



Dishonest behaviour by health and care professionals:

Exploring the views of the general public and professionals

A report for the Professional Standards Authority for Health and Social Care

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Executive summary

Maintaining public confidence in health and care professionals is critical to the success of these sectors, not only in terms of quality standards and professional competencies but also in terms of standards of conduct and public faith in the integrity of professionals. The issue of dishonesty and dishonest behaviour cuts to the heart of public perceptions of integrity, not least because patients and service users are, by definition, vulnerable.

As the oversight body with responsibility for scrutinising nine UK health and social care regulators, The Professional Standards Authority (The Authority), commissioned Policis to undertake qualitative research both with the public and professionals with a view to:

- Understanding the views of the public and health and care professionals across the UK on how different types – and degrees of – dishonest behaviour are seen to influence fitness to practise and professionalism in different contexts and in a range of health and care professions.
- Drawing out any implications for regulators to inform thinking around the issues and best practice in addressing dishonesty in both the health and care professions and more widely.

The research method was entirely qualitative resting on eight extended focus groups held in each of the four nations of the UK.¹ Four groups were held with consumers, variously with ABs, C1C2s, DEs and heavy users of health and care services. All were structured to include a range of ages and life-stages. These were supplemented by eight depth interviews with residents in nursing homes or living at home and dependent on care and / or nursing support.

Four groups were held with professionals, variously non health and care professionals, frontline social workers and nurses and midwives working in hospitals and in the community, senior professionals and managers drawn from a range of health and care professions and registered professionals in complementary practice.

In each case research participants considered a range of scenarios largely drawn from real life Fitness to Practise (FtP) cases that had been appealed by the Authority, though in some cases scenarios were adapted to simplify presentation. Respondents were asked to consider, in the light of the regulators' remit and guiding principles, what disposals would be appropriate in each case and to respond both to initial FtP disposals and the outcome of appeals by the Authority.

Nine scenarios were considered involving:

- Dishonesty in relation to patient records
- Dishonesty in relation to qualifications or employment history
- Dishonesty in relation to registration status or indemnity insurance
- Dishonesty in relation to working at another job
- Dishonesty (tax fraud) outside the immediate context of professional practice
- Dishonesty in relation to convictions or previous identity
- Dishonesty in relation to patient interactions

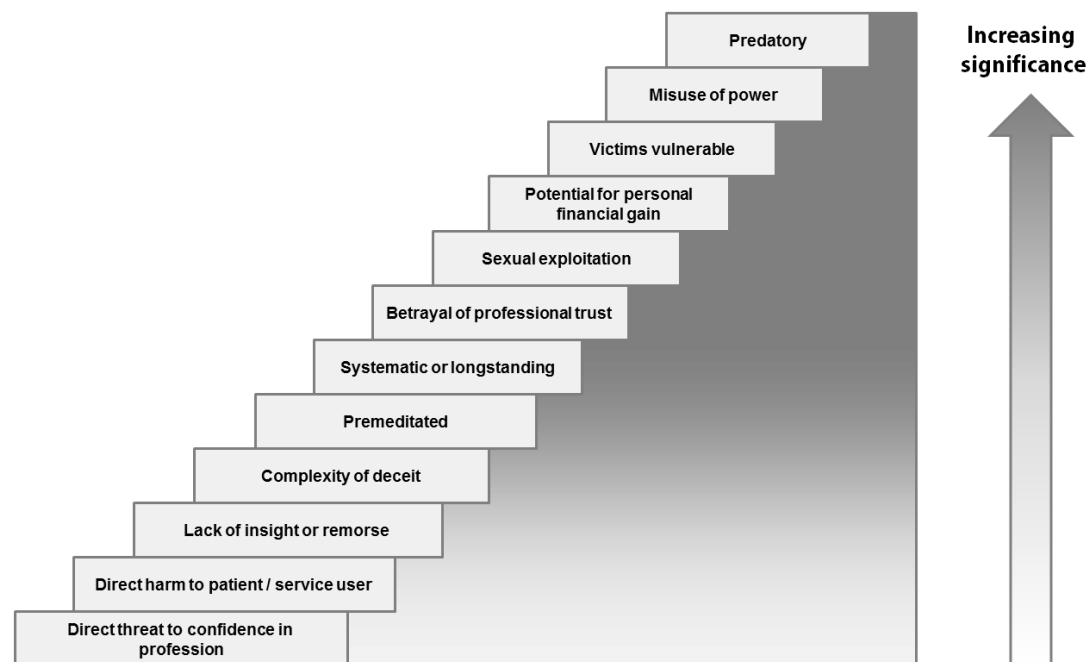
¹ Given that the research is fundamentally exploratory, an entirely qualitative approach was adopted as likely to deliver the richness and depth of insight required to fully understand views on a complex subject area. A qualitative approach will not however provide a sense of scale for how widely the views expressed by research participants are held by the public as a whole.

- Lying about relationships with colleagues or patients to conceal inappropriate practice
- Theft from patients or colleagues

We made the following observations in the course of the fieldwork:

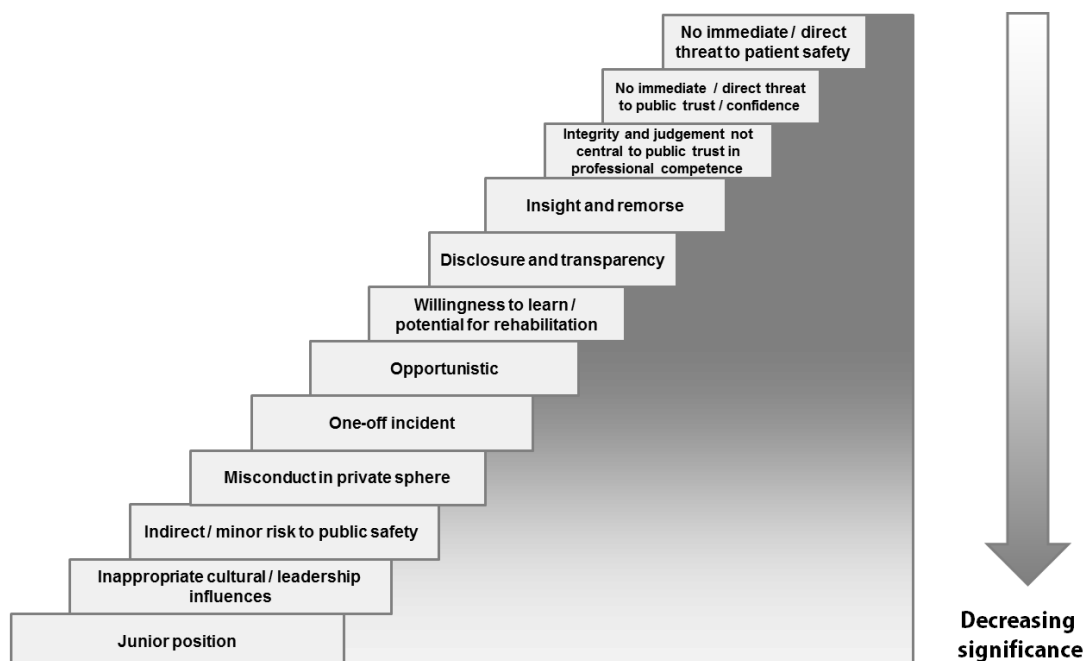
- The public and professionals were agreed that attitudes to health and care professionals have undergone something of a sea change, with deference towards the professions having given way to a need to earn respect from a more empowered and demanding public. That said, there was a high degree of respect for health and care professionals among the public, with little or no awareness of cases of dishonesty within the professions. Professionals were more cynical, with health professionals conscious that fraud was an issue for the NHS.
- It would appear that both the public and professionals have a clear mental framework and a shared moral compass through which they view and conceptualise dishonesty by health and care professionals.
- Although there are some differences between professionals and the public, there are clear common elements, with both public and professionals having a shared view of what constitutes aggravating and mitigating factors in professional dishonesty.
- There was also remarkably little variation by socio-economic group or educational attainment in views on dishonesty and appropriate disposals among the public. Those most exposed to the health service and more dependent on health or care professionals felt more strongly than those who had less personal experience.
- There was a minority who saw issues in black and white and who judged any incidence of dishonesty as grounds for immediate expulsion from the profession. The great majority of both public and professionals took a more nuanced view with judgements more finely balanced around aggravating and mitigating factors.
- There was a consensus that premeditated, systematic or longstanding abuse of professional trust or dishonesty in the context of financial gain or sexual exploitation should be grounds for – rapid – deregistration.
- The majority however, with the exception of the most egregious cases, took a pragmatic and tolerant view on the appropriate disposals for dishonesty in FtP cases. The tendency was towards an emphasis on behaviour change and learning and rehabilitative and constructive outcomes, which allowed registrants to continue in the profession. This was particularly the case where individuals showed insight and remorse and seemed willing and capable of changing their behaviour.
- Predatory behaviour, misuse of power, abuse of vulnerable individuals, behaviour motivated by personal financial gain or sexual exploitation of patients were seen to lie at the extreme end of seriousness in terms of aggravating factors. Thus a psychiatrist who had lied about targeting ex-patients for sexual relationships and a nurse stealing from a care home resident were both seen as candidates for immediate and permanent deregistration.
- Dishonesty that involved pre-mediation, systematic or longstanding abuse or complex deceit was also seen as rendering dishonesty more serious, as was a lack of insight or remorse. These views on aggravating factors are captured in Figure 1 following.

Figure 1. Aggravating factors in professional dishonesty
A stairway of significance within professional dishonesty



- By contrast, opportunistic and one-off incidents and dishonest behaviour by junior staff were seen as less serious. Full disclosure, remorse and insight as to why dishonest behaviour was unacceptable and willingness to learn and change were also seen as powerful mitigating factors.
- Dishonesty cases where public safety or confidence was not directly at risk were also seen as less serious, as were dishonest behaviours occurring outside the professional context – unless the dishonesty was so egregious as to raise clear issues of public trust. A conviction for theft was felt to disqualify a nurse for a role in caring for the vulnerable elderly, for example, while tax fraud on earnings from buy to let property was not seen as relevant to a dentist's fitness to practise.
- It was clear the importance of integrity to fitness to practise varied between professions. How far dishonesty influenced fitness to practise appeared to hinge on how far absolute integrity was believed to be critical to public trust or professional competence, being relatively unimportant for professions seen as "practical" (such as dentistry or osteopathy) but critical for professions (such as psychiatry or social work) involving either vulnerable individuals or momentous decisions with far reaching consequences. A social worker who had lied about having a second job and knowingly not complied with the terms of her (entirely separate) child-minding licence, was thought to lack the integrity essential to her profession and thus was not fit to practise as a social worker or care for children.

Figure 2. Mitigating factors in professional dishonesty
 A stairway of decreasing significance within professional dishonesty



- There were some clear gender and generational differences, particularly around cases involving professional boundaries or which contained a sexual element. Women of all ages were more conscious of boundaries, more suspicious of sexual intent and less tolerant of either sexism or inappropriate sexual behaviour. Older men were less aware of boundaries and more tolerant of sexualised relationships between professionals and patients. That said, both sexes and all ages had zero tolerance for predatory sexual behaviour or serial sexual misconduct.
- The public often did not appreciate how dishonesty in relation to insurances, registration status qualifications, experience or research results and similar might jeopardise public safety or public trust. Professionals by contrast were highly sensitive to the safety implications of breaches of codes of conduct and the requirements of registrants and deeply unforgiving of both failure to abide by codes of conduct, the rules for registration or any falsification of qualifications.
- The public, and to a lesser extent the professionals (who were more protective of the reputation of the professions), were also pragmatic in assessing the validity of any threat to public confidence in the professions. In thinking through appropriate disposals, the majority sought to balance any potential threat to public trust and the public interest with the rights of the registrant, registrants' investment in their careers and their ability to earn. Generally both public and professionals appear to take a more sceptical view than the regulators of threats to public confidence, unless impacts were clear and direct.
- Both public and professionals were highly sensitive to the cultural context in which dishonesty took place and were conscious of the potential for systemic failure in conduct standards (for example, the condoning or encouragement of the falsification of patient records). While respondents were aware that individuals were responsible for their own conduct, where dishonesty cases occurred in the context of perceived systemic, cultural or leadership failures, it was felt that there was a risk of individuals being "scapegoated" for the wider dysfunction. FtP hearings were seen as inappropriate in such cases. Instead, both public and

professionals rather put the emphasis on empowering individuals to act, escalate issues and challenge conduct standards.

- Broadly speaking, where the Authority had appealed FtP disposals as too lenient or as having put insufficient emphasis on the dishonesty element of the case, both public and professionals were largely supportive of the Authority's actions and of the typically more severe disposals that resulted. That said both public and professionals opined, on the basis of the cases shared with them, that there appeared to be a lack of organising principles or any coherent hierarchy of seriousness to underpin consistent treatment of dishonesty cases.
- Clearly in selecting cases to appeal, the Authority is bound by case law and the need to meet legal tests and must consider how far the appeal is likely to succeed. The research suggests that the Authority's actions are largely in line with the attitudes to dishonesty of both public and professions.
- Two areas would appear to arise for future thinking around how most effectively to handle dishonesty within FtP cases. Firstly there would appear to be a perception among both public and professionals that some instances, cases are being brought on confidence grounds where the link to public confidence is seen as too tenuous. This would seem to imply a potential use for a set of principles underpinning risks to public confidence and with it a more nuanced hierarchy of more or less serious risk.
- The other major implication of the findings for further development of thinking around the regulation of health and care professions may be the desire expressed by both public and professionals for a greater focus on rehabilitation, learning and behaviour change and managed re-entry to the professions in those dishonesty cases which are not so egregious as to merit immediate and permanent expulsion from the professions.

1.0 Policy and project background, aims and methods

This chapter describes the background to the commissioning of the research, the over-arching project aims and the specific research objectives and describes how the research was undertaken.

1.1 Project background

Maintaining public confidence in health and care professionals is critical to the success of these sectors, not only in terms of quality standards and professional competencies but also in terms of standards of conduct and public faith in the integrity of professionals. The issue of dishonesty and dishonest behaviour cuts to the heart of public perceptions of integrity, not least because patients and service users are, by definition, vulnerable.

The Professional Standards Authority (The Authority) is the oversight body with responsibility for scrutinising nine UK health and social care regulators. It seeks to ensure the effective regulation of health and social care professionals in the interests of patients, service users and the public. Registration and supervision of professionals such as doctors, dentists and social workers as appropriately qualified, and meeting competence standards and public expectations of integrity are central to public confidence. Where things go wrong or individuals fall short of expected standards, “Fitness to Practise” proceedings – and the various sanctions that can be applied, including effective expulsion from the profession² – provide the necessary backstop to protect the public and maintain public confidence in the health and care professions.

The Authority has responsibility for reviewing final Fitness to Practise adjudications and is concerned that judgments made and sanctions applied by regulators protect the public, maintain public confidence in health and care professions, and maintain proper professional standards and conduct. It does this by reviewing every final decision made by Fitness to Practise panels and, if it considers that a case meets the legal tests and that it has a reasonable chance of a success, it will refer it to the courts. At this point, the Authority can sometimes agree with the regulator and the professional concerned what the outcome should be, and get the court’s approval of that agreement. This can involve sending the case back to the regulator’s panel for reconsideration. If not, as happens in most cases, it will be heard by a judge. If he or she finds in the Authority’s favour, the judge can either substitute the Panel’s decision for his or her own, or send it back to the regulator to be considered again by a Fitness to Practise panel. For the vast majority of cases, either the case is sent back to a regulator’s panel, or the judge substitutes the original sanction for his or her own. In neither scenario does the Authority have a say in the final outcome.

Fitness to Practise panels, the Professional Standards Authority, and the judges hearing appeals must all have regard to the relevant case law when considering whether an outcome sufficiently protects the public, maintains public confidence in the profession, and upholds proper professional standards. The Authority has seen an increase in cases in recent times in which it has judged the outcome of dishonesty cases it has reviewed as being inappropriately lenient. These are cases in which the Authority has judged that Fitness to Practise panels have given insufficient weight to the dishonesty elements of the cases brought before them, or that allegations relating to dishonesty have not been properly pursued by the regulator.

² This is the most severe sanction available to panels making decisions about a professional’s registration with a regulatory body. However, even when a health or care professional has been struck off, they retain the right to apply to rejoin the register after a time specified in legislation – usually five years.

There has however been some suggestion that regulatory intervention and sanctions have in some cases been disproportionate. Indeed the Law Commission in its response to the consultation on the reform of the regulation of health and social care³ has questioned whether regulators and Fitness to Practise panels, under the guise of maintaining public confidence in the professions, were not going too far by intruding inappropriately into the private behaviour of registered individuals with insufficient regard for the human rights implications⁴.

However, since publication of the Law Commissions' Report in April 2014, and as at the end of April 2016, the Professional Standards Authority has referred a total of 37 cases to the courts under its Section 29 powers. Of these referrals, 20 involved dishonest behaviour by a registrant, and all but four cases which are awaiting hearing were either upheld by the courts or conceded in the Authority's favour by agreement between the parties.

Against this background, the Authority were keen to understand the public and professions' perceptions of the appropriate regulatory response to dishonesty on the part of health and care professionals. The Authority wanted also to understand how far the Authority's regulatory approach in this area is aligned with these perceptions.

Little was known however about these issues and there is relatively little research coverage in the literature, albeit that the treatment of dishonesty has been a key theme in some professional blogs and discussion forums. The research was undertaken to fill this important knowledge gap.

1.2 Project aims and research objectives

1.2.1 Overarching project objectives

- To understand the views of the public and health and care professionals across the UK on how different types – and degrees of – dishonest behaviour are seen to influence fitness to practise and professionalism in different contexts and in a range of health and care professions.
- To draw out any implications for regulators to inform thinking around the issues and best practice in addressing dishonesty in both the health and care professions and more widely.

1.2.2 Detailed research objectives

For both members of the public and health and care (and some other) professionals:

- To understand whether, how and why dishonesty is seen to undermine health and care professionals' fitness to practise.
- To understand whether different types of dishonesty or dishonesty in different contexts are seen to undermine fitness to practise in different ways or to different degrees.

³ See Law Commission, Scottish Law Commission, Northern Ireland Law Commission. March 2014. *Regulation of Health and Care professionals, Regulation of Social Care Professionals in England*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300018/Cm_8839_Law_Comm_web_part_accessible.pdf See para 3.15

⁴ See Law Commission response to consultation on regulatory reform. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300018/Cm_8839_Law_Comm_web_part_accessible.pdf Chapter 3 Discussion pages 38 – 40.

- To understand whether, how and why dishonesty in the health and care professions is viewed differently to dishonesty in other professions (such as the law or accountancy).
- To understand perceptions of different degrees of dishonesty – what constitutes more or less serious dishonesty and the basis on which dishonesty is categorised as more or less serious.
- To understand views on whether – and, if so, why – dishonesty outside the context of professional practice is seen to impact fitness to practise.
- Where dishonesty occurs within a professional practice context, to what extent the nature of the patients / service users influences perceptions of the seriousness of dishonesty.
- To understand how offending registrant's own attitudes to their dishonest behaviour is seen to influence fitness to practise.
- To understand views around learning, rehabilitation, re-entry to the professions in the wake of dishonest conduct and how this might vary between different types of dishonesty or dishonesty in different contexts.
- To understand views on any perceived distinction between public confidence and public safety in the case of dishonesty, and how regulators should act in relation to each.
- To understand views around registrants' interests and rights and how these should be handled and balanced within the Fitness to Practise and disposal / sanctions process in dishonesty cases.
- To understand perceptions of regulators' actual disposals and the outcomes of specific cases of dishonesty (across a spectrum of seriousness) and how far these are seen to be aligned with views on appropriate disposals.

1.3 Methods and approach

Given that the research is fundamentally exploratory, an entirely qualitative approach was adopted as likely to deliver the richness and depth of insight required to fully understand views on a complex subject area. A qualitative approach will not however provide a sense of scale for how widely the views expressed by research participants are held by the public as a whole.

Extended focus groups were chosen as likely to generate the appropriate creative dynamic. Eight focus groups, each consisting of eight individuals, were held in London, Belfast, Cardiff and Glasgow in February 2016.

Four groups were held with consumers, with all the groups having a spread of ages and life-stages:

- ABs
- C1C2s
- DEs
- Heavy health service users with patients with chronic and serious conditions
- Additionally six depth interviews were held with older consumers living in care homes or dependent on live in or pop in carers at home.

Four groups were held with professionals:

- Non-health and care professionals (including architects, solicitors and accountants)
- Frontline social workers, including those working in adult social care, child protection services, those working with learning disability and addiction and nursing, including those working in hospitals, with GPs and community services and midwifery professionals
- Senior health and care professionals and senior managers in a range of health and care professions (including dentists, doctors, pharmacists, chiropractors, opticians, osteopaths, chiropractors and senior social workers managing teams of social workers in a variety of adult care and child protection contexts.
- Registered professionals in complementary practise (including counsellors, psychotherapists, homeopaths, reflexology specialists)

In all of the groups and depths, respondents explored issues of dishonesty in health and care professionals in structured discussion. The groups then worked through a series of case studies of Fitness to Practise cases and considered the disposals arising, the focus of Authority appeals on these cases and the final outcomes arising from that appeal. The groups then undertook a series of team exercises exploring aggravating and mitigating factors in dishonesty.

The early structured discussions explored public and professionals' spontaneous perceptions of dishonesty and appropriate disposals. For the later stages of the group, respondents were informed about the Authority's aims and remit and the regulators' commitments on how they will approach the exercise of investigations and their regulatory powers. These were presented to the groups as follows:

The remit of the regulators and their commitment as to how they would conduct investigations was presented to consumers and professionals as:

The Regulators' Remit	The regulators' commitments
<ul style="list-style-type: none"> ▪ Promoting health, safety and well-being of service users ▪ Monitoring and enforcing high standards of competence and integrity ▪ Maintaining public confidence in the health and care professions 	<ul style="list-style-type: none"> ▪ To focus on the public interest ▪ Independence ▪ Fair ▪ Transparent ▪ Proportionate

Respondents were also told about the sanctions available to Fitness to Practise panels which were described as follows:

The sanctions available to the regulators were presented as:

Available sanctions

- Permanent Disqualification / Deregistration (not able to practise in future)
- Temporary suspension (allows re-entry to profession)
- Conditions or undertakings (continue to practise):
 - behaviour change
 - recognise failings, demonstrate intent to change
 - new learning / skills
- Warnings and cautions

Finally, the groups were presented with a digest of the key concerns raised by the Law Commission in relation to the operation of Fitness to Practise cases.

The concerns raised by the Law Commissions on fitness to practise cases were presented as:

The concerns about fitness to practise proceedings raised by the Law Commission

- Inappropriate imposition of moral judgements on private matters
- Fitness to practise cases being brought inappropriately in cases of minor dishonesty or minor misconduct in private life
- Need for connect with patient safety or public confidence in profession as a whole

The groups then worked through the various case studies, having been asked to bear in mind the regulator's remit and commitments and the concerns raised by the Law Commission. These case studies and the supporting stimulus material used in the groups are described and presented in Chapter 3.

Although the case studies were based on real cases, they were anonymised and adapted so they could more easily be presented and discussed in the context of the focus groups. The cases as presented here are therefore not precise representations of the facts.

In addition, some of the technical terminology used to describe the regulatory processes were replaced with commonplace terms that were more likely to be understood by professionals and members of the public.

For some of the groups of interest, notably residents of care homes and those living at home and supported by live-in or visiting carers, it was not practicable to conduct a

focus group discussion. For this reason we conducted eight individual depth interviews, split between residents of care homes and those still living at home with the support of carers. In these cases, in the interests of time and not over-tiring or taxing the respondents, the interviews consisted of a broad discussion of the issues around professional dishonesty and their own perceptions and concerns in relation to dishonesty and discussion of a sub-set of cases, selected to be of most relevance for this group. The views of these respondents were analysed within the same analytical thematic framework as the rest of the qualitative material and contributed to the overall analysis on public perceptions of professional dishonesty and of the public response to the various case studies.

2.0 The context – changing public and professional perceptions of the health and care professions and the regulatory environment

This chapter seeks to provide some context around changing attitudes to the health and care professions as context for the description of response to the various case studies and the issues raised by them in Chapter three.

2.1 Public perceptions of the health and care professions and their regulation

Consumers reported that their attitudes to health and care professionals have shifted in recent years. This was in part a function of the wider phenomenon of the “death of deference” to authority, with professionals such as bank managers or doctors no longer seen as the respected figures of authority they once were.

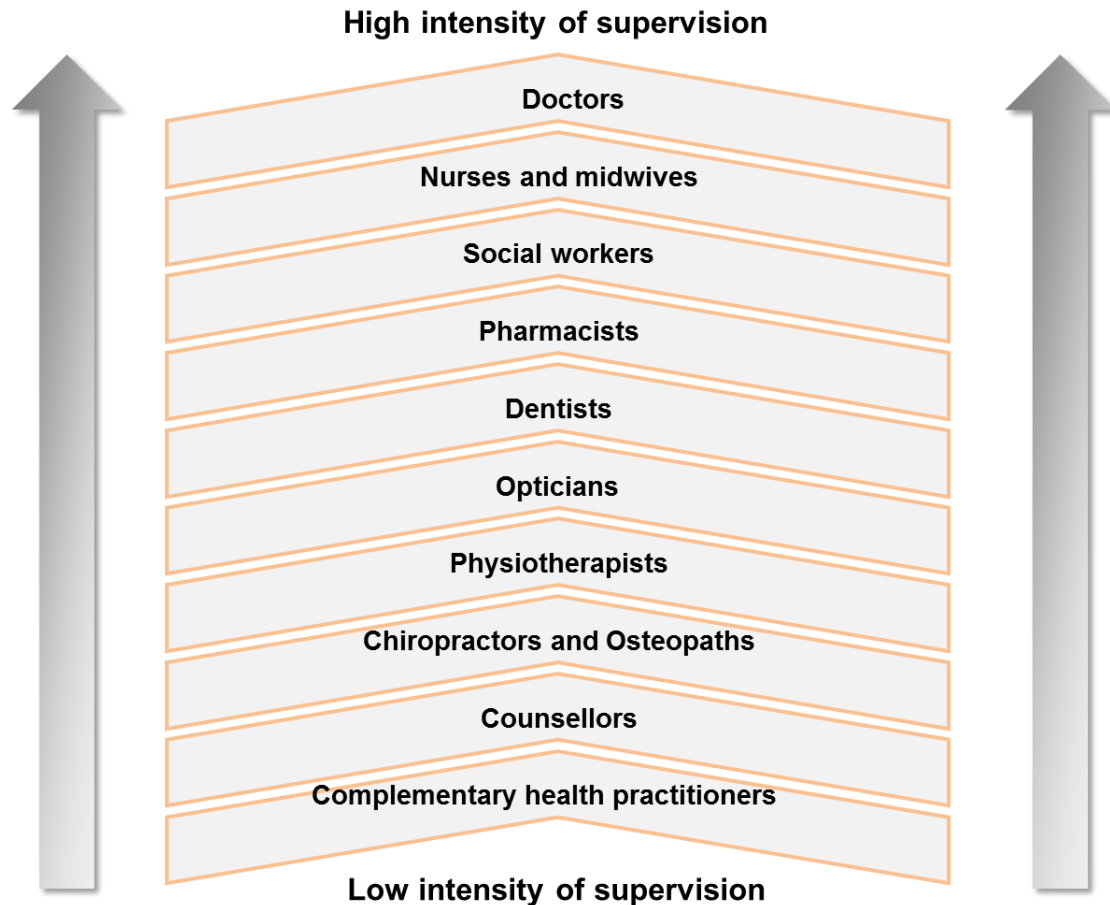
This decline in respect was also influenced by what was seen as an ongoing de-personalisation of relationships with health professionals, particularly within the NHS. Personal relationships with GPs and local health practitioners were felt to have become increasingly intermediated by reception staff or computer systems. These were seen to be acting as gate-keepers, controlling access to health professionals and often as standing between patients and health professionals.

A further major factor was the “Google Effect”, again particularly in relation to health professionals. Knowledge about health and health care was no longer seen as the exclusive preserve of health professionals. Consumers rather felt empowered to investigate their own health conditions and care options using the power of search engines and the internet and so felt less dependent on, and better able to challenge, the health professionals they dealt with. This sat alongside a wider sense of consumer empowerment with users of health and care services increasingly seeing themselves as entitled service users.

Another thread running through discussion of relationships with, and attitudes to health and care professionals, was a sense of disillusionment, though also sympathy for, health professionals. This appeared to be driven by the perception that the NHS is over-stretched and that health and care professionals are under increasing pressure. There is a strong sense that processes and interactions with health and care services are driven by internal targets and cost-saving and efficiency measures, again seen as undermining personal service and relationships. This did not arise in the same way where service users or patients were using private sector services.

There was a clear view that what were seen as the core mainstream health and care professions – doctors, dentists, nurses, midwives, pharmacists and to a lesser extent social workers – were heavily regulated and monitored and that these professions were working to a set of rules and standards. There was much less clarity, however, on how far practitioners such as osteopaths or chiropractors were regulated and supervised with mixed views on whether and to what extent complementary and alternative medicine practitioners were regulated. There appeared to be something of a perceived spectrum of supervision – with doctors, dentists and nurses at one end, followed by pharmacists and opticians, osteopaths and chiropractors – with alternative health professionals, counsellors and care workers at the opposite end.

Figure 1. Perceived spectrum of regulatory intensity



Concerns about over-stretch in the NHS had given rise to some concerns about tired and over-worked staff, resourcing and corner-cutting in the interests of cost saving but these concerns clearly did not extend to doubts about health and care professionals integrity or honesty.

2.2 Public perceptions of dishonesty in the health and care professions

Dishonesty was clearly a long way from front of mind concerns about health and care professionals. There was a strong perception, on the one hand, that health and care professionals were “caring” by nature and motivated by a desire to help others, and, on the other, that there was little opportunity for dishonesty.

It was difficult indeed to get service users and the public to even to conceptualise and focus on the idea of dishonesty among health and care professionals. The groups struggled to spontaneously come up with instances of what dishonesty might look like in a health and care context and how dishonesty might play out in the professions. Suggestions of false record-keeping to cover up mistakes or dishonest claims in CVs being the most commonly put forward as possibilities. Few members of the public could recall media coverage of any incidence of dishonesty. The only cases they could recall were sensational ones, such as that of the doctor Harold Shipman, where the major offence was not dishonesty, albeit that there was an element of dishonesty in the case.

The one exception was in relation to vulnerable and elderly patients. In these cases, there was a sense that the elderly and service users with disability could be at risk of being exploited or taken advantage of financially. The residents of care homes and those dependent on live-in or pop-in care were particularly conscious of this possibility.

2.3 Professional perceptions of the public's view of the health and care professions

Professionals were conscious of changing consumer attitudes and also described more empowered and demanding patients and service users. There was a strong sense that the idea of automatic respect and deference to professionals and professional judgement had been eclipsed by a contemporary notion that respect from clients, patients and service users had to be earned.

Those in all professional walks of life pointed also to the "Google effect" and a greater likelihood of challenge. They also made the point that while consumers of health and care services were better informed, they were also more likely to be misinformed and to be unable to discriminate between sources of information.

Professionals from a range of sectors reported a strong cultural shift towards greater risk aversion within their profession and a greater reliance on process and paperwork and, to a greater or lesser extent, the development of a "box-ticking" culture. All reported that they now devoted a higher proportion of their time to paperwork and record-keeping.

As professionals, individuals reported that they had become much more risk-averse in dealing with clients / patients, colleagues and superiors and in making decisions. As a result, decisions had become more considered and were filtered through the potential for any decision to create a risk for the individual's reputation and professional record. Many reported that they now sent even marginally risky judgement calls up the management line, to avoid having to take personal responsibility for a decision which may have adverse consequences.

Generally speaking, mainstream health and care professionals saw regulation of their profession as largely effective in maintaining standards and integrity. Regulators were also seen, however, as strict and intolerant.

Complementary practitioners on the various accredited registers, though not regulated as such, were more likely to see the supervision of their profession as inadequately developed or promoted to the public with professional bodies seen as not putting sufficient emphasis on communicating to the public that these practitioners are subject to supervision, work within a framework of professional rules and standards and are required to abide by codes of conduct.

2.4 Professionals' perspectives on dishonesty in the health and care professions

The professionals were more cynical than consumers about the incidence of and potential for dishonesty in professional practice and interaction with patients and service users. The view was that in every profession, where there are opportunities for financial gain, there will always be the potential for dishonesty in varying degrees of seriousness.

Frontline staff and professionals of varying levels of seniority reported personal experience of dishonesty in a professional context, most commonly falsifying records, false reports of conduct or patient interactions or theft and fraud. Indeed fraud was

seen to be an endemic issue in the NHS. A number of respondents described a culture of covering up failures or incompetence.

“I’ve been lied to. I’ve had colleagues, you know, lie about things that they haven’t done and I’ve questioned it and took it up and nothing really was done. I’ve tried to escalate it because it was harmful to the patient and nothing was done”

“A lot of the time it’s just glossed over and you find that you cover, you try to cover your team because you need to look out for your colleague ... but then the whole team looks bad and you don’t want to take the fall for anybody.”

NHS staff saw the regulators as overwhelmed by the incidence of dishonesty cases, particularly fraud, as ineffective and slow to deal with even serious cases of dishonesty and fraud.

“It (dishonesty) is a huge issue ... It’s not that I’m pro NMC by any stretch of the imagination but they are just overwhelmed. They are overwhelmed with the amount of referrals they are getting. If you refer someone to the NMC it’s lucky if they get dealt with within 2 years.”

The way Fitness to Practise hearings were conducted and the outcomes of Fitness to Practise hearings were widely seen as inconsistent. There was a view that panel members were not always well informed and were not always on top of the issues and thus ill-equipped to make fair and effective judgments.

“I’ve known cases where there’s clear evidence of dishonesty, falsifying notes ... and it was very long to deal with and then it was light sentence. It’s really not dealt with correctly.”

“It’s not structured and it’s not consistent ... You think, do you really understand what you’re actually making an assessment on? It’s quite mindboggling. They’re not even using the correct terminology.”

3.0 The scenarios and case studies

This chapter provides an overview of both consumers and professionals' perspectives on the appropriate sanctions for dishonest behaviour by health and care professionals. It also describes the responses to the various case studies and scenarios presented to the groups.

3.1 Public perceptions of appropriate sanctions for dishonesty

In each of the groups, across the socio-economic spectrum, there was a small minority who saw issues in black and white and judged any instance of dishonesty as being grounds for exclusion from the profession. In the case study that involved an immigrant, these individuals tended also to think in terms of deportation. This group were generally much more punitive in their approach, regardless of context.

The majority, however, took a much more nuanced view of the issues, which they saw in any cases in terms of shades of grey and mitigating and aggravating factors. Judgements were more finely balanced. Strikingly, these respondents were more focused both on patient safety and on the potential for rehabilitation of dishonest practitioners.

There was remarkably little variation by socio-economic group or by educational attainment, with similar proportions in each group inclining to a zero tolerance view or being more nuanced in their views of appropriate sanctions and outcomes in different cases. However, those members of the public who had had experience of exposure to disadvantage, either personally or professionally, were generally more inclined to empathy with offenders. These respondents were also inclined to see rehabilitative sanctions as appropriate, unless the cases involved the exploitation of the vulnerable or were clearly egregious in the extreme.

There were some very marked generational and gender differences, particularly around cases involving professional boundaries or containing a sexual element. Women of all ages saw demarcation lines more clearly, were more suspicious of motivation and less tolerant of either sexism or sexual intent. Men, and older men in particular, were less aware of boundaries. They were also more tolerant of sexual intent and more forgiving of transgression, provided always that it was not part of a pattern of systematic or serial exploitation.

3.2 Professional perspectives on appropriate sanctions for dishonesty

Overall, professionals, both within and outside the health and care professions, were more judgemental and less tolerant of transgression than the public, with little difference between the regulated and registered professionals. Unsurprisingly, they were much better informed than consumers on issues around boundaries and the nature of ethical behaviour and best practice. They tended also to be heavily invested in professional standards and to be highly conscious of the importance of the codes of conduct and professional guidelines in safeguarding the reputation of the professions.

Professionals also had a much greater appreciation of the nature of public safety issues and risk and were more focused on the reality of the public safety impacts of misconduct. Professionals also placed greater emphasis on true and complete record-keeping as protecting the public and the integrity of professional standards of care and service delivery.

Professionals were however much more likely to interpret dishonest behaviour in terms of the cultural context in which it had taken place. Those working in hospital

environments, large practices or institutions such as residential homes were more likely to see dishonest behaviour as the product of systemic or leadership failures, inadequate resources, a bullying culture or a cultural complicity in cover up or endorsement of false recording, misconduct or abuse.

3.3 Perceptions of the outcomes of Fitness to Practise panels and Authority Appeals

Broadly speaking, both public and professionals tended to align with the Authority in terms of thinking that the outcomes of certain of the Fitness to Practise cases were too lenient and generally regarded the outcomes of Authority appeals as superior to the original Fitness to Practise judgment.

However, there were also two striking differences between the views of both professionals and the public and the Authority and the Fitness to Practise panels.

Both the public and professionals appeared to be focused far more than the regulators on whether the case implied what they saw as either a direct risk to public safety or a significant risk to public confidence in the professions and professional standards.

Both the public and professionals, except in the most egregious cases, were much more focused than the regulators on the possibility of redemption and rehabilitation. In both cases respondents were more likely to think in terms of re-training and re-education to address the specific problem and enable the offender to return to the profession and contribute to it.

The attitudes to sanctions here described, the concern with the directness of the risk to public safety or confidence and the focus on a rehabilitative response can be seen in the reactions to the various case studies presented to the groups.

3.4 Case study 1. Dishonesty in relation to patient records

Context:

- It is universally recognised within the nursing profession that the use of unauthorised restraints on patients is abusive.

The fitness to practise case:

- Nurse A was working a night shift at Hospital X.
- Patient A was an elderly patient with dementia whose hand and lower arm had been restrained in an unauthorised manner (using an incontinence pad and tape).

The fitness to practise charges:

- **Charge 1. Competence:** Nurse A identified the use of the restraint but did not remove it.
- **Charge 2. Dishonesty:** Nurse A refused to countersign the nursing records of Patient A which recorded that Patient A had been restrained in the manner described until the reference to the restraint had been deleted.

Contextual evidence arising during the during the fitness to practise hearing:

- Nurse A had subsequently asked another nurse, Nurse B, to remove the restraint before the start of the next shift.
- It was common practice at Hospital X for patients to be restrained in this way.

3.4.1 The public response

The public generally had difficulty in separating the competence from the dishonesty element of the case and tended to focus on Nurse A not having removed the unauthorised restraint. For most, however, the issue lay with Nurse A having “covered up” her omission and putting her own fears about getting into trouble before the patient’s interest. That Nurse A had falsified the record was of more significance to the more educated and professionals.

Overall, however, the case was interpreted in terms of the predominant culture in the hospital and the fact that the use of unauthorised restraints was apparently widespread practice. The thinking was that it was the authorities (i.e. the hospital management) who were ultimately culpable for having allowed a culture of unauthorised restraint and tolerance of inaccurate record-keeping to have developed.

Here the interpretation was that if Nurse A had removed the constraint this might have been seen by other staff as a reproach or a challenge to the status quo. It was also thought that removing the reference to the restraint in the records may have been less a matter of collusion than desire for disassociation from a practice she did not approve of. There was a strong sense that singling out Nurse A for a Fitness to Practise hearing in this context was potentially a case of the nurse being used as a scapegoat by the authorities. Any idea that regulated professionals are individually accountable

to the regulator for their actions, was simply overwhelmed by the larger sense that this incident was a function of a poor culture and inadequate leadership.

Appropriate remedies in this case were seen as awareness-raising among staff more widely, re-training and re-education, for Nurse A, but also for other staff. As in other case studies, there was a strong element of rehabilitation and re-education in the public response to this case.

Case study 1. Concerns of public focused on cultural environment and pernicious impact on individuals

“Once that mind-set gets in a hospital or a ward where it’s OK to deliberately do something wrong and then cover it up, it’s a hard nut to crack.”

“I think she’s just doing what everyone else has done, just following everyone else but she’s the one who has been caught.”

3.4.2 The professional response

There was a strong sense among the professionals that this instance was not an appropriate use of Fitness to Practise procedures for this individual, who was almost universally seen as a scapegoat. There was a minority view that a Fitness to Practise case was justified, but only in the sense that, while Nurse A was unfortunate in facing a Fitness to Practise panel, the case would send a strong message to other staff that such behaviour was unacceptable, even where apparently condoned by the culture.

The issue at stake was seen to be the culture of Hospital X which had allowed abusive practices to develop and potentially go unreported and unrecorded.

Professionals interpreted the situation in which Nurse A acted as she did as a whistleblowing opportunity which she chose not to pursue, either because she was unwilling – and potentially collusive – or because she felt unable to do so in the prevailing culture. Although falsifying records was seen as a serious issue by the professionals, there was also some sympathy with Nurse A in the sense that the professionals took the view that standing out by removing the unauthorised restraint might have had a negative impact on the way that colleagues and supervisors interacted with her. The interpretation of Nurse A’s behaviour in insisting that there was no reference to the restraint in the records was that she was probably trying to cover her own back and not get involved.

The frontline professionals, and again particularly for those working in hospitals or larger practices or institutions the case raised issues around the bullying culture in some hospitals and about the abuse of power – both in the sense of the abuse of the patient and in the sense of singling out Nurse A as a scapegoat. The issue was sent to be a lack of leadership and a failure to provide ethical direction on the part of the management of Hospital X. Nurse A was seen simply as having been unlucky – being in the wrong place at the wrong time. As professionals, there was awareness of the registrant’s personal accountability to their regulator for their actions. However this was overwhelmed by the sense that the registrant had been unfairly “scapegoated” for what was seen as an organisational and leadership failure.

“I think she was just a scapegoat because it’s something that is going on there.”

“She was the wrong person in the wrong time with the wrong question. This was a random chosen in a whole wrong process which needs review... sometimes you need to pick somebody to be the bad one and she was unlucky. That’s why we are under pressure, you never know when you could be the one.”

As with the public, the focus in arriving at appropriate remedies was on how to change the wider situation for the benefit of patients and staff. The emphasis was on awareness-raising and behaviour change, for Nurse A but also for staff more widely. Professionals were more conscious than the public that individuals in a large organisation may find it hard to challenge established culture or more senior staff. As importantly as focusing on education and behaviour change, it was felt that effort should be focused on empowering Nurse A and other staff in such a situation, so that they were more confident about addressing misconduct or poor practice and were able to escalate their concerns to more senior staff. This view sat alongside a very strong sense that what was really required was action to address the culture and leadership issues at Hospital X.

“If this is someone who’s quite junior and there is a bullying / harassment culture... what she needs is a warning and caution and education so that she then is able to know how to escalate. That for me would change things.”

The groups were then presented both with the outcomes of the original Fitness to Practise hearing and the Authority Appeal.

Case study 1. Outcomes of Fitness to practise panel and Authority appeal

Fitness to practise outcome:

- The Nursing and Midwifery council imposed a 4 year caution against the name of Nurse A on the register but imposed no restriction on her right to practice.

Outcome of PSA appeal on fitness to practise verdict:

- Six month suspension of right to practise.
- Review of Nurse A’s suitability to practise at end of 6 month period.

Here the response was telling, and illustrative of the wider mind-set that both professionals and the public were focused on how to empower Nurse A and change the wider situation for the better.

Case study 1. Consumer response sympathetic to cultural pressures Nurse A may have been under and focused on rehabilitation

Four-year caution:

“I don’t think it would scare anyone else in the, like that same hospital.”

“Who is actually going to see that caution? What will it actually do to change the situation?”

“Now a wee bit of extra training. She’s maybe going to be disillusioned about the whole thing, you know people checking up on her name. Whereas training would maybe give her a little bit more confidence how to deal with that situation.”

Six-month suspension and review of suitability:

“I think the other solution was actually proportionate and I think actually depriving her of her ability to work for six months is a very severe thing... If she had

exceptionally gone out and done something which isn't normally done, then you may want to be harsher."

"That's harsh. That's not fair. She's been made a scapegoat here... But maybe it sends a message to other staff in the hospital and that's their intention."

The professionals saw the outcome of the original case as ineffective in changing behaviour or raising awareness of the issues, and both the Fitness to Practise case and the outcomes of it as side-stepping – and even covering up – the real issues, seen to lie in cultural failure.

The outcome of the Authority appeal, and the six-month suspension in particular, was seen as harsh and unfair and the sentence as disproportionate and inappropriately punitive.

Case study 1. Professional response mirrored consumer response and raises both privacy issues and lack of focus on behaviour change

Four-year caution:

"It may be correct but equally, with what we've just said, if she was kind of a scapegoat and all that, it seems a bit harsh... I think the Trust should be bought to disrepute."

"What does that caution entail? Does it entail that she is to be supervised while she is working as part of her re-training thing or is it just a caution slapped on a piece of paper and they just leave it?"

"I think the four years is a bit meaningless in some respects because it just lies on the record... but actually maybe a year's imposed supervision would be more effective in the rehabilitation."

Six month suspension and review of suitability:

"So she's got loss of earnings, and, well, you know, her professional credibility has been brought into disrepute... I think it's really unfair and everything, you know, that the Law Commission called out, it now affects this person."

"It does seem a little bit like smoke and mirrors. They've picked on her for whatever reasons and, it is quite punitive, a six-month suspension. That is loss of earnings... That is not proportionate."

"The first part, the six-month suspension is probably a bit strong but think it should just be the second part, sort of six-month assessment of suitability to practise because I think re-training people, people respond better to re-training than to suspension."

3.5 Dishonesty in relation to qualifications

Case study 2. Dishonesty in relation to qualifications

The fitness to practise case:

- Biomedical Scientist A applied for a job which required a master's degree and was offered job.
- At interview he claimed to have MSc but had not brought degree certificates to interview.
- Biomedical Scientist A subsequently applied to University X to have MSc certificate of another person changed to his own name on pretext of name change on account of religious conversion.
- NHS Trust X suspicious of certificate provided and instigated investigation.
- In course of investigation Biomedical Scientist A admitted certificate not his own but claimed to have completed masters by distance learning but never to have received certificate.
- Biomedical Scientist A charged by police with false representation for personal gain and received 6 months imprisonment suspended for 12 months plus 200 hours community service.

The fitness to practise charge:

- Biomedical Scientist A's dishonesty in relation to his claimed qualifications implied impairment and thus a lack of fitness to practice.

Contextual evidence arising during the during the fitness to practise hearing:

- Biomedical Scientist A appeared competent to do the job despite not having appropriate qualifications.

3.5.1 The public response

To some extent perceptions of Biomedical scientist A's behaviour in this case was coloured by a sense that embroidering CVs and over-stating accomplishments is widespread. What was seen to distinguish this case was the lengths to which Biomedical Scientist A went to falsify his MSc. This behaviour was seen as profoundly dishonest.

In the consumer groups, there was relatively little consideration of either the public safety or public confidence implications of Biomedical Scientist A's behaviour. Indeed the fact that he was not treating patients and there was no direct contact was seen as a mitigating factor by many. There was also little/no consideration of whether these actions were indicative of an attitudinal problem that might make the person untrustworthy, and of what this could mean for a professional in his role.

There was universal agreement that sacking from his current position and referral to the police was the appropriate course of action and that the subsequent prosecution and conviction was right and proper and an appropriate response to profound dishonesty.

Thereafter views diverged. There was a minority who felt that permanent expulsion from the profession was the only course of action. The majority took the view that the criminal prosecution and resulting punishment were sufficient and that Biomedical Scientist A would find his career prospects profoundly damaged in any case. Overall, the majority view was that Biomedical scientist A should be allowed to acquire legitimate qualifications and then re-enter the profession, being allowed to prove himself under a period of supervision.

Case study 2. Public had little sense of the safety implications and were more concerned with effective management of rehabilitation

“It is concerning though, the lengths to which he went to get it (false MSc). It’s not like he just ticked a box... if he is a scientist is he going to falsify other aspects? ... He should maybe continue at his level but not be able to progress until he has been regularly checked up on, make sure he is not doing anything dodgy.”

“He made a mistake. He done wrong and he got punished for it. He got a six month conditional prison sentence. So after that, if he’s going to learn from that, he can apply for a job and produce the appropriate paperwork. Then so he should and then they can judge him on his work after.”

3.5.2 The professional response

The professional response to this case was very different to that of the public and deeply felt, even visceral. Educational qualifications had been hard-earned over years of study and were absolutely central to the professionals’ identity and sense of self and the legitimacy of their standing as registered practitioners.

Falsifying qualifications was seen to strike at the heart of what it means to be a professional and public confidence in the professions. Beyond this, the complexity of the deceit and the determination with which the dishonesty had been perpetrated was seen as indicative of a wider attitude to dishonesty which was seen as completely inconsistent with professional standards and practice and the character and ethics expected of a professional. There was a very strongly held view that individuals would not want to work alongside or for such a colleague.

“He’s a fraudster...It’s one of the worst. I wouldn’t want him working for me. I wouldn’t want him working near me.”

“I think he deserves the punishment to be quite harsh... he has really gone out of his way to hide the real truth... It’s not a moment of weakness it is a premeditated act.”

The professionals were much more conscious also of the public safety risks and the implications of dishonesty in the presentation of research. The sense was that if someone was prepared to falsify a key qualification then it was a small step to falsifying results to advance career progression.

“A research paper can do just as much damage as practising. Look at the MMR vaccination. That guy never went anywhere near patients but there’s plenty of people who have had mumps and measles and rubella because of that paper which was essentially falsified.”

While the referral to the police and criminal prosecution was seen as appropriate, right and just, there was no question in the minds of professionals that this was sufficient. There was universal consensus that in this case the dishonesty was so profound that there could be no possibility of redemption or rehabilitation. The case was also seen to raise serious issues and direct threats both to public safety and public confidence in

the professions. The unequivocal view was that Biomedical Scientist A could not credibly or safely remain in the profession.

“I don’t see how he could get to work in that field again. Struck off. You can’t practise in that field again.”

“No way. It’s Tesco’s for him... OK he can make good in another field but he can’t work in research again. No way.”

The outcomes of the Fitness to Practise panel and the Authority appeal were then presented to the group as follows:

Case study 2. Outcomes of Fitness to Practise panel and Authority appeal

Fitness to practise outcome:

- The Health and Care Professions Council found that the maintenance of public confidence in the professions did not require a finding of impairment. The judgement was that Biomedical Scientist A was therefore fit to practise and the council imposed no sanction.

Outcome of PSA appeal on fitness to practise verdict:

- The high court made a finding of impairment and imposed a 12 month suspension of Biomedical Scientist A’s right to practice.
- Review of Biomedical Scientist A’s suitability to practise at end of period.

The public response to the Fitness to Practise disposal was broadly that while it was appropriate to allow Biomedical Scientist A to re-enter the profession, the disposal was both inappropriately lenient and ineffective in that it was insufficiently focused on behaviour change. For this reason, the reprimand and allowing Biomedical scientist A to continue to practise was seen as inadequate.

“I’m ok with that...I don’t think it’s a risk to the public... He’s good at his job. He’s got history. And in fact he didn’t start that other job.”

“Let him back in, fair enough, if he’s learnt his lesson but he needs to be kept an eye on.”

There was a minority who felt that Biomedical Scientist A should have been expelled from the profession, but the majority took the view that the offence had already been punished and that he deserved a second chance, albeit that some had concerns which it was felt should be addressed by re-education and behaviour change. The major failing of the Fitness to Practise disposal was seen to be that it did not contain any element of supervision or rehabilitation or requirement to obtain higher qualifications while some were concerned about whether there was a mechanism for ensuring that his conviction would be disclosed to future employers.

Against this background, the 12-month suspension and review of Biomedical scientist A’s fitness to practise at the end of the suspension was felt to be, on balance, a superior outcome in that the scientist was made more accountable, there was a mechanism for managed re-entry to the profession and that he would have time to

reflect on his actions and learn from them.. Many commented that this period of suspension would enable the scientist to acquire legitimate qualifications.

“That’s fine. I think that’s a better one... Everything is a consequence of your actions and that’s more accountable.”

“Having a review and stuff. It’s not like he’s just suspended and then back straight to work. He’s got a proper review process.”

That said, some took the view that the 12-month suspension and associated loss of earnings was harsh in that it layered a significant financial penalty on top of criminal sanctions.

“I think he would have had enough time to sort of think about it the first time. With the prison sentence as well. I think the first one was fair, still. I think that that’s a bit extra, it’s punishing him a bit too much.”

The professionals, on the other hand, were stunned by the outcomes of both the Fitness to Practise panel and the Authority appeal. They were both incredulous and angry, feeling strongly that a genuine risk to public safety and confidence had been effectively ignored. Both disposals were seen as high risk and inappropriately lenient, with the disposals themselves seen to bring the profession into disrepute.

Case study 2. Professional response to Fitness to Practise disposal and outcome of Authority appeal reflects value placed on hard-won qualifications and better understanding of potential implications of falsifying research results

Reprimand and allowed to continue to practise:

“Wow”... That would ruin public image if that got out.”

“That’s unbelievable. Do they really believe that dishonesty doesn’t matter?”

“It’s not just... I think you just have to accept the fact that you just need to leave the profession. It’s just not right. They should have struck him off.”

12-month suspension and review of suitability to practise at the end of the period:

“It’s not acceptable that he is going back at all... he should be permanently disqualified.”

“If you go back to the regulator’s remit of monitoring and enforcing high standards of competence and integrity, that’s an integrity issue if ever there was one... it (outcome) doesn’t make sense... Yes they can be rehabilitated – but it doesn’t mean they can continue in the same job – it doesn’t mean they can just be let loose on society again.”

3.6 Dishonesty in relation to registration status or insurances

Case study 3. Dishonesty in relation to registration status or insurances

Context:

- The General Chiropractic Council offers two types of registration:
- Non-practising @ £100 p.a.
- Practising @ £1000 p.a.
- Practising chiropractors are required to have appropriate public indemnity insurance.

The fitness to practise case:

- Chiropractor A had been registered since 2001 and in 2012 applied for non-practising registration and was registered as such for whole of 2012.
- GCC informed Chiropractor A that if he resumed practising he would need to register as practising and pay the full £1000 fee.
- During 2012 Chiropractor A was provisionally employed by Chiropractor B pending a registration check and began practising in Chiropractor B's employ.
- Registration check revealed Chiropractor A's non practising registration. Chiropractor A told Chiropractor B that this was oversight and he had consulted GCC and been told situation could be remedied by immediate full registration.
- Further checks by Chiropractor B with GCC revealed that no such conversation had occurred and that Chiropractor B also had no indemnity insurance.
- Chiropractor B then reported Chiropractor A to GCC as practising while unregistered and uninsured.

The fitness to practise charge:

- Chiropractor A had been practising without either appropriate registration or indemnity insurance.

Contextual evidence arising during the during the fitness to practise hearing:

- Chiropractor A did not appear to appreciate the significance of the risks to patients of his having practised for even a very short period without registration or insurance.
- Chiropractor A did not appear appropriately remorseful – rather representing his lack of registration and insurance as an administrative oversight which he had intended to remedy forthwith.

3.6.1 The public response

Only a minority of the public picked up the public safety implications of Chiropractor A practising without indemnity insurance and this lack of understanding coloured views. The majority were inclined to be forgiving and to see Chiropractor A as having

behaved stupidly, to have been thoughtless and disorganised and then been panicked into telling a stupid lie rather than as having been premeditated in his dishonesty or as having deliberately put patients at risk. For some, the fact that no-one had been harmed was seen as a mitigating factor, while others thought this irrelevant.

“He panicked. It was almost not premeditated. So it’s not a premeditated lying. It’s tricky. So is that a kind of a warning situation?”

“I think if I was Chiropractor B I would have phoned him up and said ‘Listen, maybe there’s a little misunderstanding. I’d like to offer you the job and I’m going to phone up in seven days to make sure you have the practising one because as far as I’m concerned they’re saying you haven’t.”

Those who had grasped the insurance implications saw the case as much more serious, analogous to driving without insurance. Again, however respondents tended to think in terms of stupidity and lack of organisation rather than deliberate or premeditated action.

There was consensus that the lack of insight and remorse at the hearing was problematic, and indicative of a wider casual attitude. It was felt however that this could be addressed with training and re-education.

Appropriate remedies were seen as a substantial fine – consistent with his potential motivation in seeking to avoid the additional cost of a proper registration – warnings and re-training to address the lack of insight and remorse. Respondents felt it was important that Chiropractor A was made to understand the issues and implications and that this would be the most effective way to prevent a re-occurrence and ensure that behaviour change would stick.

“It sounds more like he was a bit like not on top of the game. He’s a bit thoughtless. He panicked. It doesn’t sound deliberate... you’d probably have to suspend him but not for too long, a bit of a warning.”

Most took the view that this was not a suspension or disqualification issue on first offence, but that if he were to treat patients again without insurance this should then be viewed very seriously.

3.6.2 The professional response

The professionals took a much harsher view of the seriousness of the offence and the dishonesty around it. Their immediate reference point was the code of conduct which is quite explicit about the need for registration and appropriate insurances. For the professionals this was a cut and dried public safety issue, with the dishonesty around it compounding the seriousness of the offence by seeking to cover up a breach of the code.

The view was that it was not credible that Chiropractor A did not know that he was in serious breach of the code and that he was putting patients at risk. Some were prepared to give him the benefit of the doubt in terms of intention to pay while others were more cynical. In either case, the fact of practising without insurances and then lying about it were sufficient offence regardless of intention.

“Everybody knows you have got to pay your fees to work. There’s no way you can’t know that... You can’t get away with that. And especially if he’s said to Chiropractor B he had spoken to the GCC and that turns out to be a lie.”

“It’s no indemnity. If he had done something wrong, there’s no cover. So basically he is just a man off the street, it could be anyone off the street. He knew it. And he didn’t care and he just carried on... And he knew he wasn’t covered.”

You're told over and over again that you have to have insurance. You cannot call yourself a chiropractor unless you're registered with the GCC... So it's dishonesty to the patients... you are misleading them."

The lack of insight and remorse shown by Chiropractor A was seen as arrogance and as speaking to a lack of responsibility or proper recognition of his professional obligations and professional ethics.

"He's not taking it seriously because he is admitting that he knew. He's not showing insight and accepting, recognising and that is what is wrong here... It's quite arrogant."

For the professionals, the appropriate course of action was an extended suspension and heavy fine to send a clear message about the seriousness of practising without insurance or registration. It was also felt that Chiropractor A should be required to undertake further training and education before being allowed to re-enter the profession.

The outcomes of the Fitness to Practise panel and the grounds for the Authority appeal were then presented to the groups:

Case study 3. Outcomes of Fitness to Practise panel and Authority appeal

Fitness to practise outcome:

- The General Chiropractic Council imposed a six month suspension of Chiropractor A's suspension of registration.

Outcome of PSA appeal on fitness to practise verdict:

- The Professional Standards Authority won its appeal that the sentence was too lenient on two grounds:
- That the Council had failed to bring charges of dishonesty against Chiropractor A in relation to representations made regarding his registration and insurance.
- The sanction was unduly lenient given the Committee's comments on lack of remorse or insight.
- The Court ordered the case to be put back to a fresh GCC panel for a new decision. The hearing has not yet taken place.

Consumers saw a six-month suspension as appropriate in that it would impact Chiropractor A's ability to earn and would thus hit him in the pocket. Some however saw the disposal as harsh.

“Well this time I’d say that they got it about right. Six months is a long time not to be earning.”

“I’m torn in the middle because he could have paralysed somebody so I don’t think six months is too harsh

Professionals saw six-month suspension as too lenient.

“This isn’t enough. Because they are upholding their own professional standards and code of conduct.”

“Essentially he is bringing them (the GCC) into disrepute... I’d say a 12-month suspension of not being able to practise.”

“I must admit I don’t think it’s enough because I would have gone for something more than a temporary suspension really because I think it is a real integrity issue and he was putting people at risk. It’s an illegal act to practise as something you are not registered as.”

Both public and professionals took the view that the disposal lacked provision for re-education to address the lack of insight and remorse.

“OK, the person does the six months... but then I think it needs to be checked. Going back to this thing, I think they need a counsellor who is going to help him come back into the fold as it were.” (Consumer)

“If he’s just being dishonest, he’s still going to be dishonest at the end of six months... and if he doesn’t understand what he did is wrong, he’s not going to be any the wiser. He’s maybe just going to get a chip on his shoulder. So I don’t see what a suspension on its own actually changes.” (Professional)

3.7 Dishonesty in relation to working at another job or conduct in another professional context

Case study 4. Dishonesty in relation to working at another job or conduct in another professional context

The fitness to practice case:

- Social Worker A was registered as a social worker with the health and care professions council and at the same time as a childminder with Ofsted.
- Social Worker A was running a child-minding business with its premises registered as at her home.
- At the same time Social Worker A was also working as a locum social worker.
- On an unannounced inspection of Social Worker A's home, Ofsted inspectors found that:
 - Social Worker A was not on the premises.
 - There were several adults in charge of six children in her home, none of which were registered with Ofsted or had had criminal record checks.
- When inspectors called Social Worker A on her mobile, she claimed simply to be absent temporarily because out shopping for essentials.
- At the subsequent hearing, Social Worker A would not admit that she had been working as a locum social worker (despite evidence to this effect) nor did she recognise her childminding service were in breach of regulations.

The fitness to practice charges:

- That Social Worker A's behaviour in relation to her child minding service rendered her unfit to practice as a social worker.

3.7.1 The public response

This case evoked the most consistent response of all those explored, with little variation between consumer groups or between professionals and the public. The response was both highly emotional and deeply judgemental. Strikingly, and in contrast to some other cases, there was little or no interest in the context for Social Worker A's actions or any potential mitigating factors. The issues were seen simply in black and white with no sense of shades of grey.

"If she can lie about the job and not having them police checked or anything, she could lie about the social work, going to a child and saying they're OK when they're not... She needs striking off as quickly as quick".

"Well seeing as she had other people looking after the kids she's supposed to be looking after, that just says to me not only that she's incompetent and prepared to break the rules but that she can't be trusted... How can she make sure other

people's children are in a safe environment, if she's got to remove them from families? She wouldn't be able to distinguish... she's unfit to be a social worker."

The strength and depth of feeling appeared to derive from the nature of the social work profession. Social workers are seen as, by definition dealing with vulnerable individuals, often children and to be making far-reaching, high-impact decisions on the most important and intimate areas of personal and family life. Sound judgement and absolute integrity are thus seen as absolutely critical requirements for social work professionals.

"You require a level of integrity because your clients are in need and are vulnerable ... and she showed a careless disregard for the safety of the children. She's untrustworthy ... and she lacks judgement – and she should be stopped (from being a social worker) is my feeling."

The failure to observe regulations and dishonesty in the child-minding areas were seen as evidence of a lack of judgement and dishonesty more widely. As a result the read-across from the child-minding arena to that of social work was seen as legitimate and an essential move to protect social work service users and the integrity of the profession.

"She needs to work in another industry... her judgement is not very good... but it's not a judgement thing. It's a complete disregard of the vulnerabilities and then there is the dishonesty."

There was an almost unanimous view that Social worker A could not be allowed to continue in the social work profession, with no room seen in this case for redemption and rehabilitation. The lack of insight or remorse was seen as an aggravating factor. Equally, however, had Social worker A shown insight and remorse, this was not believed to be sufficient to alter the consensus judgement that Social worker A simply did not have the character or judgement to remain a social worker.

3.7.2 The professional response

The professionals, and especially the social workers within the groups, were, if possible even more unforgiving than the public judgement on this case. There was a strong perception that Social worker A must have known that non-compliance with Ofsted requirements and parallel-working in an alternative social care role was both dishonest and a flagrant breach of regulation and professional codes. Deliberate non-compliance with Ofsted requirements within the child-minding business was seen to have put children at risk while the dishonesty around that non-compliance was seen as compounding serious errors of judgement.

"Social workers have a massive amount of power. Social workers in children's care literally tell parents how to be parents and criticise them if they think what they are doing is not in line ...to allow her to go back into that situation where the people you are dealing with are vulnerable and relying on your guidance and judgement as a social worker. In this case I'd really have an issue with that... I'd dismiss her as a social worker."

"I wouldn't have any confidence in her as a social worker or indeed as anything else... there's too much dishonesty, too much disrespect for the professional aspects of both jobs. Her lies... she wouldn't make good judgements. She doesn't have a future as a social worker."

The social workers and those working with the elderly and young children and those with learning disability felt most strongly and were more conscious also of the potential impact on the reputation of the profession, which was seen to be under constant media scrutiny.

Social worker A's behaviour was seen as a direct threat to the reputation of the profession and to pose a clear risk to public safety and all were adamant that she should not be allowed to practise in future.

"I think it is down to public perception... she's dealing with vulnerable people who are putting their trust in her because she is a social worker. And for them to find out she's done something dishonest, how could she continue in that role?"

"You can dress it up anyway you want to. At the end of the day she's a crook because she's flouting the law... and how can somebody like that be a social worker."

The groups were then shown the disposal from the Fitness to Practise panel and the outcome of the subsequent Authority appeal.

Case study 4. Outcomes of Fitness to Practise panel and Authority appeal

Fitness to practice outcome:

- The Health and Care Professionals Council imposed a 12 month caution.

Outcome of PSA appeal on fitness to practice verdict:

- Health and Care Professionals Council struck Social Worker A from the register.

The initial disposal of a 12-month caution against Social worker A's name on the register was met with disbelief, even outrage. The subsequent disqualification of Social worker A following the Authority appeal, by contrast, was met with strong approval, with respondents, professional and public, identifying strongly with the Authority as having intervened on behalf of the public and professions.

Case study 4. Respondent response

12 month caution against Social Worker's name on register

Public:

"That's disgusting. She should have been struck off. I hope they appealed that?"

"What? Are they that desperate for social workers?"

Professionals:

"What? Oh God. Who sits on this panel? Who makes these decisions?"

"Did they appeal? Please say they appealed."

Disqualification on Authority appeal

Public:

"Good. We scored a goal then. Don't mess around when it comes to things like that."

Professionals:

“Brilliant they did the right thing in the end.”

“Yes, quite right. Well done PSA... It went right now. We got that one right.”

3.8 Dishonesty outside the immediate context of professional practice

Case study 5. Dishonesty outside immediate context of professional practice

Context:

- Registrants are required to advise their professional body of any convictions or cautions.
- Professional bodies have a duty to consider whether non work-related dishonest conduct on the part of a registered professional (but which does not result in criminal proceedings) will undermine public confidence in the profession.

The fitness to practise case:

- Dentist A was investigated by HMRC who suspected that he had defrauded the revenue of tax by knowingly understating the profits of his buy-to-let property portfolio over a period of some years.
- Dentist A admitted the fraud and reached an arrangement with HMRC to repay the lost tax together with appropriate penalties and therefore escaped criminal prosecution.

The fitness to practise charge:

- That Dentist A's admitted dishonesty in relation to his tax affairs brought the dental profession into disrepute and thus undermined public confidence in the profession, and that his fitness to practise was therefore significantly impaired.

Contextual evidence arising during the fitness to practise hearing:

- There was no evidence of any lack of professional competence in relation to Dentist A's professional practice as a dentist.

3.8.1 The public response

This case was the other study which elicited an entirely consistent response across the socio-economic groups and across both the public and professional respondents.

There was a near universal view that tax fraud, unrelated to the dental practice itself, was not to fitness to practise as a dentist, no matter how senior or high profile the dentist. Dentist A's practice as a dentist and his role as a landlord were seen to be operating in entirely separate spheres.

“I'd still go to him... Dentists, I don't like them and I don't like him but I think he should still practise.”

“I think that they punished him by making him pay it back and put more on there and I think that's OK. It's nothing to do with the dentist bit.”

The public were clear that they did not see Dentist A's tax fraud as impacting on their confidence in the profession. Their concern was rather with his skill and integrity as a

dentist, with respondents happy to use Dentist A and interested only in his competence as a root-canal specialist. When probed about why their response to this case was so different to that preceding which had involved the social worker whom they had seen no option but to disqualify, respondents explained that social workers were involved in “the stuff of souls” – the most important and intimate areas of personal and family life and that their decisions had momentous personal consequences while dentistry was rather seen as a skilled profession more akin to that of a mechanic.

Attitudes were also shaped by a perception that Dentist A had admitted the tax fraud when investigated by HMRC, that he had subsequently collaborated fully with the investigation and had voluntarily brought the matter to the attention of the General Dental Council. Against this background, the view taken was that Dentist A had already been punished by HMRC and had paid a substantial fine and that to punish him further would be to punish him twice, which was not seen as fair or just.

“And he was honest, he told them (HMRC). The two things are separate, aren’t they? His profession is one thing and that’s (his property business) a business and that was something else. He did wrong, he owned up to it. It shouldn’t affect his practice.”

“He’s made a bit of an error and he obviously realised that so he showed some remorse. But because he was dishonest, I’d probably give him a caution but I wouldn’t take any more action because he’s obviously been fined.”

Moreover the groups felt that the dentist had a right to a livelihood. The consensus was that this was not a Fitness to Practise matter and that no action needed to be taken in that there was no risk either to public safety or to public confidence.

3.8.2 The professional response

The professionals’ views were very similar to those of the public. Dentist A’s activities as a dentist and as a landlord were seen as unconnected. Misconduct in his role as a landlord was not seen to impact on his competence or integrity as a dentist. As individuals, very few had any qualms about using Dentist A in a personal capacity if his skill-set was best fit with needs.

When probed further, professionals echoed the views of consumers that dentists’ credibility was not seen to rest on good character in the same way as doctors, psychiatrists, social workers or counsellors. Moreover they also saw any risk to the credibility or integrity of the dentistry profession as having been mitigated by Dentist A’s collaboration with HMRC and his voluntarily having brought the matter to the attention of the GDC.

This case was also felt to involve Dentist A’s human rights, to invoke privacy issues and Dentist A’s right to a livelihood.

Against this background there was consensus that the GDC did not need to take action in this case. A minority took the view that an audit of the tax affairs of the dental practice might be appropriate to allay any potential concern that his dishonest behaviour as a landlord did not extend to the dental business.

The outcome of the Fitness to Practise panel was then presented to the groups.

Case study 5. Outcomes of Fitness to Practise panel

Fitness to practise outcome:

- The General Dental Council determined that Dentist A should be removed from the register thus preventing him practising as a dentist in future.

Here consumers took the view that striking Dentist A from the register on public confidence grounds was unduly harsh and disproportionate and unjust.

“Oh my goodness. That’s harsh, that is really harsh. Please tell us it was appealed!”

“That’s ridiculous... the guy has a right to earn a living. It’s not fair to take that away from him. Alright, he fiddled his taxes but he’s already paid the price.”

When questioned about whether the disposal could be understood or justified on public confidence grounds, consumers were clear that they did not see a public confidence issue.

“(Q. justifiable on public confidence grounds?) Not at all. No way. They’d have to prove that surely? He was already found guilty of doing this and yes, he owned up for it and he paid it back. No way. It’s too harsh”.

“That’s really bad. And he wasn’t hurting anyone because he paid it back... That’s ridiculous. (Q. Could it be justified on public confidence grounds?) Why would they even think as broad as that?”

Professionals were less shocked by the disposal in that they saw the outcome as consistent with regulator messaging on dishonesty and thus with their own expectations of the consequences of dishonesty or fraud outside the professional context.

“I can’t say I’m actually surprised. But it is very harsh. Very harsh.”

“I know one of the easiest ways for pharmacists to get struck off is tax evasion and so you do know that... but that doesn’t make it (outcome) right... (Q. Is it fair?) No, it’s not. It’s not just.”

They nonetheless saw the judgment as unduly harsh and inherently unjust, and did not see the disposal as genuinely justifiable on public confidence grounds.

“I think (it’s wrong) because they’ve taken away his opportunity to practise at what he’s trained to do, when the thing he’s been struck off for had nothing to do with that.”

“I think in some of these cases they’re (the regulators) thinking about themselves rather than the public. Rather than the public would hate that, it’s we hate that, we’ve got a reputation to protect, especially if, as you say, it is a high profile dentist.”

3.9 Dishonesty in relation to previous convictions or identity

Case study 6. Dishonesty in relation to previous convictions or identity

Context:

- Registrants are required to advise their professional body of any convictions or cautions.
- Registrants are also supposed to advise professional bodies of any change of name or previous identity when applying for registration.

The fitness to practise case:

- Nurse C was born in Liberia. He moved to the United States of America in 1984. In December 1988, he was arrested, and later charged with armed robbery and unlawful possession of a firearm. He escaped from custody prior to his trial.
- In 1993 he was arrested in the Netherlands and deported to the US where he was convicted and served 3 and a half years in prison before being deported to Liberia.
- Nurse C subsequently applied for asylum in the UK under a new name and eventually obtained British citizenship in 2013.
- In 2004 he applied to study nursing at the University of Salford and did not admit to his convictions or previous identity on the application form.
- In 2010 Nurse C applied for registration with the Nursing and Midwifery Council, again mentioning neither convictions nor previous identity. He declared that his health and character were sufficient to allow him to practise medicine safely and he was registered in 2010 and gained nursing employment in 2011.
- Subsequently, in 2011, he was arrested for a relatively minor non work-related matter. The police uncovered his previous convictions and identity.
- The matter was referred to NMC in 2012.
- Employer dismissed Nurse C in 2013 for failing to disclose 1993 convictions for 1988 crimes.
- He obtained further employment through an agency in 2013. He disclosed his convictions, but not that he was under an investigation by the NMC.

The fitness to practise charge:

- That Nurse C's failure to disclose his previous crimes (1988) and related convictions (1993) and former identity in his various 2004, 2010, 2011 and 2013 applications in the UK implied impaired fitness to practise as a nurse.

3.9.1 The public response

This case divided opinion to a greater extent than any other. The small minority who consistently saw expulsion from the profession as the appropriate response in all cases of dishonesty were more inflamed by this case study than any other examined. These respondents were outraged by the idea that any nurse could have a history of conviction of such serious crimes and saw no mitigating factors in Nurse C's efforts to make a new life and establish a nursing career. Indeed Nurse C's efforts in this regard were seen as an extended deception, a continuation of criminality, rather than as turning over a new leaf.

"Armed robbery. I don't care how young he was. You have to be a certain type of person to do an armed robbery, to hold a gun to somebody. He has got to be messed up."

"I mean armed robbery is a pretty serious crime. I'm trying to think if, you know it maybe didn't involve guns and violence... but he's been so dishonest. It's been lies all the way through. I mean he came into this country on a fake name."

For these respondents, the appropriate response was not only disqualification but in many cases, a criminal prosecution and deportation. Those who took this view also believed strongly that asylum and British Citizenship had been obtained through deception and should be revoked.

"I would say stick him a rowing boat and let him row back to Liberia...No way should he practise in this country."

"He shouldn't even be in this country. He should have been deported as soon as they realised it wasn't him... I don't think as a nurse anyway people would be comfortable with him treating them when he done such a big crime... So no, no way can they let him back as a nurse. Deport him."

A rather larger group were relatively tolerant of his prior conviction, albeit that they recognised that serious crimes had been committed. These respondents admired Nurse C's commitment to rebuilding his life and his choice of nursing as a caring profession and the contribution he had made to Society.

"You know, I think he could have had a tough life. I don't think, you know, that we should, you know, sort of give up on him. He has re-built his life and he has gone into a caring career. He is helping people... He has been dishonest for a very long time, I get that. But once he had started with the new identity, and we don't know his circumstances at that time, there was maybe no going back".

They struggled however to accommodate the idea of sustained deceit over a long period. For these respondents, had Nurse C been honest and declared his prior convictions and history, there would be no question of disqualification. These respondents tended to think in terms of recognising that the dishonesty was long-standing and putting in place mandatory extended supervisory arrangements, possibly a period of suspension with mandatory education and training. All these respondents would have stopped short of permanent disqualification.

Yet others empathised with the dilemma that had been faced by Nurse C in seeking to rebuild his life and recognised that the practical reality was probably that if he had disclosed he might not have gained asylum or the opportunity to obtain his qualifications and start a nursing career. These respondents felt that Nurse C had proven himself over many years and should be given the benefit of the doubt and allowed to continue to practise.

"This individual was trying to leave their past life behind and move on and they've not chosen bricklaying. They actually want to be up there, caring for

somebody...obviously he couldn't disclose because he wouldn't have got the job... The identity thing. He was just desperate to get away. It's not as if he didn't serve his time."

"I think that one of the major aims of punishment is to try to get people to turn the corner and do something which is valuable and useful for the community... he is somebody who is trying to make something of their lives and a nurse is a very giving and caring profession. I'm going to try and be tolerant... he was scared, he couldn't disclose, could he?"

Nonetheless, even among those who were inclined to give Nurse C a second chance, there was recognition that such a course of action might be ill received by the media and would therefore pose reputational challenges for the regulators. As a result, they could, often reluctantly, see this case as arguably being one where some would see legitimate public safety and confidence concerns and that tolerance might be a difficult stance for any regulator to defend.

3.9.2 The professional response

The professionals were markedly less tolerant than the public and more inclined to think in terms of safeguarding the reputation of the profession and to think of the case as turning on a public confidence issue. The majority therefore felt that it was neither tenable nor credible for the regulators to allow Nurse C to remain in the profession. A small minority went further and thought in terms of a criminal prosecution and deportation.

"For a profession like nursing, it's very important not to have a criminal record... I think that would be important to patients, to the public."

While the seriousness of Nurse C's previous convictions were alarming, none of the professional respondents took the view that in reality Nurse C was a public safety risk, given his nursing track record.

The issue – and Nurse C's dishonesty in relation to his identity and previous convictions – was rather seen in black and white terms as a simple transparency and disclosure issue. Here the view was that the dishonesty represented a sustained and deliberate non-compliance with one of the key pillars of the profession's risk management approach.

"The trouble is he's lied about something fundamental – who he is even – throughout his career from the beginning. So he does not deserve that career."

"When you apply for a job, you know, there is a section on the form, isn't there, for convictions. Now if you put those down, they make their judgements but if you put 'None' and then they find out after, you're gone straightaway. No difference in this case."

The perception was that if Nurse C was allowed to remain in the profession, this would bring the nature of these controls into question.

"The most important point as my colleague said, is he's not been dishonest for one time and he regretted it. He's been like that all the time, half a lifetime... He's gotta go. It's a no brainer. Otherwise what's the point of those questions on the form if you're just going to go, OK, You've had a hard life."

A minority took the view that had Nurse C disclosed, his previous identity and convictions would not be an issue. The majority, however, took the view that the nursing profession should not be open to someone with Nurse C's history and that Nurse C should have sought an alternative line of work.

“It clearly one of the most unfortunate beginnings possible and who knows why he is in the situation but then he’s trying to make a better life for himself. It’s a shame because obviously he has done well and he did end up serving time. He should be able to make a new start after that but you can’t make a new start in a profession where you can’t have a criminal conviction. Then you’ve got to choose something else.”

“If he put any criminal record down, he would not now be out of a job... but then again I would understand his point, no-one would employ him or give him a job in most scenarios. But again that is no reason to lie. Could be honest and try your chances or just accept you’re going to have to do something which is not dealing with the public or with vulnerable people like patients.”

“You know, I’m torn, and it’s all very admirable what he’s done but, you know, he has got himself into a pickle of his own making... He’s been lying and lying and getting deeper into lies over the years and he should just have thought maybe right back in the beginning, maybe I ought to try doing something else.”

There were some dissenting voices, however, primarily those who had direct experience of working with offenders, asylum seekers and the deeply disadvantaged in a professional capacity. These individuals were more likely to understand the barriers that Nurse C would have faced in seeking asylum and the reality of the risks he might have faced if he had disclosed. These individuals thought in terms of rehabilitation and of providing Nurse C with a route to return to the profession. Suggestions included providing a means for Nurse C to make full disclosure and contextualise his history and subsequent dishonesty and managed re-entry to the profession under supervision, allied to education to facilitate the development of adequate insight and remorse. For these respondents, such a course would ensure that there was no risk to public safety while also minimising risks to public confidence.

The groups were then presented with the outcome of the Fitness to Practise panel and the Authority appeal as follows:

Case study 6. Outcomes of Fitness to Practise panel and Authority appeal

Fitness to practise outcome:

- The NMC panel found that the Registrant's fitness to practise was impaired by reason of misconduct and suspended the Registrant for four months.

Outcome of PSA appeal on fitness to practise verdict:

- The PSA challenged the NMC panel decision, and the High Court ordered that Nurse C be struck off from the NMC register.

The consumer response to the original Fitness to Practise disposal reflected the wider thinking and themes in the public response to the case studies. The minority who were adamant that Nurse C should be disqualified and in many cases, also prosecuted and deported, were, perhaps predictably, outraged.

“That is so wrong. No way should he be in this country. No way should be allowed to be a nurse. Where are these people’s values?”

The majority saw as overly lenient but, more importantly, as not constructive and not paying sufficient emphasis on supervision, to minimise public safety and confidence risks, or on education, to facilitate insight and remorse.

“So what exactly is that going to change? Nothing. It fails on all counts.”

There were very mixed views among consumers on the outcome of the Authority appeal. Those who had argued for disqualification felt vindicated, albeit that some felt that it did not go far enough.

Others took the view that the appeal and verdict was vindictive, unfair and unjust and disproportionate to the offence, given Nurse C’s track record as a nurse. These respondents saw the outcome as a waste of skills and human potential. Some felt the case raised issues about Nurse C’s human rights.

“It just makes me feel very sad. He didn’t get the best chance in life and he has tried to make the best of himself and, you know, it feels wrong. He’s been a good nurse and he deserves a second chance, which he’s not going to get.”

All that said, there was acceptance that in a risk-averse climate, the decision to disqualify was probably inevitable and recognition that such a disposal would be the safer option for regulators.

“ I guess, realistically, what were they going to do? He may have been a good nurse and yadayadayada – but they’re not going to stick their neck out for him are they? Safety first, I can see that. It’s just his bad luck.”

3.10 Dishonesty in relation to patient interaction

Case study 7. Dishonesty in relation to patient interaction

The fitness to practise case:

- Patient B, who had severe pain in the lower jaw was seen by Dentist A. Dentist A did not take the medical history or carry out the necessary tests or examinations.
- Dentist A then proceeded to extract a tooth without telling Patient B or obtaining consent.
- The patient returned to the practise that same afternoon to complain that the wrong tooth had been extracted.
- Subsequently, in a letter to Patient B, Dentist A claimed that the patient had identified the tooth that was extracted as the one that needed to be removed, and that he had obtained the patient’s consent to remove it.
- Both of these claims were found to be false.

The fitness to practise charge:

- That Dentist A’s fitness to practise was impaired by virtue of his dishonest behaviour in relation to his interaction with Patient B.

3.10.1 The public response

Response to this case also featured a clear consensus on both the seriousness of the case and the appropriate disposal, among both public and professionals. In sharp contrast to the previous case, which generated much, often heart-felt, discussion, views in this case were rapidly arrived at and the case was seen as straightforward and black and white.

The issues around competence (lack of X-ray or taking a medical history) and false record-keeping were entirely overwhelmed by a deeply-felt reaction to the dishonest attempt to cover up Dentist A's behaviour. This was universally regarded as very serious. Dentist A was seen as profoundly dishonest and as unfit to practise.

"That's very serious. You lie to cover up your mistakes instead of putting your hand up and admitting it. He should be struck off for a good long period at least."

"It's very serious. Strike him off. I'd give him imprisonment."

Dentist A's behaviour was seen not only as dishonest but also as an abuse of power and the professional relationship on two counts; firstly by making false claims in his letter to Patient B and secondly in seeking to persuade the dental nurse to collude with him in the cover up. This behaviour was seen to speak to a profound lack of integrity and good character.

"For me, in some ways, the worst aspect of this case is that he was arrogant enough to assume he could get away with it because he could pressure his dental nurse to back him up.... He's the worst kind of weasel. He should be gone."

There was a near universal consensus that appropriate response was disqualification because Dentist A was seen as having so bad a character as to not being amenable to re-education and behaviour change.

3.10.2 The professional response

The professionals' response mirrored that of the public. Dishonesty in seeking to cover up incompetence was seen as profoundly dishonest and indicative of an amoral character not suitable for a caring profession. Dentist A's behaviour was also seen as an abuse of power on a number of levels.

"He's lying about a patient and he's falsifying the notes and he wants his nurse to lie for him. He could do anything to save his bacon basically. He thinks he can do anything. He needs to be struck off."

For professionals, this case raised issues of patient trust which were seen to lie at the heart of the patient relationship and public confidence. Dentist A was seen as a clear public safety risk and the case was seen to encapsulate a clear public confidence issue.

"That's a public confidence thing right there. I think he should be struck off. I wouldn't want him to be my dentist."

"I think that this is at the heart, very much of the trust that you put in people like that... you know, you can't practise if you can't be trusted."

The egregiousness of the case was also seen to be aggravated by a lack of insight and remorse on the part of Dentist A.

"The thing is, going back to being proportionate and all that, I think if he behaved differently, if he had insight, if he had said 'I made a mistake, you know and I'm going to do X, Y and Z about it, then it might be different. But he's not saying any of that. Is he retiring? He needs to be removed."

There was near unanimity that Dentist A should be struck from the register.

The groups were then shown the outcomes of the Fitness to Practise panel and the Authority appeal as follows:

Case study 7. Outcomes of Fitness to Practise panel and Authority appeal

Fitness to practise outcome:

- The GDC panel imposed a reprimand (mark against his name on the public register of dentists). This was the lowest form of sanction available to them.

Outcome of PSA appeal on fitness to practise verdict:

- The earlier GDC decision was replaced with:
 - A three-month suspension
 - A review at the end of three months to determine whether the registrant was fit to return to practise

In this case there appears to have been a mismatch between the public and professionals' interpretation of the seriousness of the case and that of the Fitness to Practise panel and the Court of Appeal.

Both public and professionals were taken aback by what they saw as the inappropriately lenient disposal of the Fitness to Practise panel. Consumers saw the reprimand as overly lenient and unlikely to preserve faith in professional regulation.

"That is not going to make the public have any faith, is it? Why even bother in the first place. It's just going through the motions."

"No! They're having a laugh. That's light. Too light."

Professionals took the view that such a minor sanction was disproportionate to the serious nature of the offence.

"Wow". Just a warning? Wow!"

"It's just a slap on the wrist."

The imposition of a reprimand, as the lightest form of available sanction, was interpreted as the panel not taking seriously what was seen as grave dishonesty striking at the heart of patient trust, and thus a clear public confidence issue. The disposal was felt likely to undermine public confidence in the profession and, as importantly, in regulation of the profession.

The outcome of the Authority appeal was seen as only a marginal improvement in that it was still seen as inappropriately lenient and contained no element of behavioural change. Consumers saw a three-month suspension and review of Dentist A's fitness to practise as still too lenient a sentence and as unlikely to effect behaviour change.

It's better but I still don't think that's severe enough."

“The thing is he’s not going to be any more trustworthy, is he, after three months or six months or 12 months or whatever. He’s just not a nice man. You go to the dentist or the doctor or whatever and you’re entitled to feel you can trust them.”

Professionals felt that the outcome of the appeal did not reflect the seriousness of the case. Most remained convinced that the appropriate disposal was disqualification or a very extended suspension and re-education.

“It’s better. But it still doesn’t seem to be severe enough.”

“It almost seems a bit sexist here. Reverse sexism. This young guy gets away with it and that poor nurse (case study 1) gets the book thrown at her.”

“I think that’s quite lenient. It isn’t a long time, is it, for doing something so wrong.”

“That’s not enough. It should be six months or a year and check his records and competence before you let him back in... But you know, hang on, why are we giving this guy a second chance, remind me?”

Indeed the overall outcome of the case – and allowing Dentist A to practise with no restraint on his behaviour – was seen as perverse. The view was that the public had not been protected from a genuine risk to public safety. The case was not only seen as a missed opportunity to reinforce public confidence in the profession but rather as likely to undermine confidence in both the profession and the regulators.

3.11 Dishonesty in relation to relationships with colleagues or patients

The case study was presented to the groups in two stages. In the first instance it was not revealed to the groups that there had been a pattern of prior complaints from female patients. This was revealed only once spontaneous responses to the case study without this element of the case had been elicited.

Case study 8. Dishonesty in relation to relationships with colleagues or patients

Context:

- Good medical practise guidelines are clear that doctors should not pursue a romantic or sexual relationship with patients.
- It would also be regarded as unethical for a doctor to end a professional relationship with a patient in order to pursue a romantic or sexual personal relationship with that patient.

The fitness to practise case:

- Following the death of her husband, Patient A was referred to a consultant psychiatrist, Consultant B by her doctor, Doctor C.
- Following several sessions of therapy, Consultant B brought their professional relationship to an end and discharged her as his patient. Writing to Doctor C, Consultant B gave it as his opinion that Patient A's outlook was much improved and she did not require further counselling sessions.
- Some weeks afterwards Consultant B invited Patient A to dinner by telephone which she accepted.
- At dinner Consultant B suggested to Patient A that they pursue a romantic relationship.
- Patient A declined and mentioned the incident to Doctor C in conversation.
- Doctor C discussed this conversation with a senior colleague who referred the matter to the General Medical Council.
- Consultant B accepted that the dinner had taken place with his ex-patient but denied that he had suggested a romantic or sexual relationship and suggested that the dinner had rather been to discuss charity business in which the two had a mutual interest.

The fitness to practise charge:

- That Consultant B's fitness to practise was impaired by his deliberate targeting of a vulnerable individual for inappropriate personal relationships.

Contextual evidence arising during the during the fitness to practise hearing:

- During the course of the hearing it transpired that over the previous 10 years 3 of Consultant B's patients had reported to their doctors that Consultant B had sought to pursue a romantic relationship with them after the ending of their clinical relationship.
- Consultant B appeared to have little insight into the inappropriateness of his relationships with his ex-patients.

3.11.1 The public response

The response to this case study revealed some striking gender and generational differences in the way that the various research participants responded to the initial presentation of the case (i.e. before it was revealed that there had been a pattern of prior complaints from female patients).

Men, and older men in particular, were more inclined not to see anything unethical or inappropriate in Consultant B's approach to his ex-patient. Even where they accepted that approaching an ex-patient and inviting her to become involved in a romantic relationship may not have been entirely appropriate, they saw the incident in terms of a minor misdemeanour or lapse of judgement or as "political correctness gone mad." Older men were also more inclined to give Consultant B the benefit of the doubt in terms of both his intent and his understanding of appropriate boundaries around patient relationships. They were also more likely to see mitigating factors in Consultant B's interaction with his patient. They tended to point to the fact that Patient A had not complained and did not appear to have seen the incident as inappropriate. They also pointed out that, according to Patient A's account, Consultant C had not pressed her when she declined his invitation. For these respondents the differing accounts of the incident given by Patient A to Doctor B and by Consultant C were simply a matter of one person's word against another.

"It's not in the least bit serious. It's all got blown out of all proportion. I mean the guy has a got a life to live." (Older male)

"He's moved on, I think, you know, and there's been a certain amount of time. Maybe he shouldn't have done it two months after. He's been a bit silly there, a bit ill-judged maybe." (Older male)

"This is a case of political correctness. She's not complaining, is she? I mean, we don't know, she maybe enjoyed the attention. She's not worried anyway is what I'm saying." (Older male)

These attitudes contrasted strongly with those of the women and some of the younger men, who were much more likely to see the case as a violation of appropriate boundaries and ethics and an abuse of power in relation to a vulnerable patient. Women were also much more suspicious of Consultant C's motives on a series of dimension. They were more likely to suspect a pattern of inappropriate sexual behaviour with patients. Some were also concerned about a possible financial motivation in courting bereaved women. Women showed very little tolerance of the notion put forward by the older men that Consultant C's behaviour was simply ill advised or an instance of poor judgement. Here their view was that a psychiatrist of all people should be hyper-aware of boundaries and patient vulnerability. For these women Consultant C's behaviour was a serious breach of ethics in patient relationships, with this perspective overwhelming concern about any potential dishonesty in his reporting of his motivation in approaching and having dinner with Patient A.

"For someone working in psychiatry, psychology, they should know why it's wrong."

"That's what he does. That's his field. There is no excuse." (Older female)

"It was planned. I think it's wrong. I would be really quite worried about him. It's the principle." (Younger female)

"She's vulnerable 100%. And it's abuse of a position of trust. I think that is completely wrong and I'd take it seriously, very seriously." (Younger female)

"There you go. Professional boundaries. Don't even go there. Even if you haven't seen her for a year." (Younger female)

A number of the older men thought that the Fitness to Practise case should not have been brought in the first place. Alternatively, appropriate remedies were seen as informal warnings and possibly reminders about appropriate boundaries and how his actions might be interpreted.

“A warning and a reminder that this behaviour is not acceptable. He didn’t actually do anything.” (Older male)

Women’s views were mixed. Some, and especially younger women, thought in terms of a severe reprimand and an extended suspension, re-training and managed re-entry to the profession.

“I think he needs to be off for a while. I think it needs to be treated seriously. I’m not saying that he should be off forever. I think that would be very harsh. But it’s such a basic principle, in my perception.” (Younger female)

A significant sub-set, however, felt that it would be appropriate to strike Consultant C from the register, even if this was an isolated case.

“I’d sack him. He’s abusing his trust, yes. That’s a vulnerable person.” (Older female)

When it was revealed that there had been a pattern of prior complaints, the attitudes of both men and women shifted decisively. Once told that there had been a number of complaints about Consultant C making sexual advances to ex-patients, both men and women across the age ranges took the view that this behaviour represented predatory and systematic abuse of power and abuse of vulnerable patients. The view was that Consultant B should be subject to a period of extended suspension, or more commonly, that he should be permanently deleted from the register.

“Wow. Oh well now that’s completely different. That’s an abuse of his position. They struck him off completely did they? Quite right too if they did.” (Younger male)

“Oh, that’s different now. He needs to be seriously suspended. He’s done wrong. If there are other cases.” (Older male)

“He’s a sexual predator, isn’t he? He needs to be struck off.” (Older female)

3.11.2 The professional response

The professionals were more aware than the public of the boundaries within professional and patient relationships and had greater clarity on ethical issues. Nonetheless there were parallels to the gender and generational differences in views of the seriousness and nature of the offence.

There were clear differences also between different types of professionals. Those working with vulnerable individuals or with greater experience of mental health issues were more likely to be conscious of boundary issues and took the case more seriously, even when initially presented as a one-off incident.

Male professionals, particularly older men and those in professions such as surveyors, accountants, chiropractors, pharmacists and opticians were more likely to view the case as less serious and to give Consultant A the benefit of the doubt.

“If she wasn’t disturbed about it, then that’s not an issue, is it?” (Male Optician)

“I don’t really see what the harm that has been done here. As I understand it, he didn’t harass her and she didn’t complain. It happens every day. I don’t think this case is that different. She wasn’t still his patient. That would have been different.” (Male Pharmacist)

Women, and those working in the medical professions, family lawyers, social workers or counselors, were more wary and judgemental and more likely to regard Consultant C’s behaviour as a risk to patient safety.

“I’m not necessary saying there was any intention there. But he should have known better in his profession... so I think it is quite serious.” (Male Counsellor)

"I think they definitely need to investigate into it. Because being a psychiatrist you are getting privileged information about the client's state of mind and that's why you're not meant to be asking them out for a certain length of time." (Male Social Worker)

"He should have safeguarded himself. You know, even if the intent was honourable, you have to be that one step ahead and she is vulnerable and he knew that because he treated her. I would be very concerned." (Female Nurse)

These views were reflected in attitudes to appropriate remedies. Men and those from non-medical backgrounds or where practitioners were not dealing with vulnerable individuals tended to see appropriate sanctions in terms of warnings and cautions.

"I think it's very stupid. But it's a slap on the wrist and don't do this again kind of thing." (Male Pharmacist)

"I think if it had just been the one person you could maybe, not overlook it... but I was thinking well it's obviously against the rules and ethics but, you know, maybe he's done it as a lack of judgement then certainly review it with some form of punishment or warning but I'm not sure what that would be." (Male Architect)

Women and those with a medical background were much more likely to view the incident as a serious transgression, with extended suspension or disqualification the appropriate sanction.

"I'm really concerned here about the future patients in his hands... it sounds like a private matter but I don't think it is. It's a matter of professional boundaries and he of all people should know that. I wouldn't give him the benefit of the doubt." (Female Midwife)

"You know, it must be against the code of practice and the boundaries. The lady was probably vulnerable as well and it could have done a lot of harm. So it was unethical practice. Yes, very much... as a psychiatrist he was in a position of power and he was abusing that." (Female Counsellor)

As with the public, the revelation that there had been prior complaints from female ex-patients transformed views, with professionals across the board united in the view that Consultant C could not remain in the profession, and that he represented a significant risk both to patient safety and patient confidence.

"Oh No! He's got to be struck off."

"It's a different story altogether if you're talking about a history of them. I would strike him off."

"He's a predatory individual, first. Second he lied about the case. He was far from naïve, was he? He's got to be out permanently."

"He's abusing his position and there's a history there so if you let him continue it could continue and then there is a risk to vulnerable patients. It's their (regulators) responsibility to protect patients from that risk."

When shown the outcome of the Fitness to Practise hearing, which resulted in the disqualification of Consultant C, this was very much seen as the only appropriate regulatory response.

Case study 8. Outcomes of Fitness to Practise panel

Fitness to practise outcome:

- The GMC rejected the defence argument and concluded that Consultant B's behaviour was predatory and further aggravated by two important factors:
 - That the women targeted were vulnerable individuals
 - That Consultant B had not been honest in his account of the dinner with Patient A
- The GMC ruled that Consultant B should be removed from the register, thus preventing him from professional practice in the future.

The response to the Fitness to Practise disposal in this was universal approval and relief, among both public and professionals, with all taking the view that striking off what was seen as a predatory individual was the only appropriate course of action.

"Quite right too. What else could they have done? Oh, it's horrible ... He was grooming, grooming. He could not be allowed to remain in the profession."

"I think that is the crux of the matter because if a patient doesn't complain, either they haven't got a voice, they don't have insight or there isn't anybody on their behalf to raise that concern ... And that is what they are there to do. To protect the public from people like him"

"Brilliant. That's what he deserved. And it's just a pity he didn't get caught the first time."

3.11.3 Theft from patients or colleagues

Case study 9. Theft from patients or colleagues

The fitness to practise case:

- Nurse C was convicted at Newcastle magistrates' court of theft, and sentenced to 4 months' imprisonment, suspended for 12 months.
- The theft conviction related to the registrant making three unauthorised withdrawals from an ATM on 3 separate occasions, of £200 each, using bank cards belonging to a 71-year old resident of the Care Home (Patient D) where Nurse C worked at the time.
- The first two withdrawals were made on the same card, which subsequently was reported lost by the daughter of Patient D (it is not known whether this is because Nurse C took it). The third withdrawal was made on the new card that the bank sent to replace the lost one.
- The total loss to the patient's account was £604.
- Nurse C had significant financial problems of her own at the time and was herself in ill health.
- On discovery of the unauthorised withdrawals, Nurse C wrote to Patient D to apologise and returned the funds in full.

The fitness to practise charge:

- That by virtue of her conviction for theft from a vulnerable patient in her care, Nurse C's fitness to practise was impaired.

3.11.4 The public and professional response

This was also a case in which public and professionals were entirely in agreement and response was unequivocal, with little or no nuance.

Even small-scale theft from vulnerable individuals in a care home environment was regarded as totally beyond the pale by both public and professionals.

The referral of the nurse for criminal prosecution and her subsequent conviction were seen as right and proper but not sufficient and no substitute for disciplinary sanction by the profession.

There was little or no sympathy for any contextual difficulties the nurse might have been experiencing nor any acceptance of potential mitigating factors. The nurse's remorse and return of the stolen funds was seen simply as an irrelevant attempt to avert the consequences of her actions once she had been found out.

"She's got health problems? Don't make me laugh. That's disgusting. What about the health problems of the patients she stole from? What about the emotional impact? She wouldn't want anyone stealing from her in her own home... if you let her stay (in profession) you say to every other carer, if you have financial problems, you can just steal from the person you are looking after."

Indeed the case was seen rather to feature aggravating factors in that the offence was seen as pre-meditated and executed to obtain the maximum funds possible.

“She didn’t do it the one time. She done it three times. She kept going back and taking money... And she took the limit... That’s planned. I’m not being funny but I’d send her to prison to think long and hard about what she done and she should never be let near old people again.”

The public saw theft from vulnerable patients unequivocally as clear grounds for permanent expulsion from the profession.

“Especially working in a care home. What else has she been stealing? Jail definitely, and not suspended either. Completely struck off. She’s not fit to take care of any person.”

“She should be struck off. All trust is gone. She shouldn’t ever be in a position where she could do that again to someone else. She has only been caught once. But how do you know how often she has done this. She could be looking after someone with Alzheimer’s who wouldn’t even know.”

“This is about protection of vulnerable adults, isn’t it? You do it once and you’ll do it again. Sack her and don’t give her her licence back neither.”

Both public and professionals saw the case as a clear public confidence issue, with the view being strongly held that allowing the nurse back into the profession would damage public confidence in the nursing profession. Any lesser sanction could not address the patient trust issue and respondents saw no potential for redemption or rehabilitation in this case.

“It’s the abuse of trust and she’s been in a position, you know, where there may be old people who don’t have family and they put a lot of faith in that person and in her status as a nurse. She may be the only person they have that they can turn to and that’s what she does to them in return. I think there’s a huge public confidence issue here.”

Professionals also felt strongly that the case illustrated abuse of trust of the worst kind and that the fact that the nurse had preyed on a patient rendered her totally and evidently unfit to practise.

“If it hadn’t been a patient, I might have understood it and she still gets a criminal conviction and then she can get another job if they can overlook that conviction. Fair enough. But I think that the fact that it’s a patient is the unfit to practise indicator to me.”

As with the consumer groups, the view of the professionals was that disqualification was the only option and that Nurse C’s financial problems at the time of the offence were irrelevant to fitness to practise considerations in such a serious case.

“There’s no question. She should be struck off completely. What have her financial problems got to do with it? There is no question about that.”

“She’s abusing her position and preying on the vulnerable so she’s unfit to be a nurse. Period. Strike her off and do it quickly.”

The outcomes of the Fitness to Practise panel and the Authority appeal were then presented to the groups as follows:

Case study 9. Outcomes of Fitness to Practise panel and Authority appeal

Fitness to practise outcome:

- The Nursing and Midwifery Council panel took into account in its decision a number of mitigating circumstances including the Nurse's own financial problems and ill-health, and the fact that she had written to the patient to apologise and returned the funds. However, there were inconsistencies in the accounts Nurse C gave about her motivation for the offence.
- The NMC imposed a five-year caution (mark against Nurse C's name) on the public register.
- Nurse C was able to continue to practise professionally.

Outcome of PSA appeal on fitness to practise verdict:

- The Authority appealed the case and a new NMC panel struck off Nurse C from the register.
- Nurse C was prevented from practising professionally as a Nurse in future.

Both public and professionals were bewildered and indignant when faced with the Fitness to Practise panel's disposal and highly supportive of the Authority in seeking an appeal and the subsequent disqualification of Nurse C.

4.0 Overview of aggravating factors and appropriate disposals

This chapter seeks to pull together a synthesis of the public and professional views on the relative seriousness of different types of dishonesty and to conceptualise the aggravating and mitigating factors that drive perceptions of relative seriousness.

The various groups conducted a series of ranking exercises to arrive at an overview of aggravating and mitigating factors in dishonesty. The groups were split into two sub-groups with each sub-group given a summary list of the nine case studies we had discussed and asked to rank them, in ascending order of seriousness and to ascribe a score from 1 – 10 for seriousness to each case, with 1 being low and 10 being high. Each sub-group then presented their rankings and scores to the other and explained the rationale for their selection and scoring. “Tied” places were allowed for the case studies if different case studies were thought to be equally serious.

Following this discussion, the two sub-groups were asked to arrive at a “pyramid” of first factors that would aggravate the seriousness of dishonesty and then mitigating factors that would reduce the seriousness of the offence. The most serious aggravating factors were to be placed at the apex of the pyramid, with the less aggravating factors at the base, with others placed at different points on the pyramid, to accord with the perceived relative seriousness of each factor. This exercise was then repeated with the mitigating factors. The respondents were first asked to arrive at factors spontaneously, with reference to the case studies that had been discussed, and after five minutes of discussion, were provided with a list of potential aggravating factors which they could select or reject. Each sub-group then presented their pyramid to the other and explained the thinking behind its construction.

The research team subsequently systematically analysed the results from the various groups through a thematic grid, noting any variations by gender, socio-economic group and professional background. There was however remarkably little variation and a high degree of consensus on both aggravating and mitigating factors.

The responses are synthesised in Figures 1 and 2 which provide ‘stairways’ of aggravating and mitigating factors in ascending and descending order of seriousness respectively.

The stairway of aggravating factors takes as its starting point that there is either a direct impact of the offence on either public confidence, or more seriously, public safety. A lack of insight or remorse into why the offence creates public safety or confidence risks then exacerbates the seriousness of the offence. In ascending order of significance, the next set of aggravating factors clusters around the complexity of the dishonesty, how far it is pre-mediated behaviour and, more seriously still, how far it is part of a pattern of long-standing or systematic dishonest behaviour. The importance of patient trust is reflected in betrayal of that trust being a central aggravating feature, lying directly below sexual exploitation and the potential for personal financial gain in the progression of aggravating factors. Finally a focus on vulnerable victims, misuse of power and predatory behaviour tops the perceptions of the seriousness of aggravating factors.

Figure 2. Aggravating factors in professional dishonesty
A stairway of significance within professional dishonesty

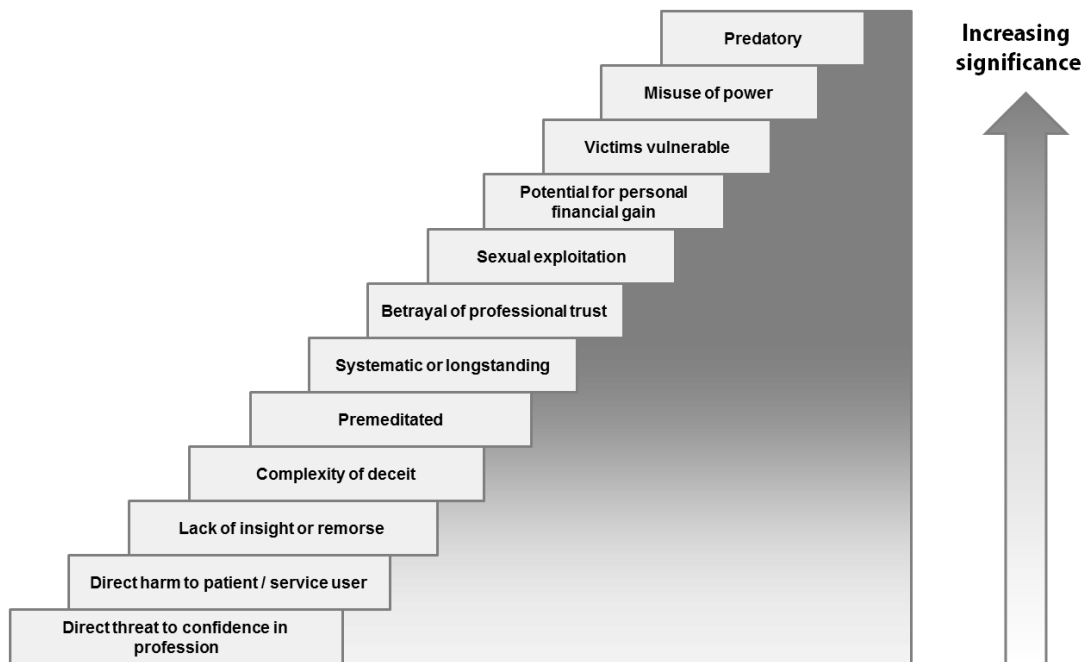
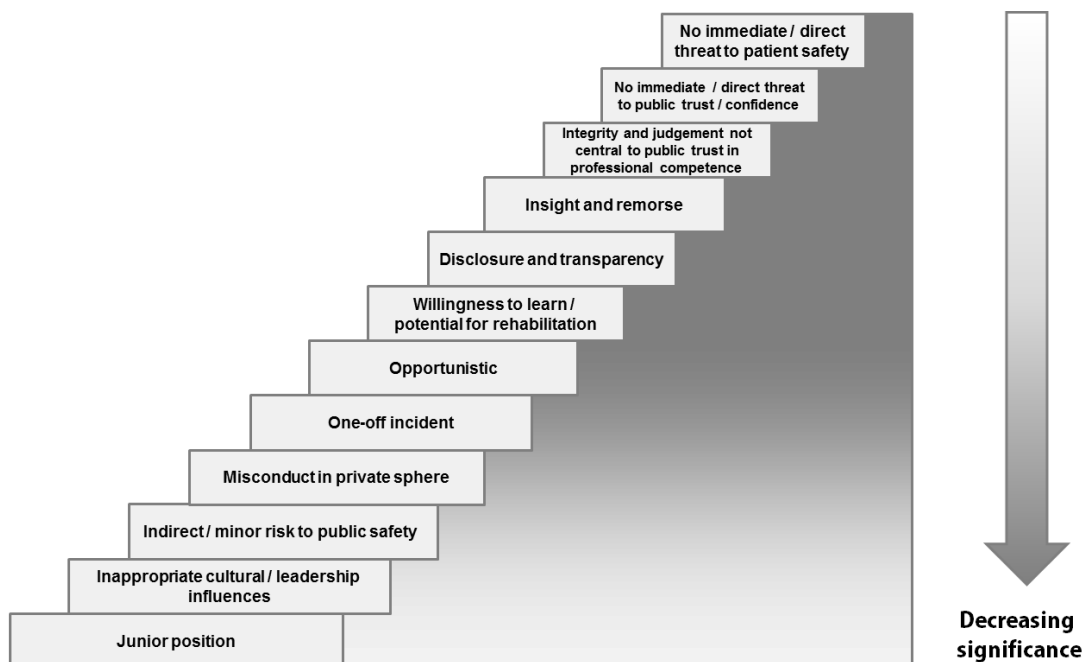


Figure 3. Mitigating factors in professional dishonesty
A stairway of decreasing significance within professional dishonesty



In many ways the mitigating factors mirror in reverse the aggravating factors. The stairway of mitigating factors takes as its starting point that there is no immediate direct threat to public safety or public confidence. Dishonesty in a context where integrity is not critical to the execution of the professional role is also seen as less

serious than where integrity and judgement are central, as would be the case for social workers or psychiatrists, for example. The presence of insight and remorse, willingness to make full disclosure of the offence, a willingness to learn, and there being some potential for rehabilitation then form a further cluster of mitigating factors. Incidences of dishonesty which are opportunistic or one-off are seen as less serious than those which are systematic or premeditated. Misconduct in the private sphere is seen as less immediately impactful and serious, depending always on the nature of the dishonesty, than dishonesty in a professional context. Finally where staff are junior or where dishonesty is a function of a cultural context, it is judged to be less serious than where dishonest behaviour is by senior staff or where there are no cultural drivers present.

5.0 Conclusions and implications

5.1 Conclusions

It needs to be borne in mind that the research findings rest on a relatively small qualitative project and that the qualitative nature of the work means that it cannot be assumed that the views expressed by the respondents are representative of the broader universe of the public or professionals. With that caveat, we have drawn the following conclusions.

It would appear that both the public and professionals have a clear mental framework and a shared moral compass through which they view and conceptualise dishonesty by health and care professionals. Although there are differences between the professional views and those of the public, there are clear common elements, with the public and professionals having a shared view on the aggravating and mitigating factors in dishonesty cases. There appeared to be very little difference between regulated and non-regulated professionals or between health and care professionals and those drawn from other sectors such as the law or accountancy.

Similarly although there are clear gender and generational differences, particularly around cases involving professional boundaries and containing a sexual element, there was remarkably little variation by socio-economic group or educational attainment in terms of core values and the conceptualisation of dishonesty and its impacts. Women of all ages saw demarcation lines and boundaries more clearly and were more suspicious of motivation and less tolerant of either sexism or sexual intent, while older men were less aware of boundaries and more tolerant of sexual intent. However where cases involved predatory behaviour or serial sexual misconduct, both sexes took a zero-tolerance view. This is best exemplified in response to case study 8 involving the psychiatrist and dishonesty in relation to relationships with patients, which clearly shows both the gender and generational differences alongside the absolute consensus on the appropriate response to predatory behaviour by professionals.

There was a small minority who saw issues in black and white and judged any instances of dishonesty as being grounds for expulsion from the profession. The great majority of both professional and public respondents, however, took a much more nuanced view of the issues with judgements more finely balanced between aggravating and mitigating factors. The majority also, with the exception of the most egregious cases, took a pragmatic and tolerant approach to optimising outcomes of dishonesty hearings and balancing the public interest and the rights of the registrant.

There is consensus that premeditated, systematic or long-standing dishonesty or abuse of professional trust are manifestly aggravating factors and that dishonesty in the context of sexual exploitation or personal financial gain, particularly involving vulnerable people or predatory behaviour, stand at the apex of professional wrongdoing and cannot be tolerated within the health and care professions.

Equally, however, although there will always be a minority who would wish to see registrants expelled from the professions for any instance of dishonesty, both public and professionals, outside the context of the most egregious cases, appear relatively tolerant and constructive where offenders display insight and remorse and appear capable of changing their behaviour. Given the emphasis on rehabilitation and re-education, insight and remorse were seen as a key first step in behaviour change and rehabilitation of fitness to practise. Conversely, a lack of insight or remorse was seen as arrogance and an indication of risk and lack of fitness to practise. Both public and professionals appear to have a significant degree of sympathy for offenders

interpreted as disadvantaged or under pressure (as in case study 6 where the registrant had been dishonest about previous convictions but had gone on to develop a career in a caring profession), particularly where there is seen to be no direct victim (as in case 6), although this tolerance did not extend to cases involving vulnerable individuals. Conversely, where there was an immediate victim, dishonest behaviour was seen as greatly aggravated, particularly where that victim was vulnerable, (as in case 9, theft by a nurse from a resident in a care home) or case 8 where the patient exploited by the psychiatrist was a bereaved woman).

It is a striking feature of the research findings that both public and professionals appear much more focused than the regulators on disposals that rehabilitate where possible, which change the behaviour of an individual and enable registrants to re-enter or continue in the profession on a managed and supervised basis (examples might include case study 1 where a nurse was dishonest in the treatment of patient records but in the perceived context of a wider cultural failing or case study 3 where an otherwise competent chiropractor was dishonest in relation to his registration status). Where Fitness to Practise disposals and the outcomes of Authority appeals were criticised in the case studies, it was frequently because they were seen as insufficiently constructive in changing behaviour or supporting learning (again as in both case study 1 and case study 3). In such cases, a perception that the disposal was too harsh, was less important to respondents than the fact that the disposal had not educated or empowered the individual.

Similarly it would appear that both public and professionals are alive to the cultural context in which dishonesty takes place and are intolerant of 'scapegoating', particularly of junior staff. Where dishonesty or misconduct appeared at least in part a function of cultural factors or a leadership failure, respondents took the view that Fitness to Practise cases involving individuals were not necessarily appropriate or fair and would not address the underlying problems. For such cases, the view was that the focus should be not on sanctions against an individual but rather on supporting and empowering individuals to escalate concerns and on addressing what was seen as the wider systemic failure. Participants were aware that the remit of professional regulation does not extend to systems or organisations and were aware also that individuals were accountable to regulators for their professionalism, and the duties it brings with it. They acknowledged the importance of professionals speaking up about systemic problems and professionals understood that this was indeed the duty of professionals. This awareness was rather subsumed in a broader concern that targeting individuals was unfair and unjust allied to a strong pragmatic sense that individual registrants could lack the skills and confidence to escalate concerns. The failings at Mid Staffordshire were very much front of mind and the Francis Report was mentioned by a number of health professionals, particularly in the context of case study 1, where the nurse had failed to address abusive practice and sought to falsify the record, albeit in a context of a wider cultural and leadership failure.

Both public and professionals appear also to be more sceptical than the regulators of potential risks to public confidence in the professions, unless the impact is unambiguous and direct. The public in particular, and professionals to a lesser extent, felt that cases brought on public confidence grounds should represent a clear and direct risk to confidence or safety, albeit that it was clear also that risks to public safety were not always fully understood by the public.

That said, where dishonesty involved a clear betrayal of patient trust or where there was a failure of integrity which would fundamentally compromise public trust in an individual as a health or care professional, both public and professionals took a zero tolerance view. They were uncompromising in their view that in these cases the individual concerned should be permanently – and rapidly – excluded from the profession. Examples would include case study 4, where a social worker was

dishonest about working in another job when acting as a registered childminder and case study 7, where a dentist lied about his interactions with a patient and sought to involve his nurse in the cover up.

Whether this view was adopted appeared to reflect how far integrity was regarded as critical to the professional role of the individual concerned and how relevant the specific instance of dishonesty or misconduct was to the core function of the profession. Integrity and judgement were regarded as critical for social workers and psychiatrists for example, but less so for professions seen as less likely to be serving vulnerable individuals or dealing with deeply personal or intimate matters, such as osteopaths or dentists (the latter likened to “mechanics”, in several instances). For example, in case study 4, where the social worker had lied about holding a second job while acting as a registered child-minder, her lack of integrity and willingness to put children at risk was seen to disqualify her as working as a social worker, for whom integrity is critical to the effective discharge of their duties. By contrast, in case study 5, where a dentist had defrauded HMRC, his dishonesty in relation to his taxes was seen irrelevant to his ability to practise effectively as a dentist. The fact that the public pay for and tend to have a choice of dentist was not seen as relevant, in this case, with respondents actively prepared to choose treatment from this dentist because of his specialist skills. Both professionals and public distinguished between dishonest handling of his tax affairs on his buy to let properties and the potential for dishonest handling of client monies or revenues from his dental practice. Had either of the latter been the case, individuals were clear that they would have taken a different view of his fitness to practise.

For these cases where a fundamental betrayal of trust has occurred, both public and professionals appear less tolerant than the regulators in their view of appropriate disposals. Those case studies where both public and professionals were most approving of the Authority action in bringing an appeal tended to fall into this category of betrayal of trust or a critical failure of integrity, typically being cases where a lenient disposal was overturned on appeal, resulting in disqualification. Conversely cases falling into this category resulting in a comparatively lenient disposal even on appeal, was where public and professional were most critical of the regulators.

There were however some significant differences between the public and professionals. Professionals differ from the public primarily in three respects. Professionals have greater clarity on professional boundaries and professional ethics, reflecting their training and the way that these are enshrined in professional codes of conduct. They are also more conscious of – and have a better understanding of – risks to public safety. They are thus highly intolerant of non-compliance with elements of the professional code designed specifically to ensure public safety, such as the requirement to be registered and have appropriate insurance. Finally, perhaps unsurprisingly, they are more concerned than the public with defending the reputation of the professions.

There are clearly some cases – those involving betrayal of patient trust or a serious compromise of integrity – where ultimate outcomes of Authority appeals (whether by agreement, by order of a judge or after a further hearing by the regulator) have still produced disposals which the public and professionals regard as too lenient. Both public and professions would want to see a greater focus on managed re-entry to the professions where rehabilitation is possible and more attention paid to the cultural context for dishonest behaviour. There are also some instances where the public and professions would view the link to public confidence as too tenuous to justify a Fitness to Practise hearing. Overall, however, it is clear that where the Authority have acted to appeal Fitness to Practise disposals as inappropriately lenient, their actions are largely in line with the perspectives of both public and professionals on appropriate

responses to dishonesty in the health and care professions and were largely supported by both audiences.

That said, both the professional and public respondents were bemused and dismayed by what they felt to be inconsistencies in both the treatment of Fitness to Practise cases and the resulting disposals and in the ultimate outcomes of appeals. However, both public and professional respondents felt strongly that, based on the scenarios presented to them and the cases and disposals they had been shown, that there was something of a systemic failure in the treatment of dishonesty cases. This rested on a perceived lack of a clear set of organising principles to underpin a coherent hierarchy of seriousness for dishonesty cases and a corresponding gradation of appropriate remedies.

5.2 The implications for regulation and guidance

The Professional Standards Authority has a duty to promote the interests of users of health and social care in matters relating to professional regulation. It appeals decisions about the fitness to practise of professionals based on whether the decision is sufficient to protect the public, maintain public confidence in the profession, and uphold proper professional standards.

Clearly in selecting cases to appeal the Authority is bound both by the legislation and the extensive case law, and whether the case meets the legal tests. There are also considerations around how far the appeal is likely to succeed. Fitness to practise panels and court judges are similarly bound by legislation, legal tests and case law. The research may nevertheless have implications for the stages of these decision-making processes in which the wider public interest and the need to maintain public confidence are considered.

It would appear that some cases involving what the public or professionals would see as a fundamental betrayal of patient trust or a serious compromise of a practitioner's integrity are resulting in what was viewed by both public and professionals as inappropriately lenient outcomes, where both groups saw the rightful disposal as being rapid and permanent exclusion from the profession.

At the same time, however, the public and professionals also feel that some cases are being brought where the link to public confidence is, conversely, too tenuous to justify proceedings on confidence grounds. These twin perspectives – of inadequate sanctions in the most egregious cases and insufficiently well-grounded pursuit of some cases on confidence grounds – would seem to imply a potential use for a set of principles underpinning risks to public confidence. There would appear to be a case for developing a more nuanced spectrum of threat and a clear hierarchy of more or less serious risk.

Further work may be needed to fully explore the issues and how most effectively to frame the spectrum of risks to public confidence and feed it most appropriately into guidance on selection of cases and appropriate disposals. Such work could also usefully further explore the appropriate degree of separation and / or read-across between the public and private spheres, and the basis on which more or less egregious behaviour or different types of dishonesty or misconduct in the private sphere would impact on public confidence.

The other major implication of the findings for further development of thinking on regulatory focus and appropriate disposals stems from the findings that both the public and the professionals who took part wished to see a greater focus on facilitating insight, rehabilitation and managed re-entry to the professions. The question of whether a registrant has demonstrated insight into their dishonesty, and the linked

question about whether they can be rehabilitated, are central to decisions about whether the registrant is fit to practise, and what sanction would be appropriate. Further research into these topics would help to gain a deeper understanding of how decisions hinging on these two questions can maintain public confidence. The focus on rehabilitation is in tune with the current trend for regulators to seek powers to dispose of cases through undertakings from the registrant, rather than sending them to a hearing.

Finally, it is clear that the public and professionals do not wish to see individuals targeted or scapegoated in cases where there appears to be a broader cultural or systemic problem. They rather take the view that where dishonesty or abuse arises in the context of a culture of tolerance or tacit encouragement, it is the proper job of regulators to address the wider failure of standards and the drivers of it. This suggests a mismatch between the expectations of what professional regulation can do to address the cultural factors that can drive a failure to uphold high standards of competence or integrity, and the reality of what they can address through the limited powers of fitness to practise. In a post-Francis era, professional and system regulators may wish to consider how to work together most effectively to capture indicators of cultural or leadership failures and to address both systemic and individual failings. This finding could also suggest that there is an appetite for a more preventative approach to regulation generally, with the focus on equipping and supporting professionals to abide by the regulator's standards.

Finally, given the marked differences in attitudes to the different professions that emerged in this small-scale study, the regulatory bodies may wish to consider carrying out similar research to gauge attitudes to dishonest behaviour by the professions they regulate. Further research could also be carried out into attitudes to other types of misconduct, such as sexual boundary violations or the failure to have appropriate indemnity insurance.