# Sexual behaviours between health and care practitioners: where does the boundary lie?

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The views expressed in this report reflect
the research findings and the authors' interpretation;
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# Executive summary

Qualitative research was undertaken with 22 health and care practitioners and 36 members of the public to explore views on sexual behaviour between colleagues working in health and care, and the potential effect on patient safety or quality of care.

The approaches taken by practitioner and public participants to assessing examples of sexual behaviour between colleagues were entirely consistent, although there were differences in emphasis and focus reflecting different perspectives on the topics being discussed. In line with this, a single summary covering both practitioner and public views is presented below.

While our findings have clear relevance to the specific questions we were asked to investigate, we believe they may also have wider relevance, in so far as they provide:

- A case study of public and practitioner understanding of the purpose of the fitness to practise process and of sanctions applied through that process, in relation to a particular issue (sexual behaviour between colleagues).
- A case study of views on the boundaries between acceptable and unacceptable sexual behaviour between colleagues, and the role of workplace culture, in relation to a particular set of workplaces (health and care settings).

## Boundaries with colleagues

While there was considerable variation in *what* participants thought about specific behaviours and scenarios presented in interviews, there were clear patterns in *how* they thought about them. For example, two distinct approaches – which we refer to as 'protocols' – were used in deciding whether or not a specific behaviour with/towards a colleague crossed a boundary:

- The standards protocol: a boundary is crossed if the behaviour contravenes a standard (which is *independent* of the relationship between these two people).
- The relationship protocol: a boundary is crossed if one of the people is unhappy (meaning that the behaviour breaks the norms *within* the relationship).

Two further factors influenced which protocol a participant used in any specific assessment:

- *Seriousness*. Certain kinds of behaviour (such as physical and intrusive behaviour) were consistently seen as more serious. Participants were more likely to see the relationship protocol as *inapplicable* to more serious behaviours.
- *Setting*. Some settings – such as being in front of patients – require strict application of the standards protocol: others – more *social* settings – allow application of the relationship protocol instead.

The clearest examples of social settings are those *outside* the workplace. Within the workplace, however, quasi-social settings may exist in which the relationship protocol may be applied. The more intensive, stressful and emotionally demanding a working context, the more valuable these quasi-social settings may be.

However, quasi-social settings are bounded by:

- The need for parity between the people involved. For example, application of the relationship protocol may be less appropriate where individuals are at different levels of seniority.
- The need for privacy – and in particular the absence of patients. The standards protocol is applied in any setting in which there is a risk of being seen by the public.

Within quasi-social settings groups may develop *shared* norms regarding the kinds of things that are (and aren't) talked about, and the kinds of jokes that are (and aren't) made. Team cultures can develop in which certain kinds of sexual behaviour (e.g. sexual jokes) form part of the everyday interaction of team members; and consensual interaction of this kind within a team – banter – may be seen positive. However, such shared norms are *not* seen as legitimising behaviour with/towards an individual colleague that makes that colleague unhappy. Indeed, where such behaviour arises it may call into question the legitimacy of the culture as a whole. There can be a fine line between banter and bullying, which is crossed when consent is not given. Managers and seniors in particular are expected to exercise caution in their workplace relationships, as a power imbalance makes it harder for the junior party to express their unhappiness with unwanted behaviour. Managers are also expected to exemplify standards.

When a boundary is crossed with a colleague, then factors such as past relationship, culture, naivety and emotion may lead to a diagnosis of the behaviour as a one-time error. In these instances, there is a good chance of resolving the matter informally within the team. Two factors, however, make the diagnosis of an error less plausible.

- If the behaviour in question is so serious that it is beyond the scope of the relationship protocol, and therefore hard to understand how it could have been an 'honest mistake'.
- If the behaviour in question persists – and in particular if it persists *after* being called out in some way.

These factors are seen as evidence not of an *error* but of an underlying *flaw* in the individual in question. Two main classes of flaw were identified by participants.

- Flaws of understanding (failing to assess what is appropriate in certain situations, or failing to pick up on the reactions of other people).
- Flaws of motivation (motivations that are inconsistent with the purpose of a health and care practitioner).

The diagnosis of a flaw suggests a need to move beyond informal approaches to resolution, which may be appropriate to errors, and take a more formal approach.

## Fitness to practise

Participants developed two types of argument for the relevance to fitness to practise of inappropriate behaviour with colleagues.

The first type of argument focuses on the **impact** of the behaviour in question, and the negative consequences for public confidence or patient care.

If witnessed or heard about by a patient subsequently, behaviour may have a direct impact on public confidence. Behaviour that is known about may *not* in fact stop an

individual patient from being willing to see that practitioner, but only because factors other than confidence may come into play in the decision.

Behaviour may also have an impact on quality of care, for example if those participating in the behaviour are not concentrating, or if there is a negative impact on the performance of the team and individuals in it. A key concern was the impact of *unwanted* behaviour on the person on the receiving end of that behaviour.

The second type of argument focuses on the person who has behaved in this way – and on what the behaviour tells us about them, and the **risks** they pose in a practitioner role. Such arguments appeal to a causal element, of which the actual behaviour is evidence and the possible behaviour a possible consequence. Risk-based arguments, that is, depend on the diagnosis of a flaw. Again, these may be flaws of motivation or flaws of understanding.

Flaws of motivation include: the presence of desires or intentions which are incompatible with the purpose of a practitioner; the absence of desire and intentions which are critical to that purpose – such as caring; a *failure to control* desires and impulses; or being *too controlling,* and abusing power in interactions with others.

Flaws of understanding include:

- A lack of empathy. Failing to pick up on the reactions of other people. The fact that behaviour is unwanted, and the inability to pick up on this in advance, may raise particular concerns about a practitioner's ability to understand and establish consent.
- A failure to assess what is appropriate in a situation. Some public respondents described this flaw in terms of a lack of 'respect'.

Flaws of understanding – a lack of empathy or respect – were seen by participants as incompatible with successful practitioner-patient interaction.

Both flaws of motivation and flaws of understanding were seen as raising fundamental questions about fitness to practise. The fact that the evidence for these flaws was derived from behaviour with colleagues, rather than behaviour with patients, was not seen as removing the risk in interactions with patients.

## Regulatory response

Two key considerations shaped participants' views on appropriate sanctions: rehabilitation and messages.

The emphasis placed on rehabilitation was in part driven by a recognition of the investment made in practitioners, and of what is lost if a person is erased too readily. There was also a view that giving people another chance is the *right* thing to do – at least when the chance remains that the behaviour in question is a mistake. In line with this, factors which support the diagnosis of a one-time error were all seen as increasing the chances of rehabilitation, and weighed against erasure as a sanction.

On the other hand, factors which call that diagnosis into question – seriousness and persistence – were seen as indicating the need for a more severe response. For an attempt to be made to rehabilitate a practitioner, there must be reason to believe that a flaw is not too deep-seated for rehabilitation to be possible.

With regard to the message sent by a sanction, three key audiences were identified:

- The individual practitioner – at this level, messages are linked to rehabilitation.
- The profession as a whole – who may draw inferences about what is and isn't acceptable.
- The public – whose confidence may be undermined if sanctions are perceived as inadequate.

# Introduction

## Context and aim

One of the functions of the statutory professional regulators is to address misconduct amongst health and care practitioners through their fitness to practise processes. This may include when practitioners are perpetrators of, or party to, sexual misconduct. This is deemed contrary to the standards which registrants must comply with as part of their professional registration and, following investigation and a hearing, may result in a sanction. Sanctions may range from a warning through to temporary or permanent removal from the register, preventing them from continuing to practise. The Professional Standards Authority for Health and Social Care (the Authority), as part of its statutory role overseeing the UK professional regulators, reviews fitness to practise cases that go to final panel hearing and can appeal cases where the sanction is 'insufficient to protect the public'.

The Authority produced guidance in 2008 for fitness to practise panels, the public and registrants on maintaining appropriate sexual boundaries *between practitioners and patients*. This guidance is still widely used and referenced by regulators and others. Although cases of sexual misconduct and abuse continue to arise, they are generally treated as being of serious concern by fitness to practise panels and sanctions are usually correspondingly serious.

In recent years, however, the Authority noted that cases involving sexual behaviours *between colleagues* are treated differently, with Panels sometimes concluding that there is not a direct risk to patient safety and that a strong sanction is not therefore required. These cases range from examples of serious sexual misconduct or assault through to lower level harassment and potential breach of boundaries between colleagues, and sometimes involve a power imbalance between colleagues or abuse of a supervisory relationship.

The Authority therefore commissioned this research to explore the views of practitioners and the public on sexual behaviour between colleagues working in health and care, and the potential effect on patient safety or quality of care. Specifically the research explored:

- Participants' perceptions of sexual behaviour between colleagues working in health and care services.
- Participants' views on how such behaviour aligns with the culture within health and care, and their perceptions of how prevalent it is.
- Participants' views on the appropriateness of sanctions imposed for sexual misconduct between colleagues working in health and care.
- Whether participants felt that inappropriate sexual behaviour or breach of sexual boundaries between colleagues working in health and care is likely to have a detrimental impact on the quality of care or patient safety.

In order to meet these objectives, qualitative research was undertaken with practitioners and members of the public to address the following three questions:

- When do participants think that behaviour towards/with a colleague crosses a boundary?

- What are participants views on how (if at all) such behaviour is relevant to fitness to practise?
- How do participants think that regulators should respond to such behaviour?

## Sample

A total of 58 participants took part in the research, comprising:

- 22 practitioners, each of whom took part in a face-to-face semi-structured interview lasting 60 minutes.
- 36 members of the public, each of whom took part in a face-to-face single gender* semi-structured group interview with three participants (a 'trio') lasting 90 minutes.

### *Practitioner sample structure*

In line with the focus of the research, all participants worked in teams, with colleagues with whom they spent a reasonable amount of face-to-face time. practitioners who work primarily on an individual basis or whose contact with a team is primarily remote (e.g. via telephone or e-mail) were excluded from the sample.

18 of the 22 participants were statutorily regulated. The remaining four worked in health or care settings in teams which included statutorily regulated colleagues, but were not themselves statutorily regulated.

The final sample included at least one (and in some instances more than one) of each of the following types of practitioner: care assistant; clinical psychologist; community pharmacist; core trainee year 1 (CT1) medic; dental nurse; dentist; general practitioner; mental health support worker; midwife; nurse; paramedic; physiotherapist; practice manager; psychiatrist; radiographer; surgeon; ward assistant.

Across the sample as a whole, care was taken to ensure a diversity of team contexts and relationships. In particular:

- Seniority: some participants held management positions in teams or organisations, others were team members.
- Experience: some participants were senior/experienced within their professions, others had trainee or newly qualified status.
- Setting: participants worked in a range of different settings, including in-patient, out-patient, residential, community, care homes and mental health.
- Organisation: some participants worked in large organisations, such as hospitals, others in small organisations, such as GP/dental practices.
- Team-patient interaction: some participants worked in a context where diagnosis, treatment or care was typically delivered by a single member of the team, others in a context where it was typically delivered by members of the team working together.
- Intimacy of patient context: some participants worked in a context where diagnosis, treatment or care could involve i) the patient having to undress or ii) the patient

* All three participants were the same gender: the researcher was not always the same gender as the participants.

discussing matters of a sexual nature, others in contexts where it did not (or was very unlikely to).

- Frequency of patient context: some participants typically had ongoing, daily contact with patients over a period of time, others typically had occasional or episodic contact with patients.

The sample comprised 10 male and 12 female participants. Care was also taken to ensure gender diversity for the seniority and experience dimensions above, i.e. both male and female participants who held management positions were recruited.

The sample had a good spread of ages, with representation of ethnic minorities.

### *Public sample structure*

The sample excluded individuals who either i) themselves worked or had worked in the health or care sectors or ii) had family or close friends who worked or had worked in the health or care sectors.

The sample was structured in six clusters, each comprising 3 men and 3 women (two trios). These clusters were structured to ensure diversity across the sample as a whole in terms of age, socioeconomic group (SEG), urban vs rural location, and cultural background. The six clusters are shown in the table below, along with the letter code used to refer to each trio in the rest of this report.

| **Profile** | **Trio code** | |
|---|---|---|
| | Female | Male |
| Aged 35-50, living in an urban location, ABC1[†] | A | B |
| Aged 35-50, living in an urban location, C2DE | C | D |
| Aged 35-50, living in a rural location, mix of ABC1/C2DE | E | F |
| Aged 35-50, members of established minority community (in a location with such a community) | G | H |
| Aged 18-25, all pre-family | I | J |
| Aged 70–85 years old | K | L |

### *Quotations in the text*

Quotations in the text are attributed using a unique identifier code for each participant. Practitioner participants are coded with 'Prac' followed by a unique number (01 to 22). Public participants are coded with 'Public' followed by a code indicating the trio (see letter codes above) and the numbered participant in that trio (1 to 3). The gender of the participant is also indicated (m or f).

Hence [Public A3 f] is a female member of the public, participant 3 in trio A above; [Prac 05 m] is a male practitioner, coded 05.

Please note that, while the range of types of practitioner interviewed has been indicated above, the role of individual interviewees is *not* specified. In some instances, only one

[†] See https://www.mrs.org.uk/resources/social_grade (accessed 19/3/18) for details of the classification of socioeconomic groups using the ABC1C2DE system.

interviewee from a given group was interviewed; and we are keen to avoid any risk that their views are interpreted as being representative or typical of that grouping, which may of course not be the case. Our sample was structured to provide a diverse range of views *across* health and care practitioners in general, but not to ensure diversity *within* any particular group of practitioners.

## Fieldwork

Participants were recruited by professional research recruiters in five locations: Edinburgh, Leeds/Bradford, rural areas around York, Greater Cardiff area, and London. Interviews and trios were undertaken by one of two researchers (one male, one female) and were audio-recorded and transcribed. Participation was remunerated at market standard rates.

Participant consent to participation, audio-recording and subsequent use of transcripts and anonymised quotations was sought during recruitment and confirmed at the beginning of the interview. See below for further discussion of research ethics and consent procedures.

Both the interviews with practitioners and the trios with public participants followed the same broad structure:

### *Initial context setting*

For practitioners this involved a brief discussion of the individual's own working context; for public participants, this included a brief, open-ended conversation about expectations of practitioners' behaviour with i) patients and ii) colleagues.

### *Scaling exercise*

Participants considered where they would place behaviours by practitioners on a scale, discussing their reasons for doing so and other factors (such as context) which would make a difference to the placement.

For practitioners, the scale ran from "makes no difference to their fitness to practise at all" to "makes a great deal of difference to their fitness to practise"; for public participants, the scale ran from "makes no difference to me at all" to "makes a great deal of difference to me". For both groups, the scale was initially set up using two examples which almost all participants agreed sat at either extreme of the scale:

- Has lied about their professional qualifications to their employer.
- Was recently fined for doing 34mph in a 30mph speed limit.

Participants placed and discussed six behaviours. These were selected from a long-list of possible behaviours prior to the fieldwork, with the choice being driven by a desire to i) cover as wide a range of types of behaviour as possible and ii) include behaviours which *in our estimation* were of different levels of seriousness. Each behaviour involved two colleagues, A and B, and described something that A did to or with B. Participants were also told that B was not comfortable with the behaviour. Public participants were asked to imagine that A was a practitioner they themselves were going to be seeing. The six behaviours were:

- A sends an explicit photo of themselves to B.

- A asks B out on a date.
- A talks about their sex life to B.
- A asks questions about B's sex life.
- A grabs B's bottom.
- A makes rude sexual comments about B on social media.

Note that, owing to the way in which these cards were written, some quotations in this report refer to A, the person whose behaviour may have crossed a boundary, and B, the colleague on the receiving end of that behaviour.

Participants were reminded as necessary during this discussion of the purpose of the fitness to practise process: see Section 5.4.

### *Scenarios*

In the final part of the interview/trio, participants considered three scenarios based on real cases. The scenarios are presented in Appendix 1. Before considering any scenarios, participants were briefly introduced to the scale of sanctions available to a fitness to practise panel, using the simplified model also shown in Appendix 1.

After reading the scenarios, participants were asked to summarise the points that they thought were most relevant to fitness to practise and, if willing, to select the level of sanction they thought most appropriate. The actual decision was then shared with the participant, and their views on this sought.

In practise, there was rarely enough time to discuss all three scenarios. Scenarios 1 and 3 were prioritised for discussion – with the exception of some practitioners who themselves had teaching responsibilities, with whom Scenario 2 was prioritised.

Even using the reduced number of scenarios, it was clearly not possible for participants to gain a full grasp of the details and nuances of the real cases on which the scenarios were based. This exercise was designed to explore the factors which participants considered relevant to selecting a sanction. It clearly does not provide evidence of how participants *would* have responded if they had had the full facts of each case at their disposal, along with adequate time to consider those facts.

## Analysis

An iterative approach to analysis of transcripts was adopted, as follows:

1. Material relevant to themes, observations and patterns was grouped together and reviewed. This included supporting and counter-evidence for each point.
2. The initial long-list of themes, observations and patterns was then revised and developed:
    a. Items were provisionally validated, refined/sophisticated to reflect supporting material, qualified to reflect exceptions, replaced with a better item, or rejected entirely as unsupported.
    b. In particular, over successive iterations, themes (categories) were replaced with propositional findings (statements).

c. Where needed, items were grouped together to create new superordinate categories/statements, or split to create separate items. Connections between items were also noted.
d. New items were added as needed: in particular, material which had not been grouped under existing items was reviewed, and new items were identified.

Review of the material focused not just on what participants said, but also on how they said it and in response to what. Care was taken to ensure that material which was grouped under items contained adequate indication of context: for example, researcher questions or notes on what had happened earlier in the same interview.

3. The new revised list of themes, observations and patterns was then used as the starting point for a new round of grouping (step 1) and reviewing (step 2). The process was iterated until a stable, propositional structure emerged which both was supported by and accounted for the evidence.

A final detailed evaluation of the relationship between propositional findings and evidence was also undertaken. Where necessary, final checks were also made on the original context of material, to ensure it was not being quoted out of context.

## Ethics

An assessment of ethical risks was undertaken prior to recruitment and fieldwork. Detailed project-specific ethics procedures were developed for each risk identified, covering mitigation steps and, for risks associated with possible eventualities during interviews/trios, the assessment protocols and actions to be used by researchers.

Given the sensitive nature of the topics being discussed, a key concern was to ensure genuine informed consent from participants. There were two key steps to this process for all participants:

- During the recruitment process, prospective participants were provided with and taken through an information sheet. A copy of the information sheet is provided in Appendix 2.
- At the beginning of interviews/trios, the researcher confirmed that participants had received the information sheet, and read through it again to ensure full understanding. Participants then read and signed a consent form. A copy of the consent form is provided in Appendix 2. The right to withdraw – including the right to withdraw *after* the interview was completed – was carefully explained, and researchers provided their contact details.

For public participants, an additional step was included at the very beginning of the recruitment screening process, and *prior* to information being given about the research. Prospective public participants were told that participation would involve discussing "behaviour in the workplace" and asked, for a list of topics, whether they would be "willing to discuss any of the following topics in a small group setting". The topics were:

- Racism in the workplace.
- Sexism in the workplace.
- Criminal behaviour in the workplace.
- Sexual behaviour in the workplace.
- Bullying/harassment in the workplace.

- Drinking alcohol in the workplace.

Response options were:

- I would be willing to discuss.
- I'm not sure if I'd be willing to discuss.
- I wouldn't be willing to discuss.

For the recruitment conversation and the information sheet to be presented, participants had to select "I would be willing to discuss" for both of the topics "sexual behaviour" and "bullying/harassment". This additional step was designed to maximise opportunities for people to express discomfort with the topic, and to minimise the risk that the information sheet itself might cause distress.

Alongside the need to ensure consent, a number of other risks were addressed in the design of the recruitment process and interview/trio guides. Other steps taken included:

- Explaining that the research was specified *before* a wave of media news stories relating to sexual misconduct in Hollywood and other locations at the end of 2017, to ensure participants were clear that the research represented serious consideration of important issues by the Authority, and not a 'knee-jerk' response.
- Clarifying that there is no reason to believe that behaviours such as those discussed are more (or indeed less) prevalent among health and care practitioners.
- Ensuring that all questions asked related to views, not to experiences; explaining clearly to participants at the beginning of interviews/trios that, while they were welcome to talk about their experiences if they wished to, they would only be asked questions about their views; and taking care to ensure that, when participants did describe experiences, follow-up questions were limited to clarification questions.

One risk that was especially hard to mitigate was the possibility that the actual decisions made in the scenarios might undermine some participants' confidence in the fitness to practise process if they were seen to be unduly lenient or severe. When this did in fact happen – see Section 9.2 – we noted that the decisions in two of the scenarios being considered had in fact been contested, and that this was one reason to seek views from practitioners and the public. In the event, the most effective mitigation of this risk may have been the research itself: a number of participants indicated that they were heartened by the fact that research was being undertaken to seek their views on questions which a number of them also acknowledged were complex:

> *You need a whole change-over, which is what you're… you're going to supply all the evidence. […] As long as you relay all this back accurately, which we know you will, let's hope. [Public J2 m]*

## PART A
# Boundaries with colleagues

In this part of the report, we describe patterns in participants' views on the boundaries on behaviour with/towards colleagues: where these boundaries lie, when they are crossed, and why this happens. We postpone the question of whether and how boundary-crossing behaviour is relevant to fitness to practise until Part B.

There was considerable variation between participants in terms of *what* they thought about the different behaviours and scenarios presented in interviews. For example, the three quotations below, from practitioner participants, illustrate the wide range of assessments made of the behaviour 'A talks to B about their sex life'.

> *Why should you do that? No, it's a workplace. That's somewhere you go to work. […] I don't even talk about my sex life with my friends or I don't even talk about my sex life with my children. And they never have, no, it's something very private. [Prac 22 f]*

> *Not that I do, but just putting it in that context, like…. so you can say something to someone and they would it find it funny and then you'd have a joke and you'd have that sort of relationship with them. Just like you would in any other place with friends outside of work. [Prac 03 m]*

> *You can talk about what you want. I think that quite often people who get offended by chat, that the fault is with the person who is offended not with the person who is doing the chat. […] You've got a right to say whatever you want – as long as you're not hurting anybody, as long as it's not you know… anything that's against the laws like racially motivated – out to cause harm intentionally. [Prac 11 m]*[‡]

Different participants arrived at different conclusions with regard to this and other behaviours discussed. Similarities emerge, however, if we turn our attention from the conclusions themselves to the *routes by which* participants arrived at these conclusions: the categories used, the arguments deployed, the factors considered. It is patterns at this level which we report here: patterns not in *what* participants thought about behaviours and scenarios, but in *how* they thought about them.

Many of the behaviours being discussed, and especially more serious behaviours, lay outside our practitioner participants' own direct experience – and indeed, prior to this interview, consideration.

> *I'm just thinking thank God none of these things happen where I work. That's very bad. [Prac 04 f]*

> *I have to say in my personal experience I've always worked in teams where people have been stressed, cross words have been exchanged, but actually sexual misconduct has not been top of the agenda. […] They [the behaviours] are a little bit abstract for me and I'm pleased at that. [Prac 05 m]*

[‡] This was an atypical quote, used here to illustrate an extreme in the range of opinions expressed. In general, as we shall see, participants took the view that behaviour of this kind breaches a boundary if the person on the receiving end is not happy with it. The participant quoted here also took this view with regard to some other behaviours.

> *I've never experienced this so I really have no idea. [Prac 22 f]*

With this in mind, participants' responses should be understood in the way that they were for the most part given: not as the reporting of pre-formed, settled opinions, but as the construction of tentative, provisional assessments – often through the interrogation of an initial gut reaction.

> *You don't really know what you think about these things until you have to think about them. [Prac 08 f]*

The same observation applies to our public participants: if anything, more so, since the scope of discussion included behaviours between colleagues which are not witnessed by patients; that is, behaviours which our public participants could not *by definition* have experience of.

Leaving aside the specific behaviours being discussed, it is also obviously the case that the realities of relationships between colleagues working in health and care are part of everyday life for those who are themselves working in health and care, but remote and abstract for those who are not. As such, our public participants had less to say about behaviour between colleagues in and of itself (though plenty to say about its possible implications for patients and the public, as we shall see in Part B). In Chapter 4, we shall argue that responses from public participants were entirely in line with the patterns identified in the responses of practitioner participants: but it is unlikely that we would have identified these patterns if we had had only those public responses to analyse. In light of this, Chapters 1–3 focus solely on the responses of practitioner participants.

# 1. When does behaviour cross a boundary?

In this section, we examine the ways in which practitioner participants went about assessing whether or not behaviour with/towards a colleague crossed a boundary (for discussion of the views of public participants see Chapter 4). Two distinct approaches to making this assessment – or 'protocols' – were apparent, with the choice of which approach to use in any instance being influenced by the seriousness of the behaviour and its setting. Most participants argued that quasi-social settings exist in the workplace where behaviour is acceptable provided all of those involved are happy: but that these settings are limited by needs for parity between participants and privacy from patients and the public.

## 1.1 Two protocols for assessing behaviour

How did our practitioner participants go about deciding whether or not a specific behaviour with/towards a colleague crossed a boundary? Two distinct approaches to answering this question were apparent in their responses.

The first approach starts from the recognition that working in a role requires conformity to certain standards of behaviour. For example, behaviour has to be 'professional', in the everyday sense of that term which applies to anyone working with other people, and which includes within its scope behaviour with colleagues.[§] It also has to conform to more concrete sets of standards, such as organisational policies, professional codes of conduct, and the law.

The first approach to deciding whether a boundary has been crossed appeals to these standards: if behaviour contravenes a standard, then it crosses a boundary. For example, consider the following reaction to the behaviour 'A grabs B's bottom'.

> *You know, we've got professional standards setting what we need to fall in line with and that wouldn't be falling in line with what we should be doing. That's breaking our professional standards of the code of conduct and how we should and shouldn't behave. You know, it's not appropriate. [Prac 01 f]*

This, however, is not the only way of deciding whether behaviour has crossed a boundary. Less than two minutes later, the same participant demonstrated a different approach to the question.

> *Everyone's got what they would accept as, you know, that's a bit of a laugh. I think if, say, I don't know, somebody saw my colleague pinch my bum at work and I just laugh it off and, you know, that's just us and this is a bit of a laugh. [Prac 01 f]*

Behaviour is here being assessed relative to the norms developed *within* a working relationship, rather than to standards *independent* of that relationship. If one of the people in the relationship is unhappy, then a boundary has been crossed; if not, then everything is fine. The same approach is apparent in the participant's earlier response to the behaviour 'A sends an explicit photo of themselves to B'.

[§] We will return in Chapter 5 to the question of whether and how this informal sense of 'professionalism' relates to the formal concept of 'fitness to practise' for statutorily regulated health and care professionals

> *Well I suppose it's going to depend on the relationship A and B have got. If B didn't want to see this photo and it's not something that is between A and B then obviously this is an issue because it's not professional to act in that manner with your colleagues. [Prac 01 f]*

For want of a better word, we shall refer to these two approaches to deciding whether behaviour with/towards a colleague crosses a boundary as 'protocols':

- The standards protocol: a boundary is crossed if the behaviour contravenes a standard (which is *independent* of the relationship between the two people involved).
- The relationship protocol: a boundary is crossed if one of the people is unhappy (meaning that the behaviour breaks the norms *within* that relationship).

It is worth pausing to be completely clear about the status of these protocols. These are not themselves views on whether a behaviour has crossed a boundary, but *ways of coming to such a view*. Moreover, these are protocols for assessment: ways of deciding whether or not behaviour with/towards a colleague has crossed a boundary *after* that behaviour has already taken place. We are not suggesting that these protocols play (or don't play) a role in *generating* behaviour, or that someone who sends, say, an explicit photo of themselves to a colleague is (or is not) in some way *enacting* one of these protocols.

The existence of these two distinct protocols – along with the fact that, like the participant quoted above, participants used both – raises an obvious and fundamental question: if we want to decide whether a specific behaviour with/toward a colleague has crossed a boundary, which protocol should be used? Before we can assess the behaviour, we need to decide *how* to assess the behaviour. Two key factors influenced our participants' selection of protocol: the seriousness of the behaviour, and the setting in which it takes place.

### 1.2 Relative seriousness of behaviour

The first factor that influenced which of the two protocols participants used to assess a behaviour is the relative seriousness of the behaviour.

Across our sample, certain kinds of behaviour were consistently seen as worse than others. For example, there was a general view that physical behaviour (e.g. 'A grabs B's bottom') is worse than verbal behaviour (e.g. 'A talks to B about their sex life').

> *So there was a remark that was made on social media, but grabbing someone's bottom is physical contact. So that's even more serious. [Prac 14 f]*

> *Words can be very cutting and everything like that, but the physical act of groping or grabbing a person, I think, that is… the line is stepped way over then. [Prac 03 m]*

> *I just think when people are making… touching you or doing something to you, in your space, if you're not wanting it to happen, then it would… I would take it as a greater deal than somebody just asking me a question about something. [Prac 10 f]*

As the last quotation indicates, part of the problem with physical behaviour is that it is more intrusive; and more intrusive behaviour was also seen as more serious. For example, 'A asks questions about B's sex life' was seen by a number of participants as worse than 'A talks to B about their sex life' (although others saw these two as broadly equivalent).

> *So if they're talking about their own sex life, that's personal, that's up to them how much they want to disclose and not disclose. But it's when you start to ask about someone else that you're almost invading their privacy. [Prac 16 f]*

> *If you're asked a direct question you have to in some way respond to that, even if that is to say: 'I don't think we should be talking about that. Enough.' It feels very intrusive. [Prac 17 m]*

One of the key concerns of participants with regard to social media was its potentially intrusive nature.

> *I think it's intrusive. You're moving into somebody's sphere too much. [Prac 22 f]*

> *If you're making rude sexual comments on social media, in some ways, actually, you're not just making it to one person, you're making it to the whole world, which it's not just breaking boundaries, it's literally destroying them and jumping on them. [Prac 07 m]*

Some participants noted that behind these assessments of the relative seriousness of behaviours lie wider social norms about what is and isn't acceptable. This was especially apparent with regard to the behaviour 'A sends an explicit photo of themselves to B'.

> *You ask anyone on the road, on the street, out on a date, and it may not be appropriate but it's not offensive; but that [sending an explicit photo] is potentially offensive. […] There are certain things which are more personal and which step over a boundary, I think, which in our culture, at least, is inappropriate. [Prac 07 m]*

> *It's not within the norms, I guess. It's not in the norms of society. [Prac 20 m]*

There were a number of comments from participants about the ways in which these background norms are changing with, on the one hand, a greater sexualisation of society as a whole and, on the other, the ongoing challenging of behaviours in the workplace that were once more widespread.

How did the seriousness of behaviours relate to the selection of protocols for assessing those behaviours? The simple answer is that participants were more likely to see the relationship protocol as *inapplicable* to more serious behaviours. More serious behaviours, that is, cannot be justified by the relationship between the two colleagues: the standards protocol has to be applied. For less serious behaviours, by contrast, it is appropriate to apply the relationship protocol. In the following quotation, for example, a participant argues that context is irrelevant to more serious behaviours (i.e. the standards protocol has to be applied in making an assessment), but that less serious behaviours may be justified by the norms of a relationship (i.e. the relationship can be applied in making an assessment):

> *I think context is… I wouldn't say all important. There's no context where that ['A sends B an explicit photo of themselves'] is right if B has not asked for that. There's no context where that ['A grabs B's bottom'] is right at all; there's no context where that is right, I don't think. But some of the things… That ['A talks to B about their sex life'] might be acceptable in some way if B says it's okay or encourages it. [Prac 18 m]*

It is important, however, to stress the probabilistic nature of the statement above: participants were *more likely* to see the relationship protocol as inapplicable to more serious behaviours. There was considerable variation with regard to where the cut-off point for application of the relationship protocol was seen to lie. Consider, for example, the following opinions with regard to whether 'A grabs B's bottom' could be legitimised by the norms of a relationship.

> *That's assault so that's absolutely unacceptable. […] Well I mean that's criminal. [Prac 17 m]*

> *No, even if they're married, at work you can't do that. […] Even if they're married house officers who have just started, you can't do that, it's not appropriate. [Prac 06 m]*

> *I'm a strong believer of professionalism. They may be friends, they may be colleagues and everything, but that is totally inappropriate. What they do outside of work, that's fine, but that is totally unacceptable. [Prac 19 m]*

> *The thing is if you're talking A and B are mates, are friends, and that's the kind of what they do, that's not an issue to me. Like as in they're both having… not in front of patients, that's completely unprofessional, but if they're in the, what you call it, the doctors' mess or whatever, I don't consider that an issue. […] If you're on your own time, in your own safe zone and that's acceptable, then I don't see a problem right now. [Prac 04 f]*

> *If two single 30-year-olds playfully do it in the kitchen on their meal break, although B is offended by it… it was maybe just a miss you know, a wee slight misreading of their relationship and the turnaround and the eye contact that happened afterwards, that person might learn straight away that that's not to be done again. [Prac 11 m]*

### 1.3 Social settings

In references such as "at work", "outside of work", "your own time, in your own safe zone" and "the kitchen on their meal break", the quotations above point towards the second factor that influenced which of the two protocols participants used to assess behaviour: the setting in which the behaviour takes place. Some settings – such as being in front of patients – require strict application of the standards protocol: others – more *social* settings – allow application of the relationship protocol instead.

The clearest examples of social settings are those *outside* the workplace altogether.

> *If it was outside of work, then lots of things can be said as long as it's, you know, in a friendly way. If you take yourself out from a colleague to a friend situation, I think it is very different. [Prac 06 m]*

> *I've probably been in situations through my work on a night out where people probably say things that they slightly regret, but nothing more comes of it and people are a bit over-familiar perhaps. [Prac 12 m]*

> *Because they've gone on a social, they've gone on a drink, then it kind of makes it a bit more acceptable. Not saying it's acceptable, it shouldn't really come up. But they're both let… That line's now moved a bit further because you've gone away from your profession. Which is why Christmas parties are a bad idea. [Prac 20 m]*

As the reference to Christmas parties in the final quotation above indicates, there are risks associated when these social settings move *into* the workplace. Indeed, some participants questioned whether there was any scope for the relationship protocol inside the workplace.

> *We have to be professional at all times. We put our personal views or our thoughts or behaviours separate. We're doing a job, and that's exactly what we're doing. [Prac 19 m]*

> *In a workplace you should be working. You shouldn't do these things. [Prac 22 f]*

In general, however, participants took the view that there have to be times and places in the workplace when strict application of the standards protocol is relaxed: quasi-social settings in which the acceptability of behaviour can be assessed using the relationship protocol.

> *It could be within a general conversation and just you know a bit of banter with your colleagues, which happens and which the… You know the good will that we've got between each other and the friendships that when you work with people… That still has to continue I think. We can't be too fixed and forgetting that they are our friends, they are our colleagues; we are sharing things with them. That you are going to share details of your life with people. Some people may feel more comfortable than others. I think it's up to each to obviously be mindful of who they are discussing these things with; as I would as well. [Prac 02 f]*

The existence of relationships outside the workplace, for example, was seen by some participants as a potential reason to apply the relationship protocol at work.

> *We socialise out of work as well. Which I think makes it more acceptable than if you just came to work nine to five and went home and didn't have interaction with that person. [Prac 16 f]*

A number of other participants highlighted that the issue was not time spent together outside work, but the sheer quantity of time being spent together in the workplace. When you are spending this much time with colleagues, often under stress, sticking to the rigid standards protocol would be inhuman; the flexibility of the relationship protocol is essential.

> *I certainly have had these conversations. We spend 12 hours a day in [work setting] with friends… the last guy I worked with, I worked with for five years. We're the best of friends; if we can't talk about these things with each other then… then something is wrong with our relationship. [Prac 11 m]*

> *Within working shifts you get that four o'clock-in-the-morning conversations that quite frequently go on in the middle of the night. So, you know, you talk to see you through another hour. […]You spend probably more time with your colleagues than you spend with a lot of your friends and family. So there are lots of intimate conversations that you're… So some of this can be quite normal. [Prac 02 f]*

> *You're stuck in this room, for […] 9 hours a day. You know, you're with these people more than you are with your family and everything like that. So you've got to chat. You know, people talk and people do start talking and you may talk or you may just talk rubbish. Some people talk rubbish all day. But it's just to keep the mentalness from building up. To keep it going, like. So if someone goes off on a bit of a tangent and starts talking about their sex lives, some people will be like: God, oh no. And others then would be thinking it's hilarious and: oh God, tell me more. So it's all dependent on the person. [Prac 03 m]*

As the following participant noted, these may not be relationships of a kind that would last outside the work context. In some cases, they are survival strategies.

> *I've certainly experienced this phenomenon within healthcare where you work busy and stressful jobs with people, and you suddenly feel much closer to them as people than you would outside. And you talk about all sorts of things that are very… even though you've only known them for three months of a four month rotation. And then after that you don't see them much again and suddenly you can't… although you like them, they haven't done anything wrong, you suddenly can't understand why you felt so close to them at the time. But people do get stressed in healthcare and then end up talking about all sorts of things that upset them. [Prac 05 m]*

The references to factors such as time spent together, collocation and stress in the above quotations imply that the working practices of a team may have a bearing on the extent to which quasi-social settings – times and places where the relationship protocol can be applied – are acceptable within that team. In line with this, one participant who worked in both a community and a hospital setting, contrasted the two:

> *I think in a [community] setting, like I said, because it's so close-knit and you see those people day in, day out, and it does become a really sort of personal relationship with those people, it might be a little more acceptable to start talking about personal things than in hospital. So I see this. So we will talk about everything under the sun in the [community setting]. Whereas in the [hospital setting] it's only when I get off the ward and I'm with the colleagues in the buzz room and stuff, and I'll overhear a conversation. […] So thinking in community it's probably more likely to be acceptable than in hospital. If it did happen in hospital you'd be like whoa, you know. [Prac 16 f]*

Alongside the working practices of the team, the nature of the work – and the behaviour of patients – may also have a bearing.

> *You know, we do contraceptive clinics, people talk. […] In that environment, people don't even think of it as a topic because it's just a normal conversation. [Prac 04 f]*

> *Well, I am in urology. So, it's like you've got guys that lie about with their bits hanging out. Which is really inappropriate. And they know it's inappropriate. But – I don't know why – they, you know… it's like: cover up! We've seen it all before, you know? So, I suppose a lot of our colleagues talk about sex and bits. You know, it's like a big part of your job. You know? [Prac 09 f]*

The more intensive, stressful and emotionally demanding a working context, the more valuable it may be to establish quasi-social settings where the rigid standards protocol is relaxed and the more flexible relationship protocol applied.

However, these quasi-social settings are strictly bounded – as indicated by the qualifications in the following quotation.

> *These sort of conversations [talking about sex] go on all the time at work, but not when there's patients around, and you need to be careful about who's there because someone might not want to talk about that. […] If you're just sat chatting about it and the manager's there and everybody's there, then it's quite unprofessional, but if you're at lunch, and you're just with your colleague, I don't see a problem. [Prac 15 f]*

Two conditions in particular stand out, which we shall discuss further in the following sections:

- The need for parity between the people involved.
- The need for privacy – and in particular the absence of patients.

### 1.4 Parity

The first limit on quasi-social settings at work is the need for *parity* between the people involved.

For example, application of the relationship protocol may be less appropriate where individuals are at different levels of seniority – and in particular if one is a manager. Managers may feel that they need to maintain standards more consistently – at least with subordinates. The following quotation is from the participant who was quoted above talking about the need to "talk rubbish" to "keep the mentalness from building up". Here he reflects on the way in which his own position as the lead practitioner and manager of the team limits his ability to participate in that rubbish-talking:

> *It's almost you like you have your game face on. So, as soon as you walk into the [workplace], you act in a particular way and you, you know, talk maybe a little bit differently. […] Especially with the girls [team he manages] as well then. Obviously, as with most jobs, there's things like that: they're managerial, they're boss. So you kind of act in a particular way because you wouldn't have the respect and everything like that. [Prac 03 m]*

We will have more to say about the situation of managers and leaders, and the reasons why they need to exercise caution in their workplace relationships, in Section 2.3.

The need for parity in a quasi-social setting at work may not be limited to a need for *organisational* parity and seniority. Some participants indicated that, in practice, other factors may come into play, such as age, gender and professional grouping. In the case

of the manager quoted above, for example, it is striking that he is not only the manager but also the only male, with a team he refers to as "the girls".

> *I'm thinking: girls, they chat. And I don't get involved. [Prac 03 m]*

As with judgements of the relative seriousness of behaviours (see Section 1.2) wider social norms appear to be at play here. The application of the relationship protocol is more acceptable – rightly or wrongly – between people who are seen as being *more likely* to be friends, and less acceptable where a friendship is harder to imagine. The following quotations, for example, all relate to 'A talks to B about their sex life'.

> *Okay so it's all female and they're all heterosexual… so I think because of that it is more acceptable because they're all sharing their own experience. [Prac 16 f]*

> *If A and B are both women, if A and B are both men, [that would make it] a little bit less [concerning]. If, again, they were the same sexual orientation. There are so many different ways that these could slant, obviously. If A, again, is a 60 year old woman who is talking to a 23 year old male house officer, it's completely inappropriate and unacceptable. [Prac 06 m]*

> *For example, in work settings, often you have a gaggle of nurses who do, you know… sex life it's a normal conversation, just like the supermarket and they're all having a chat about it. […] But obviously, then you get that position, not to be stereotypical, but you get potentially an older male GP talking to the young, new reception staff. I know it's terribly stereotypical. Yes, but if we go into the stereotype, that's the type, you know, saying about that, then it would to me… would be like what you're trying to achieve from that? [Prac 04 f]*

One reason for questioning the application of the relationship protocol to behaviour between people of different levels of seniority is the simple fact that it is not *normal* for such people to have that kind of relationship.

> *In our organisation [a manager] doesn't usually have a lot of chitchat with somebody from these sort of [team member] level. That would be a different sort of interaction I think than people in my team of the same position who often sort of chitchat as they… You know, before a team meeting starts or whatever, that sort of thing. [Prac 12 m]*

> *If one SHO asked another SHO out on a date and the other one was made uncomfortable I think that could be… that would probably be looked on as a normal social interaction. […] I think if A was very much more senior or very much more junior than B then I don't think… I think that would be, sort of, less likely to be seen as a normal social interaction and more likely to be seen as something slightly odd within the context of the normal workings of the hospital and I think that would. [Prac 05 m]*

### 1.5 Privacy

The second condition placed on application of the relationship protocol is the need for *privacy*, and in particular the absence of patients. Any setting in which there is a risk of being seen by the public is a setting in which the standards protocol should apply.

> *The thing is, in a work environment, it's not just how those people feel about each other, it's also that we have a responsibility to care for patients, and you wouldn't want – if there was some sort of jokey behaviour going on between those two – somebody to come out of the room and see something like that happening, because it's just not a professional way to conduct yourself. [Prac 13 f]*

> *Even if say between myself and my [colleague] pinching my bottom was fine, acceptable, that wouldn't be acceptable if they did that at a patient's house in front of a patient because I've got professional standards to maintain and I expect my patients to see me at the top of my game. [Prac 01 f]*

Concerns about behaviour being seen by the public were particularly acute with regard to social media. In part, this focus reflects the stimulus presented in interviews (one of the behaviours referred to social media; and one of the scenarios largely turned on social media posts). However, a number of participants also noted that this was an issue on which they had received frequent communications from organisations such as employers or professional bodies.

The problem posed to health and care practitioners by social media is embedded in the name. On the one hand, this is a 'social' arena, within which the relationship protocol ought to be applicable. On the other, these are communications 'media', which breach the privacy condition required for the application of the relationship protocol in the workplace.

> *You just have to be ever so careful about who's seeing what; what you're doing in…. When what should be your private life is not, you know, private. What is private any longer? [Prac 02 f]*

> *It's important that people realise that our professional persona is important and the way people view you as a person, it is important when you're in a position that… People's lives are essentially in your hands sometimes and nobody wants to think that you're a person that isn't trustworthy or… It is important, how we portray ourselves on a public platform. [Prac 13 f]*

Part of the reason why inappropriate behaviour on social media – or indeed in any public context – is a problem is of course because of the obvious reputational risks it creates.

> *If it involves other colleagues, it really seems quite a serious thing because you're bringing your workplace into disrepute or your profession into disrepute perhaps [Prac 12 m]*

We shall discuss the possible impact of public behaviour further in Section 6.1.

Alongside these risks, however, participants also discussed the ways in which public behaviour may have more serious consequences for the *colleague* on the receiving end of it. For example, one participant commented on the potentially serious consequences for female members of some minority groups if their being a victim of unwanted behaviour is made public. The ramifying impacts of social media posts were also noted.

> *A comment like that could be viewed by lots of people. It could be viewed by other colleagues, it could be viewed by potentially family, friends, young*

*people; who knows? I feel like that could have a much wider impact on something that's potentially private between two people. [Prac 13 f]*

# 2. What role does team culture play?

In this section, we examine the views of practitioner participants on shared norms or cultures that can develop in teams (for discussion of the views of public participants see Chapter 4). Participants acknowledged that team cultures can develop in which certain kinds of sexual behaviour (e.g. sexual jokes) form part of the everyday interaction of team members. Consensual interaction of this kind within a team – banter – may be seen positive. However, participants were also clear that, even if such a team culture exists, it can *never* legitimise behaviour with/towards a colleague that makes that colleague unhappy. Indeed, such behaviour may instead call into question the culture in which it arises. The reality of banter within the workplace creates challenging issues for managers, who must exercise caution in their own behaviour while also deciding whether and where to draw a line for their team.

## 2.1 Can shared norms justify individual behaviour?

Within the quasi-social settings described in Chapter 1, colleagues interact not just one-to-one but also as a group. As such, it may make sense to talk about norms that exist not just within a working relationship between two people, but across the group as a whole. For example, one participant described how, working in a team whose work involved sitting for long periods in a position which caused back and neck discomfort, it became completely acceptable for colleagues to give each other neck messages.

> *I wasn't fussed about doing that at all. I knew him well. I knew that it was fine for me to touch him in that manner. Same with a lot of the assistants that we worked with. […] I think if there's a culture of it as a group, I don't see a problem with it. [Prac 15 f]*

In particular, groups may develop shared norms regarding the kinds of things that are (and aren't) talked about, and the kinds of jokes that are (and aren't) made.

> *We know our scrub team very well, combination of men and women, and gay and straight […]. There's innuendo left, right, and centre. [Prac 06 m]*

> *You know we always say there's a lot of banter and sort of dark humour in our job, but then there's certain things that you'd say well that's not acceptable. [Prac 01 f]*

> *Bantering. You should be able to enjoy your workplace, and you should be able… Should be wanting to go to your workplace, and if that's the banter that you're having, then fine. [Prac 20 m]*

As the last quotation above indicates, the kinds of interaction made possible by these shared norms – the "banter" – may be seen as positive. For example, consensual banter of this kind was described as making work more enjoyable for the individual, and promoting team-building within the group.

> *I mean, it's friendly banter/chat/playfulness in the work place which should be encouraged. [Prac 11 m]*

> *I think in certain contexts it's [banter] sort of a group, team-building, friendly thing, but I think it's only sort of acceptable if you're friends with*

> *people and it's sort of in a controlled context, obviously, away from patients, etc. [Prac 15 f]*

At the same time, however, individuals within those groups will retain their own views on what is and is not acceptable.

> *Everyone is different, you know? Some people are more open. Some people are private. Some people are… Yes. So, everyone is different. [Prac 09 f]*

> *There are a lot of people that are uncomfortable with all kinds of things. We are not machinery. We are very… we have very different ways of reacting to things. [Prac 22 f]*

So what happens when the norms of the group diverge from the views of an individual who is part of that group? Can the existence of shared norms ever legitimise behaviour with/towards a colleague that makes that colleague unhappy? To put the point another way, does team culture underpin a third protocol for deciding whether behaviour crosses a boundary?

The short answer to these questions is: no. Asked to consider situations in which individuals sought to justify their behaviour on the grounds that it was in line with shared norms (for example in Scenario 3, in which a practitioner seeks to justify their behaviour by appealing to a "culture of banter"), participants consistently invoked the relationship protocol: a boundary is crossed if one of the people is unhappy.

> *To be honest, I don't care whether there's a culture of banter in the ward, if someone is uncomfortable with it, then it's not appropriate, it's not acceptable. [Prac 07 m]*

> *I think if one [person] thinks it's a joke and the other doesn't, it's not appropriate really. [Prac 15 f]*

> *I suppose it's not acceptable if someone is feeling really uncomfortable. […] It's about how everyone's an individual, and if you don't feel comfortable in your work, you shouldn't be having to listen to that, you know? [Prac 09 f]*

> *Banter's banter until you… Until someone calls it not, kind of thing. [Prac 20 m]*

Attempts to justify behaviour by reference to the shared norms of a team were given short shrift.

> *It's used as an excuse. I see that a lot. [Prac 06 m]*

> *If the culture of sexually explicit conversations existed [as claimed in Scenario 3] then they would have not been offended by this. This has obviously overstepped the line and his idea of sexually explicit is different to whatever the culture is. [Prac 11 m]*

> *I think a direct personal justification in relation to the specific interaction of A and B is much more satisfactory and shows much better insight than: oh well, that's just how we are. [Prac 05 m]*

One could not, participants argued, generalise from what is acceptable in one relationship or set of relationships to another relationship, just because the people involved all happen to be in the same team. Instead, one needs to get to know each individual in their own right, and develop each relationship in a way that suits the individuals involved:

> *What me and my [colleague] may see as acceptable I wouldn't see as acceptable with another colleague, but then that's because me and my [colleague] have a different relationship. [Prac 01 f]*

> *We do have nurses on the ward who have banter and they say: oh, it's only banter. But the two particular people that I'm thinking of, they're like best friends. […] If someone else comes along and tries to join in with that or starts saying inappropriate comments, which might have a different meaning to it, then it's more just a kind of a way of bullying people sometimes. [Prac 21 f]*

> *You need to sort of get to know people in your team and work out what is acceptable, what's not acceptable, what are their religious beliefs, what are their culture beliefs, what are they comfortable with. […] It's just the same as life, just trying to work out how you can have fun with people, but not offend them. [Prac 06 m]*

In the absence of a relationship with a given individual, and notwithstanding any norms developed in relationships with other members of the team, the standards protocol applies.

> *If you don't know someone in the room, you keep it straight, and so if someone's new, everything's just by the book, normal, until you get to know them and all. [Prac 15 f]*

### 2.2 Culture, consent and risk

Not only do shared norms not justify behaviour that crosses a boundary: such behaviour may actually call into question the legitimacy of the team culture in which it arises. In considering the explicit appeal to a "culture of banter" in Scenario 3, for example, some participants argued that this implied a need to investigate the professionalism of the team as a whole.

> *Maybe it's actually a culture that needs to change and he is sort of, not a scapegoat because he's done it, but actually is this just the tip of the iceberg? Is there a deeper, fundamental problem about respect within that department? [Prac 04 f]*

> *I think they need to look at the whole department if it's that bad, because that's pretty bad. [Prac 15 f]*

> *He's a male, so again you've got that culture of males being dominating, you've got all that picture. [Prac 20 m]*

As noted in Section 2.1, consensual banter may be seen as positive, both for the individual and for the team as a whole. As long as banter remains consensual, an appeal to shared norms may justify it.

> *I know things like that happen, but there is an acceptable level and a consensual level where people are playful and mess about and make stupid comments, which is fine. [Prac 07 m]*

As soon as consent is lacking, however, banter turns into something darker. For example, one participant argued that the idea of a "culture of banter" can itself become

not a description but a *tool*, used by those in power to hold an unhealthy culture in place.

> *There is a risk that it [an appeal to a culture of banter] would be employed by people who are senior and in a more dominant role. […] If this is a top down culture where people are not… where people are forced to accept something that in other work places they wouldn't. [Prac 05 m]*

There is, as one participant quoted summarised it: "a fine line between banter and bullying" [Prac 20 m]. A similar point was made by others.

> *Banter sometimes is basically just… can be an excuse for bullying as well. It can be: oh, well that's only banter. Is it banter, or is it… It depends kind of the context and how it's used. […] It's knowing the boundaries and what to say. And for me, it's the relationship between the two people as well. [Prac 21 f]*

Unfortunately, the absence of consent may not always be readily apparent – especially in a context where other members of a team *do* consent to a behaviour. For example, participants highlighted reasons why, in practice, individuals may fail to express their unhappiness with colleagues' behaviour.

> *People here are very nice and polite, and wouldn't necessarily say stop. It doesn't mean that by not saying stop they're actually consenting or agreeing to hearing about this. They're just being polite. [Prac 17 m]*

> *I think sometimes when people laugh these things off they're not really laughing. They just want it to go away. So it doesn't necessarily make it any better. [Prac 18 m]*

There is a risk at the heart of the relationship protocol: the possibility that A may cross a boundary with B and yet not know that they have done so.

> *If it hadn't been raised and the person hadn't said it, then they [A] would have presumed that the person was okay with it to happen. [Prac 03 m]*

Who is responsible for managing this risk? One possible view is that it is the responsibility of B, the person who is unhappy, to speak up.

> *It's still B's position to go: don't do that, please. Or walk away from the conversation, because there's always that option as well. [Prac 11 m]*

One participant from a traditional background even described herself as having a "safe word", which she used to indicate to colleagues that the conversation was going too far for her – at which point her colleagues would shut up.

Among our participants, however, the more common view was that it is the responsibility of A, the person whose behaviour makes B unhappy, to pick up on the impact of what they have done. Indeed, it was argued by some, this is the kind of thing that health and care practitioners *ought* to be good at picking up (a point to which we will return in Section 7.3).

> *If somebody's upset by it then it's not acceptable at all is it? You know, we're all professionals, we should be able to see when our actions are causing distress and upset somebody.* [Prac *01 f*]

Whatever they ought to be, however, it was also noted that some practitioners are not in fact good at picking up on such things.

> *Having said that [...] it's important that healthcare professionals are able to judge social situations and judge, I do know that a lot of us don't judge things very well. [Prac 05 m]*

> *Some people are very, very good at judging what's appropriate and what isn't and to whom. Some people aren't, they will just get the wrong end of the stick and they will do something completely... Which then suggests that you have a common set of guidelines that people do whether they're good at judging that or not. [Prac 07 m]*

The combination of people who don't speak up and people who aren't good at judging social situations creates an unavoidable set of risks for the relationship protocol – one that can only be avoided, as the last participant quoted above concludes, by falling back on the standards protocol.

### 2.3 Culture and managers

Power imbalances can further exacerbate these risks inherent in the relationship protocol. For example, it may be especially hard for a junior member of a team to express unhappiness with unwanted behaviour from someone more senior.

> *If your manager is the one that's done something wrong then it's much more difficult to escalate the issues than it is if it's obviously a colleague. [Prac 01 f]*

> *If A is sort of a senior, their employer, it could make B feel very compromised regarding their job. [...] That may stop them seeking help for it. [Prac 04 f]*

As noted in Section 1.4, participants argued that quasi-social settings in the workplace are limited by a need for parity between participants. Where a power imbalance exists, the application of the relationship protocol may be considered inappropriate – even for less serious behaviours. For example, the behaviour 'A asks B out on a date' – considered unproblematic by most participants – can become problematic if A is in a position of authority.

> *For example, A is a GP partner who is mentoring for a few weeks a nurse trainee, a nurse student, and she's got exams coming up that he's helping her with, and all of a sudden he decides to ask her out, I think then it becomes a bit more sinister. [Prac 18 m]*

> *I think actually, if you're someone's manager, are they in a position where they can easily say, no, I don't want to go on a date with you without that being... compromising their workplace? [Prac 17 m]*

Participants also highlighted the need for managers to *exemplify* standards.

> *I would definitely say that they should know better. [...] I feel that if they're doing that, then what example does that set to the people below them, who are working with them? [Prac 14 f]*

> *They are my staff. I'm their manager. I have to be seen to be professional and act appropriate. [Prac 19 m]*

Describing the situation in the organisation where his partner worked, one participant highlighted the problems that can arise if those who may have to deal with complaints (in this instance, people working in HR) fail to exemplify the standards to which they will need to appeal.

> *They've encouraged and participated in this culture in the organisation for a couple of years. And so anybody making a complaint, the fall-back position for the person having an allegation made against him is: this is acceptable behaviour where I work. [Prac 18 m]*

Another participant discussed at some length how the experience of becoming more senior in his profession had changed his perspective on the topics being discussed.

> *You do have to, I think, check… not everything you say, but check how you come across, check how you're perceived and how your team act. […] I've got a professional responsibility to those that are junior, in training and still being moulded, learning, finding their own way. […] It is my responsibility to try and teach… probably the wrong word, but almost to tell them what is acceptable in the team and what isn't. And I think that just comes from, you know, two years ago I didn't have that patient group responsibility. I was working for someone. [Prac 06 m]*

As well as exercising caution with regard to their own behaviour, of course, managers also stand on the front-line when the behaviour of one of their team members with/towards a colleague crosses a boundary. In the next section, we will consider the factors which participants felt needed to be considered when dealing with boundary-crossing behaviour. Where the transgression is a relatively minor one, however, the first question for a manager may be whether to do anything at all. Diversity within a team cuts both ways: and the unhappiness of some team members needs to be balanced against the needs of others.

> *There are 180 folk that I work with and they're all very different and one of the good things about the [service] is the variety of people and some of them have got actually diagnosed mental health, social problems, […] people on the autistic spectrum as well who have problems with communication obviously, and there are people that talk about their sex life probably a bit too much as well. […] You just find the right job for them. It certainly doesn't… they shouldn't be losing their job because of this. As long as it's not illegal, overly offensive, impacting on their patient care, getting complaints […]. There will be a line that gets crossed at some point, but there's a huge amount prior to that line that just needs to be monitored potentially from afar with a quiet word [if they move] towards the line. [Prac 11 m]*

Once again, the key challenge is to decide where the "line that gets crossed at some point" lies. What one person perceives as monitoring a situation may be seen by another as negligence.

> *I have seen it in the workplace, where someone has put – it's not sexual – but put comments up on social media about other people. And nothing has been done about it. Nothing is done about it. And it's a big issue between the team. [Prac 09 f]*

> *I think even in our team it's quite diverse but we have certain characters who like: oh yes, just ignore him, that's just what they're like. That's a joke to them. They don't mean anything by it. But I suppose if you look at that more in depth, really they shouldn't be doing that if it's making somebody else uncomfortable. [Prac 01 f]*

In the end, as the participant quoted below argues, the only way to establish where the line lies may be to look *outside* the team and its internal norms to external standards of behaviour: that is, to fall back on the standards protocol.

> *If somebody comes in and they hear somebody else saying it, they might think: oh, well that's normal for here, so we can get away with it. We can say this, we can say that, because so-and-so does it. And I've heard somebody else doing it, so therefore we can do it. Whereas… And it can get quite like that on a ward setting. Because you need somebody who can take a step back and come in and say, well actually, that's not appropriate. [Prac 21 f]*

# 3. Why was the boundary crossed?

In this section we examine the views of practitioner participants on the reasons why behaviour with/towards colleagues sometimes crosses boundaries. An important distinction was drawn between one-time errors, which can often be resolved within the team, and deeper flaws in individuals. More serious behaviours and persistent patterns of behaviour were seen as evidence of flaws – either in a person's understanding, or in their motivation.

## 3.1 Errors

When behaviour with/towards a colleague crosses a boundary, then someone – typically a manager in the first instance – has to decide what to do about it. To make this decision, they may first need to establish *why* the person has behaved in this way.

In some circumstances, the behaviour may be diagnosed as the result of a one-time *error*.

> *Everyone's human. […] Sometimes you make the wrong choices. [Prac 01 f]*

The critical requirement for this diagnosis to be made is that the context makes it easy to understand how someone might have made the error in question. For example, the history of previous interactions between the people involved, and the norms developed in their relationship, may make it easy to see behaviour as an inadvertent overstepping of the mark.

> *If there's something that's led up to that, if it's been something that they've been talking about before, and they're kind of happy with that, then it probably would make it slightly less [serious]. [Prac 21 f]*

Some participants described their own experiences of overstepping the mark with colleagues, or at least fearing they had done so.

> *Everybody can probably say at some time in their life they've done something and they've not meant any harm by it but it's upset somebody. Again, that doesn't necessarily mean they're bad at their job. It's just that they made a misjudgement on that occasion. [Prac 01 f]*

> *Sometimes I think, oh God, I shouldn't have said that, you know? And it's human nature, you know? [Prac 09 f]*

A number of other factors can contribute to the plausibility of the diagnosis of an error. For example, the shared norms of a group – while they in no way *legitimise* behaviours, as we saw in Section 2.1 – may make the diagnosis of an error more plausible.

> *You get somebody new coming in and they hear something and think, oh, that's normal, I can get away with saying that. [Prac 21 f]*

> *[If] they come in and that's what people are doing, you become a bit brainwashed about it? [Prac 04 f]*

The same is true if the individual in question is young or naïve: the behaviour is not thereby legitimised, but it is easier to see it as an error.

> *I'm thinking this [Scenario 3] is a very naive person who is, you know, doesn't have a clue really. I'd question his maturity, his actual understanding. I'd be interested in how old he is.* [Prac *04 f*]

Alongside these factors, mention was also made of the role emotion and stress can play in leading people to make mistakes. As with culture and youth, these factors don't excuse or legitimise behaviour; but they do can make the diagnosis of an error more plausible.

> *We work in some quite high intensity scenarios where feelings and emotions that wouldn't necessarily be drawn out of you in say a dead test, for example, get drawn out of you, so then people react and manage those feelings in different ways. Sometimes they might do something inappropriately in the moment but they don't actually mean it, or especially say something inappropriate in the heat of the moment that they didn't actually mean, but that's because they were struggling to deal with their emotions regarding whatever it was that we may be dealing with. […] I think there's more appropriate ways of letting off your steam. [Prac 01 f]*

Where behaviour is the result of an error, there is a good chance of settling it informally within the team – with the aim being to prevent a recurrence of similar behaviour.

> *I think if it's a one-off you can probably speak to that person and say look this behaviour isn't acceptable. This had this impact on this person, for example, and then that person's got a chance to deal with that and rectify that. […] You know, everyone makes mistakes. I'm a firm believer in that. People do sometimes judge a situation incorrectly. But that doesn't necessarily mean they're bad at their job just because they've made one error. [Prac 01 f]*

> *We are all human. We have all got individual personalities. And you know we've got to work with different types of people rightly or wrongly. They may not sit comfortably with us but that's how they are and that's how we are and we all lead a life slightly differently. […] We can't go immediately to Fitness to Practise for everyone. [Prac 02 f]*

An apology can also play an important role in the satisfactory resolution of an error – or indeed may be all that is needed.

> *I think that's [an apology] an appropriate resolution. I think we are all human. Sometimes our humanity's exposed and doesn't look great but, you know, that would be an appropriate resolution. An apology and no repetition of the event. [Prac 05 m]*

### 3.2 Flaws

While factors such as a past relationship, culture, naivety and emotion can all make the diagnosis of an error more plausible, others make it *less* so.

Two factors in particular stand out. The first of these is if the behaviour in question is so serious (see Section 1.2) that it is beyond the scope of the relationship protocol, and therefore hard to understand how it could have been an "honest mistake". In these

cases, for example, participants felt that apologies were completely irrelevant to a resolution of the matter.

> *I think it [an apology] potentially does [help] if some of the things we talked about where somebody has completely misread the situation and… I might find this one acceptable ['A asks B out on a date']. I still think I would struggle with most of these because I struggle to see how you would so misread a situation that you might do something this extreme. [Prac 17 m]*

The second factor which makes the diagnosis of an error less plausible is if the behaviour in question persists – and in particular if it persists *after* being called out in some way.

> *That ['A asks B out on a date'] happens, and that's life, isn't it. That's how things are. Provided it's not more sinister than that, provided it's not B has already said no, and they keep pestering them, or it's done in a particular way that makes B feel uncomfortable. [Prac 18 m]*

> *For that person to do it again shows that it's a different trail of thought going through their minds. […] It would be a bit more… How to say? A bit more of a darker problem, I would say. Because the person has obviously thought about it, knows they're not happy but yet still doing it. So it's a bit more sinister as towards a jovial, sorry, you know, we were all having a laugh and things got a bit out of hand and everything like that. [Prac 03 m]*

Either of these factors, severity or persistence, suggests that it may be necessary to move beyond mere error in explaining behaviour and instead look for some kind of underlying *flaw* in the individual in question.

> *If you've done that, then the thought behind it… The action in itself is, yes, it's bad. But then the action, the thoughts behind it are even worse. […] It's a question of the mindset of colleague A. [Prac 20 m]*

> *You know, what sort of person is this that is prepared to have that conversation repeatedly maybe? [Prac 18 m]*

> *Somebody that doesn't understand the impact that they might have had, or somebody that's misinterpreting, doesn't believe that B is actually upset, or somebody who's doing these things out of malice, I suppose. [Prac 13 f]*

The last of the quotations above neatly illustrates the two main classes of flaw suggested by participants. On the one hand, there are what we may call **flaws of motivation** – something "sinister" explaining the behaviour of the individual.

> *I think if they've sent something to somebody with the intention of hurting them or upsetting them or offending them, that's a lot different to somebody that said something meant as a joke or meant in jest. [Prac 01 f]*

> *I guess it's the intention behind it. […] That person [A in 'A makes rude sexual comments about B on social media'] has to know that if they do that on a public platform that that could have ramifications that are much wider. [Prac 13 f]*

On the other hand, there are what we may call **flaws of understanding** – the lack of, or failure to use, what the participant quoted below elsewhere called a "sixth sense".

> *For the most part, if you're the right sort of character, you know what can be said and what shouldn't be said, and I think… If you don't know where the line is, you probably shouldn't be a healthcare professional, to be honest.* [Prac *15 f*]

The flaw here is that an individual lacks some part of the cognitive apparatus necessary for successful social interaction: for example, they are failing to assess what is appropriate in certain situations, or they are failing to pick up on the reactions of other people. For one participant, the mere fact that someone else was offended was evidence that the individual in question "lacked insight into how to deal with the situation and what's appropriate" [Prac 06 m]. Another argued that the failure to apologise for an error would be similarly worrying.

We shall have more to say about both classes of flaw in Chapter 7, as they are central to a key argument for the relevance to fitness to practise of behaviour with/towards colleagues. They also suggest a need to move beyond informal approaches to resolution, which may be appropriate to errors, and take a more formal approach.

# 4. Public perspectives on behaviour with colleagues

So far in this part of the report we have focused on the responses of practitioner participants. In this section, we turn to the responses of public participants. These responses, we shall argue, were entirely in line with the patterns identified in Chapters 1-3 – although it is unlikely that we would have identified these patterns if we had had only those public responses to analyse. In general, public participants had less to say about behaviour between colleagues in and of itself – though plenty to say about its possible implications for patients and the public, as we shall see in Part B.

## 4.1 Out of sight, out of mind?

The everyday realities of relationships between colleagues working in health and care are remote and abstract for those who do not themselves work in these settings. Instead, our public participants tended naturally to start from what lay within their own actual and possible experience: behaviour between colleagues that breaches the privacy constraint described in Section 1.4.

> *It depends where the conversation is happening as well, because obviously if it's in a hospital or wherever, you can't just have it in a corridor where patients and people are walking around, like, oh, okay, I just heard that doctor talking about his sex life. [Public K1 f]*

We shall discuss the impact of behaviour that is witnessed or heard about by the public further in Section 6.1.

Notwithstanding this natural focus on behaviour they saw or heard about, however, public participants did recognise that practitioners had lives beyond their public-facing professional personas – lives in which they should not be expected to maintain the standards required of them in front of patients.

> *I wouldn't expect somebody in a caring profession to be an angel. I'd still expect them to be human. [Public G1 f]*

> *We all do what we want to do when we're not working. When I'm at work, you've got to have to be a professional and everything else. But when you're not, you don't hold it. You let your hair down. In that respect, I personally wouldn't judge them. [Public H1 m]*

Like practitioner participants, public participants applied the relationship protocol to social settings outside work, but the standards protocol to patient-facing settings at work. Also like practitioner participants, there were differences in their views on *private* settings at work, and whether or not these might reasonably be seen as quasi-social settings in which the relationship protocol applied. Some participants questioned whether there was any scope for the relationship protocol at work:

> *It shouldn't be happening in the workplace. Wait until you're outside, going home, do it in private. […] You're there to do a job not talk about your sex life. [Public J2 m]*

> *If there is a code of conduct and your code of conduct explains that you have rights not to be offended in this way, then that person has broken that code of conduct and to me I'd put it right at the top. […] If there is*

> *nothing in the code of conduct, then really there is nothing to say that they've done anything wrong. [Public D2 m]*

More common, however, was a degree of realism about what would probably be going on when patients were not present.

> *In today's day and age, it's one of those things that happens in every workplace. [Public L2 m]*

Television may have played a role here – as one practitioner participant also noted – with reality TV programmes and dramas giving people at least the *feeling* of seeing what they don't normally see.

> *You know like on telly, you have One Born Every Minute? And you have them sitting in the, like, the staff catering unit or whatever, and they're talking about personal stuff, like relationships and stuff. So it's a bit, like, I don't know, they're just normal people. And I would expect any one of these professions to be a normal person. So they would have general conversations like that. [Public K1 f]*

> *We all watch Holby[**], it ['A asks B out on a date'] happens all the time on Holby. [Public E1 f]*

> *They [reality TV show] show a lot of in-theatre footage and a lot of the time they're doing the most complicated operations. And they're bantering, you know: I hope you had your Weetabix this morning, boys. Or, you know, this kind of stuff. [Prac 05 m]*

The kinds of "general conversations" and "bantering" being considered in our interviews went beyond eating breakfast, of course. Nevertheless, the idea that practitioners might be talking about sexual topics was unproblematic for some public participants, provided it was not witnessed by patients.

> *When they are in the staffroom, they are kind of… they are not off duty, but it's their social time, with their friends, isn't it? [Public E1 f]*

> *If you're both just having a conversation and you're having a laugh, yes, that's fine. You're two consenting adults having a chat. […] At the end of the day, hopefully we all have it, it's a natural thing for us all to do and to talk about. It's just knowing appropriate times to do that and who is within earshot and things. [Public A1 f]*

In line with the reflections of some practitioner participants, one public participant noted how discussions that would be unacceptable in front of patients might, in private, be part of a survival strategy.

> *People develop a sense of humour or a funny sense of humour sometimes doing the job they are, as to say to get rid of stress maybe. […] Just make sure it doesn't get overheard in the conversation. [Public D1 m]*

As the last quotation indicates, however acceptance of the fact that practitioners might talk in these ways in private was tempered by a need for caution. Practitioners might have quasi-social settings at work like those working in any other sphere; but the need for caution in health and care may be more pronounced.

[**] A popular hospital-based soap opera in the UK

> *Well, they are all people and they are all entitled to a life, but I think they just…. that just goes with the territory, I think some professions, that you have got to be mindful of your behaviour. [Public E1 f]*

> *The difference in healthcare professions to offices is obviously in the offices you've only got your staff so it's totally different. You've not got any outsiders watching you. [Public H1 m]*

The need for caution is perhaps best illustrated by the setting of an operating theatre, where the patient is physically present but, if all goes to plan, does not witness anything that goes on. One practitioner participant noted that he had non-medical friends who were outraged by the thought that teams might listen to music during an operation. One public participant, meanwhile, described how a relative had remained partly conscious while under general anaesthetic, and so had heard the team operating on him make sexual comments about his body.

### 4.2 Assessing the unseen

When it came to deciding whether or not behaviour which they did *not* see crossed a boundary, the responses of public participants were entirely in line with the patterns identified in Chapters 1–3. Often, public participants would develop their thinking by means of analogy with the fields in which they themselves worked. For example, such analogies are used in the two quotes following to introduce the relationship protocol, and to argue that it is inapplicable to more serious behaviours.

> *If they've worked with each other for 10 or 20 years, then they're going to have that open relationship. If somebody just walked into there, then they're not going to know that person. It varies, it really does. I think that varies in every profession, not necessarily the medical side of it. [Public H1 m]*

> *If I think about it in the context of my own industry, or in my entire career. Where even if I've been quite chummy, or there's been a good level of banter, and a very similar wavelength of humour that I could have had with either a male or a female colleague, would there have been any scenario at all that I would have sent an explicit photo of myself to them… Even in the context of a good friend at work the answer is absolutely no. [Public B3 m]*

Both physical and intrusive behaviours were identified by public participants as being more serious – with a particular focus among our public participants on intrusive behaviours. One of the younger trios (aged 18 to 24) argued that asking questions about someone's sex life is worse than sending an explicit photograph of oneself, because it is more intrusive.

> *[Asking questions is] Putting them on the spot and making them feel uncomfortable and not really giving them a choice. Whereas this, if someone's sending you a picture, you just go ugh that's disgusting, brush it to one side and just ignore it. Talking about your sex life as well you can just say: I don't want to know, and just walk away can't you? But if someone's harassing you, sort of like: oh, what do you do in your sex life? [Public K2 f]*

As already noted, the scope of the relationship protocol was also limited to quasi-social settings; and while the main focus was on the need for these settings to be strictly private, and not witnessed by patients, mention was also made of the need for parity.

Again drawing on their own experiences in workplaces, public participants also took similar lines on the possible benefits and definite risks of a shared norms and banter.

> *What's the alternative to living? You're not allowed to have a joke. And it's when the joke goes too far and the banter becomes too far. […] You have banter, it will be friendly, and then it's something that goes just that little bit too far. And where is that dividing line, where is it too far? [Public J3 m]*

> *You've got to be careful with banter. I've fallen foul of it, you know, I've taken the piss out of people and they've got offended by it and therefore I've apologised to them. Whereas most of the time, you give what you get back and that's banter, but as I said sometimes, you know myself, I've overstepped the mark. [Public D3 m]*

Like our practitioner participants, public participants were clear that banter was only acceptable if it rested on the genuine consent of all of those involved – and that establishing this consent can be difficult.

> *When we talk about banter right, you know that means sort of two, let's say mutually minded, or like-minded people who think that, that level of humour is acceptable to both, that's how I interpret that. [Public B3 m]*

> *I know it's different, I'm in an office. But we've got a group of four or five of us and we do have banter and we sometimes think what if someone overheard us talking like this. […] That's fine if everyone is on the same page. But it's really difficult to assess if everyone is on the same page, I guess. […] If B hasn't expressed discomfort or whatever word we would want to use, then you kind of think, well, it's difficult. It is hard because you think, should they [i.e. the people engaging in banter] be doing it in the first place? [Public A1 f]*

The idea that shared norms could be used to justify behaviour was rejected, and the point again made that, if such a justification was offered, this called the team culture into question as well.

> *If the people who, like the females and that, have said they haven't liked it basically, and they've gone and complained about it, then obviously it's not a joke within the group. [Public K2 f]*

> *I think you need to look at the whole department. You speak to everybody, not just that one person. [Public E3 f]*

> *If that sort of thought continues, then it's never going to change. […] It's not acceptable in any culture and in any way. It just has to change, you know. I don't want to be spoken about like that. And it's not okay just because this is lads' talk. It's not okay. [Public C3 f]*

### 4.3 Errors and flaws

Public participants also drew a distinction between errors and flaws along the same lines as that seen in the responses of practitioner participants.

> *There could be absolutely no intent, they could be completely innocent, real misjudge of character, real misjudge of situation. And to lose a job because of that seems a bit sad. [Public A1 f]*

> *I'm quite a realist with stuff in life. Stuff goes on, we make mistakes. [Public D3 m]*

In line with practitioner participants, public participants took the view that minor errors can be resolved informally. Indeed, there was some sympathy expressed for practitioners making minor errors.

> *I don't think that would bother me in that respect. If he's genuinely accepted that he has done something and he just got past the line a little bit and realised he has made a mistake and apologised for it. [Public H1 m]*

> *I would be thinking that they are in these roles but they're also human. And I would not forget the fact that you can't teach human aspects of anyone's specific role. There's still a human being behind it. [Public J3 m]*

> *I think it's quite unfair that we can raise them up because they are human and everybody makes mistakes. I'm not saying that's just a mistake and we can all forget it and move on blah, blah, blah. I'm not saying about that. But I just think it's quite a lot to take on, you know what I mean? [Public C3 f]*

One topic discussed in rather more depth than by practitioner participants concerned the relevance of youth and naivety to the diagnosis of an error. Some public participants again felt that this was a consideration.

> *In your 20s you're quite young and you might do this. […] Yes, naïve. And do these stupid things … well, silly things. Whereas if you are older, you would have more common sense. [Public G2 f]*

> *The age of A as well, you know. If he or she is 20 years old, or if he is 50 years old I think it is different you know, we can excuse the youth you know more than… You know what I mean? [Public B2 m]*

However, the argument was also made that, given the level of training they receive, even younger practitioners should have better judgement.

> *You would expect them to have a certain level of training before they come into the profession about how they should conduct themselves. So regardless of age, whether they are both in their 20s, you would still expect them to have that level of training before they come into the profession. [Public G1 f]*

Specifically with regard to social media, one participant argued that younger people ought to be *more* aware of the risks, on the grounds that they had been taught about at school as older people had not. Another participant argued that it is sometimes older people who make errors because they have failed to keep up with social change.

In line with practitioner participants, a diagnosis of error was rejected for more serious behaviours and patterns. There was particular concern about patterns of behaviour, which were once again seen as evidence of a flaw.

> *It [repeated behaviour] shows that there is something wrong at a deeper level. [Public G1 f]*

*Their head might be a bit messed up. If someone is telling you to stop that and you keep doing it then you have to question are they all right in the head at the moment? [Public L3 m]*

*If B is looking uncomfortable, and doesn't want to talk about it, then I would be concerned that A is still asking them the questions. […] So A is not that caring, not a particularly nice person, is probably not in the right job. [Public E2 f]*

## PART B
# Fitness to practise

In this part of the report, we describe patterns in participants' views on whether and how behaviour with/towards a colleague that crosses a boundary is relevant to fitness to practise.

The Professional Standards Authority (2014) states in '*A statement explaining the purpose of the fitness to practise process'* that:

> *Although each regulator has their own different [fitness to practise] process, they all share the same purpose which is to protect the public and maintain public trust in the professions they regulate. The regulator will take action against a professional if it decides it is necessary to:*
> - *Protect the public*
> - *Maintain public trust in the profession and/or*
> - *Declare and uphold professional standards.*

Protecting *colleagues* from inappropriate behaviour is not explicitly mentioned in this high-level of statement of purpose. The question of when and how such behaviour is relevant to the stated purpose of the fitness to practise process is therefore a substantive one.

It is also a question that our participants found taxing. One practitioner participant noted how easy it was to "tie yourself in knots" on these issues, while another remarked at the end of the interview that: "I didn't expect that to hurt my head so much." The focus on patient safety and public confidence in the stated purpose of the fitness to practise process led to hesitation and self-questioning throughout our interviews with practitioner participants: in first responses to behaviours;

> *I'm not sure if it means they shouldn't be what they're doing [...]. But I don't think it's right at all. [...] I don't know if it's... they should be marched out the door, but I don't think they should be getting away with that. [Prac 10 f]*

in reflections on experience;

> *Your direct fitness to practise and your qualities as a colleague can sometimes be quite different things. I mean, I've got no personal experience but you do hear stories of everyone's favourite colleague being a complete drunk and not being able to get an IV in a patient because... and this is years ago because they had shakes in the morning before they'd had a drink and all this kind of stuff. But they're an amazing colleague, supportive, a shoulder to cry on when, you know, when things were going badly. And in that case they would be not fit to practise, but a great colleague. And conversely you hear about these very high powered teaching hospitals where people are incredible professionals and amazing with their patients. But it's like working with a Tyrannosaurus Rex, you know, if you don't watch your back you just get eaten because they're just toxic human beings. [Prac 05 m]*

and in assessment of scenarios.

> *It would then be difficult just to strike this guy off [Scenario 1] and say you're not fit to be a dentist, unless the definition of a dentist includes showing respect to your colleagues or not abusing colleagues, if you like. [Prac 12 m]*

Public participants wrestled with similar hesitations and questions.

> *Again, if they send a picture of their you know what… but they could be an amazing dentist, by sending that, does it really affect how well he looks after your teeth? And I do believe that that is serious, but I'm just saying it doesn't affect their ability to do their job. [Public A1 f]*

Despite these difficulties, practitioner and public participants alike developed arguments for the relevance to fitness to practise of behaviour with/towards colleagues. These arguments turned on an analysis of i) the impact of behaviour with colleagues or ii) the risks highlighted by such behaviour. They are discussed in Chapter 6 and Chapter 7.

Before looking at these arguments, however, we first explore in a little more depth the reasons *why* the concept of fitness to practise proved so tricky to work with.

# 5. Fitness to practise and other constructs

In this section, we explore the overlaps and disconnects between, on the one hand, the technical concept of fitness to practise and, on the other, the ways in which practitioner and public participants actually made sense of inappropriate behaviour with colleagues. Fitness to practise co-exists with a number of everyday, ready-to-hand constructs – professionalism, technical competence, willingness to see – which at times confuse, at times illuminate.

## 5.1 Fitness to practise and professionalism

The first construct from which fitness to practise needs to be disentangled is "professionalism". As we noted in Section 1.1, the everyday sense of this term – which applies to anyone working with other people, and which includes within its scope behaviour with colleagues – is one possible source for the standards invoked in applying the standards protocol. The statement that a given behaviour was "unprofessional" was common in our interviews with practitioners and public alike.

Unlike fitness to practise, there is no need to establish the relevance of inappropriate behaviour with colleagues to professionalism in this sense: it is part of the meaning of the term. Professionalism, we might say, is *larger* than fitness to practise.

For practitioner participants, moreover, there was a strong resonance between this inclusion of behaviour towards colleagues and the actual behavioural concerns of managers and employers. Some participants used the potent phrase "duty of care" to capture the real responsibilities that exist within teams and organisations.

> *I think a manager has a duty of care towards the staff that they work with. [Prac 16 f]*
>
> *We also have a duty of care to our colleagues. [Prac 13 f]*
>
> *Because every single profession has a duty of care to patients and to each other as well, so whether you're a pharmacist or a midwife or a GP, just because you're a GP doesn't mean you can fondle a midwife. [Prac 21 f]*

Whatever its relationship to fitness to practise, professionalism towards colleagues is a real and legitimate concern for anyone trying to maintain an effective team.

> *Again, it doesn't have to just be in [healthcare], it happens in management in an office. If a manager did that [send an explicit photo of themselves], the same with the colleague, and then the colleague felt he couldn't come into work and they'd go off with stress and sick. All because of what? All because the [practitioner] couldn't act professionally […] It's okay to be good at your job, but you can't… You've got to work with people as well. And you can't work with people if you're acting that way. [Prac 03 m]*

We suspect that matters may be further confused here by a tendency to misunderstand the technical relationship between fitness to practise hearings and escalation processes within organisations. Within an organisation, as we saw in Chapter 3, errors may be dealt with informally within the team; but more serious or persistent behaviour, suggesting flaws, is likely to require escalation – which involves a shift in both style (informal to formal) and scope (team to organisation).

Fitness to practise proceedings represent a *parallel* and distinct process to any formal process instituted by an employer. The responses of some practitioner participants, however, suggest a tendency to view fitness to practise proceedings as a further, *serial* escalation, involving a further shift in scope (organisation to national) and gravity (job to career).

> *If I ever hear that the [Regulator] is involved in something bad, I think; someone's done something really bad and they're going to go. [Prac 10 f]*
>
> *Supervision was like a way of assessing cases to identify the ones that were appropriate to send to the [Regulator] and the ones that could be dealt with within the trust. [Prac 13 f]*
>
> *I have been involved with some like on-going type bullying issues. And again they have been taken towards a disciplinary approach as well. And a local disciplinary approach, not as far as the [Regulator] or anything as far as that… But certainly down a local disciplinary approach. […] And again that goes back to the bullying coming from someone that blankly has completely got no self-awareness. They can't see that they're talking to people in that way despite several conversations and it being on their records and it being discussed lots of times. At that point you wonder, should it… Could it escalate further within Fitness to Practise? Because locally they're struggling to deal with it. [Prac 02 f]*

Further evidence for this tendency to understand fitness to practise as a serial escalation, rather than a parallel process, may be found in cases where issues are 'resolved' at an organisational level by someone leaving their job, and so never referred to a fitness to practise process – even though the individual in question may be continuing similar behaviour in a new job. (Scenario 1 could be read as providing an example of this kind of case.)

> *We've had this situation where someone's been marched out the door. But I know that they have restarted and still do it at another office, another practice. They're no longer with us, but they're still doing it elsewhere now and started again. So I don't know. They definitely would be out of our practice for something like that. [Prac 10 f]*
>
> *He was too clever to ever have an improper relationship with a patient, and I was glad when he went [meaning no further action was taken]. He was a nasty piece of work, and he certainly could've… The level of manipulation and intimidation that I've no doubt he exercised, he was capable of absolutely anything. [Prac 18 m]*
>
> *Because what can happen is somebody might get reported, but then if it's all kind of hush-hush, all undercover, they'll just move jobs, go to another hospital, and the same thing will be repeated and repeated until eventually something even bigger happens. [Prac 21 f]*

It is our hypothesis that this tendency to misunderstand the technical relationship between fitness to practise hearings and escalation processes within organisations further confuses the relationship between fitness to practise and the more everyday concept of professionalism. After all, if fitness to practise processes were a further, *serial* escalation of proceedings within the organisation, then it would be reasonable to

expect them to address the same range of behaviours as processes at the lower, organisational level – including behaviour towards colleagues.

Confronted with the reality that protecting *colleagues* from inappropriate behaviour is not part of the fundamental purpose of the fitness to practise process, some practitioner participants responded that it *should be*.

> *But because it's a colleague it's different. […] No, what, why..? No, I don't think so. What… why should it be different? […] I don't think that we should be treated any different, whether we're a patient or not. What makes… why can they take more advantage of us? I get that they work with us and they maybe know us better and what have you. But still, we've got a right not to have these things said to us and touched and what have you. I know it's a more bigger deal if it's a patient. I understand that. But I still think that, yes, for us… [Prac 10 f]*

A similar view was expressed in one of the public trios.

> *Why should a female member of staff be any different to a patient. It's the same thing. [Public D1 m]*

### 5.2 Fitness to practise and technical competence

In our interviews, we were careful to explain the focus of the fitness to practise process on patient safety and public confidence. In response, some participants fell back on another ready-to-hand construct which clearly does *not* include behaviour towards colleagues: technical competence. In the following quotation, for example, a public participant distinguishes competence from professionalism.

> *It just makes you question professionalism. Not competency, because you can be a sleaze and still be able to do your job, but it just makes you question their make-up, really, and the way they conduct themselves. Professionalism, really, is the main thing. [Public A3 f]*

The irrelevance of behaviour towards colleagues to technical competence was commented on by some of our practitioner participants.

> *['A sends an explicit photo of themselves to B'] Unacceptable. it doesn't, really doesn't affect how they can do their job, but it's a behaviour that is just not tolerated. [Prac 06 m]*

It was also discussed in a number of the public trios.

> *The fact that someone sent a picture to someone isn't going to affect that person's professional opinions. You are there for one reason and one reason only. While you might think well, that's wrong, it's bad and all that, is it going to make you to go home and think oh, well, I need to get a second opinion because that person sent a picture? [Public L2 m]*

If professionalism is *larger* than fitness to practise, however, then technical competence is clearly *smaller*. The recognition that behaviour towards colleagues is not relevant to technical competence was never the final word in a developing line of thought, but instead the acknowledgement that the connection to fitness to practise did not lie here. For our public participants in particular, considerations about technical competence

were often embedded in a larger argument about whether you would be *willing to see* the practitioner in question as a patient.

> *If the dentist slapped the dental nurse's bum, it would make me uncomfortable. And I would be happier to see a different dentist the next time I came. But it wouldn't make me question his ability to do my teeth. But I wouldn't necessarily approve of what he did, especially if the dental nurse was upset about it and you know she was crying in the corner. Then I would say: I don't want to see this dentist again because I don't approve of the behaviour. […] And however good they are, if you feel uncomfortable being treated by them because of something they've done, whether to you or somebody else, then that makes all the difference. [Public C2 f]*

### 5.3 Fitness to practise and willingness to see

The construct of a patient's 'willingness to see' a practitioner – along with related constructs, like being happy or comfortable seeing them – was used by some of our practitioner participants as a way of exploring their sense that certain behaviours towards colleagues would have an impact on a practitioner's fitness to practise even though they did not call into question their technical competence. Scenario 1 in particular elicited this line of reasoning.

> *Would a young attractive female patient be happy lying in his chair and being treated with him after if she knew all of these things that he'd done? […] If all of his patients know, would they say: oh, he's brilliant, you know, I'm going to go and lie in his chair. I don't think they would. I think that would impair his fitness to practise. [Prac 05 m]*

> *Would I want him treating anyone in my family? No. Would I want him working with anyone I know? No. [Prac 06 m]*

> *I think they're very vulnerable. I think in a dental chair you're back there. It's a fairly… And actually I think actually this person… I feel vulnerable already. As I read about this, telling her you could look down her top, I just feel like you wouldn't feel safe. And if patients… I think patients would equally feel vulnerable in that setting. [Prac 17 m]*

Responding in the first person, some members of the public also indicated that they would not be willing to see the dentist in Scenario 1.

> *If I found out that that was my dentist and he was practising elsewhere, I would be mortified. […] No, I would not go and see him, I would not want to go to that practice if they were still employing him. [Public E3 f]*

Like fitness to practise, willingness to see is *larger* than technical competence, but *smaller* than professionalism. Unlike fitness to practise, however, willingness to see is shaped not only by the behaviour and qualities of the practitioner, but also by the situational needs of the patient.

> *And would I want to be treated by someone who is making sexual comments about someone else on social media? It wouldn't be ideal. It's not the end of the world but it's not… If they're going to keep me alive, then fine, but I'd rather someone that's more respectful. [Prac 07 m]*

> *How long have you got to wait to get a doctor, how long have you got to wait to get a surgeon? If I find out in the waiting room that he'd sent a dirty photo to someone and I didn't like it and there's a complaint about it, I'm not going to get up and walk out and wait another 4 weeks for a doctor's appointment. [Public D3 m]*

A number of factors were identified by public participants as having a bearing on their willingness to see a practitioner. One interesting feature of these factors is the extent to which they lead to *differentiation* between different professions. For example, consider the following quotations, from the three public participants in a single trio, illustrating how factors such as the nature of the treatment, its urgency, and whether one has a meaningful choice influence willingness to see; and how these factors lead to differentiation between professions.

> *I don't know why I would feel I would find that okay, to go and see them, to be honest. The radiographer, I just think that's… it's quite a procedural thing: right, get that done, I don't need to know their backstory. [Public F2 m]*

> *Gynaecologist, midwife, the quite invasive, quite personal… I think it's as they get more personal, I think as it gets more into medical, as opposed to audiologist and optician is quite a routine… [Public F1 m]*

> *Those where you're laying yourself up and then you're actually thinking, I just desperately need some form of medical intervention, I think you're not bothered, no. You're less bothered. [Public F3 m]*

> *An optician or a dentist and the audiologist, you could almost change where you're going to go to. You could go to a different optician, Specsavers, or a different place, a different dentist. [Public F1 m]*

A key consideration across our public participants was the extent to which their interaction with a practitioner would make them vulnerable – or at least feel vulnerable. There was particular concern among female public participants about roles such as GPs and gynaecologists.

> *It's just personal, it's your personal bits, isn't it? It makes you feel vulnerable. It makes you feel vulnerable when you sit in there, not to sound graphic, but your legs up there, you're vulnerable. Whereas if you're having your eyes looked at, you're not as vulnerable. You're still vulnerable because they're still doing things that could potentially hurt you. But there is that element of vulnerability with gynaecologists. [Public A1 f]*

> *Maybe if A was a gynaecologist and I was going to see this person, I would worry that they would take explicit photographs of me and send them to somebody else. So it would depend on what they are. If it's, I don't know, an optician, does it really make any difference to how they're going to look at my eyes? I don't think so. [Public C2 f]*

> *I think because they're … it's kind of more physical, isn't it? They are being … for example, if you go into the bank and you found out your bank manager was doing this kind of thing, the interaction between the bank manager and yourself is not physical at any stage so … But with a GP, they might need to touch you, they might need to see certain parts of your body. [Public G1 f]*

Similar points were made by male participants with respect to wives and sisters.

> *If I saw, say, my GP grab the nurse's or whatever arse, I'd think: what if my sister were alone in the room with him, what would he try then? [Public L.1 m]*

Not surprisingly, in these instances, the gender of the practitioner was also seen as very relevant to willingness to see.

> *My feelings might be different as to whether that was a male gynaecologist or a female gynaecologist. […] A woman, I would feel less threatened by her behaviour, whereas if it was a man, I would feel more threatened by that particular behaviour. [Public E1 f]*

> *Yes, that's why I said it depends largely on who they are because if A was a male gynaecologist sending explicit photographs of himself to a female colleague, then you'd think why is he a gynaecologist? [Public C2 f]*

While mention of intimate physical examinations was frequent, respondents were clear that this was by no means the only way in which patients might be vulnerable to practitioners who engaged in the kinds of behaviours being considered. One participant, for example, drew attention to the potential vulnerability of certain groups of patients.

> *For example, if they were seeing somebody who was disabled or you know they were seeing somebody who had mental health problems or they saw somebody who was particularly vulnerable … How would they behave towards that person? [Public G1 f]*

Others drew attention to less obvious ways in which *any* patient might be vulnerable in their interactions with health and care practitioners, perhaps without knowing it.

> *Because if they can ask B about their sex life, what can they ask you? Or what could… I know they could ask you a question that you might think: oh, it's nothing, but they're… It would be something different to them. Because you don't know what they need to ask you, so they could be asking you questions for themselves. [Public K1 f]*

> *I think with all these professions, you're [i.e. the practitioner] dealing with, not necessarily vulnerable people, but people with issues they can't resolve themselves, whether it be physical or dental or anything like that. You're [i.e. the patient] relying on them to provide you a service to help you make yourself feel better. [Public A1 f]*

As one practitioner participant pointed out, it is unavoidable that patients are vulnerable and that health and care practitioners have power.

> *You know, that patient has a lot of faith and trust in you and they are very vulnerable then to anything you do because their health is so important to them that you're made very powerful. [Prac 04 f]*

Perhaps this is the fundamental reason why fitness to practise has to be distinguished from willingness to see: that the willingness of a vulnerable person is something that a powerful person can manipulate.

The perspective of a regulator, determining the fitness to practise of a practitioner, is distinct from the perspective of a patient making a pragmatic, situational decision

about whether they are willing to see that same practitioner for a given purpose. The point was made well by a public participant who had been clear that he probably would be willing to see practitioners who had behaved in the ways being discussed, when asked what his view would be if he were instead working for the regulator:

> *I think that's different then. From a regulator's point of view, they're asking: have they got a right attitude towards people? Which they haven't. [Public D3 m]*

### 5.4 Fitness to practise, patient safety and public confidence

Everyday, ready-to-hand constructs such as professionalism, technical competence and willingness to see are part of the way in which our participants made sense of inappropriate behaviour with colleagues. But none of them is the same as fitness to practise, a technical construct, remote from everyday experience, which is *smaller* than professionalism, *larger* than technical competence and, unlike willingness to see, *independent of the situational needs of a specific patient*.

Our task was to seek participants' views on whether and how inappropriate behaviour with/towards colleagues is relevant to fitness to practise. In order to help participants keep their focus on this question, we reminded them of the purpose of the fitness to practise process: "to protect the public and maintain public trust in the professions they regulate".

In response, participants developed two types of argument for the relevance of inappropriate behaviour with colleagues to fitness to practise.

- The first type of argument focuses on the **impact** of the behaviour in question, and the ways this may have a negative effect on public confidence or patient care. These arguments are discussed in Chapter 6.
- The second type of argument focuses on the person who has behaved in this way – and on what the behaviour tells us about them and the **risks** they pose in a practitioner role. These arguments are discussed in Chapter 7.

# 6. Impact based arguments

In this section, we consider arguments for the relevance to fitness to practise of inappropriate behaviour towards/with colleagues which focus on the impact of that behaviour. These arguments highlight either the possible impact of such behaviour on public confidence, if witnessed or heard about; or the possible impact of such behaviour on quality of care.

## 6.1 Impact on public confidence

For behaviour with colleagues to have an impact on public confidence, it must first be *known* to members of the public: either because it is directly witnessed by patients, or because it is heard about subsequently.

With regard to witnessing behaviour, we have already highlighted in Section 1.5 and Section 4.1 the critical role played by privacy in setting limits to quasi-social settings in the workplace – and therefore to the kinds of consensual banter that might be acceptable in a canteen or staff room. One practitioner participant expanded on her concerns about how patients might react if they witnessed this kind of behaviour.

> *Our duty of care is really important, that basically the patients are our priority, and some of these things could potentially be taking away from the patient as the focus, or even worse, could be portrayed, if seen by patients, to be something that makes them feel uncomfortable, which is even worse when they're somebody that could be potentially ill or going through a difficult time. It's just not what you need to see. […] They may see the person who's caring for them in a different light or the team that's caring for them in a different light; that might make them worried for other aspects of their care that are unrelated, I suppose. […] I guess it could break the bond, the trust that you build up with someone, the rapport, and make them generally feel quite uncomfortable. [Prac 13 f]*

The responses of some public participants suggested that these concerns are well-founded.

> *I might not want to ask the questions I might want to ask, you know, I might sort of leave it, rather than… […] I might sort of not pursue what I wanted to find out, I might find someone else to go and talk to. […] It's that whole thing of me wanting them to be a professional, rather than a real person. So I don't think I would want to open myself up [Public E1 f]*

It is worth noting that the quotation above is from the same participant who was quoted in Section 4.1 arguing that "they are all people and they are all entitled to a life", and accepting that some of this life may be going on behind the scenes at work on the grounds that "it happens all the time on Holby". But she does not want to be *reminded* of all this when she (or, in this instance, a family member) is in the role of patient: in that context she wants practitioners "to be a professional, rather than a real person".

One practitioner participant commented on the high expectations patients can have of practitioners in patient-facing contexts.

> *You think, okay, I'm coming here for a professional advice and they're just joking about. And we've often had patients that will come, and we might be having a laugh or a joke. Excuse me. And will make the comment: oh, you know, what's so funny? I've come here to collect my medicines. And some people mind, I think they almost expect you to be quite serious, quite focused on the job at hand and I think maybe they forget that you're people. And I think to a certain extent, you've got to be professional. To those people I just go up and say: sorry, you know, we're just human, we're just having a little laugh. Which is absolutely fine, but there's things that I would deem acceptable that are not acceptable. [Prac 16 f]*

These high expectations were also discussed in public trios. For example, some participants compared practitioners to people working in other sectors – such as supermarkets, banking, engineering or construction – to shed light on the reasons why witnessed behaviour might be seen as more problematic in the health and care context. A number commented on the vulnerability one experiences as a patient to explain the difference.

> *For me, it's just that thing where it's very personal. It's not like your bank manager or where it's not sort of in that same personal way, so I think it probably makes you slightly more uncomfortable, when the sexuality is brought into that sort of forum. [Public E2 f]*

> *The difference is, we [in engineering] make inanimate objects and our customers are faceless airlines who have sent representatives in. We're not hands on dealing with people and emotional issues, and for me a key bit of it is establishing trust. Absolute… You've got to trust these people to be impartial, to be very professional, have the ability to make you feel at ease, that you're going to be treated fairly, there's going to be no unwanted, sort of invasion of your privacy. [Public B3 m]*

> *Having a laugh, a joke, when you could be with a loved one who's dying or going through a traumatic time, and just somebody's having a laugh and a joke about whatever, anything. [Public F3 m]*

> *And you can hear them moaning about them [colleagues]: oh, it's him, he's a right… and you just think, okay, well, that's not really what I expect. I want trust in the system, I want… because I'm at my most needy at this point. [Public F2 m]*

Some participants also reflected on the ways in which patients may project an image of a practitioner to which real practitioners must then try to live up.

> *It's because you expect, because of where they are, you put them on that pedestal that they should be acting a little bit different. [Public E2 f]*

> *I think it is because you hold them in such a high light, the NHS; it is one of the few things that is a cherished national asset. [Public F1 m]*

> *We've been conditioned to think this is how a GP should act and this is how a doctor should act. This is how a surgeon should act. […] To then suddenly find out they're actually human, that's I think for some people that's a bit of a shock. [Public C1 f]*

Even if behaviour is not directly witnessed, it may have an impact on public confidence if people subsequently find out about it.

> *If patients overhear this sort of thing or get wind of that, reputationally it's not good. It's not good for the organisation. […] Once a patient loses individual respect or trust in a clinician, once that's broken, that's it. That's done with those two people. [Prac 18 m]*

As we saw in Section 5.3, finding out about inappropriate behaviour may *not* in fact stop an individual patient from being willing to see that practitioner – at least in the cool consideration of hypothetical situations in the context of a research interview. But that is only because other factors come into play: the behaviour may still reduce the patient's confidence in the practitioner, just not enough to outweigh other considerations. This is especially true for more serious behaviours: as one participant put it, less serious behaviours make a person look foolish, whereas more serious ones undermine confidence:

> *It loses trust and confidentiality, respect, all for that person. And that's all the things that you expect them to have as a professional. [Public K1 f]*

Finding some people who are still willing to go to see a practitioner despite what they have done is not enough to establish that public confidence has not been damaged.

> *Even if we lived in an absolute world where it was absolutely right or wrong, there would still be a relative element where a large proportion of the public, the people who A might come into contact with in their daily lives, would feel that that is inappropriate behaviour. And that would damage their standing in the eyes of the people they're paid to treat. [Prac 05 m]*

Focusing on impacts on public confidence is perhaps the most straightforward way to establish the relevance to fitness to practise of inappropriate behaviour with/towards colleagues. However, arguments of this kind are also limited in scope, since – as noted at the beginning of this section – they apply only to those behaviours which are known to members of the public.

> *The thing is, the patient doesn't know any of this has gone on because it's not on record. You can't find that out so you're unaware, so how would it affect you really if you didn't know a thing about it? [Public I3 f]*

In fact, if this were the *only* argument for relevance to fitness to practise, it would seem to imply that keeping inappropriate behaviour hushed up was a legitimate way of maintaining one's fitness to practise.

## 6.2 Impacts on quality of care

A second type of argument for the relevance to fitness to practise of inappropriate behaviour with/towards colleagues focuses on the possible impact of that behaviour on quality of care.

> *As long as it ['A asks B out on a date'] doesn't have an impact on their work, I can't see that there's a problem with it. [Prac 02 f]*

> *I guess in every case it's different, but what we wouldn't want is for any of these behaviours to impact on how the person is in their role at work. [Prac 13 f]*

One way in which inappropriate behaviour could have an impact on quality of care is via what we might call a competition for attention. While practitioners are engaging in banter – even consensual banter – or thinking about sexual matters, they are not concentrating on the work they should be doing.

> *If this is happening when they're both at work, then clearly, on the fitness to practise, they're not concentrating on the job that they're employed to do at the time. [Prac 02 f]*

> *Is that person [Scenario 1] going to be distracted when they're doing my teeth? I'd be feeling that they couldn't, as a dentist, provide the best quality of work. [Prac 14 f]*

> *It would make me think when he's [Scenario 1] doing my filling is he concentrating on what he's doing or is he looking up the dental nurse's skirt? [Public C2 f]*

The main focus of participants' attention, however, was on the potential impact of behaviour with/towards colleagues on the performance of the team and the individuals in it, and the consequences of this for quality of care.

> *I think it would be on looking at the impact on the people that he's working with. [Prac 03 m]*

This kind of argument was developed most fully in the responses of practitioner participants, probably because they see at first hand the way in which quality of care depends on the effective functioning of a team. For some of our practitioner participants, indeed, this was the main connection between behaviour with/towards colleagues and fitness to practise. Arguments of this kind were also touched on in the public trios, but not in the same depth.

A key concern was the impact of *unwanted* behaviour on the colleague on the receiving end.

> *It's not just about the practice of the person that's being unprofessional. It's considering the practice of the person that's being affected by it. [Prac 15 f]*

For example, this colleague might understandably seek to avoid interactions the person who had behaved in this way – with possible consequences for quality of care.

> *One person might not want to go out while the other one's serving, and it might often lead to, sort of, quick shifts and a medicine is out, maybe not giving advice as much as they wanted. [Prac 16 f]*

> *If B has a concern about a patient, they might not feel comfortable talking to A about it, which means that the patient care might get impacted. [Prac 07 m]*

If the colleague did have to work with the person who had behaved this way, this could cause discomfort, stress and anxiety, again with possible consequences for quality of care.

> *If I had to work with that person then it definitely would affect my care that is given to patients. I think maybe not so much if I didn't have to see that*

> *person, if I was on different shifts. But certainly if you're having to see that person daily, and especially if you're having to work with them. Then yes, it's going to have an impact. [Prac 14 f]*

Moreover, there would be risk that patients would pick up on what was going on, with consequences for their confidence.

> *If they [patients] pick up on any of this uncomfortable behaviour or the fact that one person feels uncomfortable towards another, it certainly doesn't come across professional. […] It can lead to them judging us differently as professionals in terms of the care that they receive if there is that misunderstanding and there's that awkwardness between the two people. [Prac 16 f]*

In line with this, the impact of unwanted behaviour on the performance of colleagues delivering care jointly to a patient was a theme in comments by public respondents, for example on Scenario 1.

> *And the dental nurse [in Scenario 1] would be, I'm guessing… because I would be nervous and, like, and not want to be there. So she wouldn't complete her job to the best of her ability. [Public K1 f]*

> *And if there is any discomfort or mistrust between the two colleagues, what is the quality of care in terms of what you are receiving. [Public B3 m]*

Indeed, if quality of care is the product of a team, then there is an argument to be made that part of one's fitness to practise lies in one's ability to contribute to a positive dynamic in that team. Versions of this argument are apparent in some of the responses of practitioner participants.

> *I think having a healthy team culture is important and if you could make the argument that A's actions towards members of his team B made the team perform less well rather than just necessarily B then you could say that that was a real fitness to practise [issue]. [Prac 05 m]*

> *And this [Scenario 1] probably isn't conducive to a functioning team within their dental practice. And I guess… Well, you do need a functioning team to be able to provide good patient… So, if the nurse, and N and D are in a consultation together with a patient, that consultation isn't going to function very well. Yes. So. And that's going to impact on patient care. [Prac 08 f]*

Even relatively minor behaviours, such as asking someone out on a date, can, if *unwanted*, have negative effects on the performance of a team.

> *A asks B out. B feels uncomfortable, but they are already on their way to respond to an emergency situation. If I'd known about that after, and there was any mistreatment of me or misdiagnosis, or B was not in a stable state of mind, or A had felt rejected or something and wasn't able to focus on the immediate first aid care that I required at the time, and it led to me having a more serious condition, then yes, I'd care about that and it would go up the scale. [Public B3 m]*

> *If somebody asks in a work setting, well then that is then on your mind and thinking: actually I feel really uncomfortable about this, but we've got to try and work together. And although I'm sure individuals can be professional,*

> *it's hard then to switch off from. And actually you might wonder about actually whether you want to be working with that person again if they're going to do that kind of thing in a work setting. [Prac 17 m]*

The final quotation above, however, also points to an important caveat. Like arguments about public confidence, arguments of this kind are limited in scope, because the impact of unwanted behaviour on quality of care can be mitigated by the professionalism of *others* in the team. In fact, if this were the *only* argument for relevance to fitness to practise, it would seem to imply that the fitness to practise of someone behaving in an inappropriate way towards a colleague depended on how well that colleague managed the potential impacts on quality of care.

# 7 Risk based arguments

In this section, we consider arguments for the relevance to fitness to practise of inappropriate behaviour with/towards colleagues which focus on the person who has behaved in this way – and on what the behaviour tells us about them and the risks they pose in a practitioner role.

> *Do you want to gamble with patient safety? He's not in the right frame of mind to be treating. [Prac 20 m]*

Arguments of this kind see behaviour towards colleagues as evidence of underlying flaws in motivation or understanding which could also lead to inappropriate behaviour with patients, and which are incompatible with the role of an practitioner.

## 7.1 Who's to say they won't do it to patients?

Risk-based arguments were prominent across the responses of both practitioner and public participants. At their heart is the concern that something could carry over from one context – interaction with colleagues – to another – interaction with patients.

> *In terms of their fitness to practise, it doesn't mean that they're a bad healthcare professional, but it concerns me about does this carry over to patient care [Prac 07 m]*

> *You think, would that… is that going to transfer onto you? If you're going in to see this person, is this going to transfer onto you, the fact that, you know, they're treating their staff or colleagues like that? [Public I2 f]*

In their simplest form, such arguments turn on the possibility of a direct transfer of behaviour: i.e. the risk that the practitioner will behave with a patient in exactly the same way as they have with a colleague.

> *If he is capable of doing this with colleagues, could he be doing this with patients? [Prac 08 f]*

For example, public participants highlighted this concern with regard to online behaviour, such as making negative comments about colleagues on social media – in one case because the participant had seen examples of negative posts about patients.

> *Making certain comments on social media, I don't know. If they can do that do to a colleague, what are they going to say about me? [Public A2 f]*

> *I've actually seen posts of professionals saying: oh my god, I had this patient and I told them this. And having rants about patients. I have actually seen it myself on social media and it's … I think it's very unprofessional. [Public G3 f]*

However, participants were not just worried about the same behaviour being transferred to patient interactions. Inappropriate behaviour with a colleague poses a broader question: what else might this person do?

> *If A is capable of doing that to B, then, yes. What other behaviours? For example, in a consultation room, when it's just A and a patient, what other behaviours are they doing? [Prac 08 f]*

> *If you're capable of doing that in a place like this, you're probably capable of doing just about anything, and it would worry me. [Prac 18 m]*
>
> *If they're doing this to B, what else could they possibly be doing to other colleagues or patients? [Prac 07 m]*

At this basic level, all of these arguments share a common structure – often reflected in rhetorical questions posed by participants themselves. If a person has behaved in this way to a colleague, who's to say they won't do it, or something similar, to patients?

> *What's to say he's [Scenario 1] not doing it to other patients? Did it say he was looking down her top and what bra? What's to say he's not doing it to somebody who is in the chair? [Public F2 m]*
>
> *Well, I would think, well, if he's [Scenario 3] posted that about his colleagues and put their names and made them look embarrassed on social media, what's to stop him doing it with a patient? [Public C2 f]*
>
> *If he [Scenario 1] started on the nurse, who's to say it's not going to continue on the patients? [Public I1 f]*
>
> *Like, what would they do to a patient? Or would they do more things that they shouldn't be doing but make out as if they are meant to do it in like an exam or something? I don't know. [Public K2 f]*

The potential weakness of the argument at this basic level is captured nicely by the last words of the final quotation above: "I don't know". Because one might just as well ask: who's to say they *will* do it to patients?

To carry weight, risk-based elements require a third element: not just the actual behaviour with a colleague and the possible behaviour with a patient, but a linking *causal* element of which the actual behaviour is evidence and the possible behaviour a possible consequence. Risk-based arguments, that is, rest upon the diagnosis of a flaw, of the kind introduced in Section 3.2 and Section 4.3

> *What does it say about the character of A and how they are with patients? And should they be looking after vulnerable patients? Should they be looking after children? It sort of says to me you're getting to that point of are they professional enough to be working with patients, etc.? [Prac 15 f]*
>
> *If you perceived them as being flawed in some way, and what that might… it might be their personality or it might be their professionalism, it might be their actual skillset, and if you've got that kind of doubt, then you've got that lack of trust, I think. [Public F2 m]*

In Section 3.2 we distinguished two classes of flaw for which behaviour with colleagues may be seen as evidence – especially if it is serious or persistent. Each of these classes – flaws of understanding, and flaws of motivation – was seen by participants as implying risks for interactions with patients as well, and therefore as relevant to fitness to practise.

### 7.2 Flaws of motivation and risk to patients

In some instances, behaviour with colleagues was seen as indicating a flaw in motivation: for example, the presence of desires or intentions which are incompatible with the purpose of a health and care practitioner.

> *I think you've got that chip in your brain, some people have got chips missing, but if you've got that intent in you to be able to do it… I mean I could never treat someone like that, but if you've got that in you, then you haven't got the ability to differentiate customer, patient, employer. It doesn't matter to you. [Public A1 f]*

With regard to Scenario 1, for example, a number of participants argued that the behaviour demonstrated an unhealthy interest in sex.

> *Just everything's sexual, everything's sexual. There's something wrong with the dentist. There's something wrong. [Public I2 f]*

> *If he is thinking these thoughts about a colleague, he is going to be thinking these thoughts about patients. He's not going to just switch off because it's a patient. [Prac 09 f]*

> *He's a horny little bugger, isn't he? He might be a bit… [gestures to indicate a problem in the head]. [Public L3 m]*

Flaws of motivation could, however, take a number of different forms. While the quotations above highlight the *presence* of desires or intentions which are incompatible with the purpose of a health and care practitioner, fitness to practise may also be called into question by the *absence* of desire and intentions which are critical to that purpose – such as caring.

> *You would expect somebody in a caring profession to be caring towards people regardless of whether they are a service user or not. And I don't think that's a caring attitude to have towards anybody, whether it's a colleague or a service user. [Public G1 f]*

Other participants highlighted the possibility of a flaw involving a *failure to control* desires and impulses.

> *They're obviously out of control with it. I would say that they've not got really a hold of what they see as right and wrong. [Public F1 m]*

> *It's a kind of sexual impulse that they are not able to control. So, it would make me feel like I can't trust this person because they are not able to control that aspect of their impulse. [Public G1 f]*

> *It's not like the one thing that he [Scenario 2] has done maybe out of stupidity. You know? […] So, he has obviously got an issue that he can't help himself, you know? [Prac 09 f]*

Among practitioner participants in particular there also were concerns about people who are *too controlling,* and who abuse the power that they have in interactions with others. Scenario 1 in particular was understood in terms of an abuse of power, with clear risks of this abusive intent spreading to interactions with patients.

> *He is like a sexual predator. It really feels like he's a predator and he's going towards somebody who is young and newly qualified and can't do anything. He is nasty. [Prac 22 f]*

> *He's using his position of his authority. That's completely wrong. He shouldn't be abusing that position of authority. […] You know he's in a position where he has got people that are vulnerable; patients come in there lying on his dentist chair and he's asking all these sort of questions around… Before they're coming in… You can't think of someone's thought process, can you? [Prac 02 f]*

Similar concerns were raised by participants who looked at Scenario 2.

> *Well, if he's doing this for his trainees, what's he doing to the…? If you think that the trust that the trainees will have in… the patients would have a lot more trust in them or would have as much trust or more trust. So, is he taking advantage of that? [Prac 03 m]*

> *It's abusive power and I think, as a [practitioner], potentially you can be quite powerful to the public because they're all trainee, because you're in an area that they rely on you for… and I think if you compromise that, then your whole being as a [practitioner] is put into question. [Prac 04 f]*

Motivational flaws such as these were seen by participants as incompatible with the purpose of a health and care practitioner: to help, or at the very least to do no harm. The fact that the evidence for these flaws is derived from behaviour with colleagues, rather than behaviour with patients, was not seen as removing the risk in interactions with patients.

### 7.3 Flaws of understanding and risks to patients

In other cases, behaviour with colleagues was seen as indicating a flaw in understanding: that is in the cognitive apparatus necessary for successful social interaction. Critically, however, the kinds of flaws highlighted were seen to be not just important to getting on with team members, but also critical to a satisfactory practitioner-patient interaction. As such, flaws of these kinds raise fundamental questions about fitness to practise.

> *I think the basic standards of these professions should be empathy, respect, and being sympathetic. […] I just think that the crux or the nature of all these roles are to help people. I work in admin, I can sit in a foul mood and do my admin work and not bother anyone because I don't actually deal with anyone. Whereas all these people are frontline, and they deal with people on a daily and hourly basis. I think if you looked at all these job descriptions, they would probably have an element of empathy, that kind of nature. [Public A1 f]*

> *God, doctors aren't perfect, even nice doctors are… they have to whatever. But it's like an ethos that for some things, it's difficult to turn on and off. […] You're talking about actually quite fundamental issues that make… like quite core issues and they're hard to turn on and off, I think. [Prac 04 f]*

The first kind of flaw in understanding highlighted by participants is a lack of empathy: failing to pick up on the reactions of other people.

> *If A can't, as a healthcare professional, whatever their role is, if they can't identify that what they are saying is making B uncomfortable, then how*

> *can we rely on them to have that correct approach with me as a patient? [Public E1 f]*

> *Because fitness to practise is all about your ability to correctly judge interpersonal dynamics, to empathise about how other people are feeling whether they be your patient or a colleague and act appropriately to that. [Prac 05 m]*

One of the reasons why apologies play such an important role in addressing errors (see Section 3.1) may be the fact that apologising demonstrates a degree of empathy. At any rate, a failure to apologise can serve as evidence of a lack of empathy.

> *[If] they don't show any remorse or don't realise what they've done wrong, then that's worse. Because that means they don't understand the reactions, they don't understand their behaviour and they don't understand, kind of, how they're acting is influencing other people, which could then escalate into something else. And if they can't understand that, then what else are they not kind of understanding? [Prac 21 f]*

The fact that behaviour is unwanted, and the inability to pick up on this in advance, may raise particular concerns about a person's to understand and establish consent.

> *For me, if B was uncomfortable and A knew that, my issue would be about [how] they understand and give consent [with patients]? Because consent runs through everything you do. [Prac 04 f]*

A second kind of flaw in understanding highlighted by participants involves not a lack of empathy but a failure to assess what is appropriate in a situation.

> *Their personal and social moral compass is a bit off. [Prac 11 m]*

> *The person should know better and if they don't know better, then they shouldn't be working in an environment where you were working with colleagues, male or female, in a profession where you're, again, face to face with the public. [Prac 06 m]*

The quotations above are from practitioner participants. Interestingly, public respondents who made what appears to be the same point did so using a very specific term: respect.

> *Then you start thinking about their professionalism, and they're not respectful of other people's feelings. So you think: well if they don't respect their colleagues, they're not going to respect their patients either. [Public C3 f]*

> *If they're not respecting colleagues, they're not respecting anybody, to be honest. Colleagues obviously work with him, right? And if he's got no respect for this colleague, what respect would he have for me? [Public H2 m]*

Flaws in understanding – a lack of empathy or respect – were seen by participants as incompatible with a successful practitioner-patient interaction. As with motivational flaws, the fact that the evidence for these flaws is derived from behaviour with colleagues, rather than behaviour with patients, was not seen as removing the risk in interactions with patients.

# PART C
# Regulatory response

In this part of the report, we describe patterns in participants' views on how regulators should respond to inappropriate behaviour with/towards colleagues. In particular, we consider participants' views on the appropriate responses to the scenarios used as stimulus for discussion.

Consideration of these scenarios was framed by a reminder of the purpose of the fitness to practise process. However, it was apparent that participants' responses were also shaped by everyday, ready-to-hand constructs such as those discussed in Chapter 5: professionalism, technical competence, and willingness to see. There was also evidence – as noted in Section 5.1 – of participants confusing the fitness to practise process with processes that might take place within an organisation: for instance, even when reminded, some participants struggled to distinguish the question of an individual's professional registration from the question of whether they should lose their job.

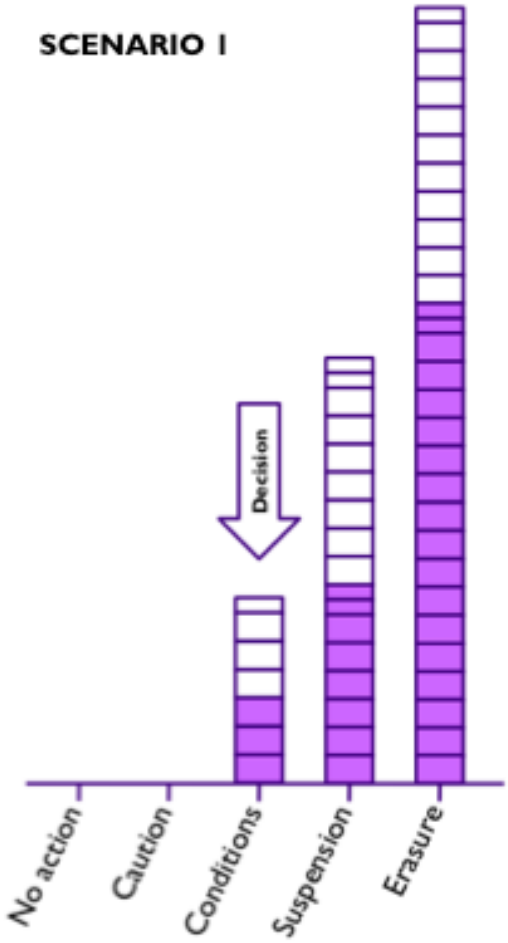
In light of this, considerable caution is required with regard to interpretation of the actual sanctions selected by participants for each scenario – caution which a number of participants themselves articulated in selecting an option. It is also worth remembering that participants were presented with highly condensed and edited details of the scenarios, making comparison of their sanctions with the actual sanctions selected by fitness to practise panels problematic.

With these caveats, the sanctions selected by participants for each scenario are summarised in in the graphics on the next page.

- Each box indicates a participant who selected this sanction for this scenario.
- The shaded boxes at the bottom of each column represent public participants; the unshaded boxes higher up the column represent practitioner participants.
- In some instances participants were undecided between two sanctions: this is indicated by a half-height box for each sanction selected.
- The actual decision made by the fitness to practise panel in the case on which the scenario is based is indicated by an arrow.
- The total number of boxes does not correspond to the total number of participants involved because:
    - Not all participants considered every scenario; in particular, scenario 2 was considered by only a relatively small number of participants.
    - Some participants failed to decide on any sanction for a scenario.

Notwithstanding the caveats above, it is of interest that in only one instance (in response to Scenario 2) did a participant choose a sanction that was *lower* than that selected by the fitness to practise panel. There were many instances in which participants selected *higher* sanctions. We shall discuss participants' responses to the actual decisions made by fitness to practise panels in Section 8.2.

**SCENARIO 1**




**KEY**

Public participant

Practitioner participant

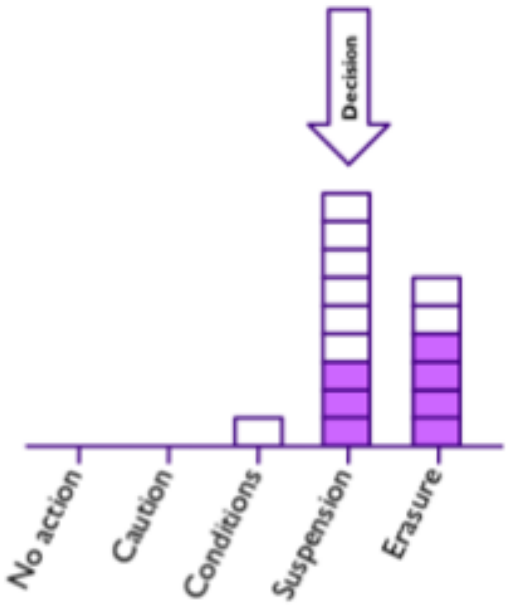
Where participants were undecided between two sanctions, this is indicated by a half-height box for each selected.

The arrow shows the decision made by the fitness to practise panel in the case on which the scenario is based.

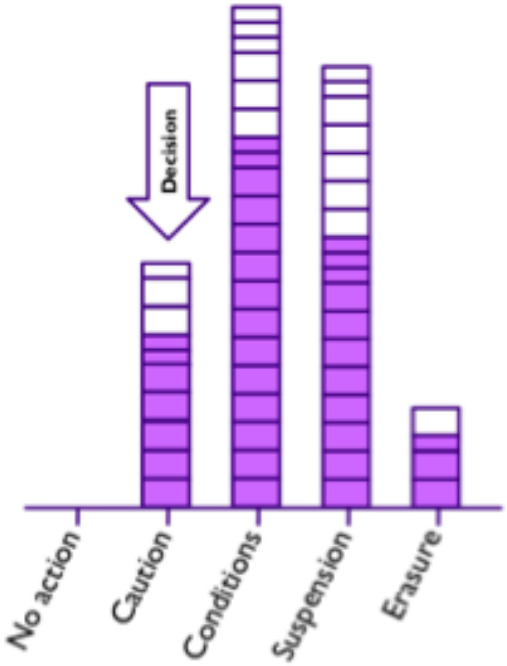
The total number of boxes does not correspond to the total number of participants involved because:

- Not all participants considered every scenario
- Some participants failed to decide on any sanction for a scenario

**SCENARIO 2**




**SCENARIO 3**



# 9. Considerations in selecting sanctions

In this section, we explore participants' views on appropriate regulatory sanctions. As with their assessment of behaviours, participants differed in *what* they thought the appropriate sanction would be in the scenarios discussed. Once again, however, there are patterns in *how* participants thought, and in the factors which they considered in selecting a sanction. Two factors in particular were prominent: the possibility of rehabilitating the practitioner; and the message sent by the sanction chosen.

## 9.1 Rehabilitation

The first consideration which played a role in participants' selection of sanctions was whether and how the person in question might best be rehabilitated as a practitioner.

In part, this was driven by a recognition of the investment made in health and care practitioners, and of what is lost if a person is erased too readily.

> *It's a shame to have got somebody or, I don't know… who is a risk and served in a particular field… to say, actually we just give up on all those years of skills and training and abandon it. [Prac 17 m]*

> *I do think his [radiographer in Scenario 3] lesson will be learned and I don't think he'll do it again, and I think for the money invested in him as a radiographer and the potential good he can do, and this is a lesson that will be learned. [Prac 04 f]*

> *If he's [dentist in Scenario 1] done all the training and he's probably quite senior, can we support this person to not do this…? And to use all their skills, because I'm sure they're very skilled. [Prac 07 m]*

The level of investment in health and care practitioners was noted by public as well as practitioner participants.

> *Quite sad, really, isn't it, because they're [radiographer in Scenario 3] probably very good at what they do, and through some foolish actions, they've got themselves sacked, but we've lost probably a very good radiographer. [Public F3 m]*

> *There's an awful lot of money spent on each one of these professionals. A lot of their time, university's time, teachers' time, tutors' time, getting to that sort of level, to then write them off because of a moment of madness… [Public J3 m]*

On the flipside, one public participant pointed out that it was important this did not lead to an unduly lenient approach, and argued that the dentist in Scenario 1 would have been treated more harshly if he had not been a health and care practitioner.

> *I think it's unfair … I think the reason why the [regulator] have decided on that is because of the type of profession that he's in. […] I think if it was a [regulator] that was dealing with manual labourers, I don't think they would treat that person in the same way. [Public G1 f]*

Alongside the desire to protect the investment in practitioners, the focus on rehabilitation was also informed by a sense that giving people another chance is the

*right* thing to do – at least when the chance remains that the behaviour in question is a mistake.

> *People make mistakes. So, I think that they [radiographer in Scenario 3] should be given another chance. [Prac 09 f]*

In line with this, factors which support the diagnosis of an error (see Section 3.1) were all seen as increasing the chances of rehabilitation, and weighed against erasure as a sanction. For example, the absence of a pattern, the presence of remorse and age were all mentioned as relevant to the selection of a sanction in Scenario 3.

> *I'd be looking at what his work practice history was like. If this was the only blot on his file, his record, then from a professional point of view, if it was deemed that his working practices from a patient to him was acceptable or with no issues, then I would possibly consider allowing him another opportunity to continue. [Public BI m]*

> *I guess it depends how much remorse this person showed, what they were prepared to do to change, and whether they actually saw that it was a problem. I suppose if they did all of those things, they could potentially reform, become a reformed character. [Prac 13 f]*

> *It feels like a bigger mistake if they're older, and actually that shouldn't necessarily be the case, but I feel like someone that's young and potentially stupid, not literally stupid but can do something stupid, it feels serious but it feels less serious than if it was someone that was more senior did that sort of thing. [Prac 07 m]*

One participant concluded that, in this scenario, a relatively light sanction was all that was needed.

> *A tap on the knuckles and behave and don't do it again. Because at this point, he's probably kind of doing his nut because he's like, oh my God, I've just been fired. And that should be enough I think. [Public C1 f]*

Others felt that conditions would be required – but the focus remained on rehabilitation.

> *It's wrong they're young, but is there a degree of: we need to put you through a process of understanding what you're thinking about this and the appropriateness? And say, do you understand all of this? [Prac 07 m]*

> *I think a lot of people need more education. He has… I don't know enough, again, but he's possibly, based on what we've got there, he possibly thinks it's okay to say these things because of the culture in the workplace, he thinks it's okay. [Public J3 m]*

Differences of opinion remained, however. In response to the last quotation above, for instance, another participant in the same trio rejected the suggestion that the behaviour in Scenario 3 might be seen as an error and treated accordingly.

> *Anyone working as a radiographer knows better than to behave like that, I would say. […] I think probably erasure. [Public J1 m]*

While factors which supported the diagnosis of an error were seen as suggesting less severe sanctions, factors which called that diagnosis into doubt – seriousness and persistence (see Section 3.2) – were presented as evidence of the need for a more

severe response. For example, the persistence of behaviour in Scenario 1 was highlighted as a reason for erasure.

> *See, he's done it before, so to me that would say he needs to be erased. If it was a first offence, I would say suspension. [Prac 15 f]*

> *It's more the fact that it's not just the once, he's done it before. I think if this happened the once, to get struck off first time, I wouldn't possibly say that would be right. To strike him off the first time… more like suspension. But because this happened twice, that shows form then. [Public D3 m]*

If an attempt is to be made to rehabilitate a practitioner such as the dentist in Scenario 1, then it needs to be one with a chance of success. A number of participants questioned the sanctions actually imposed on the grounds that they did not seem likely to achieve to the change required.

> *I would say it's a bit short, like, if he's displayed this adverse behaviour over a reasonably sustained period of time, multiple dental nurses. Then he needs to prove for longer than 12 months that he's capable of sustaining, you know, appropriate behaviour or a change. [Prac 05 m]*

> *Some miracle's going to have happened in this developmental plan to address the behaviour. [Prac 17 m]*

> *Is working with a post-graduate dental dean going to make a scrap of difference to his behaviour, potential behaviour? No. So I think that is wrong. [Prac 06 m]*

Commenting on Scenario 2, the last participant quoted above argued that age, as well as making the diagnosis of an error less plausible, may also lower the chances of rehabilitation.

> *My worry is that he's still got… there's a… whatever age the consultant is they've learned a particular behaviour which is inappropriate. [If he were younger] I'd be more confident that the suspension could lead to reinstating, you know what I mean? [Prac 06 m]*

Others pointed out the need to accompany measures aimed at rehabilitating practitioners such as the dentist in Scenario 1 with measures designed to protect others in the event of repeat behaviour, both during and after the period of sanction.

> *I wouldn't let him necessarily be supervising trainees following this. And I would want him to be chaperoned in all contexts with patients following this. [Prac 17 m]*

> *It doesn't say he's got to tell them why he's on a conditional registration. I think he should have to disclose the reasoning so that anyone that does employ him can protect their current staff and not put anybody else in the position where he could potentially reoffend. [Prac 01 f]*

> *It won't remain on his record, so he can then go out of town to another dental surgery and do the exact same thing and then get another caution, or conditions, sorry. I feel like it's just a bit… it's too light. Say I had a daughter, she was nurse N and I found out that this has happened twice before, how annoyed would you be? It's happened twice before and no one has done anything about it. [Public L1 m]*

A number of participants took the view that the patterns described in Scenario 1 were simply too deep-seated for rehabilitation to be possible.

> *My immediate instinct is to say this is a recurrent event, it's on… It's multiple people affected, it's time to draw a line and to remove them from further practice. [Prac 17 m]*

> *If a psychologist looked at this and looked at all the stuff he'd been saying, they wouldn't allow him in a dental surgery. Because if someone can say that to someone and continue doing it, then they're not fit for that job. [Public K1 f]*

> *It's repetitive behaviour, it's deep-seated and, for me, suspension is something that you think could be reversed, so I'm afraid I'd go for erasure for this. [Prac 06 m]*

> *If he is doing that, he is never going to stop doing that. That's in his nature, you know? So, he shouldn't be allowed to work. [Prac 09 f]*

A particularly telling feature of Scenario 1 for some participants was the fact that the pattern of behaviour had persisted even after the dental nurse had complained.

> *She's told him that it was inappropriate, and instead of him saying, oh, I'm sorry, I misread the signs or whatever, he's basically threatened, in a way, her. This is not someone that's remorseful for what they've done, this is somebody who clearly is not showing remorse and, even worse, is quite threatening towards the person. They could quite easily behave in this way again. [Prac 13 f]*

Others, however, focused instead on the fact that this was the first time the dentist in question had come before the regulator, arguing that this implied that there were still grounds for an attempt at rehabilitation.

> *I toyed with suspension, but I feel like if… Because he lost his job at his previous practice and he's not come to the attention of the regulator yet, I wonder whether if you punish him in some way, will that rectify something? [Prac 07 m]*

> *This is the issue. This is the first time this has come before us. I would go with conditions for now. [Public C1 f]*

This is a good illustration of how the application of similar ways of thinking could lead to very different outcomes. There was broad agreement that failure to respond to a warning increased the seriousness of a case.

> *If someone had been given a caution and continued to flout the rules, then it potentially shows complete disregard for any set of regulations. […] I would say there should be an increased level of seriousness. [Prac 07 m]*

This general principle, however, leaves open the question of what counts as a caution, given by whom. Does the complaint of the dental nurse count as a 'caution' from the perspective of those determining fitness to practise? Or could a more robust 'caution', from a different source, still bring about change?

These questions point towards the second consideration which played a role in participants' selection of a sanction: the message communicated by that sanction.

### 9.2 Messages

The second consideration which played a role in participants' selection of sanctions was the message communicated by that sanction. At least three important audiences for that message are apparent in participants' responses.

First, a sanction may send a message to the individual practitioner about the gravity of what they have done and the need for them to change. At this level, the messages sent by sanctions are clearly linked to rehabilitation.

> *I'd go with suspension because he's [radiographer in Scenario 3] gone too far in my opinion. [...] Because he needs to know this is absolutely unacceptable. [Public C3 f]*

For example, one participant argued that one of the problems in Scenario 2 was that a strong enough message had not been sent the first time a complaint was made two years previously.

> *The person that complained two years ago, like, the things that she's complained about are pretty bad, but nothing was done about it. And then the stuff that's happened now is even worse. So it's like he's got away with it once and then two years later again he's tried it again. [...] Because if they didn't think the first time he did it, if they didn't think it was that big for them to suspend him, then in his mind he hasn't really done anything wrong. So it needs a suspension or something to happen for him to think about what he's done. [Public K1 f]*

As on so many other points, there were differences of opinion with regard to what message would in fact be sent by different kinds of sanction. For example, consider the two participants quoted below, the first of whom argues for suspension in Scenario 1 on the grounds that it will send a strong message, the second of whom rejects suspension in the same Scenario precisely because the message will be overlooked.

> *I think that he really needs to be learned a lesson. I think that I would do a suspension, so he really understands that you can't do it like this. Yes, I'd go for suspension. [...] You need to have a real telling off and so maybe he realises what he's doing is really, really wrong. [Prac 22 f]*

> *I feel like he should have a suspension. But then if he's done it before, even after the suspension, he could come back and still think: I've gotten away with it, I've only had a suspension. Come back and do it again. [Public K3 f]*

The actual sanctions applied in this case – and in particular the length of time involved – were also questioned on the grounds that the message sent was not strong enough.

> *It's only 12 months. I probably would've done it for probably five years, something a bit longer because I think that's easy.*[††] *After 12 months, knowing... Well, it's like saying, well, you want to send me to prison, but after six months, I'll be out, and I can carry on doing what I want to do. But if you put a harsher sentence on, well, they're thinking, well, hold on here. I've just thrown my career and my reputation and everything away. I can't do that. So you're not suspending them altogether, you can never, ever do*

[††] Note that participants were not informed of the formal constraints on the length of certain sanctions: however, it is not reasonable to suppose that, if they had been informed, they might have asked in turn why these constraints exist.

> *your job, but you're putting a harsher sanction where you're thinking, whew, I'll never do that again, not in a million years. [Prac 19 m]*

The second audience for the messages sent by sanctions is the profession as a whole.

> *I think often people slip through the net and not enough examples are made and people think, oh it'll be fine. You know, they won't do anything. So I think an example and a standard need to be set that actually we are not accepting this. [Prac 16 f]*

One participant argued strongly against suspension in Scenario 2 on the grounds that this would not send a strong enough message to others about the behaviours involved.

> *So, it is like everyone would know about it. And then people would know that this person has just been suspended. Came back. That's showing other people that it's acceptable. And you will get away with that behaviour, you know? [Prac 09 f]*

Another argued that more serious sanctions should have been applied in Scenario 3 for similar reasons.

> *All the health care professionals that go on to the [regulator] website and other websites, the harder the penalty, they all think, I'm not going to do that because this is what's going to happen. [...] I think the harsher the penalty, it will deter others from doing inappropriate stuff. [Prac 19 m]*

Alongside the individual practitioner and the profession as a whole, the third audience for the messages sent by sanctions is the general public. For example, one public participant noted how a failure to deal appropriately with behaviour – albeit at an organisational rather than a regulatory level – could undermine confidence.

> *I think you would have less confidence in the hospital, because you rely on the hospital to do all their checks and to ensure that the patients are safe, so I would have a loss of confidence in the hospital. [Public E1 f]*

There were mixed reactions to the actual sanctions applied by fitness to practise panels to the scenarios considered in interviews. Moreover, as noted earlier, participants were presented with highly condensed and edited details of the scenarios, meaning caution is needed in interpreting these reactions.

However, the overall balance of reactions is noteworthy. Some participants thought the sanctions were appropriate, including some who had initially opted for more severe sanctions. With one possible exception, however – a participant who had chosen conditions for Scenario 2 on the understanding that the practitioner had not had a prior caution – no-one felt that the sanctions were too severe; and certainly no-one was outraged by their severity. By contrast, a number of participants felt that the sanctions applied were too lenient.

With regard to Scenario 1, for example, there were a number of comments on the length of time for which conditions would be applied. As we have seen, some of these related to concerns about the chances of rehabilitation, the protection of others, and the strength of the message being sent. In some responses, however, there is a clear sense that the length of time involved is just not adequate for the scale of the offence. Perhaps prompted by a reference to speeding in a stimulus card used at the beginning of the interview, more than one public participant made a comparison with points on one's driving licence.

> *Even if you get points on your driving licence it stays on for… what? Three years? So this is far more serious than that and it's only for 12 months. It doesn't seem to make any sense. [Public C2 f]*

Other participants were more profoundly shocked by the decision in Scenario 1. The question apparent in a number of responses was: what do you actually have to do to get erased?

> *It just makes me think; what actually do you need to do to get struck off? Because obviously that's not that bad in their eyes. It's bad, but it's not enough to even be suspended. [Prac 10 f]*

> *It's shocking, isn't it? I'm actually completely flabbergasted. I can't actually believe that they were the outcomes. I expected more. I'm just, well I'm wondering; what would be so severe to have even a suspension? That's what's going through my mind. If that isn't severe enough, then what is? [Prac 14 f]*

> *I'm surprised at that. I would have thought he would have lost his practice or and at the very least have to reapply after five years. I'm very surprised. What concerns me, because I'm thinking how bad does it need to get. [Public B1 m]*

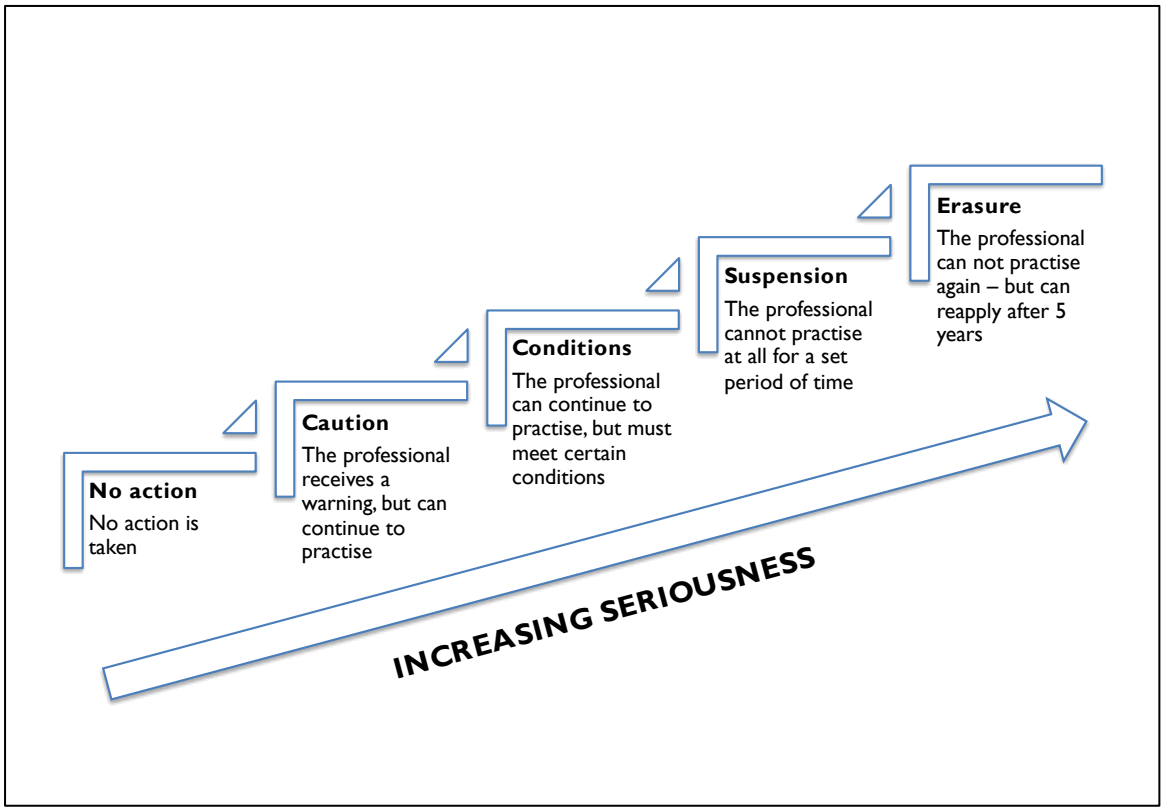
Given that part of the purpose of the fitness to practise process is to maintain public trust, the reaction of some members of the public to the decision in this case are noteworthy.

> *The general public would be horrified to read… If they were to read this scenario first and, once you read the outcome, a lot of people would be thinking, hang on that's not right. [Public D1 m]*

> *I don't feel like whichever body made that decision is looking out for the public there. I would think that that was more in favour of him, rather than in favour of any prospective patients, so I feel quite aggrieved by that decision. [Public E2 f]*

# Appendix 1

## Scale of sanctions




## Scenario 1

N, a female dental nurse, aged 19 and newly qualified, was assigned to work with dentist D. Examples of D's behaviour included:

- telling her she was the only good looking person in the town
- asking for her mobile number so he could send her dirty pictures
- suggesting they should go out because he was "anyone's" after two glasses of wine
- telling her he could look down her top
- touching her back and asking what colour bra she was wearing
- sending her text messages outside of working hours, for example asking what she was doing
- backing her into a corner of the surgery and telling her he was going to "shove" an object "up her backside".

After six weeks N told D his behaviour made her uncomfortable. D responded by saying that a young dental nurse had complained about him in his previous practice, and had "faced repercussions". N, who was aware that D was buying the practice and would subsequently be her direct employer, took this as a threat.

D's behaviour continued until the practice manager became aware of what was going on. At this point, N discovered that D had also been behaving in similar ways towards other members of staff.

As a result, D lost his job at this practice, but was subsequently employed elsewhere.

***Outcome***

D was given a 12-month period of conditional registration.

This meant that he was still able to work as a dentist, but with some restrictions. These included telling any new employer about his conditional registration, and working with a Postgraduate Dental Dean to develop and implement a development plan to address his behaviour.

There was no requirement to share any information about what had happened, or the conditional registration, with patients.

Once the 12-month period was over, the incident would not remain on D's publicly available register entry.

## Scenario 2

X is a male consultant doctor working in a hospital and providing supervision for trainees. Complaints were made by two of these trainees.

One, a female trainee doctor, described behaviour such as:

- commenting on the size of her breasts, and telling her she was pretty
- hugging her and giving her a prolonged kiss on the cheek
- holding her hand and placing it on his own thigh/crotch.

The other, a female trainee dentist, had complained two years earlier, describing behaviour such as

- rubbing her leg to 'demonstrate how to examine a patient's leg'
- putting his stethoscope under her clothes and bra without consent
- touching her breast, shoulder and leg.

In response to the complaints, X claimed that he was a very tactile person, and that his behaviour had been misinterepted. He denied any sexual intent.

***Outcome***

D was suspended for a period of 12 months (the maximum possible). This means that, during that 12-month period, he could not practise as a doctor.

At the end of the 12 month period, a panel would review X's case to establish whether he had addressed all of the issues raised fully, in which case the suspension could be lifted and X could return to practice; or whether further work would be needed.

## Scenario 3

R is a male radiographer qualified for two years and working in a hospital. An anonymous complaint was made that R had made sexually explicit posts on Facebook regarding work colleagues and that he had asked another work colleague an inappropriate question of a sexual nature. The colleagues were aware of the Facebook posts and this caused distress.

The Facebook posts posed questions such as:

- whether anybody had masturbated thinking about a named female colleague
- which two named male colleagues would be chosen for sexual contact if it had to be with a male
- whether sexual intercourse would be preferred with one named female colleague or another
- whether anybody engaged in anal intercourse.

R also asked another fourth female colleague what her favourite sexual position was and said he needed to know so he could report back to other colleagues.

In response to the complaints, R admitted posting the comments on Facebook, but argued he had not written them himself. Instead, two colleagues had written them, and he had merely 'liked' them while off duty. R also admitted asking his colleague the inappropriate question of a sexual nature, but suggested there was a culture of sexually explicit conversations between radiographers in the workplace.

R had lost his job at the hospital as a result of these posts.

### *Outcome*

R received a caution, which will appear on his publicly available register entry for one year, but otherwise could continue to practise.

# Appendix 2

## Information sheet

We're carrying out this research for the Professional Standards Authority (www.professionalstandards.org.uk), which helps to protect the public by improving the regulation and registration of people who work in health and care.

Sometimes health and care professionals behave in ways that they should not. In this research, we will be seeking views on the way health and care professionals should and shouldn't behave with their colleagues. In particular, we'll be talking about behaviours which are, or could be seen as, sexual. This will include topics such as the use of sexualised language, unwanted physical contact, and other kinds of sexual behaviour.

We won't, however, ask you any direct questions about your own experiences, unless you yourself choose to talk about these.

The PSA has commissioned this research because it sometimes needs to take action on cases like these, and would like to understand better how professionals and patients view them.

The discussion will be audio recorded, and transcripts of recordings analysed by the researchers. Quotations may be used in a report published by the Professional Standards Authority, presentations, or papers in academic journals. However, any such quotations will be fully anonymised, so that they cannot be linked to you.

If you wish to discuss this any aspect of this research directly with the Professional Standards Authority, please contact [contact supplied]@professionalstandards.org.uk.

## Consent form

Thank you for your interest in taking part in this research.

Before you agree to take part, the person organising the research must explain the project to you. Only complete this form after s/he has done so.

If you have any questions at all about the research, including questions about how what you say will be used, please ask the researcher before giving your consent to participate below.

Statement

- I agree that the research project has been explained to me to my satisfaction, understand the range of topics to be covered in discussion, and agree to take part.
- I understand that my participation will be audio recorded, and consent to the use of this material as part of the project.
- I consent to the processing of my personal information for the purposes of this research study; and understand that all such information will be treated a strictly confidential and handled in accordance with the Data Protection Act 1998.
- I understand that anonymised quotations may be used in a report published on the Professional Standards Authority website, presentations, or in academic journals.

- I understand that, if I decide at any time that I no longer wish to take part in the project, I may withdraw at any time prior to submission of the research report to the Professional Standards Authority (in March 2018).