cases reviewed the three most particular kinds of dishonest activities were firstly, failure to disclose convictions/cautions to the regulator either upon registration or for the purposes of retention on the register (19 cases). Secondly, simple theft of identified monies, prescription pads and medication or drug paraphernalia (18 cases) and finally, receiving sick pay and salary from a 2nd employer simultaneously (13 cases).

3. Identifying, if possible, any patterns relating to the environmental circumstances in which dishonest acts occur across the three categories

It is difficult to identify any patterns relation to the environmental circumstances in which dishonest acts occur across the categories. Clearly personal gain is key in most of the cases involving dishonesty whether it is to not disclose convictions/ cautions for fear of losing an existing position or positive acts of dishonest appropriation for monetary/property gain. When looking at environmental factors some of the cases do refer to registrants taking advantage of opportunities presented to them. This could be considered environmental, in that the opportunity was presented due to the customs and practices within the registrant's workplace.

In a GPhC case the Registrant was found to have manually added reward points to a store's discount card. The amount of points on the Registrant's card was not insignificant. It was noted that the Registrant herself manually put these points onto the Registrant's card during a number of financial transactions. The Registrant was serving herself. This was contrary to that store's staff security rules. It was also discovered the Registrant had also given a second staff discount card to her sister who did not reside with her (a condition of the second staff discount card). The Panel found the use of the second staff discount card was dishonest but the manually added reward points were not. The Panel indicated that the registrant admitted knowing that it was wrong to do this but the registrant indicated that everyone did it in the store suggesting the opportunity for developing this custom and practice was apparent.

This opportunity to develop a dishonest custom and practice within the work place could also be seen as an environmental factor in two NMC cases

where the Registrants faced charges of accepting and cashing cheques given to them by a resident of a nursing home where both registrants worked. It was argued that monies given were either gifts or reimbursement for shopping purchased. This was contrary to the gift policy of the nursing home and both registrants had engaged in accepting significant amounts of money from an identified client. Once again opportunity was seen as a factor in another NMC case where the site of the offence was a prison where the Registrant worked and once discovered it became apparent a course of conduct had been undertaken for a period of 2 months which although deemed to be out of character was possible because the drugs were available for dispensing to prisoners within the prison.

Sometimes incidents of dishonest practice have taken place in the context of a busy workplace which has been acknowledges by panels. In a GOC case falsification of a patient's signature on an application for an eye exam and for optical repair took place due to the Registrant forgetting to obtain these from the patient at the time of the examination this therefore being for administrative convenience rather than financial gain. In these circumstances the Panel decided a warning was a suitable sanction. Similarly in another GOC case the Registrant removed some cosmetics from the shop floor without paying for them. The Registrant indicated to the Panel that she had not acted dishonestly because she had been absent minded, the shop had been busy and she had not wanted to queue. The Panel accepted this and no sanction was imposed.

4. Identifying, if possible, any patterns relating to the professions involved in dishonest acts across the three categories

Of the three most particular kinds of dishonest activities identified under question 2 the identifiable patterns from the 151 cases reviewed indicate that in the first category of failure to disclose convictions/cautions there is no particular pattern as to each profession beyond the incident itself. Of the 19 cases identified examples from the GMC, GDC, GOC, NMC, HCPC (HPC), RPSGB and GPhC all appear and certainly no discernible pattern can be located.

In the second example of simple theft it would appear, once again, that a range of cases from a range of regulators feature. This time however of the 18 cases identified a smaller range of regulators appear. There are examples from the HCPC (HPC), NMC, RPSGB and GPhC.

In the final example of receiving sick pay and salary from a 2nd employer simultaneously, an even smaller range of regulators feature but perhaps here there is a clearer pattern emerging. Of the 13 cases identified the HCPC, NMC, GMC and GDC appear but of these cases 9 of them were cases involving registrants with the NMC.

5. Identifying, if possible, any patterns relating to the personal circumstances of those committing dishonest acts, looking for example at evidence brought forward in mitigation.

Mitigation is routinely presented by registrants once detected and during the course of disciplinary proceedings. During these cases the regulators routinely refer to their own indicative sanction guidance to explain how evidence of mitigation should be considered. One particular mitigating factor that is considered by some panels is the youth and/or inexperience of the registrant. An example of this is in a GOC case where the Registrant was a student on a professionally accredited course. The student had taken a ruler into the examination, which had a series of unauthorised annotations on its rear face. These annotations could have been useful during the examination. The ruler was confiscated and the Panel were asked to consider whether the behaviour of the Registrant was dishonest and whether it impaired the registrant's fitness to practise. The Panel decided that given the timeframe in which the offence was committed and the registrant's youth they would not issue a sanction believing that a more mature registrant would have been sanctioned more punitively.

Similarly youth is seen as key in another GOC case where the Registrant was a trainee health professional and during her training her supervisor left. The Registrant needed to sit an examination as part of her professional accreditation and so she forged the signature of her now former supervisor to give the impression she was being supervised. The Panel decided this was clearly misconduct but then considered the question of impairment. In the Panel's decision it is indicated that a number of factors were taken into account of which youth was one. The Panel decided the Registrant's fitness to practise was not impaired.

In some cases panels have taken into account a registrant's medical circumstances especially if there has been a mental health problem, which has arguably impaired the registrant's judgment. This was the case in both a NMC and a RPSGB case. In another NMC case the Panel heard that the Registrant had been convicted of theft having stolen drugs from their workplace. In mitigation the Registrant's depression, Opiate Dependency Syndrome and other personal circumstances were considered and the Panel imposed a caution order, which was deemed proportionate to the offence committed. Whilst the Authority did not question the sanction issued they did raise concerns about the lack of corroborative evidence for the mitigation presented suggesting panels are willing to rely on oral testimony alone.

This willingness to consider personal mitigation was also apparent in a GMC case where the Registrant was on certified sick leave and was receiving sick pay from their employer but then undertook private practice during

this period of sick leave. The Panel considered and appeared to accept oral testimony of the Registrant believing they suffered memory loss and had muddled thinking when it came to their understanding of what the certified sick leave meant for their practice. The Panel still felt there was an opportunity for rational thought here and so found the Registrant's fitness to practise impaired but they issued no sanction. It was alleged that the private practice at this time was for continuity of care rather than monetary gain and the Panel's sanction does appear to have taken into account the personal mitigation of the Registrant. The Authority took the view this was lenient but not unduly lenient.

6. *Considering whether the data suggests future preventative interventions, regulatory or otherwise, of different dishonest acts across the categories.*

We have suggested an approach to an educational intervention that seems likely to raise registrants' awareness of issues relating to honesty and dishonesty in professional practice in Section 7 of this report.

We strongly recommend that educators and regulators capitalise on the rich resource of cases in their databases to illustrate types of dishonesty and also to urge reflection on strategies that registrants may use to develop their moral resilience.

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10. APPENDICES

10.1 APPENDIX 1

General Medical Council
http://www.gmc-uk.org/guidance/good_medical_practice.asp

Good medical practice (2013) Act with honesty and integrity

Honesty

65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

66. You must always be honest about your experience, qualifications and current role.

67. You must act with honesty and integrity when designing, organising or carrying out research, and follow national research governance guidelines and our guidance.[2]

Communicating information

68. You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

69. When communicating publicly, including speaking to or writing in the media, you must maintain patient confidentiality. You should remember when using social media that communications intended for friends or family may become more widely available.[10,19]

70. When advertising your services, you must make sure the information you publish is factual and can be checked, and does not exploit patients' vulnerability or lack of medical knowledge.

71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.[16] You must make sure that any documents you write or sign are not false or misleading.

a. You must take reasonable steps to check the information is correct.

b. You must not deliberately leave out relevant information

Openness and legal or disciplinary proceedings

72. You must be honest and trustworthy when giving evidence to courts or tribunals.[20] You must make sure that any evidence you give or documents you write or sign are not false or misleading.

a. You must take reasonable steps to check the information.

b. You must not deliberately leave out relevant information.

73. You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in *Confidentiality*.

74. You must make clear the limits of your competence and knowledge when giving evidence or acting as a witness.[20]

75. You must tell us without delay if, anywhere in the world:

a. you have accepted a caution from the police or been criticised by an official inquiry

b. you have been charged with or found guilty of a criminal offence

c. another professional body has made a finding against your registration as a result of fitness to practise procedures.[21]

76. If you are suspended by an organisation from a medical post, or have restrictions placed on your practice, you must, without delay, inform any other organisations you carry out medical work for and any patients you see independently.

Honesty in financial dealings

77. You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals.[22]

78. You must not allow any interests you have to affect the way you prescribe for, treat, refer or commission services for patients.

79. If you are faced with a conflict of interest, you must be open about the conflict, declaring your interest formally, and you should be prepared to exclude yourself from decision making.

80. You must not ask for or accept – from patients, colleagues or others – any inducement, gift or hospitality that may affect or be seen to affect the way you prescribe for, treat or refer patients or commission services for patients. You must not offer these inducements.

9.4 APPENDIX 2

Health and Care Professions Council (2016)
http://www.hpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics/

Your duties as a registrant – Standards of conduct, performance and ethics

8 Be open when things go wrong

Openness with service users and carers

8.1 You must be open and honest when something has gone wrong with the care, treatment or other services that you provide by:

– informing service users or, where appropriate, their carers, that something has gone wrong;

– apologising;

– taking action to put matters right if possible; and

– making sure that service users or, where appropriate, their carers, receive a full and prompt explanation of what has happened and any likely effects.

Deal with concerns and complaints

8.2 You must support service users and carers who want to raise concerns about the care, treatment or other services they have received.

8.3 You must give a helpful and honest response to anyone who complains about the care, treatment or other services they have received.

9 Be honest and trustworthy

Personal and professional behaviour

9.1 You must make sure that your conduct justifies the public's trust and confidence in you and your profession.

9.2 You must be honest about your experience, qualifications and skills.

9.3 You must make sure that any promotional activities you are involved in are accurate and are not likely to mislead.

9.4 You must declare issues that might create conflicts of interest and make sure that they do not influence your judgement.

10.3 APPENDIX 3

General Dental Council

http://www.gdc-uk.org/dentalprofessionals/standards/pages/default.aspx

Standards for the Dental Team (2013)

Standard 1.3
You must be honest and act with integrity

1.3.1 You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them. This applies to any business or education activities in which you are involved as well as to your professional dealings.
1.3.2 You must make sure you do not bring the profession into disrepute.
1.3.3 You must make sure that any advertising, promotional material or other information that you produce is accurate and not misleading, and complies with the GDC's guidance on ethical advertising.

10.4 APPENDIX 4

Nursing and Midwifery Council

https://www.nmc.org.uk/standards/code/

Preserve safety

You make sure that patient and public safety is protected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this, you must:

13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

13.3 ask for help from a suitably qualified and experienced healthcare professional to carry out any action or procedure that is beyond the limits of your competence

13.4 take account of your own personal safety as well as the safety of people in your care, and

13.5 complete the necessary training before carrying out a new role.

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

Nursing and Midwifery Council

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers, and

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.1 only act in an emergency within the limits of your knowledge and competence

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly, and

15.3 take account of your own safety, the safety of others and the availability of other options for providing care.

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other healthcare setting and use the channels available to you in line with our guidance and your local working practices

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working

The professional duty of candour is about openness and honesty when things go wrong. “Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.”

Joint statement from the Chief Executives of statutory regulators of healthcare professionals. Within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern, and

16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised.

For more information, please visit: www.nmc-uk.org/raisingconcerns.

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information, and

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people.

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

10.5 APPENDIX 5

Summary of 151 Cases Examined

- **General Chiropractor Council - GCC**
- **General Dental Council – GDC**
- **General Medical Council – GMC**
- **General Optical Council – GOC**
- **General Osteopathic Council - GOsC**
- **Nursing and Midwifery Council – NMC**
- **Royal Pharmaceutical Society of Great Britain (Until 2010)- RPSGB**
- **General Pharmaceutical Council (since 2010) – GPhC**
- **Health Care Professions Council (formerly Health Professions Council) – HCPC/ HPC**
- **Pharmaceutical Society of Northern Ireland - PSNI**

Private	Professional	Theme
	GOC – Dishonesty regarding qualifications and members of professional organisation	Omission – withholding information from employer
Overlap	GOC – Unauthorised access of database using brother in law's log in	Assuming false identity to access database
	HCPC – ODP - Alleged theft of medication from theatre	Theft of medication
Overlap	GMC – Sitting exams (X6?) on behalf of others [family members/friends?]	Impersonating/assuming false identity in exams
NMC – forged letter to send husband's accuser overseas		Assuming false identity and forging letter to suggest registrant's husband was not guilty of said offence
	NMC – claiming sick pay whilst working night duty elsewhere	Dishonest about sickness and non-entitlement to sick pay
	GMC – submitted misleading statement regarding monitoring of patient	False/untrue statement re clinical care/treatment
GMC – misuse of status to secure ESA for personal acquaintance		Represented herself as a relevant doctor for for the purposes of an ESA assessment. Personal rather than professional.

	HCPC – allegedly stole £6050 from service user	Theft from service user
	HCPC –claimed to be duty SW when community care worker	Lying about role
	GMC– falsifying patient satisfaction survey	Fraud/impersonating patients to gain credit for quality of service
	GOC – ordered contact lenses without due process	Omission – not following ordering process
	NMC – plagiarism of assignment	Academic dishonesty
GMC – failed to disclose fixed penalty re drunk and disorderly		Omission re disclosing criminal offence
	HCPC – received sick pay and salary from 2nd employer	Dishonesty and theft
	NMC – falsified supervision records and did not conduct supervision	Falsifying records and lying about provision of supervision
HCPC – failed to declare conviction for speeding and assault		Omission – non-disclosure of conviction to employer
	GMC – lied about professional indemnity for training role	Lied about insurance cover
	NMC – took dihyrocodeine for own use X 3 times	Theft of drugs for own use [claim that it was 'standard practice']
	GPhC – added points to Boots care for patient purchases	Theft of points and Dishonesty As not due to own purchases? [standard practice – hazard?]
	NMC – withheld reason for leaving previous employer – said for 'new challenges' when had been dismissed	Dishonest and omission regarding previous employment
	NMC – allocated HCA to administer medication and then lied about it	Lying about delegation
	HCPC (paramedic) – used film star names instead of colleagues on transfer records.	Dishonestly inventing names for clinical colleagues – a form of administrative

		convenience
GMC – developed APP – question of plagiarism and posting favourable review	Overlap	Possible theft of idea and impersonating impartial reviewer
HCPC (SW) – claiming supportive lodging payment fraudulently	Overlap	Fraud and theft
	GMC – misrepresentation of employment history	Fraud/lied about qualifications
	HCPC – plagiarism re portfolio and failure to disclose	Both professional and academic dishonesty
	GOC -– forged signature to take exam	Forgery [one off act of foolishness – owned up and blamed culture]
	HCPC (OT) – withheld info about dismissal on job application	Omission – withholding information on job application
	GOC – using annotated ruler in exam	Cheating in exam [one off foolishness]
	GMC – falsified records of 6 patients	Falsifying patient records
	NMC keeping records in drawer & sent case conference report by email	*Check re claim of dishonesty
	HCPC – submitted timesheets whilst on sick leave – had 2 jobs	Lying and theft
	GMC – made out prescriptions for people other than those named	Falsifying prescriptions
NMC – took money from colleague to obtain visa	Overlap	Fraud and dishonesty (Coercion with false promises)
	HCPC (paramedic) – sub standard care and then suggested patient had declined treatment	Dishonesty in the provision of treatment
GPhC – caught speeding and sent letter saying it wasn't him		Lying about offence
	HCPC (ODP) – falsified theatre sheet to cover up lack of communication about allergy	Falsifying document to cover up error
	HCPC (psychologist) –	Lying about registration

	falsely implied on website that he was registered when registration had lapsed	
	NMC – falsified signatures on clinical assessment documents	Falsifying signatures on assessment documents]remorse noted]
	NMC – theft from employer (£4700)	Theft from employer [remorse noted]
	NMC – bought football ticket for patient and slow to refund change	Not organised in accordance with the gift policy of the home
	GOC (2 cases) – manipulating sales of frames for bonuses	Lying about sales for personal gain [penalty for registrant who appeared less severe than for reg who didn't?]
	NMC – said she had portfolio when she didn't	Lying about portfolio
	NMC - prescribed medication to sister; falsified timesheets and forged signature	Falsifying prescription and timesheets and forging signatures
	NMC – falsified signature on controlled drug register	Falsifying signature on controlled drug register
	GMC – allegedly used other peoples data in an Abstract	Academic dishonesty
	HCPC – incorrectly scanned a patient with a colleague and then advised his colleagues to delete the images.	Clinical incompetence followed by dishonesty to cover the incident up.
NMC - failed to declare caution and conviction for a range of criminal offences including deception, criminal damage and common assault		Omission – non-disclosure of conviction to employer
	GMC – Incompetent clinical treatment and then dishonest attempt to cover it up. Incident of lying on oath to the coroner about the treatment.	Omission in provision of care followed by dishonest attempt to cover it up
	NMC - Worked in a home for dementia sufferers	Omission in administration of medication followed by

	where there were errors in the administration of drugs. Failure to record entries.	dishonest attempt to cover it up Falsifying signature on controlled drug register
	NMC - Worked in a home for dementia sufferers where there were errors in the administration of drugs. Failure to record entries.	Omission in administration of medication followed by dishonest attempt to cover it up Falsifying signature on controlled drug register
NMC – receiving a caution for using a false prescription for a scheduled drug with intent	Overlap as incident took place due to opportunity at work	Forgery offence followed up by dishonest attempt to cover it up. Omission – non-disclosure of caution to employer
	GMC – Whilst suspended treated a patient and failed to provide adequate information concerning a course of treatment	Practising whilst suspended and a failure to fully inform a patient as to treatment options
	NMC - received sick pay and salary from 2nd employer	Dishonest about sickness and non-entitlement to sick pay
	NMC – Altered the dates on a sick note to ensure an insurance claim for absence was honoured	Forgery to ensure gain
	NMC – falsified signatures on clinical assessment documents to cover up clinical failures and misled investigating officers	Omission in provision of care followed by dishonest attempt to cover it up
	NMC – received sick pay and salary from 2nd employer	Dishonest about sickness and non-entitlement to sick pay
	NMC - Falsified a time sheet in order to gain payment for work not done	Dishonest about extent of work by falsifying time sheet
	NMC – falsified signatures on clinical assessment documents to cover up clinical failures	Omission in provision of care followed by dishonest attempt to cover it up
	NMC – submitted 45 timesheets for 71 bank shifts- 39 of these were false	Fraud (convicted)
	HCPC – ODP – Theft of drugs	Theft
	HPC – false imprisonment – refused to allow patient	Dishonest attempt to cover up incident which

	to leave an ambulance for no good reason and then misled investigating officers about the incident	demonstrated registrant in a bad light
	HCPC/HPC – radiographer - falsified signatures on clinical assessment documents to cover up clinical failures and asked colleagues not to report clinical failings	Omission in provision of care followed by dishonest attempt to cover it up
	NMC - Theft of £15,628.22. Paid by PCT after she had left and failed to report.	Fraud (convicted)
	NMC - Theft of a prescription pad and forged a prescription of painkillers for her own personal use whilst a ward manager	Theft (convicted)
NMC - failed to declare caution and conviction for a range of criminal offences including deception and abuse of children		Omission – non-disclosure of conviction to employer
	NMC - Theft of drugs – opportunity due to work as registrant had access to drugs cabinet	Theft (convicted)
	NMC received sick pay and salary from 2nd employer	Dishonest about sickness and non-entitlement to sick pay
NMC – obtained a forged passport and worked using it for a period of time. Failed to disclose to regulator		Dishonest use of passport
	HPC – Paramedic – Theft of drugs whilst on duty	Health issues and dishonest taking of drugs at work
NMC – failed to disclose that they were subject to a FTP investigation when applying for a position as a bank nurse- 5 cases		Omission – non-disclosure of ongoing investigation to prospective employers
	NMC - received sick pay and salary from 2nd	Dishonest about sickness and non-entitlement to

	employer	sick pay
	NMC – dishonestly treated a patient by misleading them as to treatment taking place	Dishonest practice - Interesting placebo case-working in patients best interests to lie to them?
	NMC - received sick pay and salary from 2nd employer	Dishonest about sickness and non-entitlement to sick pay
HPC – ODP- convicted of shoplifting (FPN) – failed to disclose previous cautions and current offence to employer		Omission re disclosing criminal offences
	NMC– carrying out clinical procedure without authorisation and then accepted payment for the treatment	Dishonest in representing they had authority to conduct clinical treatment (gastric band infill) and took payment for said treatment
GMC –convicted of money laundering and failed to disclose previous convictions when registering		Omission re disclosing criminal offences
GMC - failed to disclose that concerns had been raised as to clinical ability	Overlap as failed to mention at interview also	Omission re disclosing of previous concerns as to the provision of patient care
NMC – made inappropriate telephone calls to social services during neighbourhood dispute- using status as nurse here?	NMC – inappropriate entries into visiting records and falsified health visitor dates of attendance	Overlap of commission of dishonest statements (lying)
	NMC – falsified signatures on clinical assessment documents to cover up clinical failures	Omission in provision of care followed by dishonest attempt to cover it up - Dispute as to dishonesty as to when treatment was actually required
Conviction for theft- drugs related	NMC Theft of drugs whilst on duty	Dishonest – to fund drug habit
	GMC - received sick pay and salary from 2nd employer	Dishonest about sickness and non-entitlement to sick pay
GMC – failed to disclose that they were subject to a FTP investigation when applying for a position		Omission – non-disclosure of FTP to prospective employers (when does this stop?)

NMC - failed to declare caution and conviction for possession of a fire arm and that a previous NMC committee had taken place		Omission – non-disclosure of conviction and FTP to employers
	NMC - dishonestly allowed individuals under supervision to work on a ward without authorisation of the trust – NOT IMPAIRED	Commission – dishonest representation that students had permission to be on the ward but NOT IMPAIRED- insufficient evidence
	NMC - dishonestly allowed individuals under supervision to work on a ward without authorisation of the trust – NOT IMPAIRED	Commission – dishonest representation that students had permission to be on the ward but NOT IMPAIRED- insufficient evidence
	NMC - received sick pay and salary from 2nd employer	Dishonest about sickness and non-entitlement to sick pay
	NMC - falsified signatures on patient's observation records to cover up clinical failures	Omission in provision of care followed by dishonest attempt to cover it up -
	GMC - falsified signatures on patients observation records to cover up clinical failures- worked in a home for learning disabilities	Omission in provision of care (there was no assessment) followed by dishonest attempt to cover it up -
	GMC - Incompetent clinical treatment and then dishonest attempt to cover it up. Incident of lying on oath to the coroner about the treatment.	Omission in provision of care followed by dishonest attempt to cover it up
NMC - failed to disclose that they were subject to disciplinary proceedings when applying for a position (8 times) then at interview failed to declare dismissed for gross misconduct		Omission – non-disclosure of FTP to prospective employers
NMC - Conviction for theft-drugs related		Dishonesty offences to fuel drug habit
GMC – falsified CV-variety of qualifications and courses attended included on CV which		Dishonest attempt to secure work and also issued a private prescription for

were inaccurate		themselves
NMC - failed to declare convictions for excess alcohol when completing registration forms		Omission – non-disclosure of conviction to employer
NMC – range of fraud offences with £97,000 gain.		Dishonesty offences
HPC - OPD– worked under forged documents, false passport and NI Card		Dishonest offences and only admitted once external audit took place
	NMC - falsified signatures on clinical assessment documents to cover up clinical failures- NO CASE TO ANSWER	Omission in provision of care followed by dishonest attempt to cover it up- NO CASE TO ANSWER
	GMC - falsified certificates of registration as to courses attended to secure work with an agency	Dishonesty in representing clinical untested competence
	GMC- submitted misleading statement regarding mentoring received during training (14 instances)	Dishonest completion of eportfolio by registrant
	HPC – drunk at work- misled investigation as to extent of alcohol use	Dishonest during investigation
GMC - failed to declare an investigation taking place against registrant when completing registration forms		Omission – non-disclosure of conviction to employer
	HPC – radiographer- set up an unofficial collection box to take money from service users- DISHONESTY NOT PROVEN	Could have been theft and fraud but insufficient evidence presented
	HPC – radiographer- poor clinical care followed up by attempt to cover this up	Both commission and omissions in provision of care followed by dishonest attempt to cover it up
	HPC – failed to carry company morphine on duty and falsified timesheet – case not well founded	Dishonesty in terms of falsifying time sheets but not well founded.

NMC - Conviction for theft-drugs related and then failure to disclose information to employer	Overlap as offence took place whilst working in a prison	Dishonesty criminal offence and then omission- non disclosure to employer of conviction
	HPC – managed professional organisation linked with profession. General dishonest mismanagement and abuse of trust	Dishonest use of professional organisation funds
	GOC - Worked as a fully qualified optician when qualifications had not been obtained due to exam failures	Commission as working whilst unqualified and omission as to notifying employer
GOC - caution for drug possession and conviction for assault and criminal damage then failure to disclose information to GOC for retention application		omission- non disclosure to GOC of cautions and conviction
GOC - convicted of drug possession and then failure to disclose information to GOC for retention application		omission- non disclosure to GOC of convictions
GOC - convicted of fraud		Commission of dishonesty offence
	GOC - Failed to pay the appropriate retention fee and then performed sight tests (Not impaired)	Dishonestly representing registration when fee not paid
GOC – submitted claim forms to health care insurer for a range of visits that never took place	Overlap as facilitated by position -	Fraud (but no prosecution) and erasure from the register
GOC – caution for fraud and then failure to disclose information to GOC for retention application		Dishonesty offence followed by omission- non disclosure to GOC of caution
GOC - shoplifting but not proven (absent minded and didn't want to queue to pay)	Overlap as incident took place at work (but not guilty)	Dishonesty offence but not guilty
	GOC - incompetence in clinical care and then falsified records to suggest pressure checks had taken place when they	Omission in provision of care (there was no assessment) followed by dishonest attempt to cover it up

	hadn't	
	GOC - falsified patient's signature on an application for an eye exam and for optical repair- no financial gain- administrative convenience	Omission in failure to follow process and then falsified signatures to appear that process had been followed
	GDC - received sick pay and salary from 2nd employer	Dishonest about sickness and non-entitlement to sick pay
	GDC - false claim for banding of treatment to NHS- single treatments claimed when part of a course	Alleged dishonest organisation of work for financial gain – NO dishonesty but reprimand
	GDC - false claim for banding of treatment to NHS- single treatments claimed when part of a course	Alleged dishonest organisation of work for financial gain NO dishonesty but reprimand
	GDC - false claim for banding of treatment to NHS- single treatments claimed when part of a course	Alleged dishonest organisation of work for financial gain NO dishonesty but reprimand
	GDC - forged course attendance certificate following a patient complaint	Omission in provision of care (there was no discussion of treatment options) followed by dishonest attempt to cover it up
GDC- police caution for common assault and failed to disclose to GDC when it came to retention. Not guilty as may have attempted to notify GDC but no records		omission- non disclosure to GDC of caution but Not proven
GDC - police cautions and a conviction for a range of offences and then failure to notify GDC when it came to retention. Misunderstood nature of cautions		omission- non disclosure to GDC of cautions and convictions
	GDC - following a patient complaint misleads response and made 3	Omission in provision of care followed by dishonest attempt to cover it up

	untrue statements	
GDC - police caution for common assault and failed to disclose to GDC when it came to retention. Misunderstood nature of police cautions		omission- non disclosure to GDC of caution
GDC - police convictions and period of imprisonment and failed to disclose to GDC when it came to restoration following erasure.		omission- non disclosure to GDC of criminal record when applying for restoration
	RPSGB- theft of monies at work	Dishonesty offence
	RPSGB - stole prescription drugs for personal use	Dishonesty offence
	RPSGB - theft of monies at work and recording a locum worked at place of work when they didn't	Dishonesty offence
RPSGB – convicted of obtaining property by deception- NHS fraud- £19,000 in total- then supplying multiple small packs of medication when dispensing larger pack sizes		Dishonesty offence
RPSGB - committed of offences under Medicines Act 1960- failed to notify RPSGB		omission- non disclosure to RPSGB of conviction
	PSNI - No sanction but registrant sold vets drugs from his pharmacy	Dishonesty offence as selling drugs not entitled to do so
	GCC- Not proven but alleged dishonest statements made to persuade woman then she, her husband and her son should have chiropractic treatment.	Linked to range of concerns as to what can be claimed by chiropractors but this case NOT proven
	NMC - worked at a nursing home when needed to be a RGN when in fact she was a RMN- at work.	Failed to disclose truth even when prompted. Dishonesty offence as to qualifications
	HPC – OPD- stole syringes and ampoules	Dishonesty offences

	with diomorphine in them and then claimed ampoules were broken	
GMC- applied for a job and included 6 publications to his CV but not an author on any of them		Dishonest attempt to secure interview and then financial gain via dishonest entries on cv.
GPhC – benefit fraud as tenancy applications		Dishonesty offences
GPhC - submitted plagiarised assessment for advanced training unit-subordinates essay.		Academic dishonesty
GPhC - secured council housing when not entitled (owned 4 properties) fraud		Dishonesty offences
	GPhC - stole money from company	Dishonesty offences
	GPhC – 11 occasions stole money from cash refunds to customers	Dishonesty offences
	GPhC - stole monies from work	Dishonesty offences
	GPhC – continued to prescribe drug to patient who was no longer in need in order to pocket payment. Tried to persuade CPN to say she took prescribed medication from service user	Dishonesty offence – commission
GPhC - Conviction for failure to provide a breath specimen in excess alcohol case and then failed to disclose conviction to employer and regulator		omission- non disclosure to GPhC of conviction
	GPhC - Stole prescription drug	Dishonesty offence
	GPhC - failed to keep correct records of treatment undertaken and then submitted claims for said treatment undertaken	Dishonesty offences (although repaid)
GMC- impersonated her daughter to obtain confidential information		

regarding the daughters medication. Note contraception and anti depression medication.		
NMC- impersonated a police officer on three occasions. Also found to be in possession of items in their car that could be used to impersonate a doctor.		Dishonesty offence.
NMC- sold 2 essays on eBay and represented that these essays had obtained higher marks than they actually had.		Dishonesty offence within an academic setting.
GMC- sold a parking ticket (permit) for personal gain and depriving hospital of parking funds- proven but not seen as dishonest due to interpretation of taxable benefit.	Overlap as ticket was for parking at hospital	No attempt to use *Ghosh* test to establish dishonesty. Did not amount to misconduct. Panel thought ill advised.