PLYMOUTH UNIVERSITY PENINSULA
SCHOOLS OF MEDICINE & DENTISTRY

Fitness to practise:

Impairment and Serious Misconduct

A narrative synthesis review

Final report

March 2018

Marie Bryce, Julian Archer, Nicola Brennan,

Lorna Burns, Tim O'Brien, Tristan Price.

Funded by the General Dental Council.

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Executive Summary

This report contains findings from a systematic review, conducted between October 2017 and March 2018, focused on impairment and serious misconduct in fitness to practise procedures.

Background and rationale

As the United Kingdom's regulator for dental professionals, the General Dental Council (GDC) is responsible for regulating the practice of around 41,000 dentists and 68,000 dental care professionals. One of the GDC's core regulatory responsibilities is to investigate cases in which dental professionals may have fallen below the standards expected of them, as set out in *Standards for the Dental Team*, and to take appropriate action if a professional's fitness to practise is found to be impaired through its Fitness to Practise (FTP) procedures.

Recently the GDC has sought to develop its FTP procedures to increase their efficiency for the benefits of both patients and practitioners. The GDC set out its plans to further develop its approach to regulating dental professionals' fitness to practise in *Shifting the balance: a better, fairer system of dental regulation.* One goal set out in that document was to achieve greater clarity about thresholds for what constitutes 'impaired fitness to practise' by developing a more transparent understanding of what is or is not 'serious' in terms of breaches of expected standards. As one way of supporting the achievement of this goal, the GDC commissioned this review of the available evidence about impairment and seriousness in relation to professional misconduct.

Aims

The aims of this review were:

- To synthesise the existing evidence base on Fitness to Practise, to support the GDC's work to refocus its approach in this area.
- To underpin the development of evidence-based policy in the field.

Study design

The review focused on the processes through which regulatory authorities determine whether a registrant remains fit to practise their profession, where this has been brought into questions, through complaints or other referrals. The review covered the regulation of both health professions and other selected professional groups in the UK and internationally, and addressed four key questions:

- What are the characteristics of professional regulators' fitness to practise (or equivalent) procedures which determine how they define, identify and categorise serious misconduct?
- What factors inform regulators' decision-making around serious misconduct?
- Are there political and social contexts that can be identified as having influenced changes to regulators' decision-making around serious misconduct?
- What is the evidence base for approaches to defining, identifying and categorising serious professional misconduct?

Material included in the review was identified through systematic searches of electronic databases plus searches of selected regulators' websites. The review included material identified during the searches that: focused on FTP or equivalent procedures conducted by regulators relating to conduct and performance; had been published since 2005; and was in English. All study designs were

included and material was not excluded on quality grounds due to the review's exploratory nature. Regulatory websites were searched for information about legal frameworks, guidance documents, and any commissioned research reports. We searched the websites of all UK health and social care regulators plus selected other professions. Internationally, we reviewed the websites of selected health professions regulators in the USA, Canada, Australia, New Zealand and South Africa. Included material was brought together through a process of 'narrative synthesis', which uses words and text to summarise and explain the findings of the review. The synthesis focused on themes arising in relation to each research question and identified areas of convergence or divergence in regulators' approaches.

Findings

From the database searches, 187 items were included in the review. These included news items (n=72), commentaries (n=43), and peer-reviewed empirical studies, including quantitative (n=30), qualitative (n=10) and mixed methods (n=12) study designs. Also included were editorials (n=5), reviews (n=4), letters (n=2) and one thesis. Eight commissioned research reports were identified from regulators' websites.

Most of the material included in the review focused on health professions regulation, including regulation of doctors (n=61), nurses (n=27), pharmacists (n=10), dental professionals (n=8), psychologists (n=3), physiotherapists (n=1), opticians (n=1) and complementary health practitioners (n=1). Other professions covered by the literature included accountants (n=19), legal professionals (n=16), architects (n=5) and teachers (n=2). There were also a number of items looking across professions (n=21).

The literature focused regulation in the UK (n=81), the USA (n=42), New Zealand (n=24), Australia (n=19), Canada (n=9), the Netherlands (n=2), Denmark (n=1), Germany (n=1) and South Africa (n=1). There were also items which looked at multiple countries (n=7).

Processes and structures

We found considerable convergence between UK regulators in terms of the structure of FTP procedures and approaches taken to identify and investigate cases of potential serious misconduct. FTP procedures are typically staged process with at least a preliminary investigation phase and an adjudication phase. There are differences between regulators as to whether decisions at the end of the initial investigation phase are taken by case examiners or by an investigating committee, with an identifiable trend towards the increased use of case examiners to make decisions at the end of investigations. Non-health professions regulators in the UK tend to have less substantial preliminary investigation stages, as it often expected that full investigations will have been undertaken locally by employers with regulators becoming involved in cases already deemed serious.

Whilst regulators often split investigation and adjudication procedures, there is also a degree of judgement-making at the end of the investigation phase, with an investigating committee or case examiners making a decision about whether a case should be referred to an FTP panel or equivalent. At this stage, the decision often involves applying a 'realistic prospect' test to decide whether there is a prospect that the facts of the case will be proved and a determination of impairment made.

A major variation in the processes used by regulators is whether they operate a single FTP panel or have separate panels for performance, conduct and health cases. Regulators who have more recently reformed their processes tend to have a single panel. Non-health regulators often do not treat health cases separately, but rather treat health as a potential mitigating factor for misconduct.

Internationally, health regulatory systems can vary considerably. In federal systems such as Canada and the United States, there are often separate regulators, or disciplinary boards, for each regulated health profession in each state. New Zealand, meanwhile, operates a more centralised system, with a single disciplinary tribunal service which operates tribunals for all health professions. Again, the international regulatory systems we reviewed typically involve a preliminary investigation phase before possible referral to a disciplinary panel of some kind.

Overall, we found much less information about guidance, criteria, and decision thresholds was available from international regulators' websites than is the case with the UK health regulators.

Definitions of misconduct

All regulators have procedures to investigate misconduct, but approaches towards defining what constitutes misconduct and, furthermore, how seriousness is determined vary. In the UK, regulators sometimes explicitly draw on definitions derived from case law with misconduct variously being described in terms of falling (seriously) short of expected standards or as conduct which fellow practitioners would find 'deplorable.' Whilst our review focused particularly on misconduct, we also considered definitions of incompetence or deficient performance, as whether regulators distinguish between conduct and performance issues, and if so how, is an area of divergence. Even where regulators operate separate FTP panels to deal with conduct and performance, the distinction is often not clear cut. One identifiable distinction is that performance issues are always related to a professional's practice, whilst conduct can often also encompass actions or behaviours outside of their work. In cases relating to practice, the boundary between conduct and performance issues is sometimes ill-defined.

Internationally, some regulators provide broad definitions of misconduct similar to those offered by UK regulators, using terms such as disgraceful, dishonourable, or improper. However, in the USA, we found examples of regulators offering lists of defined actions or failings that would constitute misconduct.

In the wider literature, we found discussion of the varying degrees of conduct issues that are encompassed by legislation in some countries, for example in Australia where there is a distinction made between 'unsatisfactory professional conduct' and the more severe category of 'professional misconduct.' Another key issue identified in relation to the definition of misconduct included the extent to which regulators can or should focus upon professionals' morality or 'good character' as much as the impacts or risks of their behaviours, with some literature suggesting that professionals may sometimes be expected to exercise moral probity beyond that expected of the wider public.

Notably, there is a tendency in some analyses to focus on determining seriousness by looking at the sanctions applied by regulators, pointing to a somewhat circular logic that considers that regulators themselves are effectively, consistently, and reliably determining seriousness and applying sanctions

appropriately. In regards to sanctions, we found that most regulators, across professions and countries typically have recourse to similar types and ranges of sanctions, including erasure or suspension from profession registers, reprimands, retraining and supervision. Some regulators are also able to issue various financial penalties.

Within the literature, the most frequently discussed types of misconduct were sexual misconduct and other types of boundary violation in the relationship between professionals and members of the public. These were typically considered to be serious in nature, although not universally with some arguing for nuance in considering individual cases. Other types of misconduct discussed in the literature included: issues relating to prescriptions or dispensing of medications; fraudulent behaviour; substandard practice; and communication skills. Sometimes categorisations in the literature identify the subject of the misconduct, whilst others focus on the underlying issues, such as dishonesty or crime, which might underpin multiple types of behaviour. We also found discussion about how far professionals' actions outside of their work should be subject to regulation, and of where the boundary between work and the private sphere might be drawn.

Factors informing decision-making

We found that regulators, both in the UK and internationally, consider a range of aggravating and mitigating factors when considering the severity of misconduct cases, and in the UK these factors are also used by many regulators to determine whether the professional's fitness to practise is impaired. Whether these factors are considering prior to making a decision about impairment, or solely in determining the appropriate sanction is a point of divergence between regulators.

The types of factors considered are typically quite consistent between regulators. These include: a professional's perceived honesty or dishonesty; whether they show remorse; whether they show insight; whether the misconduct was repeated or is on-going; the risk of harm to patients or the public; whether the professional has undertaken or could pursue remediation or rehabilitation. We found a number of pieces which argued that professional regulators often do not take into account organisational context and that this should be considered as a potentially mitigating factor. Examples cited related to instances of misconduct that had occurred when a professional was working in an understaffed service, for example, or had been provided with inadequate supervision.

Political and social contexts

We identified limited information about the political and social contexts that may influence regulatory decision-making about misconduct. There were references to the importance of changes to legislation in some jurisdictions highlighting the importance of local context. We also found some references to the importance of high profile scandals, particularly in healthcare, in driving changes in policy or perceptions of professional conduct.

The evidence base for defining and categorising misconduct

Overall, we found little evidence that regulators are drawing on a research or evidence base to inform their approaches to identifying and managing misconduct. Where available, policy and guidance documents tend to refer to legislation and legal precedents. Whilst some regulators have commissioned research, and many report on trends in their data, it is not clear how this information has impacted on policies or procedures, if at all. However, it is clear from the material identified for

inclusion in this review that there is a broad, if disparate, corpus of literature containing information, analyses and theoretical interpretation relevant to the identification, definition and categorisation of misconduct.

Discussion and conclusions

This wide-ranging review identified significant material relating to professional misconduct, though little of it focused directly on the central question of seriousness and how it is determined. Overall, our findings suggest that, whilst there are areas of commonality, the ways in which misconduct is identified and categorised can vary considerably between regulators. We identified material primarily relating to health professions regulation, though the review also encompassed other professions and covered a range of countries. Key areas currently subject to debate are the questions of the extent to which professionals should be subject to regulation for their activities outside their work, and the degree to which professions regulators should take organisational factors into account when considering misconduct cases. There are clear opportunities for learning from the varying approaches and definitions of misconduct in use internationally, and it is hoped that regulators will draw on the growing body of relevant analytical work.

Introduction

This report details findings from an extensive systematic review, conducted between October 2017 and March 2018, of published and grey literature pertaining to impairment and serious misconduct in fitness to practise procedures.

Background and rationale

The General Dental Council (GDC) is the UK dental professionals' regulator, governed by the Dentists Act 1984 (as amended).[1] The GDC is responsible for regulating the practice of around 41,000 dentists and 68,000 dental care professionals (DCPs).[2] Their core responsibilities include: maintaining registers of dental professionals; assuring the quality of dental education; and setting standards of conduct, performance and ethics for the dental team.[2 3] If it is alleged that a dental professional has failed to adhere to the standards set out in *Standards for the Dental Team,*[3] the GDC investigates through its Fitness to Practise (FTP) procedures. If, after investigation, a dental professional's fitness to practise is found to be impaired, the GDC can impose sanctions, including placing limitations upon the practitioner or remove their registration and rights to practice.

More recently, GDC has sought to develop its FTP procedures with the aim of increasing their efficiency for the benefit of complainants and practitioners alike. This process has been aided by changes to legislation which have, for example, introduced Case Examiners to streamline the investigation process.[4] The GDC shared its vision for further modernisation in regulating dental professionals' fitness to practise in *Shifting the balance: a better, fairer system of dental regulation.*[5] This document was informed by the principles of 'right-touch regulation' advocated by the Professional Standards Authority (PSA).[6 7] *Shifting the balance* sets out the importance of an understanding of what modern dental professionalism is, that is shared by all stakeholders.[5]

As well as seeking a renewed understanding of professionalism, *Shifting the balance* also identifies the concomitant goal of clarifying the thresholds for 'impaired fitness to practise'[5], through a more developed and transparent understanding of what constitutes 'seriousness' in terms of breaches of professional standards.[5] In addition, the GDC is seeking to ensure that link between impairment of fitness to practise and patient safety risks and public confidence are clearly understood.[5] This is in line with work undertaken by other regulatory bodies which have sought to explore patient and public views of dishonesty,[8] and professional views on the severity of various types of misconduct.[9]

However, the evidence around understandings of professional misconduct has not yet been synthesised. Establishing the existing evidence base about how other professional regulators define, categorise and identify serious misconduct, and how they then sanction practitioners in such cases, is a vital initial step in informing how the GDC furthers its goals.[5] This research seeks to aid the GDC

in developing its approach to FTP, as it focuses on addressing those cases which pose a risk to patient safety or to wider public confidence in dental professionals. This research will support the GDC in meeting its core objectives of protecting, promoting, and maintaining the health, safety and well-being of the public; promoting and maintaining public confidence in the professions regulated; and promoting and maintaining proper professional standards of conduct for members of those professions.[2]

Aims

The over-arching aims for this review were:

- To synthesise the existing evidence on Fitness to Practise, to support the GDC's work in refocusing its approach in this area
- To underpin the development of evidence-based policy in the field

Study design

The review focused on identifying and investigating the procedures through which statutory regulators ascertain whether a registrant remains fit to practise their profession in cases where this has been brought into question, through complaints or other sources of information. These may be termed 'Fitness to Practise procedures' but may also sometime be referred to for example as disciplinary boards or committees. The regulatory bodies themselves, therefore, were the population of interest for this review, with a particular focus on how regulators determine what constitutes serious misconduct, the thresholds for such misconduct to amount to impairment, and the major design characteristics of the processes by which such a finding might arise.

The review covered the regulation of both health professions and other selected professional groups (detailed below). Geographically, the review focused on both UK and international professional regulation.

Review questions

- What are the characteristics of professional regulators' fitness to practise (or equivalent) procedures which determine how they define, identify and categorise serious misconduct?
- What factors inform regulators' decision-making around serious misconduct?
- Are there political and social contexts that can be identified as having influenced changes to regulators' decision-making around serious misconduct?
- What is the evidence base for approaches to defining, identifying and categorising serious professional misconduct?

Methodology

We identified material for inclusion in the review through systematic database searches plus searches of selected regulators' websites (the search strategy is described in more detail below). The included material was brought together through a process of 'narrative synthesis', using words and text to summarise and explain the review findings.[10] This approach is particularly useful where, as in this case, the review generated largely qualitative information, and for considering information from across a range of different national settings and regulatory frameworks. The review is being undertaken using the Centre for Reviews and Dissemination guidance[11] and reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA)[12] framework.

Search strategy

The search strategy combined electronic database searches and website searches.

Database searches

In order to ensure coverage across the various professions and jurisdictions on whose regulatory arrangements we have focused, we searched a range of databases relating to:

- Clinical subject areas (Ovid Embase; Ovid Medline; Dentistry & Oral Sciences Source; the Allied and Complementary Medicine Database (AMED); CINAHL);
- Social sciences (Scopus; SocINDEX)
- Education (ERIC)
- Business, finance and law (Business Source Complete and Web of Science)

These databases were searched using free text terms and controlled vocabulary where appropriate, using terms centring around three themes:

1. Professional regulator terms (e.g. names of regulatory organisations & names of specific professional groups).
2. Terms relating to fitness to practise or comparable processes (e.g. tribunal, disciplinary)
3. Terms relating to misconduct (e.g. misconduct, serious concerns, professional incompetence)

Terms from these three groups were used in combination in order to identify effectively the available literature specifically relating to our topic of interest. We used synonyms in the search terms, particularly in relation to terms describing fitness to practise to practise or comparable processes, as these vary between national and professional settings. We also used synonyms in relation to terms describing misconduct, as regulators use different terminology or use the same

terms to describe differing concepts. The full details of search terms used for each database are given in Appendix A.

Study selection

We exported the records for items retrieved through the database searches into *Rayyan,* a systematic review data management application.[13] Using the inclusion/exclusion criteria set out below, we reviewed the title and, where available, the abstract for each item. All records have been double screened, with one researcher (MB) reviewing the whole amount, and three other members of the research team (NB, LB, TP) each reviewing a third. Next, the full text of provisionally items was reviewed, with further items excluded at this stage. A small number of items identified via our searches of regulators' websites were added at this point. Due to the broad nature of our interest in regulatory approaches to defining or deciding seriousness, we included literature of any type, and so we did not exclude on the basis of methodological quality or rigour. Rather, we focused on whether a piece of material contained conceptually relevant information which could add to our understanding of regulatory approaches to seriousness.

Inclusion criteria

Literature identified through the electronic database searches was selected for inclusion in the review based on the following criteria:

- Intervention: all material that focus on FTP or equivalent procedures relating to conduct and performance, but excluding those related *solely* to practitioner health issues.
- Setting: FTP procedures conducted by regulatory bodies but excluding material reporting employment tribunals or employer-led disciplinary processes.
- Types of participant: all studies of health and non-healthcare professions regulators for the professional groups covered by the regulatory bodies listed in Table 1, in the UK or in the other countries listed by the United Nations as having 'very high human development',[14] plus South Africa (known to have well-developed regulatory structures).
- Outcome: all material relating to regulators' classification of misconduct.
- Timeframe: all material published since 2005.
- Study design: all study designs.
- Language: material in English.

Grey literature

Alongside the database searches, we searched the websites of professional regulatory organisations for information and reports concerning the legal frameworks within which they operate, the guidance and criteria which shape their decision-making around misconduct, and the sanctions they

impose in cases where serious misconduct is found to have occurred. The UK regulators' websites we are reviewing are listed in table 1.

Table 1: UK regulatory websites included in review

Health and social care professions regulators (and associated bodies)	Other professional regulators
○ General Dental Council ○ General Medical Council (Medical Practitioners Tribunal Service) ○ General Chiropractic Council ○ General Optical Council ○ General Osteopathic Council ○ General Pharmaceutical Council ○ Pharmaceutical Society of Northern Ireland ○ Health and Care Professions Council ○ Northern Ireland Social Care Council ○ Nursing and Midwifery Council ○ Professional Standards Authority ○ Social Care Wales ○ Scottish Social Services Council	○ National College for Teaching and Leadership (England) ○ General Teaching Council for Northern Ireland ○ General Teaching Council for Scotland ○ Education Workforce Council (Wales) ○ Law Society of Scotland ○ Law Society of Northern Ireland ○ Solicitors' Regulation Authority (Solicitors Disciplinary Tribunal) ○ Faculty of Advocates ○ Association of Commercial Attorneys ○ Bar Standards Board ○ Bar Council of Northern Ireland ○ Architects Registration Board ○ Royal College of Veterinary Surgeons ○ Institute and Faculty of Actuaries ○ Institute of Chartered Accountants in England and Wales ○ Financial Reporting Council, 'The Accountancy Scheme'. ○ Royal Institute of Chartered Surveyors

Internationally, we searched the websites of those organisations responsible for regulating four selected health professions – dentistry, medicine, nursing, and pharmacy – in Australia, New Zealand, and South Africa. Additionally, we sampled states from the USA (New York, Texas) and Canadian provinces (Alberta, Ontario) to include in this element of the review. This selection of countries allowed us to explore international grey literature within the review whilst working within the limited timeline available for completion of the study.

Data extraction

Data extraction and analysis

Literature identified through the database searches plus any additional key documents identified from our website searches was uploaded into NVivo11,[15] a qualitative data analysis software tool. Key information on each item will be recorded including: study design; countries/countries discussed; regulator(s) and profession(s) discussed; the focus; and findings. These elements will be tagged against each item as 'attributes' within NVivo, which allowed the information to be split into

categories and explored in different ways, e.g. by study type, country, or profession, aiding the iterative process of narrative synthesis.

The included literature was then coded within NVivo 11, using a deductive coding scheme of headline codes developed from the research questions. Sub-codes were added inductively with each area of the coding framework as they were identified from the literatures.

Data extraction from websites

We extracted information from regulators' websites using an extraction table with sections mapped to the research questions. The table was piloted and revised, and used to ensure consistent information was captured, where available, from each organisation's site. A full list of the websites reviewed, along with links to key documents is included in Appendix B. Where particularly relevant standalone reports, especially of commissioned research, were identified from regulators' websites and met our inclusion criteria, these were added into the body of literature included for thematic coding, as described above.

Data synthesis

The findings from our thematic analysis were synthesised using a narrative synthesis approach drawing on Popay et al's guidance.[10] The synthesis focused on bringing together the major themes identified in relation to each of the research questions, looking to identify areas of convergence, as well as divergence within the corpus of literature. Likewise, the information identified from regulatory bodies' websites was synthesised under the research questions using rich descriptions.

Findings

Overview

In reporting the findings from the review, we bring together here information identified via the searches of regulatory bodies' websites with findings from the review of published literature. Information from the website searches is reported through description, and referenced using the acronyms for the various organisation. The list of resources informing these descriptions is provided for reference in appendix B.

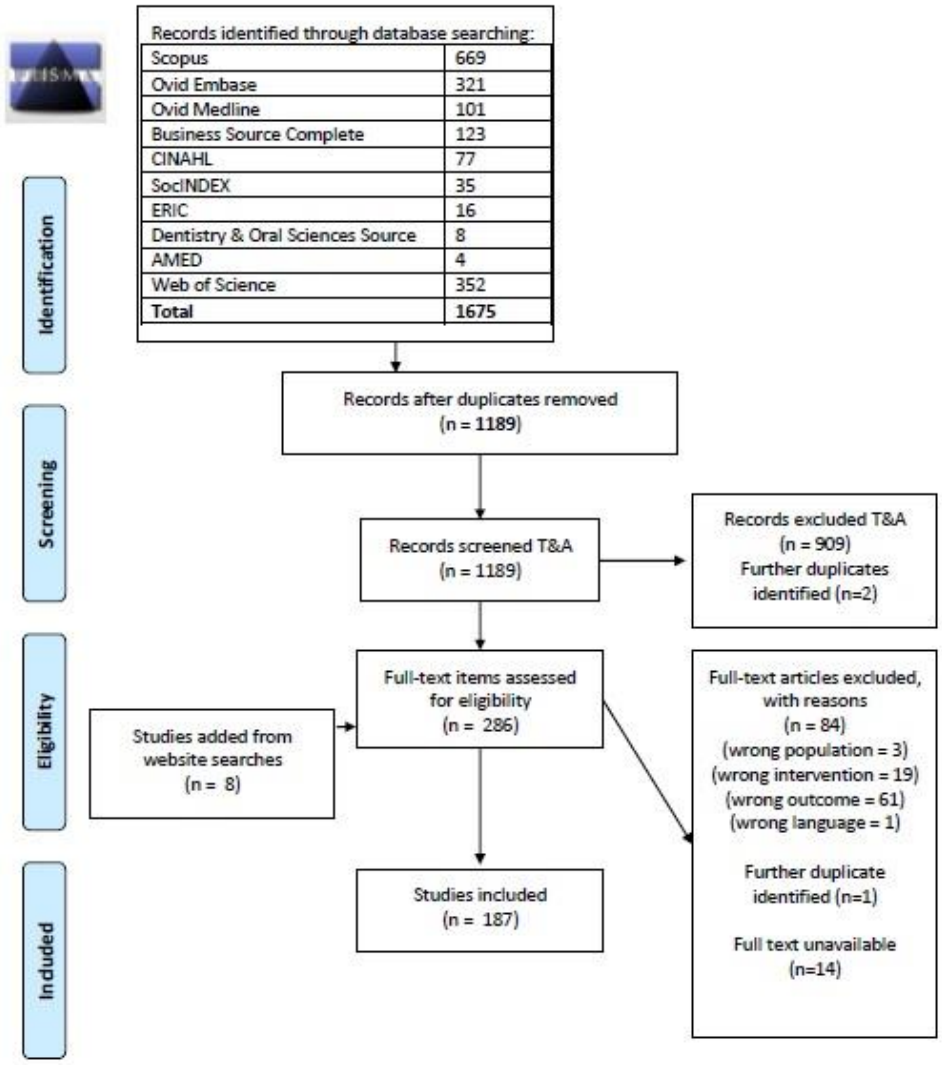
The results of the literature searches and inclusion/exclusion decision processes are shown in the PRISMA diagram below (Figure 1). These searches produced a large quantity of material, covering a range of professional regulators and countries. The initial search of electronic databases provided 1675 items. Following the removal of duplicates, and initial title and abstract screening, 266 items were considered potentially relevant, including eight items that were identified via the website searches. The full texts of these 286 items were screened, with the exception of 14 articles which could not be retrieved. Finally, 187 items were included in this element of the review and coded using Nvivo11[15] qualitative data analysis software.

The items retrieved through the database searches varied in type, and included short news items (n=72), commentaries (n=43), and peer-reviewed empirical studies, including quantitative (n=30), qualitative (n=10) and mixed methods (n=12) study designs, and commissioned research reports (n=8). Also included were editorials (n=5), reviews (n=4), letters (n=2), and one thesis.

Looked at by professional groups, most included material focused on health professions regulation with doctors (n=61) and nurses (n=27) being the most commonly occurring professions in the sample. Other items focused on the regulation of pharmacists (n=10), dental professionals (n=8), psychologists (n=3), physiotherapists (n=1), opticians (n=1) and complementary health practitioners (n=1). Regulation of social workers (n=7) and veterinary surgeons (n=5) were also included. Beyond health and care related professions, included items covered accountants (n=19), legal professionals (n=16), architects (n=5) and teachers (n=2). In addition, there were also items that covered multiple professional groups (n=21), though again these were often focused on looking across various health profession groups.

The included items focused on professional regulatory activities in the UK (n=81), the USA (n=42), New Zealand (n=24), Australia (n=19), Canada (n=9), the Netherlands (n=2), Denmark (n=1), Germany (n=1) and South Africa (n=1). There were also a number of items which looked across or compared regulatory issues or approaches across more than country (n=7).

Figure 1: PRISMA diagram for seriousness in Fitness to Practise review



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

Processes and structures

We found that there is considerable convergence in terms of the way in which UK regulators structure their FtP procedures and the approaches taken to identify and investigate potential cases of serious misconduct. Notably, the degree of convergence seems to be greater in the regulators that have undertaken more recent reviews of FtP procedures.

Preliminary investigations

All healthcare regulators surveyed conduct an investigation process that is separate from the main decision-making process. A key difference between regulators in this respect is whether case examiners are used for initial screening / triage only, with the case subsequently being referred on to an investigating committee (GCC, GOsC, GPhC, HCPC, PSNI), or whether the case examiners themselves make decisions that were formerly taken by investigating committees. In cases where the latter is system is used, an investigating committee may be involved only when two case examiners cannot reach a unanimous decision on an investigation outcome (GOC, GMC, NMC, GDC, SCCW).

There is an identifiable move amongst healthcare regulators towards streamlining their FtP processes, such as through the increasing use of case examiners or an equivalent rather than investigating committees. The rationale behind the increased role of case examiners rather than an investigating committee appears to be based on a need to reduce the burden on FtP panels, and on professionals under investigation, through earlier disposal of cases, but also to streamline the process by which interim orders can be sought more quickly to offer protection for the public. The GOC, for example, has also instigated a process whereby the registrar can at any point send a case straight to an FtP panel for an interim order. Some UK regulators, of both health and non-health professions, explicitly set out online or in their guidance documents that they risk assess cases as part of their initial screening (or 'triage') processes (GCC, NISCC, SRA). Interim orders are a feature of all statutorily-regulated UK health professions, but not of all the non-health professions; there is seemingly no provision for such orders in the legal profession. Interim orders can be issued for teachers in England, but not as part of an investigation or a tribunal process; rather, such orders are only made on behalf of the Secretary of State for Education in exceptional circumstances (NCTL). Where stated, public protection is the primary rationale behind the imposition of interim orders, with some regulators explicitly linking the imposition of interim orders to the assessment of levels of risk (e.g. SSSC, GOsC).

Non-healthcare professions vary more widely on how preliminary investigations might identify potential cases of serious misconduct. While regulators such as the Scottish Social Services Council (SSSC) operate their preliminary investigations in a similar way to the healthcare professions, others have a much less substantial preliminary investigation stage. The teaching regulators for example, only deal with the most serious cases related to FtP and full investigations are required by employers prior to any case referral. If such an investigation has not taken place then the case is sent back to the employer. Some regulators, e.g. in law, have entirely separate bodies for dealing with the investigation and performance (although performance is framed in terms of 'service') issues, and

those related to fitness to practice. Investigation and decisions on performance / service can be made at a lower level, with outcomes including the imposition of fines, whereas a full FtP panel will only consider cases where there is potential for removing a license to practice.

Adjudication process

Although regulators tend to split adjudication and investigation procedures, the investigation process invariably involves an element of adjudication. In most cases the case examiners or the investigating committee will refer a case to a panel if it is deemed from the evidence there is a 'realistic prospect' that the facts of the case will be proved (GOC, GMC, HCPC).

A number of regulators have systems for consensual disposal for situations in which the registrant accepts the facts of the case. However, this is generally only in cases whereby it is not deemed that the case involves matters of serious misconduct. In this respect it is worth nothing that the Professional Standards Association were critical of some aspects the General Osteopathic Council's proposals to enhance powers for consensual disposal in a wider variety of cases. While the PSA were supportive of efforts to streamline the process, they were concerned that the consensual disposal process did not allow for the full remit of sanctions, with the maximum sanction available under the proposal being admonishment or a warning.

Regulators vary on whether one FtP panel is used for all cases referred, or whether separate panels are convened for performance, health and conduct. Again, those regulators which have more recently reformed their FtP processes tend to have move towards a single panel. This is the case in the health professions, and also in some non-health professions (SSSC). While some regulators retain different panels, the reviews of their operation have noted that very few cases come before a health committee. In the non-healthcare professions it is unusual to have a separate panel for health issues related to adverse physical or mental health is not dealt with as a separate category of impairment. Rather, health is listed as a potential mitigating factor in cases of misconduct. This is seemingly linked to a notion of risk, given that, in non-health professions, it is unlikely that impairment by poor health is going to endanger the health and wellbeing of a service user unless health issues become manifest as poor performance or misconduct.

Health professions regulators also vary on whether deficient performance is dealt with by a separate panel from misconduct. In some of the non-health professions surveyed, performance is often not deemed to be an FtP issue. In law for example, the issue of performance is framed in terms of the 'service' received. The Faculty of Advocates (Scotland) distinguishes between professional misconduct and 'inadequate professional services'. In education, performance is a matter for employers, not the regulator (NCTL). This difference almost certainly reflects the nature of risk

posed, given that poorly performing teachers or lawyers do not pose the same immediate dangers to the health and wellbeing of those they serve.

Other aspects of the processes concerning misconduct and fitness to practise are congruent across all regulators. Where information was available, all regulators now use the civil standard of proof for determining the facts of an FtP case. In the non-healthcare professions there is more variation. The Solicitors Regulatory Authority (SRA) deals with cases of misconduct using the civil standard of proof, but more serious cases, which could result in erasure, are referred to the Solicitors Disciplinary Tribunal, which uses the criminal standard. The Faculty of Advocates and the Bar Standards Board also use the criminal standard to determine cases. However, it is noteworthy that consultations have taken place and there is a move towards considering the use of the civil standard in the legal profession for all cases, supported by the SRA.

Again, where information is available, all regulators report on the need to make decisions in light of a balance between the interests of the registrant being investigated, the need for public protection and the maintenance of confidence in the profession. Frequently cited case law in this respect includes Raschid and Fatnani v The GMC [2007]. In this case, it was determined that decision should weigh the interests of the public with those of the practitioner, with public safety taking primacy over the punishment of doctors. In the healthcare professions, sanctions are not designed to be punitive, although it is accepted that they may have a punitive effect. In law there is clearly a more punitive element and sanctions include the imposition of fines on the lawyer or the practice in which they work. The Solicitors Disciplinary Tribunal (SDT) for example, can impose an unlimited fine payable to HM treasury.

International processes and structures

When considering the processes used by health regulators in other jurisdictions, it is worth making some general observations in terms of the basic regulatory structures which all differ from the regulatory structures in the UK. In Australia, Canada and the USA, professional regulators operates within a federal system in which boards of the health professions operate within each state, the powers of which relate to state laws. New Zealand has a more centralised system with a Council that regulates each profession on a nationwide basis in a manner comparable to the UK. The system in South Africa is similarly centralised, with a Health Professions Council of South Africa which oversees the conduct of 12 different health professions boards, including medicine and dentistry, which are jointly regulated by the Medical and Dental Board. Nursing is regulated by its own board, the South Africa Nursing Council, as is Pharmacy, by the South Africa Pharmacy Council.

In the federal systems of Australia and the USA, a tribunal process is conducted by a state administrative court usually presided over by a judge. However, the board may have some say in terms of how it acts on the decisions of the tribunal.

In New Zealand there is only one tribunal – the Health Practitioners Disciplinary Tribunal – which conducts all tribunals for all the health professionals. All complaints of health professionals are referred to the Health and Disability Commissioner which processes the complaints at the investigation stage. Only those cases that related to unethical or criminal conduct are then dealt with by the relevant regulatory Council.

Another feature of the federal systems in the USA and Canada is that, while a regulator may have its own processes for conducting and determining cases, it does within the boundaries set by state laws that govern the wider health professions.

In the case of Australia, although a federal system with medical boards in each state, there is a nationwide body – the Australian Health Practitioner's Regulatory Agency – that sets out the processes for complaints procedures for all the health professions and conducts initial investigations. However, in the most serious cases concerning professional misconduct, AHPRA refers the cases to a disciplinary tribunal in the relevant state.

A notable feature of all of these regulators examined is that, when compared to the UK, there is much less information on the sanctions and thresholds guidance and the legal precedents that determine cases on the websites of either the tribunal service or the regulators. This absence of information should not be taken as an indication that such guidance does not exist, merely that it is not necessarily available online through the regulators' websites. The same caveat applies to some of the processes involved in determining fitness to practice: the identification of a procedure by a particular regulatory system – e.g. the use of interim orders or consensual disposal - should not be taken as evidence that such a process does not exist for a regulator in which such a process was not identified.

Preliminary investigations

In Canada, in both Ontario and Alberta, the relevant board or college of the health professions conducts a preliminary investigation. In Australia the investigation is conducted by AHPRA and in New Zealand it is conducted by the health and disabilities commissioner. In the State of New York, USA, the Office for Professional Conduct, an arm of the Department for Education, processes all complaints for the health professions.

In New Zealand, a complaint made to the Health and Disabilities Commissioner may be referred straight back to the relevant regulator. The Medical Council of New Zealand (MCNZ) conducts an initial complaints screening by a 'complaints triage team'. The priority accorded complaints will relate the 'seriousness' accorded to the complaint and the risk of harm posed.

All regulators conducted a complaints investigation process that determines whether the nature of the complaint should be forwarded on for some kind of panel or committee. The exact tests used to determine whether a complaint proceeds are not always made explicit, but in the federal systems the first key tests relates to the jurisdiction of the regulator to actually determine a case based on the nature of the complaint. In some cases, such as the Texas State Board of Dental Examiners (TSBDE), there are clear parallels to the realistic prospect test used in most UK regulators: 'probable cause to justify commencement of an official investigation.' The South Africa Pharmacy Council (SAPC) uses similar language, with the registrar able to refer cases for investigation in which there is 'prima facie proof of unprofessional conduct'.

Interim orders

Interim orders, or 'interim measures' or 'immediate actions' are used across regulatory systems to protect members of the public. These are determined in relation to the potential level of risk posed to the public. Where detail is provided, regulators have the ability to both suspend a license as well as restrict the scope of practise of a licensee.

Adjudication

As with the UK, there is not a clear dividing line between investigative and adjudication stages in the international regulators examined here, with investigative processes in some cases leading to an adjudication with that body, or being referred to a tribunal for a hearing.

In most cases, individual regulators can set up a disciplinary committee or equivalent to further investigate and determine cases referred to it from case workers or equivalent. At this stage it is common for there to be a process of consensual disposal or similar (e.g. alternative resolution). In some cases this is a more explicitly negotiated process that involves the complainant. For example, in the provinces of Alberta and Ontario in Canada, there is a complaints resolution process in all four of the health professions covered here that involves the complainant and requires their consent as well as that of the licensee to come to a mutually agreed resolution. This process can end in an agreement that the healthcare professional changes aspects of their practice and/or undergo some kind of remediation. In New York and Texas, USA, the complainant appears to have less of a role, with an investigative panel drawing up a proposed sanction or course or action and the licensee either accepting or declining the outcome. In the case of the Texas Board of Nursing (TBN), an

'Informal Settlement Conference' is convened in which the complainant can attend but does not appear to have a say in the outcome. In these examples, the position of the complainant, as either an observer or decision-maker, is a marked difference from the UK systems in which the complainant would only be notified of a consensual disposal and the reasons for that decision.

Discipline committees or equivalents have varying powers. In Australia, a national board can establish a performance or professional standards panel, which can determine respectively if the health professional has acted in a way that constitutes unsatisfactory professional performance or unprofessional conduct. Professional misconduct can only be determined by a tribunal and only in these cases a doctor's license be revoked. In Ontario Canada, a discipline committee convened by the relevant health professions council acts as a tribunal and has powers that include revocation of license and imposition of fines.

There is some divergence in the processes involved in cases related to performance and health. In Australia national boards can convene panels for issues related to health or performance. The relevant board may require a practitioner to undergo a health or performance assessment, and this may lead to a determination by a panel. For cases related to health and performance, sanctions are available that include reprimand and suspension, but do not included erasure / revocation of license.

In Ontario, Canada, the Regulated Health Professions Act stipulates that after the investigation stage a case can be referred to a Fitness to Practise Committee which determines if a licensee is 'incapacitated'. The committee can then revoke or suspend a license, or impose restrictions on elements of practice, but as in Australia cannot revoke a license.

Defining, identifying and categorising misconduct

Defining (serious) misconduct

All regulators have procedures to deal with misconduct. Where definitions are provided, serious misconduct is generally understood in similar ways in reference to the expectations of professionals in that field. For example, Roylance v GMC [1999] contains the definition that misconduct is: 'A falling short by omission or commission of the standards to be expected among [medical practitioners] and such falling short must be serious.' Social Care Wales draws on a similar ruling in the case of Nandi v. General Medical Council [2004], which defined serious misconduct as 'conduct which would be regarded as deplorable by fellow practitioners.' The General Teaching Council for Scotland similarly describe it as conduct that 'falls significantly short of the standards expected of a registered teacher.'

The case of Roylance is also used to determine the relationship between negligence and misconduct: 'It is of course possible for negligent conduct to amount to serious professional conduct, but the negligence must be to a high degree' (GOC).

Notions of public confidence are also used in defining the thresholds for misconduct. The SCCW makes reference to the case of A County Council v. W (Disclosure) [1997], in which conduct which is removed from professional practice, but is 'so disgraceful as to reflect on the profession'. Such misconduct is presumed to amount to impairment in particular instances, discussed below.

Defining professional incompetence / deficient professional performance

Those regulators with separate categories for deficient performance describe such practice in a number of different ways, including: professional incompetence, deficient professional performance and lack of competence. There is some continuity in terms of the tests used to determine when poor performance constitutes a level that calls into question a practitioner's fitness to practice. The GOC refers to the case of Calhaem v GMC [2007] to define 'deficient professional performance' as 'standard of professional performance which is unacceptably low', to be judged on a 'fair sample of the doctor's work'. The GDC also refers to this case in establishing that 'incompetence falling short of gross negligence' but which is still seriously deficient will fall under deficient professional performance rather than misconduct.

In common with a number of other regulators, the GOC and the GDC state that a single incidence of negligence is unlikely to amount to a judgement of deficient professional performance unless it is 'very serious indeed'. However, in reference to the case of R (on the application of Vali) v General Optical Council [2011], the GOC also note that continued cases of negligence, even if not that serious, may amount to deficient performance.

Distinguishing between misconduct and deficient performance

Our focus in this review is on the identification and categorisation of misconduct by professions regulators. However, as noted above, there is variation between regulators in whether they operate systems which treat issues of deficient professional performance separately from misconduct or not. Even where regulators do have, for example, separate panels to consider conduct and performance cases, the distinction between these categories may not always be clear cut. Whilst there are some straightforward aspects to the distinction, there are also aspects which are more problematic.

One common theme across all professions is that misconduct can encompass behaviours outside of professional practice where deficient performance, by definition, is related specifically to practice. However, when dealing with cases related to professional practice the distinction is less clear. For the healthcare regulators the key case in this regard is, again, Calhaem v GMC [2007]. As noted

above, the case determined that a single case of negligent treatment should not normally be considered deficient performance. But it likewise determined that a single negligent act or omission is 'less likely' to cross the threshold to amount misconduct, but that acts or omissions which are particularly serious may amount to 'misconduct'. Therefore, distinguishing between deficient performance and misconduct may be highly dependent on the nature of each individual case.

The need for a clear distinction is recognised by some regulators. For example, in guidance documents the GCC quotes directly from the case of Calhaem v GMC [2007] that 'it is neither necessary nor appropriate to extend the interpretation of deficient professional performance in order to encompass matters which constitute misconduct.'

Yet it seems that the more difficult issue is the other way around, whereby the definition of misconduct is extended to include matters related to professional performance. The GCC have noted in their guidance documents that, in the past, it has alleged both professional incompetence and unacceptable professional conduct in the same case, despite previous decisions that suggest this should not be done. The question raised in this respect was not the distinction between them, but which should be considered first. The lack of clarity in a distinction between misconduct and competence may also account for the phenomenon noted by the GOsC in their documentation, whereby the vast majority of cases proven relate to the charge of unacceptable professional conduct (misconduct) rather than professional incompetence. It may also be that single instances of misconduct are more readily proven than on-going substandard performance.

The GDC definition of deficient professional performance as 'incompetence that is short of gross negligence', seems to infer that the threshold for determining when negligence might constitute misconduct is a similar threshold to that which determines the difference in the English legal system between negligence as a matter of tort law, and gross negligence as a matter of criminal law. Recent guidance documents from the GDC refers to the case of Remedy v General Medical Council and, in relation to this case, states that, 'where negligence is gross, there is no reason on principle why a misconduct charge should not be sustained.'

International definitions

Misconduct

We found far less information on international regulators websites about the definitions of misconduct or incompetence than provided by UK regulators. In Alberta, Canada, the Health Disciplines Act stipulates that 'either unskilled practice' or 'professional misconduct' can be determined in cases whereby the practice of a member is: 'a) is detrimental to the best interests of

the public, (b) contravenes this Act or the regulations, or (c) displays a lack of knowledge, skill or judgment in the practice of the designated health discipline, whether or not that conduct is disgraceful or dishonourable'. Where information is available, the individual health professions within Alberta provide broadly similar definitions (as presumably they have to do given that their remits of their operations are defined by state law).

In South Africa, the Health Professions Act 1974 defines unprofessional conduct as 'conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy'. Like many of the UK regulators, this definition alludes to the standards of the profession.

In the USA, some regulators list examples of specific behaviours that constitute misconduct rather than provide an overarching standard. For example, in the state of New York, the 'Rules of the Board of Regents' of the Office of the Professions lists acts or omissions considered to be unprofessional conduct (see appendix B for a link to the complete list of provisions). The number of these provisions applicable to each professional group varies, and there are, for example, thirteen general provisions which apply to health professionals. These include 'willfully harassing, abusing or intimidating a patient either physically or verbally' and 'failing to use scientifically accepted infection prevention techniques appropriate to each profession…' In addition, there are further special provisions which vary between professional groups, including five provisions for medical professions and two for dental professionals.

A different model is that used by, for example, the Texas Board of Pharmacy, which does not specify acts or omissions but rather defines unprofessional conduct more broadly as engaging in 'behavior or committing an act that fails to conform with the standards of the pharmacy profession, including, but not limited to, criminal activity or activity involving moral turpitude, dishonesty, or corruption.' These different approaches at state level demonstrate the variety of approaches used in federal systems.

There are also differences within states between the approaches taken by the regulatory authorities for different professions. The Texas Board of Nursing provides detail on both the types and levels of misconduct, along with corresponding sanctions (see appendix C). For example, one category of misconduct is 'unprofessional or dishonourable conduct that, in the board's opinion, is likely to deceive, defraud, or injure a patient or the public'. A first tier offence in relation to this category of misconduct may be constituted by an 'isolated violation involving minor unethical conduct where no patient safety is at risk, such as negligent failure to maintain client confidentiality or failure to honestly disclose or answer questions relevant to employment or licensure'. A second tier offence,

however, may be constituted by 'repeated acts of unethical behavior or unethical behavior which places patient or public at risk of harm', or 'Personal relationship that violates professional boundaries of nurse/patient relationship.' A Third tier offence would include, 'Repeated acts of unethical behavior or unethical behavior which results in harm to the patient or public. Sexual or sexualized contact with patient. Physical abuse of patient.'

The New York Office of Professional Medical Conduct provides some information on the distinction between poor performance and misconduct. Practising the profession with 'gross negligence on one occasion' constitutes misconduct, as does 'professional incompetence on more than one occasion'. This is similar to UK health regulators where single incidents of poor performance are unlikely to constitute misconduct, whereas multiple incidences may constitute misconduct.

The Medical Council of New Zealand distinguish between malpractice, which relates to immoral illegal or unethical activity, and negligence, which involves the breach of a doctor's duty in their professional setting. However, it is not clear how either of these relate to determining professional misconduct.

Professional incompetence / deficient professional performance

International regulators websites contained limited information on overarching definitions of incompetence or performance. In Ontario, Canada, the Regulated Health Professions Act determines that a licensee is incompetent if they 'displayed a lack of knowledge, skill or judgment or disregard for the welfare of the patient'. The relevant threshold is unclear as it is determined, almost tautologically, by the nature of the sanction: 'to an extent that demonstrates that the member is unfit to continue to practise or that the member's practice should be restricted'.

The Health Professions Council of South Africa defines poor performance as 'negligence and conduct on the part of a practitioner which falls short of the required standards or generally acceptable norms in health care and which is found to be due to a lack of clinical or related skills or adequate knowledge of the management of patients or a particular health condition'. Impairment, which is only used in relation to physical or mental health, is defined as 'a condition which renders a practitioner incapable of practising a profession with reasonable skill and safety'.

Problematising definitions of misconduct

Evidently, legislation underpinning regulatory activities is a key component in regulatory bodies' approaches to defining misconduct, as our review of regulatory websites has shown. The

information contained within published literature also often focuses on definitions in legislation to identify differences in the ways that regulators define or categorise misconduct. For example, in legislation that predated the introduction of the AHPRA, nurses in New South Wales in Australia could be found guilty of by the regulator of either 'unsatisfactory professional conduct' or in more serious cases of 'professional misconduct.'[16] Similar distinctions between levels of conduct issues have also been seen in other domains, including the regulation of doctors,[17] pharmacists[18] and lawyers[19] in Australia. This distinction between categories of severity in conduct issues has been retained in more recent Australian legislation covering the regulation of all health practitioners.[20] In the United States, State Boards of Nursing use the terms 'professional misconduct' or 'unprofessional conduct' with usage varying between and defined by individual states.[21] Brous describes a broad range of activities or behaviours that may be encompassed by these terms, 'in both clinical and nonclinical arenas.'[21] In New Zealand, the terms 'misconduct' and 'unsatisfactory conduct' are used in the regulation of lawyers, with 'unsatisfactory conduct' described as encompassing 'less egregious breaches', including conduct that may be regarded as 'unbecoming or unprofessional'.[22] Misconduct is defined as including both some specific forms of conduct, such as gross overcharging, but also any conduct that 'would reasonably be regarded as 'disgraceful or dishonourable''.[22]

This latter description points to one specific aspect in definitions of professional misconduct which is identified as problematic by several authors, namely that which allows misconduct to be defined as something which 'brings the profession into disrepute', or similar. The broad nature of this approach to identifying or defining an activity or behaviour as misconduct, and therefore its potential for application by regulators as a 'catch-all', is one cause for concern about it usage. A tension exists between the circumstances of an individual case or the rights or interests of an individual professional, and the need to balance these with the notion of maintaining shared professional standards.[23]

This focus on the reputation of the broader profession body present in some definitions, and the potential for individuals to bring disrepute to bear upon it, relates to another frequently identified dimension of regulatory activity. Namely, that regulators have often focused on professionals' morality or moral standing, as much as upon the impacts or risks of their activities or behaviour. For instance, Unsworth[24] noted that the UK's nursing regulator, the NMC, often focused on the issue of whether a registrant was of 'good character', drawing on a requirement in the nursing *Code of Professional Conduct* that nurses should be honest and trustworthy, and that the notion of good

character had been subject to critique. Traynor et al suggest that this focus on character continues to be a prominent concern for the NMC.[25]

Ailsop noted, in relation to GMC disciplinary proceedings, the existence of an expectation that a professional should 'exercise a degree of honesty and moral probity beyond that expected of an ordinary member of the public.'[26] Baron makes similar observations in relation to regulatory authorities' treatment of cases relating to lawyers' 'civility' or lack of it, nothing that 'lawyers may be held to a higher standard than members of the public.'[19] Elsewhere too, this focus on professional character has been identified as a significant element in regulatory authorities approaches to professional discipline, with Bal suggesting that Medical Boards in the USA may operate with an 'assumption that character us a suitable substitute for competent and safe clinical practice.'[27]

Wachter[28] also notes a tendency on the part of medical regulatory authorities, particularly State Medical Boards in the USA, to focus their attention on matters pertaining to character rather than performance. He suggests, in common with Bal,[27] that a lack of specialty-level expertise and limited resources may limit medical boards capacity or willingness to address more complex performance-focused cases.

Establishing clear definitions from the literature of what constitutes misconduct, let alone what distinguishes *serious* misconduct, is challenging. This difficulty is explicitly acknowledged by some authors.[22 29] Definitions, where given, either cite from the relevant legislation[30 22] or otherwise focus on the application of sanctions – or disciplinary actions – to identify misconduct and judge severity. For example, Collins and Mikos[31] state that:

> '…misconduct is a violation of nurse practice acts or other regulatory standards as demonstrated by the issuance of administrative complaint by a state or federal regulatory body for rules violations that may result in licensure discipline and practice limitations to protect the public.'

Likewise, in their study of disciplinary actions against lawyers in the USA, Levin et al[32] state that:

> '…bar discipline identifies much of the most serious misconduct, including lawyers who steal from clients and those who are convicted of serious crimes. The imposition of discipline is thus at least a crude measure of whether a lawyer has departed from the standards of

professional conduct expected of members of the bar and it is the only measure that is readily available.'

This approach within the literature points to a somewhat circuitous logic, positing that 'that which is serious is disciplined therefore that which is disciplined is serious.' Such logic seems to assume that the decisions of regulatory panels and disciplinary boards to impose sanctions are axiomatic, consistent, and constant. This risks oversimplifying the concept of seriousness in professional misconduct, and obscures the important role of regulatory decision-making in determining what constitutes seriousness and the many contributory factors that influences those decision making processes.

Sanctions

With this caveat about focusing on sanctions in mind, it is undeniable that many analyses of regulatory activity in relation to misconduct either focus on, or include information about, the sanctions that regulatory bodies may impose.

The types of sanctions to which regulators have recourse when dealing with professionals deemed to have committed misconduct typically include (in approximate order of severity by impact, from most to least):

- Erasure[33 23 34] from the professional register (also described as: removal,[16 35-38] deletion,[39] or striking off[22 40-44] a professional, from the register; licence revocation[27 45 46 47-53] or withdrawal;[39] deregistration;[30 54 55] withdrawal of authorisation to practise;[56] disbarment;[32 57] or cancellation of registration[20]).
- Suspension[58 59 21 47 55 20 22 23 29 32-34 36-38 41 42 48-52 60-62] for a defined period (with examples varying from 21 days,[19] several months,[17 45] up to a maximum of one year,[39 43] two years,[35] three years,[30] or five years[16]).
- Restrictions,[21 39 51 54 55 60 63] conditions,[20 22 23 30 33 35 36 43 48 64] or limitations[29 62] on practice, also described as 'partial withdrawal of the right to practise'.[41 42]
- Reprimands,[16 27 45 47-49 55 29 61 20 32 51 53 62] warnings,[23 35 41 42 50 59 43] criticism,[56] admonishment[34 38] or censure.[21 22 30 39 52 57 58]
- Remediation or retraining.[16 17 21 22 29-32 35 43 48 53 60 62 65]
- Supervision.[16 21 30 43 53 57 59]
- Probation.[21 32 39 41 49 57-59 61 62 66]

- Fines.[17 19-22 29 30 39 41 42 45 48 49 51-53 55 59 62 63]

In some jurisdictions, licence revocation can be used to mean either permanent or time-limited exclusion from practice,[59 67] and the phrase 'exclusion actions' was also used as a term encompassing both permanent revocation and temporary suspension of the right to practice,[58] as was 'removal from practice'.[60] Likewise, there were references to the use of reprimands, warning or censure in various ways, but all entail some form of formal public expression of disapproval by the regulator about the professional's conduct.

Other types of sanction were also mentioned, but less frequently, including: advice issued by a regulator;[22] a professional being required to issue an apology, or pay compensation;[22] professionals being required to pay the regulatory body's costs;[17 19 30] or to attend counselling;[16 17 29 30 45] and action being taken to reduce or limit the fees charged by a professional.[22]

Categorisations of misconduct

Whilst there are some indications that regulators themselves identify specific categories or types of activities or behaviours as potentially constituting misconduct, usually drawn from legislation as described above, it more typical in the literature to see categories which have been developed by the authors themselves. However, it is clear that there are broad types of activities and behaviours which often feature in cases of misconduct.

The most frequently identified type of misconduct within the literature was sexual misconduct. This was often discussed in relation to medical practitoners[28 45 46 48 50 53-55 60 68-70] but also nurses,[16 30 42] psychoanalysts,[71] psychologists,[41] lawyers,[19] and social workers.[35 37 38 44 59] Elkin et al[60] found, in analysis of data from Australia and New Zealand, that doctors were removed from practice in 81% of cases involving a sexual relationship with a patient. Sexual misconduct is a broader category than sexual relationships though, and may encompass a range of behaviours including words, actions, exploitation or abuse, harassment, and unwanted touching – including examination without consent.[54] In medicine, sexual misconduct is seen as a violation of the doctor-patient relationship,[68] and across health professions can be seen as a particular breach of trust,[72] and was described in one article as 'an egregious breach of public trust.'[45]

In other articles, descriptions and analyses of sexual misconduct were offered alongside and sometimes overlapping with, discussions of 'boundary violations' as a wider category of misconduct.[16 35 37 54 64] There is some discussion about whether a professional forming a relationship with a service user or patient who is not under their direct care constitutes a transgression, or if the person concerned is a former but not current patient or service user.[35] However, both sexual misconduct and wider boundary violations are typically treated as serious misconduct by regulators.[16 30 54 55] However, this is not always the case and Manning[73] reports that in New Zealand, there has been a shift away from the assumption that sexual misconduct should always constitute serious misconduct, to a more nuanced approach focusing on the specific individual characteristics of cases. Searle et al found some differences between sanctions administered by UK health regulators in cases of sexual misconduct, with nurses more likely to be erased from their professional register than doctors, and raise the question of whether this is due to the individual details of the cases or perhaps to some form of bias.[72] The NMC's strong focus on the 'good character' of registrants, noted above, may also influence its approach to sanctioning sexual misconduct.

Other types of misconduct identified in the literature include: issues relating to the prescription or dispensing of medication;[18 20 30 45 47-51 53 55 65 66 74 75] fraudulent behaviour;[26 30 45 46 49 51 57 59 65] substandard care or practice;[21 30 37 42 43 48 50 58-60 64] and communication skills.[19 20 22 30 43 51 64 76] In addition, there is often reference to a broad category of 'unprofessional conduct' often featuring issues such as poor record-keeping and breaches of confidentiality, and generally treated as being of lesser seriousness.[18 20 29 30 43 45 46 48 51 53 58-60 75] Less frequently cited types of misconduct included: involvement in torture;[52] research misconduct;[23 61 77] and cases featuring clinicians working as expert witnesses in court cases.[78-81]

Sometimes these categorisations are drawn in terms of broad topics or areas of activity but others are focused on underlying issues or general traits, such as dishonesty[82] or crime, which could pertain to almost any topic or area of activity. For example, cases such as that of a chartered accountant found to have submitted false expenses claims[83] could be categorised as fraudulent behaviour, dishonesty or crime. In other cases, categorisations may be identified differently or overlap – for example, issues relating to social media usage[19 50 64] may also be noted as being indicative of poor communications skills.

As alluded to above, in health care professions these types of misconduct cover both clinical practice and other domains of professional activity.[21 55] In other professions too, both the quality of professionals' work and their other activities may be subject to disciplinary action.[19] Moreover, it is clear and often highlighted within the literature that regulatory actions can also focus on activities or behaviours that occur outside a professional's work at all.[72] Indeed, the scope of regulatory oversight and how far it does or should extend over professionals' 'private' lives as well as their professional activities is a key focus of attention. McLaughlin[38] recounts a case in the registration of a social worker in the UK was suspended by the General Social Care Council (the regulatory predecessor of the HCPC in this field) largely as a result of the individual having advertised their services as an escort. Whilst perhaps an extreme example, the author argues that the regulator's judgement in this case largely focused on activities which occurred in the professional's private life, and on establishing moral judgements about those activities.

Summerville[84] presents an in-depth analysis of disciplinary cases brought against teachers in the USA, and analyses these in terms of whether the regulatory authorities focused on either the 'moral exemplar' test or the 'nexus' test. She argues that over the 30 years covered in her study, there was a trend away from decisions founded primarily on moral judgement, to those focused on application of the 'nexus test.' Summerville describes the 'nexus test' as formally requiring that, for action to be taken against a professional, there must be a connection or 'nexus' between the personal behaviour or activity being investigated and their effectiveness as a professional.[84] White[85] states that there is 'a substantial body of legal and ethical literature suggesting that an individual's private behaviour is precisely that until there is a nexus – an inextricable connection – between private behaviour and one's professional performance.' Several items we identified considered regulatory actions targeting professionals' behaviour or activities outside their work.[19 27 35 37 38 43] However, as with many of the types of misconduct and wider issues, there is no clear consensus about what precisely constitutes misconduct or serious misconduct. There was though, in the website searches and the literature, clear identification of a number of factors which regulators typically consider when deciding whether an activity or behaviour should be classed as misconduct, its severity, and the appropriate sanction.

Factors informing decision-making

Impairment

Where regulators explain the temporality of impairment, it is impairment at the time of hearing (current impairment), or impairment or likelihood of being impaired if continuing to work in the profession (future impairment (GOC)). The GOsC stands alone amongst the health professions in not

seeking to make a judgement on impairment. Rather, it seeks only to prove if the facts of the case are well founded. In other words, if the facts of the case are found to show that that there has been serious misconduct, or adverse physical or mental health, it is not necessary to determine that this demonstrates impairment of a practitioner's fitness to practise at a particular point in time.

In practice, it is not really clear whether this makes the GOsC substantially different in terms of their adjudication processes. This is in part because most healthcare regulators, and some non-healthcare regulators, provide guidance that suggests that impairment can be found when it is in interest of the public and/or the wider profession. The GMC and the NMC, for example, refer to the case of Yeong v GMC [1999] and CHRE v Nursing and Midwifery Council & Paula Grant [2011] in determining the importance of the wider public interest and confidence in the profession. The GOC refer to the case of PSA v Nursing and Midwifery Council (Grant) [2011] in establishing that panels should consider not just whether the registrant continues to present a risk to the public, but whether 'professional standards and public confidence in the registrant and the profession requires would be undermined if a funding of impairment was not made in the circumstances.' The National College for Teaching and Leadership (NCTL) take do not make explicit reference to impairment, but similarly provide guidance for findings of misconduct in instances where conduct outside of the education setting 'may bring the profession into disrepute.'

The overall point here is that where the information is available, even where impairment must be proved in the adjudication process, regulators can still come to a decision on impairment on the grounds of sufficiently deplorable conduct alone, without having to establish impairment at a particular point in time.

In the case of the Solicitors Disciplinary Tribunal (SDT), assessing the seriousness of the act or omission is the first step in determining whether there is impairment. The second step is determining the level of culpability, and the third whether there are aggravating or mitigating factors. This three stage process, perhaps unsurprisingly, reflects the process in criminal law of establishing the guilty act (*actus reus*), the guilty mind (*mes rea*) and then considering aggravation or mitigation. A number of regulators also refer to the level of risk in determining the seriousness of an act or omission. The NMC for example, determine lack of competence, impairment by physical or mental health, and not having the necessary knowledge of English against the potential risk posed to the public or patients.

Issues carrying an assumption of impairment

It is common for UK regulators, both health and non-health, to list a series of acts or omissions which, unless there is specific reason not to, should guide decision-makers to a finding of impairment. In general these refer to gross abuses of trust in relation to sexual assault / abuse, whether or not in the context of professional practice. As noted above, in some cases there appears to be degree of debate over whether sexual misconduct should be assumed to warrant striking off the register, with the GPhC reportedly rescinding an earlier draft of guidelines in 2014 which had suggested such guidance. The guidance issued in 2015 retained the position that mitigating factors could lead to a sanction less severe than striking off.[86]

The use or distribution of child pornography is cited as an example of behaviour that is incompatible with professional practice and almost certainly leading to a judgement of impairment (SSSC, GOC, GDC, HCPC). Negligence considered 'gross negligence' or 'recklessness' is also cited by the GMC as presumed impairment. No particular definition of gross negligence or recklessness is given, although presumably the existing leading cases for gross negligence in criminal law would apply here as they generally concern doctors (e.g. R v Adomako [1994]).

Impairment internationally

Amongst the global regulators, the term impairment is not used in the same way as it is with most UK healthcare regulators. As noted above, in some of the global regulators impairment is only used in relation to physical or mental health issues. Accordingly, and unlike the UK health professions regulators, impairment is not a feature of the adjudication process. Thus the temporal considerations (was the practitioner impaired? Is the practitioner impaired? Or will the practitioner be impaired in the future?) does not explicitly factor into decision-making.

The concept of risk is similar and may be considered a proxy for impairment. In other words, asking whether a practitioner poses a current risk to patients and the public might be considered a variation on asking whether a practitioner is currently impaired. However, the explicit reference to risk identified on the international regulators' websites and guidance tends to focus on the earlier stages of case handing, triage and interim orders rather than final decisions made by panels or tribunals.

Where impairment is used as a test in relation to physical or mental health, current impairment is the consideration. For example, the Health Professions Council of South Africa offers guidance that a committee may find impairment in relation to a 'practitioner's current physical or mental condition'. If the performance or conduct relates to a previous condition, then it only constitutes impairment when 'it may be expected to cause a recurrence of impairment'.

Aggravating and mitigating factors

Most regulators explicitly list a series of aggravating and mitigating factors that are used to guide decisions on impairment or assist in determining sanctions. The point in the process at which these factors are considered is a point of difference between the health and non-health professions. In criminal legal proceedings, aggravation and mitigation are only considered at the sentencing stage of a case, and the non-health professions, including the legal professions, seem to reflect this. For example, the NCTL only consider the aggravating and mitigating factors when determining whether a prohibition is an appropriate sanction.

In UK healthcare professions, where a ruling on impairment is a distinct stage of an FtP process, the norm is for aggravating and mitigating factors to also be used as evidence of whether a practitioner is impaired (GMC, GDC, GOC, SCW, GPhC, HCPC). The GMC cite the case of Cohen v General Medical Council [2008] EWHC 581 (Admin), which established that evidence that a failing is remediable and has been remedied by a doctor is relevant to consideration of impairment, not just relevant to a decision on a sanction.[87] The NMC lists aggravating and mitigating factors only in its sanctions guidance, but it has more recently produced separate guidance on the role of remediation and insight in determining a decision on impairment. The GOsC, as they do not seek to find impairment, list aggravation and mitigation only in relation to determining sanctions. However, it is notable the PSA were critical of the GCC for not listing insight as a factor that might determine consensual disposal of a case earlier on the FtP process.

For regulators where aggravation and mitigation form a judgement on impairment, these factors may still be central to determining the sanction. A finding of impairment does not necessarily mean that a sanction has to be applied. In one case before the MPTS, a trainee GP who had posted photos of patients online escaped sanction because he showed 'evidence of remorse and efforts at remediation.'[88]

The level of risk posed to the public is cited as an aggravating factor (GMC, NMC, GPhC, GDC). Another common theme across most regulators is the importance of insight on the part of the practitioner during the investigation and adjudication process (GCC, GOsC, GOC, GMC, NMC, GDC, SRA, LSS, SSDT, NCTL, SSSC, BSB, RCVS, IFA). The importance of insight in the decision making process for the Medical Practitioners Tribunal Service has been noted in the public statements of decision makers. In a 2014 case before the MPTS in which the accused practitioner did not attend, the panel chair noted that while 'non-attendance cannot be held against him, it leaves the panel in a position where it has had no evidence of any apology, insight, or remediation.'[89]

Candour is also listed as mitigating factor in a number of health and non-health professions (GCC, GOC, GPhC, SCCW, GDC). In this sense candour is referred to in terms of honesty with patients when things go wrong, and honesty and openness in terms of the investigation and adjudication process. The term candour is not used outside the healthcare regulators, but the non-healthcare regulators frequently refer to honesty and dishonesty as aggravating and mitigating factors. The SRA for example, provide guidance stating that 'a finding that an allegation of dishonesty has been proved, will almost invariably lead to striking off, save in exceptional circumstances' (Solicitors Regulation Authority v Sharma [2010] EWHC 2022 (Admin)).

In cases of poor / deficient performance, the 'remediability' of the issue is cited as informing judgement on impairment (GOC, GMC, GDC, GTCS, IFA). Similarly, in cases whereby health is not dealt with separately from performance, engagement with rehabilitation programmes can be taken into account as a mitigating factor (SSCW, LSS).

Where these aggravating and mitigating factors are publically available, dishonesty is cited by all regulators as an aggravating factor that will determine impairment. The two-stage test for dishonesty is employed: whether the registrant acted dishonestly by the standards of the profession; and whether the registrant realised that what they were doing was dishonest. Cases giving legal precedence for the two stage test include: Hussain v GMC [2014] EWCA Civ 2246, PSA v HCPC and David [2014] EWHC 4657, Kirschner v GMC [2015] EWHC 1377.

Aggravating and mitigating factors internationally

Again, there is far less information on aggravating and mitigating factors in determining fitness to practice in the international regulators' websites surveyed for this review. Where there is information provided a number of the same elements can be identified that exist in the UK health regulators. For example, the Texas Board of Pharmacy in the USA includes 'self-reporting and voluntary admissions of the conduct' as a mitigating factor. This is similar to the concept of candour in the UK. The Board of Pharmacy also includes remediation as a mitigating factor.

The Texas Board of Nursing provides a detailed matrix of aggravating and mitigating factors, highlighting the factors relevant for each type of misconduct (see appendix C). Returning to the example above, 'unprofessional or dishonourable conduct that, in the board's opinion, is likely to deceive, defraud, or injure a patient or the public' has attached to it a series of aggravating and mitigating factors. For aggravation, this includes the number of events, level of material or financial gain, actual harm, severity of harm and patient vulnerability. Mitigating factors include voluntary participation in established or approved remediation or rehabilitation program and proven

competency. The level of harm caused to the patient is listed as an aggravating factor across all of the categories of misconduct.

Aggravating and mitigating factors discussed in the wider literature

In the absence of clear-cut definitions of what constitutes serious misconduct, regulators often draw upon a range of factors to inform their decision-making in this sphere. Typically, regulatory decision-makers – those on panels or boards – consider a number of factors in making their determinations and applying sanctions.

There is broad consensus in the literature about some of these factors, and these are largely representative of the information already described above drawn from regulators' websites. Aggravating factors often identified in the literature include: any potential risk of harm to patients, service users, or clients;[16 17 27 30 40 90 91 33 36] However, Elkin found that harm to patients is not a prerequisite for serious disciplinary action against doctors.[55] Jacobs has suggested that, specifically in reference to cases of research misconduct, regulators may interpret 'patient harm' too narrowly, focusing only on direct harm to known individuals rather than on the risks of wider presented by fraudulent pharmaceutical research.[23] Risk of harm was primarily identified in relation to health and social care professions, but also in relation to legal professionals, where the risk may be of financial harm.[57]

Another aggravating factor considered by regulators, that is closely linked to the risk of harm, is whether the misconduct is long-term or likely to be repeated.[19 40 37 43] This may involve consideration of a professional's disciplinary or employment history.[21 60 22 53] This is turn is linked to regulator's consideration of whether a professional is suitable for rehabilitation or remediation, which is often considered in deciding what sanctions might be appropriate in cases of misconduct.[30 60 33 36 48 29 44 28] Remediability is often judged according both to the nature of the misconduct, with some suggestions that clinical or performance related concerns may be judged more easily remediable that 'character' focused misconduct,[28] and also with regards to whether the professional has demonstrated insight and/or remorse[22 33 35 37 38 40 43 60 91 92] into the issues under investigation. Dishonesty on the part of the professional is also often an aggravating factor for regulators considering misconduct.[16 22 30 33 35 36 43 91]

Other potentially influential factors were identified by some authors. As noted above, Wachter[28] and Bal[27] suggested that the expertise and resources available to regulatory authorities may influence the types of case that they focus on at a general level.

There were also a number of references within the literature to one factor which regulatory authorities often do not appear to take into consideration – that of organisational issues which may provide contextual information about an individual professional's behaviour or activities. Searle at el state that research shows that 'external environments can have an insidious and accumulative influence in overwhelming and eroding the good intentions of individuals', referring to such negative environments as 'depleting barrels' as a counterpoint to the concept of 'bad apples', or individuals who deliberately engage in misconduct.[72 93] In some organisational environments, Searle argues, behaviours which constitute misconduct can become normalized.[72] Whilst many authors recognised that regulatory authorities typically operate within a remit focusing exclusively or primarily on the practice and behaviour of individual professionals,[25 64] several argue that regulators should place more weight on organisational context and report its significance to any instances of misconduct in their findings.[26 28 29 37 43 94] Ailsop noted in 2006 that, in health, care is 'provided within a complex system' and that poor outcomes may be due to more than simply the actions of individual practitioners.[26] Jonestone and Kanitsaki argued that errors in healthcare are often more likely to be the result of multiple factors rather than individual actions, and that adopting a 'systems approach' to investigating and addressing failings should be prioritised.[29]

Particular examples of issues with an organisational dimension cited in the literature included cases where nurses were disciplined for working whilst unwell and unfit to work, but argued that they had felt compelled to continue to work due to staffing shortages in their employing organisations,[64] and cases in which social workers reported having been unable to maintain completed records or undertake requisite visits due to staff shortages.[35 37] Again looking at social work regulation in England, Leigh et al[43] suggested that in some cases, the regulator could have looked more at what supervisory support and management had in place around professionals who were subsequently reported for misconduct, and highlight that the absence of effective supervision or management may be a contributory factor in some misconduct cases. Leigh et al[43] also suggest that, based on their findings, the HCPC as social work regulator could do more to alert systems regulators to potential organisational findings where these are identified within FTP processes. Whilst the potential for individuals to exaggerate or misrepresent organisational factors to mitigate their failings is clear, it is also evident that some misconduct cases – particularly those focusing on performance at work, or the effective delivery of service or care – may be impacted by organisational context.

Political and social contexts influencing decision-making

We identified limited information about political and social contexts that have influenced or may influence regulatory decision making about misconduct and its severity. Most references to political context simply identified differences in between different jurisdictions, particularly in federal systems such as the United States, or between nations in terms of disciplinary outcomes.[68 32 45 48 51 58 58] There were also references to differences in legislation or context specific regulatory structures,[56] including, for example, New Zealand's no-fault medico-legal system.[30]

The literature contained some references to policy change or changes to regulatory structures during the period being studied and earlier, including changes to the constitution of the GMC,[23 26 77 80] the new regulatory framework for Australian healthcare practitioners[55] (described above), and the extension of statutory regulation to social workers in Ireland[37] and changes to social work regulation, from the GSCC to the HCPC in England.[35] Such references are typically given in the brief descriptions of regulatory procedures which introduce analyses, rather than being the focus of analysis or even discussion, and are therefore limited in the level of detail they provide. However, legal or policy changes in a particular jurisdiction evidently represent important contextual elements in shaping regulatory approaches to determining what constitutes serious misconduct.

In some instances, political context has been the focus of more detailed analysis or commentary. In particular, a number of the paper identified in this review discussed the role of high profile scandals, typically those featuring healthcare failings, as drivers for change in regulatory policy, including approaches to defining and determining misconduct.[26 25 35 55 77 78 93] In particular, a shift away from past models of self-regulation to increased state oversight of regulation is, at least in part, assigned as a reaction to such scandals in relation to medical[26 93] and nursing regulation[25] in the UK, and the regulation of health practitioners in New Zealand.[30] Grant[48] cites the role of increased consumerism in the 1980s and 1990s as a contributing factor in the development of state medical boards as 'bureaucratic organizations', and consequently to the increased number of doctors disciplined by them in recent years.

Conceptually, and in line with analyses positioning regulation as a form of state oversight, Dixon[91] draws on Foucauldian theories of disciplinary power to understand treatment of unethical conduct by nurses. Discussing social context, Dixon argues that decisions about what constitutes unethical conduct are 'normalising judgements', based on socially accepted norms that can be 'defined as ideological and moral standards', and that such judgements are an expression of disciplinary power that 'enable the imposition of ideological or moral evaluations.'[91] Social norms are subject to change, however, as McLaughlin notes has been the case in recent decades with regard to attitudes

towards homosexuality.[38] These notions of moral judgement being an element of regulatory decision-making around misconduct link back to the issues of investigations focused on 'good character', and the reputation of the wider profession discussed above.

Evaluating the evidence base for approaches to identifying, defining, and categorising misconduct

Overall, in our review of regulatory websites we found little evidence that regulators are drawing on a research or evidence base to inform their approaches to identifying, defining and managing misconduct. As described above, where available, regulatory policy documents tend to refer to the definitions of misconduct set out in relevant legislation, and to legal precedents established in case law. Whilst some regulators[95-97] and other bodies,[8 72 82 98 99] mainly to our knowledge in the UK, have commissioned research on relevant topics, it is not clear how or if this activity has translated into impact on policies or procedures.

Beyond this, the wider published literature is littered with examples of authors critiquing the evidence base for regulatory activities in relation to misconduct, often identifying the limited extent of the available literature.[20 35 37 44 47 56 57 63 68 69 91] However, it must be acknowledged that many of these statements are rather formulaic statements typically included to 'identify the gap' in the literature that a study is seeking to fill.

We also found particular comments on the quality and extent of the data available for research into regulatory activities relating to misconduct, mostly pointing to its limitations. These noted inconsistencies in data collection and reporting between state level regulators in federal countries,[45 59] and the limited value of high level aggregated categorical data for exploring the nature and nuance of misconduct cases.[59] There were also concerns that aggregating data can result in non-specific categories, or the conflation of types of misconduct with the underlying reasons for it.[55 30] Elsewhere the use of disciplinary outcomes as a proxy for the prevalence of misconduct overall was noted,[65] with concerns that this leads to the under-estimation of true rates of misconduct.[70] Analyses of written case documentation, such as panel decisions, also noted that these documents sometimes do not record decision-making processes consistently or completely,[38 51] making it difficult to judge whether a particular potential aggravating or mitigating factor has been considered and found irrelevant or simply not considered at all, for example.

Through this review, we have identified that there exists a broad body of literature containing information, analyses, and theoretical interpretation relevant to matters of identifying, defining and categorising seriousness in regulatory misconduct cases. However, this information is contained within a very disparate body of work, of a range of quality and formats, and very little of it is directly or primarily focused on the question of seriousness itself. Rather, information on seriousness has been identified from amongst this disparate body of works, often with only small elements of an item being relevant. Finally, whilst our database search strategy sought to identify and include material across a range of professions, the majority of the material identified for inclusion was focused upon health and social care professions, both in the UK and internationally.

Discussion and conclusions

This wide-ranging review has sought to explore and understand the approaches taken by professions regulators internationally to define, identify and categorise professional misconduct, and in particular to consider what is distinct about serious misconduct and how it is treated. Drawing information retrieved from regulators' websites, including from their guidance documents and other publications, together with academic studies, commentaries and new items, we have identified a significant but disparate corpus of literature pertaining to professional misconduct. However, seriousness in relation to misconduct was often not the primary focus of much of the material identified though much relevant material was present.

Overall, our findings suggest that, whilst there are broad commonalities in, for example, the types of sanctions which regulators have at their disposal in cases where misconduct is identified, the ways in which misconduct is identified and categorised can vary considerably between regulators. Some regulators offer very clear definitions, including lists of specific actions or omissions, of what constitutes misconduct. However, it is far more common for regulators to offer broader definitions and to point to the necessity of considering the details of each individual case in order to decide whether a professional's actions do or do not constitute misconduct. There are clear advantages and disadvantages to each approach – whilst a list of defined actions constituting misconduct may offer a greater degree of immediate clarity, such an approach may also be too rigid to accommodate changing work practices or developing social norms, especially in contexts where legislation is required for amendments to be introduced. Broad definitions, meanwhile, may offer a greater degree of flexibility for regulators to develop their approaches on a case by case basis or in response

to political or cultural change, but they may appear more opaque for regulated professionals and members of the public alike.

The central question of seriousness is most typically determined by the assessment of a range of aggravating and mitigating factors in relation to each case. As with sanction options, the types of aggravating and mitigating factors raised were broadly similar across the literature, with questions of insight, remorse, and remediability arising particularly frequently. Our review of regulators' websites shows, though, that there can be variation between regulatory authorities in the stages at which such factors are considered, for example whether at preliminary assessment, or only in deciding a sanction after a finding of misconduct has been made.

As with all literature reviews, the findings reported here may have influenced by the search strategy employed. Whilst our strategy was tested through a number of preliminary searches, and our search terms, were deliberately broad due to the exploratory nature of the review, it was clear, for instance, that we identified a number of news articles from some publications – e.g. a publication aimed at lawyers in one particular US state – and that this is an artefact of the way in which some publications are indexed and linked to databases, whilst other similar publication may not be. However, these quirks aside, we identified material from across a range of professions and countries.

It is notable, and perhaps not unexpected, that much of the material identified in the review focused on health professions regulation in the UK and USA, as well as Canada, Australia and New Zealand. Health professions regulation is often particularly highly developed, due to the potential risk to the public of the work that health professionals undertake, and the potentially vulnerable position of patients in relation to the health care professionals with whom they interact. Through this review, we have found that health professions regulators can learn from each other and from regulatory approaches in other sectors, through exploration of varying approaches to regulating conduct. However, we found through this review that, whilst there is a significant and growing body of analytical work focusing on professional regulation and specifically on matters pertaining to misconduct, there is as yet limited evidence that regulators are drawing upon this knowledge base effectively to develop their approaches in this sphere. We therefore advocate the importance to regulators, professionals and the public, both of drawing on existing evidence and of continuing to support the further development of such analytical work.

Several issues emerged from this review as current topics of debate within the literature which may be particularly worthy of further attention from regulators. Firstly, there were differing approaches towards the extent to which professionals' actions and behaviour in their lives outside the workplace

should fall under the purview of their professional regulator, and this seems to an area where regulatory approaches differ and are currently in flux. Secondly, whilst our review focused specifically on professional regulation and misconduct relating to individuals, even within the literature we identified through these searches, there were calls for professions regulators to give more consideration to organisational or environmental contextual factors in considering cases of potential misconduct. This latter issue was raised particularly in relation to alleged misconduct occurring in relation to work, and often in relation to cases which may straddle the unclear boundary between conduct and performance. The relationship between professions and systems regulation in the UK was raised in a recent government consultation of the future shape of health profession regulation, as was the position of employers and the role they may play in relation to regulation.[100] Our review identified these as issues particularly pertinent to the regulation of professional misconduct in some instances, and such questions therefore merit continued exploration.

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Appendices

Appendix A: Database search histories

Database	No of results
Scopus	**669**
Ovid Embase	**321**
Ovid Medline	**101**
Business Source Complete	123
CINAHL	77
SocINDEX	35
ERIC	16 =**232** (auto deduplicated by EBSCO)
Dentistry & Oral Sciences Source	8
AMED	4
Web of Science	**352**
Total before deduplication	**1675**
Duplicates removed in EndNote	**486**
Records imported into Rayyan for screening	**1189**

Scopus:

((TITLE-ABS-KEY ("General Chiropractic Council" OR "General Dental Council" OR "General Medical Council" OR "General Optical Council" OR "General Osteopathic Council" OR "General Pharmaceutical Council" OR ("Health and Care Professions Council") OR ("Nursing and Midwifery Council") OR "Pharmaceutical Society of Northern Ireland" OR "Care Council for Wales" OR "Northern Ireland Social Care Council" OR "Scottish Social Services Council" OR "Medical Practitioners Tribunal Service" OR "Professional Standards Authority" OR "National College for Teaching and Leadership" OR "General Teaching Council for Northern Ireland" OR "General Teaching Council for Scotland" OR "Education Workforce Council" OR "Solicitors Regulation Authority" OR "Solicitors Disciplinary Tribunal" OR "Law Society of Scotland" OR "Law Society of Northern Ireland" OR "Faculty of Advocates" OR "Association of Commercial Attorneys" OR "Bar Standards Board" OR "Bar Council of Northern Ireland" OR "Architects Registration Board" OR "Royal College of Veterinary Surgeons" OR "Institute and Faculty of Actuaries" OR "Institute of Chartered Accountants in England and Wales" OR "Financial Reporting Council" OR "Royal Institute of Chartered Surveyors" OR podiatrist* OR dietitian* OR "occupational therapist*" OR orthoptist* OR paramedic* OR physiotherapist* OR psychologist* OR psychiatrist* OR prosthetist* OR orthotist* OR radiographer* OR "Speech and language therapist*" OR anaesthetist* OR physician* OR surgeon* OR optician* OR optometrist* OR osteopath* OR pharmacist* OR "pharmacy technician*" OR nurse* OR midwife OR midwives OR "art* therapist*" OR "Biomedical scientist*" OR chiropodist* OR "healthcare professional" OR "health

professional" OR clinician* OR chiropractor* OR dentist* OR "dental hygienist*" OR "dental therapist*" OR "dental technician*" OR "orthodontic therapist*" OR orthodontist* OR doctor* OR "general practitioner*" OR gp OR gps OR "social worker*" OR teacher* OR solicitor* OR lawyer* OR banker* OR accountant* OR architect* OR surveyor*)) AND (TITLE-ABS-KEY ("fitness to practi?e" OR "competence to practi?e" OR ftp OR tribunal* OR disciplinary OR disciplined OR (professional W/3 regulat*) OR (professional W/3 performance) OR (professional W/3 competence) OR (conduct W/3 committee*) OR (practice W/3 committee*) OR (conduct W/3 hearing*) OR (conduct W/3 panel*) OR (conduct W/3 regulat*) OR (performance W/3 regulat*))) AND (TITLE-ABS-KEY (misconduct OR impairment OR impaired OR seriousness OR "Unacceptable professional conduct" OR "Deficient professional performance" OR "Lack of competence" OR "professional incompetence" OR "serious concerns"))) AND PUBYEAR > 2004

Ovid Embase <1974 to 2017 November 09>

1	General Chiropractic Council.ab,kw,ti.	5
2	General Dental Council.ab,kw,ti.	206
3	General Medical Council.ab,kw,ti.	811
4	General Optical Council.ab,kw,ti.	4
5	General Osteopathic Council.ab,kw,ti.	8
6	General Pharmaceutical Council.ab,kw,ti.	41
7	"Health and Care Professions Council".ab,kw,ti.	11
8	"Nursing and Midwifery Council".ab,kw,ti.	363
9	Pharmaceutical Society of Northern Ireland.ab,kw,ti.	2
10	Care Council for Wales.ab,kw,ti.	0
11	Northern Ireland Social Care Council.ab,kw,ti.	0
12	Scottish Social Services Council.ab,kw,ti.	2
13	Medical Practitioners Tribunal Service.ab,kw,ti.	3
14	Professional Standards Authority.ab,kw,ti.	5
15	"National College for Teaching and Leadership".ab,kw,ti.	0
16	General Teaching Council for Northern Ireland.ab,kw,ti.	0
17	General Teaching Council for Scotland.ab,kw,ti.	0
18	Education Workforce Council.ab,kw,ti.	0
19	Solicitors Regulation Authority.ab,kw,ti.	0
20	Solicitors Disciplinary Tribunal.ab,kw,ti.	1
21	Law Society of Scotland.ab,kw,ti.	0
22	Law Society of Northern Ireland.ab,kw,ti.	0
23	Faculty of Advocates.ab,kw,ti.	1
24	Association of Commercial Attorneys.ab,kw,ti.	0
25	Bar Standards Board.ab,kw,ti.	0
26	Bar Council of Northern Ireland.ab,kw,ti.	0
27	Architects Registration Board.ab,kw,ti.	0
28	Royal College of Veterinary Surgeons.ab,kw,ti.	53
29	"Institute and Faculty of Actuaries".ab,kw,ti.	0
30	"Institute of Chartered Accountants in England and Wales".ab,kw,ti.	0
31	Financial Reporting Council.ab,kw,ti.	0
32	Royal Institute of Chartered Surveyors.ab,kw,ti.	0

33	GCC.ab,kw,ti.	2437
34	GDC.ab,kw,ti.	2231
35	GMC.ab,kw,ti.	2163
36	GOsC.ab,kw,ti.	4
37	GPhC.ab,kw,ti.	78
38	HCPC.ab,kw,ti.	153
39	NMC.ab,kw,ti.	1285
40	NISCC.ab,kw,ti.	0
41	PSNI.ab,kw,ti.	17
42	SSSC.ab,kw,ti.	47
43	exp health care personnel/	1274750
44	"Healthcare professional*".ab,kw,ti.	22756
45	"clinician*".ab,kw,ti.	247430
46	"chiropractor*".ab,kw,ti.	1576
47	"dentist*".ab,kw,ti.	66870
48	"Dental hygienist*".ab,kw,ti.	2333
49	"Dental therapist*".ab,kw,ti.	294
50	"dental technician*".ab,kw,ti.	1143
51	"Orthodontic therapist*".ab,kw,ti.	6
52	"Dental nurse*".ab,kw,ti.	412
53	"doctor*".ab,kw,ti.	154041
54	"general practitioner*".ab,kw,ti.	58448
55	"physician*".ab,kw,ti.	469499
56	"surgeon*".ab,kw,ti.	261925
57	"optician*".ab,kw,ti.	313
58	"Optometrist*".ab,kw,ti.	3146
59	"Osteopath*".ab,kw,ti.	6306
60	"Pharmacist*".ab,kw,ti.	58697
61	"Pharmacy technician*".ab,kw,ti.	1313
62	"Nurse*".ab,kw,ti.	281882
63	(Midwife or Midwives).ab,kw,ti.	17392
64	"Arts therapist*".ab,kw,ti.	43
65	"Biomedical scientist*".ab,kw,ti.	552
66	"Chiropodist*".ab,kw,ti.	155
67	"Podiatrist*".ab,kw,ti.	998
68	"Dietitian*".ab,kw,ti.	7567
69	"Occupational therapist*".ab,kw,ti.	7587
70	"Orthoptist*".ab,kw,ti.	449
71	"Paramedic*".ab,kw,ti.	9892
72	"Physiotherapist*".ab,kw,ti.	12367
73	"Psychologist*".ab,kw,ti.	20443
74	"Psychiatrist*".ab,kw,ti.	35137
75	"Prosthetist*".ab,kw,ti.	422
76	"Orthotist*".ab,kw,ti.	301
77	"Radiographer*".ab,kw,ti.	2978
78	"Anaesthetist*".ab,kw,ti.	11446

79	"Speech and language therapist*".ab,kw,ti.	1174
80	"Social worker*".ab,kw,ti.	12868
81	social worker/	8719
82	"Teacher*".ab,kw,ti.	44882
83	teacher/	28407
84	(Solicitor* or Lawyer*).ab,kw,ti.	3379
85	(Banker* or Accountant*).ab,kw,ti.	767
86	(Architect* or Surveyor*).ab,kw,ti.	124704
87	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 or 73 or 74 or 75 or 76 or 77 or 78 or 79 or 80 or 81 or 82 or 83 or 84 or 85 or 86	2385108
88	"fitness to practi?e".ab,kw,ti.	374
89	ftp.ab,kw,ti.	1135
90	"competence to practi?e".ab,kw,ti.	209
91	tribunal.ab,kw,ti.	581
92	disciplinary.ab,kw,ti.	17108
93	(professional adj3 regulat*).ab,kw,ti.	1156
94	(professional adj3 performance).ab,kw,ti.	1132
95	(professional adj3 competence).ab,kw,ti.	1798
96	(conduct adj3 committee*).ab,kw,ti.	103
97	(practice adj3 committee*).ab,kw,ti.	1200
98	(conduct adj3 hearing*).ab,kw,ti.	37
99	(conduct adj3 panel*).ab,kw,ti.	35
100	(conduct adj3 regulat*).ab,kw,ti.	205
101	(performance adj3 regulat*).ab,kw,ti.	1098
102	88 or 89 or 90 or 91 or 92 or 93 or 94 or 95 or 96 or 97 or 98 or 99 or 100 or 101	25881
103	misconduct/	376
104	misconduct.ab,kw,ti.	3012
105	professional misconduct/	3493
106	(impairment or impaired).ab,kw,ti.	694283
107	seriousness.ab,kw,ti.	6222
108	"Unacceptable professional conduct".ab,kw,ti.	0
109	"Deficient professional performance".ab,kw,ti.	4
110	"Lack of competence".ab,kw,ti.	222
111	"professional incompetence".ab,kw,ti.	20
112	"serious concerns".ab,kw,ti.	1088
113	103 or 104 or 105 or 106 or 107 or 108 or 109 or 110 or 111 or 112	707817
114	87 and 102 and 113	423
115	limit 114 to yr="2005 -Current"	321

Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R) 2013 to Daily Update

1	General Chiropractic Council.ab,kw,ti.	3

2	General Dental Council.ab,kw,ti.	60
3	General Medical Council.ab,kw,ti.	283
4	General Optical Council.ab,kw,ti.	2
5	General Osteopathic Council.ab,kw,ti.	1
6	General Pharmaceutical Council.ab,kw,ti.	5
7	"Health and Care Professions Council".ab,kw,ti.	3
8	"Nursing and Midwifery Council".ab,kw,ti.	388
9	Pharmaceutical Society of Northern Ireland.ab,kw,ti.	0
10	Care Council for Wales.ab,kw,ti.	0
11	Northern Ireland Social Care Council.ab,kw,ti.	0
12	Scottish Social Services Council.ab,kw,ti.	1
13	Medical Practitioners Tribunal Service.ab,kw,ti.	4
14	Professional Standards Authority.ab,kw,ti.	4
15	"National College for Teaching and Leadership".ab,kw,ti.	0
16	General Teaching Council for Northern Ireland.ab,kw,ti.	0
17	General Teaching Council for Scotland.ab,kw,ti.	0
18	Education Workforce Council.ab,kw,ti.	0
19	Solicitors Regulation Authority.ab,kw,ti.	0
20	Solicitors Disciplinary Tribunal.ab,kw,ti.	1
21	Law Society of Scotland.ab,kw,ti.	0
22	Law Society of Northern Ireland.ab,kw,ti.	0
23	Faculty of Advocates.ab,kw,ti.	0
24	Association of Commercial Attorneys.ab,kw,ti.	0
25	Bar Standards Board.ab,kw,ti.	0
26	Bar Council of Northern Ireland.ab,kw,ti.	0
27	Architects Registration Board.ab,kw,ti.	0
28	Royal College of Veterinary Surgeons.ab,kw,ti.	14
29	"Institute and Faculty of Actuaries".ab,kw,ti.	0
30	"Institute of Chartered Accountants in England and Wales".ab,kw,ti.	0
31	Financial Reporting Council.ab,kw,ti.	0
32	Royal Institute of Chartered Surveyors.ab,kw,ti.	0
33	GCC.ab,kw,ti.	888
34	GDC.ab,kw,ti.	695
35	GMC.ab,kw,ti.	706
36	GOsC.ab,kw,ti.	1
37	GPhC.ab,kw,ti.	10
38	HCPC.ab,kw,ti.	52
39	NMC.ab,kw,ti.	761
40	NISCC.ab,kw,ti.	0
41	PSNI.ab,kw,ti.	4
42	SSSC.ab,kw,ti.	20
43	exp Health Personnel/	100201
44	"Healthcare professional*".ab,kw,ti.	9572
45	"clinician*".ab,kw,ti.	85990
46	"chiropractor*".ab,kw,ti.	633
47	"dentist*".ab,kw,ti.	15252

48	"Dental hygienist*".ab,kw,ti.	544
49	"Dental therapist*".ab,kw,ti.	109
50	"dental technician*".ab,kw,ti.	173
51	"Orthodontic therapist*".ab,kw,ti.	8
52	"Dental nurse*".ab,kw,ti.	80
53	"doctor*".ab,kw,ti.	37041
54	"general practitioner*".ab,kw,ti.	13890
55	"physician*".ab,kw,ti.	116270
56	"surgeon*".ab,kw,ti.	73266
57	"optician*".ab,kw,ti.	78
58	"Optometrist*".ab,kw,ti.	475
59	"Osteopath*".ab,kw,ti.	1355
60	"Pharmacist*".ab,kw,ti.	11000
61	"Pharmacy technician*".ab,kw,ti.	238
62	"Nurse*".ab,kw,ti.	76445
63	(Midwife or Midwives).ab,kw,ti.	5551
64	"Arts therapist*".ab,kw,ti.	5
65	"Biomedical scientist*".ab,kw,ti.	145
66	"Chiropodist*".ab,kw,ti.	16
67	"Podiatrist*".ab,kw,ti.	258
68	"Dietitian*".ab,kw,ti.	1761
69	"Occupational therapist*".ab,kw,ti.	2314
70	"Orthoptist*".ab,kw,ti.	90
71	"Paramedic*".ab,kw,ti.	2273
72	"Physiotherapist*".ab,kw,ti.	3259
73	"Psychologist*".ab,kw,ti.	5160
74	"Psychiatrist*".ab,kw,ti.	7836
75	"Prosthetist*".ab,kw,ti.	140
76	"Orthotist*".ab,kw,ti.	65
77	"Radiographer*".ab,kw,ti.	435
78	"Anaesthetist*".ab,kw,ti.	1656
79	"Speech and language therapist*".ab,kw,ti.	264
80	"Social worker*".ab,kw,ti.	2674
81	social workers/	218
82	"Teacher*".ab,kw,ti.	14941
83	Educational Personnel/	14
84	(Solicitor* or Lawyer*).ab,kw,ti.	729
85	Lawyers/	212
86	(Banker* or Accountant*).ab,kw,ti.	145
87	(Architect* or Surveyor*).ab,kw,ti.	56116
88	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 or 73 or 74 or 75 or 76 or 77 or 78 or 79 or 80 or 81 or 82 or 83 or 84 or 85 or 86 or 87	530428
89	"fitness to practi?e".ab,kw,ti.	181

90	ftp.ab,kw,ti.	343
91	"competence to practi?e".ab,kw,ti.	68
92	tribunal.ab,kw,ti.	161
93	disciplinary.ab,kw,ti.	5090
94	(professional adj3 regulat*).ab,kw,ti.	385
95	(professional adj3 performance).ab,kw,ti.	450
96	(professional adj3 competence).ab,kw,ti.	422
97	professional competence/	4691
98	(conduct adj3 committee*).ab,kw,ti.	25
99	(practice adj3 committee*).ab,kw,ti.	377
100	(conduct adj3 hearing*).ab,kw,ti.	9
101	(conduct adj3 panel*).ab,kw,ti.	13
102	(conduct adj3 regulat*).ab,kw,ti.	70
103	(performance adj3 regulat*).ab,kw,ti.	452
104	89 or 90 or 91 or 92 or 93 or 94 or 95 or 96 or 98 or 99 or 100 or 101 or 102 or 103	7935
105	misconduct.ab,kw,ti.	1234
106	professional misconduct/	716
107	(impairment or impaired).ab,kw,ti.	203614
108	seriousness.ab,kw,ti.	1287
109	"Unacceptable professional conduct".ab,kw,ti.	0
110	"Deficient professional performance".ab,kw,ti.	0
111	"Lack of competence".ab,kw,ti.	90
112	"professional incompetence".ab,kw,ti.	6
113	"serious concerns".ab,kw,ti.	437
114	105 or 106 or 107 or 108 or 109 or 110 or 111 or 112 or 113	207210
115	88 and 104 and 114	113
116	limit 115 to yr="2005 -Current"	101

EBSCOhost Research Databases

Database - ERIC; AMED - The Allied and Complementary Medicine Database; Business Source Complete; CINAHL Plus with Full Text; Dentistry & Oral Sciences Source; SocINDEX

#	Query	Results

S1	AB ("healthcare professional" or "health professional") OR AB clinician* OR AB chiropractor* OR AB dentist* OR AB ("dental hygienist" or "dental hygienists") OR AB ("dental therapist" or "dental therapists") OR AB ("dental technician" or "dental technicians") OR AB ("dental nurse" or "dental nurses") OR AB ("orthodontic therapist" or "orthodontic therapists") OR AB orthodontist* OR AB doctor* OR AB ("general practitioner" or "general practitioners" or GP or GPs) OR TI ("healthcare professional" or "health professional") OR TI clinician* OR TI chiropractor* OR TI dentist* OR TI ("dental hygienist" or "dental hygienists") OR TI ("dental therapist" or "dental therapists") OR TI ("dental technician" or "dental technicians") OR TI ("dental nurse" or "dental nurses") OR TI ("orthodontic therapist" or "orthodontic therapists") OR TI orthodontist* OR TI doctor* OR TI ("general practitioner" or "general practitioners" or GP or GPs)	336,365
S2	AB physician* OR AB surgeon* OR AB optician* OR AB optometrist* OR AB osteopath* OR AB pharmacist* OR AB ("pharmacy technician" or "pharmacy technicians") OR AB nurse* OR AB (midwife OR midwives) OR AB ("arts therapist" OR "arts therapists") OR AB ("Biomedical scientist" or "Biomedical scientists") OR AB chiropodist* OR TI physician* OR TI surgeon* OR TI optician* OR TI optometrist* OR TI osteopath* OR TI pharmacist* OR TI ("pharmacy technician" or "pharmacy technicians") OR TI nurse* OR TI (midwife OR midwives) OR TI ("arts therapist" OR "arts therapists") OR TI ("Biomedical scientist" or "Biomedical scientists") OR TI chiropodist*	572,104
S3	AB podiatrist* OR AB dietitian* OR AB ("occupational therapist" OR "occupational therapists") OR AB orthoptist* OR AB paramedic* OR AB Physiotherapist* OR AB Psychologist* OR AB Psychiatrist* OR AB Prosthetist* OR AB Orthotist* OR AB Radiographer* OR AB ("Speech and language therapist" OR "Speech and language therapists") OR AB Anaesthetist* OR TI podiatrist* OR TI dietitian* OR TI ("occupational therapist" OR "occupational therapists") OR TI orthoptist* OR TI paramedic* OR TI Physiotherapist* OR TI Psychologist* OR TI Psychiatrist* OR TI Prosthetist* OR TI Orthotist* OR TI Radiographer* OR TI ("Speech and language therapist" OR "Speech and language therapists") OR TI Anaesthetist*	78,890
S4	AB ("social worker" OR "social workers") OR AB teacher* OR AB (solicitor* OR lawyer*) OR AB (Banker* OR Accountant*) OR AB (architect* OR surveyor*) OR TI ("social worker" OR "social workers") OR TI teacher* OR TI (solicitor* OR lawyer*) OR TI (Banker* OR Accountant*) OR TI (architect* OR surveyor*)	887,342
S5	AB "General Chiropractic Council" OR AB "General Dental Council" OR AB "General Medical Council" OR AB "General Optical Council" OR AB "General Osteopathic Council" OR AB "General Pharmaceutical Council" OR AB ("Health and Care Professions Council") OR AB ("Nursing and Midwifery Council") OR AB "Pharmaceutical Society of Northern Ireland" OR AB "Care Council for Wales" OR AB "Northern Ireland Social Care Council" OR AB "Scottish Social Services Council" OR AB "Medical Practitioners Tribunal Service" OR AB	11,414

	"Professional Standards Authority" OR AB "National College for Teaching and Leadership" OR AB "General Teaching Council for Northern Ireland" OR AB "General Teaching Council for Scotland" OR AB "Education Workforce Council" OR AB "Solicitors Regulation Authority" OR AB "Solicitors Disciplinary Tribunal" OR AB "Law Society of Scotland" OR AB "Law Society of Northern Ireland" OR AB "Faculty of Advocates" OR AB "Association of Commercial Attorneys" OR AB "Bar Standards Board" OR AB "Bar Council of Northern Ireland" OR AB "Architects Registration Board" OR AB "Royal College of Veterinary Surgeons" OR AB "Institute and Faculty of Actuaries" OR AB "Institute of Chartered Accountants in England and Wales" OR AB "Financial Reporting Council" OR AB "Royal Institute of Chartered Surveyors" OR TI "General Chiropractic Council" OR TI "General Dental Council" OR TI "General Medical Council" OR TI "General Optical Council" OR TI "General Osteopathic Council" OR TI "General Pharmaceutical Council" OR TI ("Health and Care Professions Council") OR TI ("Nursing and Midwifery Council") OR TI "Pharmaceutical Society of Northern Ireland" OR TI "Care Council for Wales" OR TI "Northern Ireland Social Care Council" OR TI "Scottish Social Services Council" OR TI "Medical Practitioners Tribunal Service" OR TI "Professional Standards Authority" OR TI "National College for Teaching and Leadership" OR TI "General Teaching Council for Northern Ireland" OR TI "General Teaching Council for Scotland" OR TI "Education Workforce Council" OR TI "Solicitors Regulation Authority" OR TI "Solicitors Disciplinary Tribunal" OR TI "Law Society of Scotland" OR TI "Law Society of Northern Ireland" OR TI "Faculty of Advocates" OR TI "Association of Commercial Attorneys" OR TI "Bar Standards Board" OR TI "Bar Council of Northern Ireland" OR TI "Architects Registration Board" OR TI "Royal College of Veterinary Surgeons" OR TI "Institute and Faculty of Actuaries" OR TI "Institute of Chartered Accountants in England and Wales" OR TI "Financial Reporting Council" OR TI "Royal Institute of Chartered Surveyors"	
S6	S1 OR S2 OR S3 OR S4 OR S5	1,790,178
S7	AB "fitness to practi?e" OR AB "competence to practi?e" OR AB FtP OR AB tribunal* OR AB (disciplinary or disciplined) OR AB professional N3 regulat* OR AB professional N3 competence OR AB professional N3 performance OR AB conduct N3 committee* OR AB practice N3 committee* OR AB conduct N3 hearing* OR AB conduct N3 panel* OR AB conduct N3 regulat* OR AB performance N3 regulat* OR TI "fitness to practi?e" OR TI "competence to practi?e" OR TI FtP OR TI tribunal* OR TI (disciplinary or disciplined) OR TI professional N3 regulat* OR TI professional N3 competence OR TI professional N3 performance OR TI conduct N3 committee* OR TI practice N3 committee* OR TI conduct N3 hearing* OR TI conduct N3 panel* OR TI conduct N3 regulat* OR TI performance N3 regulat*	78,298

S8	AB misconduct OR AB impairment OR AB impaired OR AB seriousness OR AB "Unacceptable professional conduct" OR AB "Deficient professional performance" OR AB "Lack of competence" OR AB "professional incompetence" OR AB "serious concerns" OR TI misconduct OR TI impairment OR TI impaired OR TI seriousness OR TI "Unacceptable professional conduct" OR TI "Deficient professional performance" OR TI "Lack of competence" OR TI "professional incompetence" OR TI "serious concerns"	160,617
S9	S6 AND S7 AND S8	528
S10	S6 AND S7 AND S8 (date limit 2005-current)	**263**

Web of Science Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI:

#1	TS=("General Chiropractic Council" OR "General Dental Council" OR "General Medical Council" OR "General Optical Council" OR "General Osteopathic Council" OR "General Pharmaceutical Council" OR ("Health and Care Professions Council") OR ("Nursing and Midwifery Council") OR "Pharmaceutical Society of Northern Ireland" OR "Care Council for Wales" OR "Northern Ireland Social Care Council" OR "Scottish Social Services Council" OR "Medical Practitioners Tribunal Service" OR "Professional Standards Authority" OR "National College for Teaching and Leadership" OR "General Teaching Council for Northern Ireland" OR "General Teaching Council for Scotland" OR "Education Workforce Council" OR "Solicitors Regulation Authority" OR "Solicitors Disciplinary Tribunal" OR "Law Society of Scotland" OR "Law Society of Northern Ireland" OR "Faculty of Advocates" OR "Association of Commercial Attorneys" OR "Bar Standards Board" OR "Bar Council of Northern Ireland" OR "Architects Registration Board" OR "Royal College of Veterinary Surgeons" OR "Institute and Faculty of Actuaries" OR "Institute of Chartered Accountants in England and Wales" OR "Financial Reporting Council" OR "Royal Institute of Chartered Surveyors" OR podiatrist* OR dietitian* OR "occupational therapist*" OR orthoptist* OR paramedic* OR Physiotherapist* OR Psychologist* OR Psychiatrist* OR Prosthetist* OR Orthotist* OR Radiographer* OR "Speech and language therapist*" OR Anaesthetist* OR physician* OR surgeon* OR optician* OR optometrist* OR osteopath* OR pharmacist* OR "pharmacy technician*" OR nurse* OR midwife OR midwives OR "art* therapist*" OR "Biomedical scientist*" OR chiropodist* OR "healthcare professional" or "health professional" OR clinician* OR chiropractor* OR dentist* OR "dental hygienist*" OR "dental therapist*" OR "dental technician*" OR "orthodontic therapist*" OR orthodontist* OR doctor* OR "general practitioner*" OR GP OR GPs OR "social worker*" OR teacher* OR solicitor* OR lawyer* OR Banker* OR Accountant* OR architect* OR surveyor*)	1,740,096
#2	TS=("fitness to practi?e" OR "competence to practi?e" OR FtP OR tribunal* OR disciplinary or disciplined OR (professional near/3 regulat*) OR (professional near/3 performance) OR (Professional near/3 competence) OR (conduct near/3 committee*) OR (practice near/3 committee*) OR (conduct near/3 hearing*) OR (conduct near/3 panel*) OR (conduct near/3 regulat*) OR (performance near/3 regulat*))	155,111
#3	TS=(misconduct OR impairment OR impaired OR seriousness OR "Unacceptable professional conduct" OR "Deficient professional performance" OR "Lack of competence" OR "professional incompetence" OR “serious concerns”)	644,838
#4	#1 AND #2 AND #3 (Date limited 2005-current)	**352**

Appendix B: Regulatory website searches

UK regulators – Health and social care

Acronym	Regulator	Website	Rules and guidance documents
GCC	General Chiropractic Council	https://www.gcc-uk.org/	The General Chiropractic Council (Investigating Committee) Rules Order of Council 2000, https://www.gcc-uk.org/UserFiles/Docs/Investigating%20Committee%20(Rules%20Order%202000).pdf The General Chiropractic Council (Professional Conduct Committee) Rules Order of Council 2000, https://www.gcc-uk.org/UserFiles/Docs/Professional%20Conduct%20Committee%20(Rules%20Order%202000).pdf The General Chiropractic Council (Health Committee) Rules Order of Council 2000, https://www.gcc-uk.org/UserFiles/Docs/Health%20Committee%20(Rules%20Order%202000).pdf Guidance on Sanctions, 2010, https://www.gcc-uk.org/UserFiles/Docs/Guidance_on_sanctions.pdf Code of Practice and Standard of Proficiency, 2010, http://www.gcc-uk.org/UserFiles/Docs/COPSOP_2010_for_WEBSITE_30_June.pdf Guidance on Candour, 2016, https://www.gcc-uk.org/UserFiles/Docs/Guidance/GCC-Guidance-Candour-FINAL.pdf
GDC	General Dental Council	https://www.gdc-uk.org/	The General Dental Council (Fitness to Practise) Rules Order of Council 2006, http://www.legislation.gov.uk/uksi/2006/1663/pdfs/uksi_20061663_en.pdf Interim orders guidance for decision makers – Interim Orders Committee, 2016, https://www.gdc-uk.org/api/files/INTERIM%20ORDERS%20GUIDANCE%20FOR%20THE%20IOC%20(October%202016).pdf Investigating Committee Guidance Manual (cases considered for the first time on or after 1 November 2016), 2016, https://www.gdc-uk.org/api/files/Investigating%20Committee%20Guidance%20Manual%20for%20cases%20on%20or%20after%201%20Nov%202016.pdf Guidance for handling fitness to practise cases at preliminary meetings, 2016, https://www.gdc-uk.org/api/files/Guidance%20for%20handling%20cases%20at%20preliminary%20meetings%20-%20amended.pdf Guidance for the Practice Committees including Indicative Sanctions Guidance, 2016, https://www.gdc-

			uk.org/api/files/Guidance%20for%20the%20Practice%20Committees%20-%20Indicative%20Sanctions%20Guidance.pdf Case Examiner Guidance Manual (November 2016), 2016, https://www.gdc-uk.org/api/files/Case%20Examiner%20Guidance%20Manual.pdf
GMC (MPTS)	General Medical Council (Medical Practitioners Tribunal Service)	https://www.gdc-uk.org/ (https://www.mpts-uk.org/)	GMC (Fitness to Practise) Rules 2004 (updated), 2015, https://www.gmc-uk.org/consolidated_version_of_FTP_Rules__as_amended_29Nov17_.pdf_72742310.pdf Imposing interim orders Guidance for the Interim Orders Tribunal, Tribunal Chair and the Medical Practitioners Tribunal, 2016, https://www.mpts-uk.org/DC4792_Imposing_Interim_Orders__Guidance_for_the_IOT_and_MPT_28443349.pdf Sanctions guidance for members of medical practitioners tribunals and the General Medical Council's decision makers (May 2017), 2017, https://www.mpts-uk.org/DC4198_Sanctions_Guidance_May_2017.pdf_73502816.pdf Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and case examiners, 2017, https://www.gmc-uk.org/DC4599_CE_Decision_Guidance__Making_decisions_on_cases_at_the_end_of_the_investigation_stage.pdf_58070536.pdf
GOC	General Optical Council	https://www.optical.org/	General Optical Council (Fitness to Practise) Rules Order of Council 2013, https://www.optical.org/download.cfm?docid=2A175E59-AADE-42C6-9722B070AC544E4F Fitness to Practise panels hearings guidance and indicative sanctions, https://www.optical.org/download.cfm?docid=19D7FF7C-2F61-4C47-A68AA632552E81D6 Guidance regarding warnings issued by Case Examiners and the Investigation Committee under the provisions of the General Optical Council (Fitness to Practise) Rules 2013, https://www.optical.org/download.cfm?docid=F079441B-E60A-480F-9EEB0380E6A7B562 Guidance for Case Examiners, 2013, https://www.optical.org/download.cfm?docid=5E42702F-B167-4321-82B19EBA232C7C6A
GOsC	General Osteopathic Council	https://www.osteopathy.org.uk/home/	The General Osteopathic Council (Investigation of Complaints) (Procedure) Rules Order of Council 1999, http://www.legislation.gov.uk/uksi/1999/1847/contents/made The General Osteopathic Council (Professional Conduct Committee) (Procedure) Rules Order of Council 2000, http://www.osteopathy.org.uk/news-and-resources/document-

			library/legislation/pcc-procedure-rules-2000/gosc-pcc-procedure-rules-2000.pdf The General Osteopathic Council (Health Committee) (Procedure) Rules Order of Council 2000, http://www.legislation.gov.uk/uksi/2000/242/contents/made
GPhC	General Pharmaceutical Council	https://www.pharmacyregulation.org/	The Pharmacy Order 2010, https://www.pharmacyregulation.org/sites/default/files/1116_pharmacy_order_consolidated.pdf Good decision making: Investigating committee meetings and outcomes guidance, 2017, https://www.pharmacyregulation.org/sites/default/files/good_decision_making_-_investigating_committee_meetings_and_outcomes_guidance_march_2017_0.pdf Good decision making: Fitness to practise hearings and sanctions guidance, 2017, https://www.pharmacyregulation.org/sites/default/files/good_decision_making_-_fitness_to_practise_hearings_and_sanctions_guidance_march_2017_1.pdf
HCPC	Health and Care Professions Council	http://www.hcpc-uk.co.uk/	Health Professions Order 2001, https://www.legislation.gov.uk/uksi/2002/254/pdfs/uksi_20020254_en.pdf The fitness to practise process, 2015, http://www.hcpc-uk.co.uk/assets/documents/10001FC8TheFTPprocess_cfw.pdf Fitness to Practise: What does it mean? https://www.hcpc-uk.org/assets/documents/10002FD8FTP_What_does_it_mean.pdf
NISCC	Northern Ireland Social Care Council	https://niscc.info/	Health and Personal Social Services Act (Northern Ireland) 2001, https://www.legislation.gov.uk/id/nia/2001/3 NISCC Fitness to Practise Rules 2016, https://niscc.info/storage/resources/20160513_fitness-to-practise-rules-2016_final_signed.pdf Fitness to Practise: What You Need to Know, 2016, http://niopa.qub.ac.uk/bitstream/NIOPA/4759/1/20160524_ftp_whatyouneedtoknow-1.pdf
NMC	Nursing and Midwifery Council	https://www.nmc.org.uk/	The Nursing and Midwifery Order 2001, https://www.legislation.gov.uk/id/uksi/2002/253 The Nursing and Midwifery Council (Fitness to Practise) Rules 2004, 2017, https://www.nmc.org.uk/globalassets/sitedocuments/legislation/legislation-updated/fitness-to-practise-rules-2004-consolidated-text.pdf

			Particular features of misconduct charging, 2017, https://www.nmc.org.uk/ftp-library/hearings/drafting-charges/particular-features-of-misconduct-charging/?pdf=1 Decision making factors, 2017,https://www.nmc.org.uk/ftp-library/sanctions/what-is-our-sanctions-guidance/?pdf=1 What decisions can case examiners make? 2017, https://www.nmc.org.uk/ftp-library/case-examiners/case-to-answer/what-decisions-can-case-examiners-make/?pdf=1 Not having the necessary knowledge of English, 2017, https://www.nmc.org.uk/ftp-library/guiding-principles/fitness-to-practise-allegations/not-having-the-necessary-knowledge-of-english/?pdf=1 Health, 2017, https://www.nmc.org.uk/ftp-library/guiding-principles/fitness-to-practise-allegations/health/?pdf=1 Criminal convictions and cautions, 2017, https://www.nmc.org.uk/ftp-library/guiding-principles/fitness-to-practise-allegations/criminal-convictions-and-cautions/?pdf=1 Lack of competence, 2017, https://www.nmc.org.uk/ftp-library/guiding-principles/fitness-to-practise-allegations/lack-of-competence/?pdf=1 Misconduct, 2017, https://www.nmc.org.uk/ftp-library/guiding-principles/fitness-to-practise-allegations/misconduct/?pdf=1 Interim orders, their purpose, and our powers to impose them, 2017, https://www.nmc.org.uk/ftp-library/interim-orders/interim-orders-their-purpose-and-our-powers-to-impose-them/?pdf=1
PSNI	Pharmaceutical Society Northern Ireland	http://www.psni.org.uk/	Council of the Pharmaceutical Society of Northern Ireland (Fitness to Practise and Disqualification) Regulations (Northern Ireland), 2012, http://www.legislation.gov.uk/nisr/2012/311/contents/made Interim Orders, http://www.psni.org.uk/wp-content/uploads/2012/12/Interim-orders.pdf Sanctions, http://www.psni.org.uk/wp-content/uploads/2012/12/Sanctions-available-to-fitness-to-practise-committees.pdf The Statutory Committee - Indicative Sanctions Guidance, http://www.psni.org.uk/wp-content/uploads/2012/12/Indicative-sanction-guidance.pdf Referral from Scrutiny to Statutory Committee, 2012, http://www.psni.org.uk/wp-content/uploads/2012/12/Scrutiny-Committee-Referral-Criteria-in-respect-of-an-allegation-capable-of-being-referred.pdf

			Threshold Criteria , 2016, http://www.psni.org.uk/wp-content/uploads/2012/12/threshold-criteria-amended-October-2016.pdf Procedures of fitness to practise committees, http://www.psni.org.uk/wp-content/uploads/2012/12/Procedures-of-fitness-to-practise-committees.pdf Investigation Process, http://www.psni.org.uk/wp-content/uploads/2012/12/Investigation-processes-and-committee-structure.pdf
SCW	Social Care Wales	https://socialcare.wales/	Social Care Wales (Constitution of Panels Prescribed Person) Regulations 2016, http://senedd.assembly.wales/documents/s56315/SL5032%20-%20The%20Social%20Care%20Wales%20Constitution%20of%20Panels%20Prescribed%20Persons%20Regulations%202016.pdf The Social Care Wales (Proceedings before Panels) (Amendment) Regulations 2017, http://www.legislation.gov.uk/wsi/2017/140/made Social Care Wales - Investigation Rules 2017, https://socialcare.wales/cms_assets/file-uploads/SOCIAL-CARE-WALES-INVESTIGATION-RULES-2017-APRIL-2017.pdf Social Care Wales - Interim Orders Rules 2017, https://socialcare.wales/cms_assets/file-uploads/Social-Care-Wales-Interim-Orders-Rules-2017.pdf Social Care Wales - Fitness to Practise Hearings Rules 2017, https://socialcare.wales/cms_assets/file-uploads/Social-Care-Wales-Fitness-to-Practise-Hearings-Rules-2017.pdf Guidance on Indicative Disposals for the Fitness to Practise Panel and Interim Orders imposed by the Interim Orders Panel and Fitness to Practise Panel, 2017, https://socialcare.wales/cms_assets/file-uploads/Guidance-on-Indicative-Disposals-for-the-Fitness-to-Practise-Panel-and-Interim-Orders-imposed-by-the-Interim-Orders-Panel-and-Fitness-to-Practise-Panel-April-2017.pdf

UK regulators – other

Abbreviation	Regulator	Website	Rules and guidance documents
ARB	Architects Registration Board	http://www.arb.org.uk/	Investigations Rules and Professional Conduct Committee Rules http://www.arb.org.uk/wp-content/uploads/2016/10/PCC-rules-2015-with-Form-A.pdf
BNI	The Bar of Northern Ireland	http://www.barofni.com/	The Bar of Northern Ireland Code of Conduct, 2015, http://www.barofni.com/assets/files/PCC_Code_of_Conduct_Complete_April2015_doc.pdf
BSB (BTAS)	Bar Standards Board (The Bar Tribunals and Adjudication Service)	https://www.barstandardsboard.org.uk/ (https://www.tbtas.org.uk/)	Fitness to Practise Hearings: Guidance for Disciplinary Pool Members & Clerks (Revised November 2017), https://www.tbtas.org.uk/wp-content/uploads/2017/12/Disciplinary-Tribunal-Reference-Guide-for-Pool-Members-November-2017.pdf The Bar Standards Board Handbook, 3rd Edition, 2017, https://www.barstandardsboard.org.uk/media/1901336/bsb_handbook_version_3.1_november_2017.pdf
EWC	Education Workforce Council (Wales)	https://www.ewc.wales/site/index.php/en/14-english/about	Education Workforce Council (Main Functions)(Wales) Regulations 2015, http://www.legislation.gov.uk/wsi/2015/140/contents/made Education Workforce Council (Main Functions)(Wales)(Amendment) Regulations 2016, http://www.legislation.gov.uk/wsi/2016/6/contents/made
FAS	Faculty of Advocates (Scotland)	http://www.advocates.org.uk/	Faculty of Advocates Disciplinary Rules, 2015, http://www.advocates.org.uk/media/1916/disciplinaryrules2015.pdf
FRC	Financial Reporting Council	https://www.frc.org.uk/	The Accountancy Scheme, 2014, https://www.frc.org.uk/getattachment/c77917fc-269e-4488-b1ae-ba3662d3d460/The-Accountancy-Scheme-Dec-2014.pdf
GTCNI	The General Teaching Council for Northern Ireland	http://www.gtcni.org.uk/	The Education (Northern Ireland) Order 1998, http://www.legislation.gov.uk/nisi/1998/1759/contents/made Conduct Rules 2017, http://www.gtcni.org.uk//publications/uploads/document/GTCNI_Conduct_Rules_June_2017.pdf
GTCS	The General Teaching Council	http://www.gtcs.org.uk/	The General Teaching Council for Scotland Fitness to Teach Rules 2017, http://www.gtcs.org.uk/web/FILES/FormUploads/Fitness-to-Teach-Rules-2017357770_3259.pdf

	for Scotland		The Public Services Reform (General Teaching Council for Scotland) Order 2011, https://www.legislation.gov.uk/sdsi/2011/9780111012246 Professional Competence Cases Practice Statement, http://www.gtcs.org.uk/web/FILES/FormUploads/Professional%20Competence%20Cases%20Practice%20Statement340791_3209.pdf Temporary Restriction Orders Practice Statement, http://www.gtcs.org.uk/web/FILES/FormUploads/Temporary_Restriction_Orders_-_Practice_Statement.pdf Indicative Outcomes Guidance, http://www.gtcs.org.uk/web/FILES/FormUploads/practice-statement-indicative-outcomes-guidance78555_1970.pdf
ICAEW	Institute of Chartered Accountants in England and Wales	https://www.ifac.org/about-ifac/membership/members/institute-chartered-accountants-england-and-wales	How we investigate complaints, https://www.icaew.com/-/media/corporate/files/about-icaew/what-we-do/protecting-the-public/complaints-process/how-we-investigate-complaints-booklet.ashx?la=en
IFA	Institute and Faculty of Actuaries	https://www.actuaries.org.uk/	Disciplinary Scheme, 2016, https://www.actuaries.org.uk/documents/institute-and-faculty-actuaries-disciplinary-scheme-effective-1-august-2010-amended-18 Indicative Sanctions Guidance Note, 2016, https://www.actuaries.org.uk/documents/indicative-sanctions-guidance-note-0
LSNI (SDTNI)	The Law Society for Northern Ireland (The Solicitors Disciplinary Tribunal for Northern Ireland)	https://www.lawsoc-ni.org/ (https://sdt-ni.org/)	Solicitors (Northern Ireland) Order 1976, https://www.lawsoc-ni.org/DataEditorUploads/Solicitors%20Order%201976%20consolidated%20until%20March%202011.pdf Solicitors (Disciplinary Proceedings) Rules (Northern Ireland) 1990, http://www.legislation.gov.uk/uksi/1994/288/schedules/made
LSS (SSDT)	Law Society of Scotland (Scottish Solicitors	https://www.lawscot.org.uk/ (https://www.ssdt.org.uk/)	Solicitors (Scotland) Act 1980, https://www.legislation.gov.uk/ukpga/1980/46

	Disciplinary Tribunal)		
NCTL	National College for Teaching and Leadership	https://www.gov.uk/government/organisations/national-college-for-teaching-and-leadership	The Education Act, 2011, http://www.legislation.gov.uk/ukpga/2011/21/contents The Teachers' Disciplinary (Amendment) (England) Regulations, 2014, http://www.legislation.gov.uk/uksi/2014/1685/contents/made
RCVS	Royal College of Veterinary Surgeons	https://www.rcvs.org.uk/home/	Disciplinary Committee Manual, 2013, https://www.rcvs.org.uk/document-library/disciplinary-committee-manual/ Disciplinary Committee Procedure Guidance, 2013, https://www.rcvs.org.uk/document-library/disciplinary-committee-procedure-guidance/ A note on negligence, 2014, https://www.rcvs.org.uk/document-library/a-note-on-negligence/1rcvs-note-on-negligence.pdf
RICS	Royal Institute of Chartered Surveyors	https://www.rics.org/uk/	Sanctions Policy – Guidance to RICS Disciplinary, Registration and Appeal Panel Rules, 2014, https://www.rics.org/Global/Sanctions_Policy_01012017_TP.pdf Constitution of Conduct and Appeal Committee Rules, 2017, https://www.rics.org/Documents/Constitution_of_Conduct_and_Appeal_Committee_Rules_v3_TP_04012017.pdf Disciplinary, registration and appeal panel rules, https://www.rics.org/Global/Disciplinary_registration_appeal_panel%20rules_030517_jf.pdf
SRA (SDT)	Solicitors Regulation Authority (Solicitors Disciplinary Tribunal)	https://www.sra.org.uk/home/home.page (http://www.solicitorstribunal.org.uk/)	Legal Services Act 2007, https://www.legislation.gov.uk/ukpga/2007/29/section/33 Guidance note on sanctions: 5th Edition, http://www.solicitorstribunal.org.uk/sites/default/files-sdt/GUIDANCE%20NOTE%20ON%20SANCTIONS%20-%205TH%20EDITION%20-%20DECEMBER%202016_1.pdf
SSSC	Scottish Social Services Council	http://www.sssc.uk.com/	Regulation of Care (Scotland) Act 2001, http://www.careinfoscotland.scot/topics/your-rights/legislation-protecting-people-in-care/regulation-of-care-scotland-act-2001/ Fitness to Practise Rules 2016, http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications/scottish-social-services-council-fitness-to-practise-rules-2016

			Fitness to Practise Thresholds Policy, 2016, http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications/thresholds-policy/download Decisions Guidance, 2016, http://www.sssc.uk.com/decisions-guidance/decisions-guidance/download Investigation Process for Registered Workers, 2016, http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications?task=document.viewdoc&id=3086 Fitness to Practise Impairment Hearings, 2017, http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications?task=document.viewdoc&id=3092

International regulators

Country / State	Abbreviation	Regulator	Website	Rules and guidance documents
Australia	AHPRA	Australian Health Practitioners Regulation Agency	https://www.ahpra.gov.au/	Initial Assessment, http://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process.aspx Immediate Action, http://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process/Immediate-action.aspx Investigation, http://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process/Investigation.aspx Performance Assessment, http://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process/Performance-assessment.aspx Health Assessment, http://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-

				process/Health-assessment.aspx Complaints Process, http://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process/Panel-hearing.aspx Tribunal Process, http://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process/Tribunal-hearing.aspx)
New Zealand	NHPDT	New Zealand Health Practitioners Disciplinary Tribunal	https://www.hpdt.org.nz/	Health Practitioners Competence Assurance Act, 2003, http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html A guide to disciplinary proceedings, 2009, https://www.hpdt.org.nz/portals/0/HPDT%20Guide%20to%20Disciplinary%20Proceedings%20October%202009.pdf
	MCNZ	Medical Council of New Zealand	https://www.mcnz.org.nz/	Principles for the assessment and management of complaints and notifications, 2014, https://www.mcnz.org.nz/assets/News-and-Publications/Councilsprinciplesforassessmentandmanagementofcomplaintsandnotifications.pdf What to expect if your complaint is referred to a professional conduct committee, https://www.mcnz.org.nz/assets/News-and-Publications/Booklets/CO20

				454-MED002SOComplaint-Brochure-23-WEB.PDF Conduct concerns, https://www.mcnz.org.nz/fitness-to-practise/conduct-concerns/
	NCNZ	Nursing Council of New Zealand	http://www.nursingcouncil.org.nz/	Health practitioners competence assurance act 2003 the health process, http://www.nursingcouncil.org.nz/content/download/382/1721/file/The%20Health%20Process%20January%202014.pdf Health practitioners competence assurance act 2003 complaints investigation process, http://www.nursingcouncil.org.nz/content/download/375/1700/file/Complaints%20and%20discipline%20process%20January%202014.pdf
	PCNZ	Pharmacy Council of New Zealand	http://www.pharmacycouncil.org.nz/	Professional Conduct Committee (PCC), http://www.pharmacycouncil.org.nz/New-Zealand-Registered-Pharmacists/Interns-Pharmacists-and-Pharmacist-Prescribers/Professional-Conduct-Committee
	DCNZ	Dental Council of New Zealand	http://www.dcnz.org.nz/	How we deal with complaints, http://www.dcnz.org.nz/patients-the-public-and-employers/concerns-and-complaints-for-patients/#How-we-deal-with-complaints
Ontario, Canada	CPSO	College of Physicians and Surgeons of Ontario	https://www.cno.org/	Regulated Health Professions Act 1991, https://www.ontario.ca/laws/statute/91r18/v6 The Complaints Process,

				http://www.cpso.on.ca/Policies-Publications/Complaints/The-Complaints-Process
	CNO	College of Nurses of Ontario	https://www.cno.org/	Regulated Health Professions Act 1991, https://www.ontario.ca/laws/statute/91r18/v6 Addressing complaints: Process Guide, http://www.cno.org/globalassets/docs/ih/42017_resolvingcomplaints.pdf
	RCDSO	Royal College of Dental Surgeons of Ontario	http://www.rcdso.org/	Regulated Health Professions Act 1991, https://www.ontario.ca/laws/statute/91r18/v6 Disciplinary Process, http://www.rcdso.org/publicprotection/howtofileacomplaint/disciplinaryprocess
	OCF	Ontario College of Pharmacists	http://www.ocpinfo.com/	Regulated Health Professions Act 1991, https://www.ontario.ca/laws/statute/91r18/v6 Discipline Process, http://www.ocpinfo.com/protecting-the-public/discipline-process/ Fitness to Practice Process, http://www.ocpinfo.com/protecting-the-public/ftp/
Alberta, Canada	CPSA	College of Physicians and Surgeons of Alberta	http://www.cpsa.ca/	Health Professions Act, 2000, http://www.qp.alberta.ca/documents/Acts/H07.pdf Health Disciplines Act, 2000, http://www.qp.alberta.ca/documents/Acts/H02.pdf

				Our Complaints Process, http://www.cpsa.ca/complaints/our-complaints-process/ Hearings at The College, http://www.cpsa.ca/complaints/hearings-at-the-college/
	CARNA	College and Association of Registered Nurses of Alberta	http://nurses.ab.ca/content/carna/home.html/	Health Professions Act, 2000, http://www.qp.alberta.ca/documents/Acts/H07.pdf Health Disciplines Act, 2000, http://www.qp.alberta.ca/documents/Acts/H02.pdf The Full Investigation Process, http://nurses.ab.ca/content/carna/home/complaints/complaints-processes/investigation-process.html Complaints Resolution Agreement, http://nurses.ab.ca/content/carna/home/complaints/complaints-processes/complaint-resolution-agreement.html
	ADAC	Alberta Dental Association and College	http://www.dentalhealthalberta.ca/index/Pages/home	Health Professions Act, 2000, http://www.qp.alberta.ca/documents/Acts/H07.pdf Health Disciplines Act, 2000, http://www.qp.alberta.ca/documents/Acts/H02.pdf Dentists Professions Regulation, 2001, http://www.dentalhealthalberta.ca/index/Sites-Management/FileDownload/DataDownload/7430/Dentists-Profession-Regulation-

				Health-Professions-Act_P/pdf/1/1033
	ACP	Alberta College of Pharmacists	https://pharmacists.ab.ca/	Health Professions Act, 2000, http://www.qp.alberta.ca/documents/Acts/H07.pdf Health Disciplines Act, 2000, http://www.qp.alberta.ca/documents/Acts/H02.pdf Filing a Complaint, https://pharmacists.ab.ca/filing-complaint
New York, USA	OPMC	Office of Professional Medical Conduct (medicine)	https://www.health.ny.gov/professionals/doctors/conduct/	Rules of the Board of Regents. Part 29, Unprofessional Conduct, http://www.op.nysed.gov/title8/part29.htm
	OP	Office of the Professions (other regulated professions)	http://www.op.nysed.gov/	Rules of the Board of Regents. Part 29, Unprofessional Conduct, http://www.op.nysed.gov/title8/part29.htm
Texas, USA	TMB	Texas Medical Board	http://www.tmb.state.tx.us/	Enforcement Process, http://www.tmb.state.tx.us/page/enforcement Complaint Process, http://www.tmb.state.tx.us/page/complaints
	TBN	Texas Board of Nursing	https://www.bon.texas.gov/	Board of Nursing Complaint Process: Investigation to resolution, https://www.ncsbn.org/426.htm Rules And Regulations Relating To Nurse Education, Licensure And Practice, https://www.bon.texas.gov/pdfs/law_rules_pdfs/rules_regulations_pdfs/bon_rr_Oct2017.pdf

	TSBDE	Texas State Board of Dental Examiners	http://www.tsbde.texas.gov/	State Board of Dental Examiners: Rules and Regulations, http://www.tsbde.texas.gov/documents/laws-rules/TSBDE%20Rules%20and%20Regulations%2020170320.pdf
	TSBP	Texas State Board of Pharmacy	https://www.pharmacy.texas.gov/	How to file a complaint and the complaints process, https://www.pharmacy.texas.gov/consumer/complaint.asp Disciplinary Guidelines, https://www.pharmacy.texas.gov/files_pdf/BN/Feb18/Tab_31.pdf
South Africa	HPCSA	Health Professions Council South Africa (Medicine and Dentistry	http://www.hpcsa.co.za/PBMedicalDental	Health Professions Act 56 Of 1974, http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/legislations/acts/health_professions_ct_56_1974.pdf Health Professions Act 56 Of 1974: Regulations Relating To The Conduct Of Inquiries Into Alleged Unprofessional Conduct Under The Health Professions Act, 1974, http://www.hpcsa.co.za/Content/Docs/regulation_gnr102_2009.pdf Health Professions Act 56 Of 1974 Regulations Relating To Impairment Of Students And Practitioners, http://www.hpcsa.co.za/Content/Docs/regu_imparement_students_practitioners_gg22351_08_jun2001.pdf

				How to lodge a complaint against a healthcare practitioner, http://www.hpcsa.co.za/downloads/inquiries/brochures/lodging_a_complaint.pdf
	ASNC	South Africa Nursing Council	http://www.sanc.co.za/	Misconduct, http://www.sanc.co.za/complain_misconduct.htm
	SAPC	South African Pharmacy Council	https://www.pharmcouncil.co.za/C_Overview.asp	Rules relating to acts or omissions in respect of which the council may take disciplinary steps, 1993, https://www.mm3admin.co.za/documents/docmanager/0C43CA52-121E-4F58-B8F6-81F656F2FD17/00010766.pdf Lodging a complaint: Complaint process, https://www.pharmcouncil.co.za/C_LodgeComp.asp

Appendix C: Example Misconduct Matrix from the Texas Board of Nursing

301.452(b)(10) unprofessional or dishonorable conduct that, in the board's opinion, is likely to deceive, defraud, or injure a patient or the public;		
First Tier Offense: Isolated failure to comply with Board rules regarding unprofessional conduct resulting in unsafe practice with no adverse patient effects. Isolated violation involving minor unethical conduct where no patient safety is at risk, such as negligent failure to maintain client confidentiality or failure to honestly disclose or answer questions relevant to employment or licensure.*	Sanction Level I: Remedial Education and/or a fine of $250 or more for each additional violation. Elements normally related to dishonesty, fraud or deceit are deemed to be unintentional.	Sanction Level II: Warning with Stipulations that may include remedial education; supervised practice; perform public service; limit specific nursing activities/practice settings; and/or periodic Board review; and/or a fine of $500 or more for each additional violation. Additionally, if the isolated violations are associated with mishandling or misdocumenting of controlled substances (with no evidence of impairment) then stipulations may include random drug screens to be verified through urinalysis and practice limitations.
Second Tier Offense: Failure to comply with a substantive Board rule regarding unprofessional conduct resulting in serious risk to patient or public safety. Repeated acts of unethical behavior or unethical behavior which places patient or public at risk of harm. Personal relationship that violates professional boundaries of nurse/patient relationship.	Sanction Level I: Warning or Reprimand with Stipulations which may include remedial education, supervised practice, and/ or perform public service. Fine of $250 or more for each violation. If violation involves mishandling or misdocumenting of controlled substances, misdemeanor crimes or criminal conduct involving alcohol, drugs or controlled substances, then the stipulations will also include abstention from unauthorized use of drugs and alcohol, to be verified by random drug testing through urinalysis, limit specific nursing activities, and/or periodic Board review. Board will use its rules and disciplinary sanction polices related to	Sanction Level II: Denial of Licensure, Suspension, or Revocation of Licensure. Any Suspension would be enforced at a minimum until nurse pays fine, completes remedial education and presents other rehabilitative efforts as prescribed by the Board. If violation involves mishandling of controlled substances, misdemeanor crimes or criminal conduct involving alcohol, drugs or controlled substances then suspension will be enforced until individual has completed treatment and one year verifiable sobriety before suspension is stayed, thereafter the stipulations will also include abstention from unauthorized use of drugs and

	drug or alcohol misuse in analyzing facts.	alcohol to be verified by random drug testing through urinalysis; limit specific nursing activities/practice settings and/or periodic Board review. Board will use its rules and disciplinary sanction polices related to substance use disorders and other alcohol and drug related conduct in analyzing facts. Probated suspension will be for a minimum of two (2) or three (3) years with Board monitored and supervised practice depending on applicable Board policy. Financial exploitation of a patient or public will require full restitution before nurse is eligible for unencumbered license.
Third Tier Offense: Failure to comply with a substantive Board rule regarding unprofessional conduct resulting in serious patient harm. Repeated acts of unethical behavior or unethical behavior which results in harm to the patient or public. Sexual or sexualized contact with patient. Physical abuse of patient. Financial exploitation or unethical conduct resulting in a material or financial loss to a patient of public in excess of $4,999.99.	Sanction Level I: Denial of licensure or revocation of nursing license. Nurse or individual is not subject to licensure or reinstatement of licensure until restitution is paid.	Sanction Level II: Emergency Suspension of nursing practice in light of violation that may be a continuing and imminent threat to public health and safety pursuant to the Occupations Code §301.455 or §301.4551, which may ultimately result in revocation.
Aggravating Circumstances for §301.452(b)(10): Number of events, level of material or financial gain, actual harm, severity of harm, prior complaints or discipline for similar conduct, patient vulnerability, involvement of or impairment by alcohol, illegal drugs, or controlled substances or prescription medications, criminal conduct.		
Mitigating Circumstances for §301.452(b)(10): Voluntary participation in established or approved remediation or rehabilitation program and demonstrated competency, full restitution paid.		
* Denotes a violation that is subject to disciplinary action, but may be eligible for a corrective action agreement (non-disciplinary action). The sanctions contained in this Matrix are disciplinary actions. Board rules regarding corrective actions (non-disciplinary actions) are located at 22 Tex. Admin. Code §213.32 and are not applicable to this Matrix. Further, a corrective action is not available as a sanction in a disciplinary action.		