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The concept of seriousness in fitness to practise cases

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Table of Contents

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Glossary of key terms

Many of these terms are used in common parlance. However, this glossary defines the way in which the terms are used within this report.	
Academic literature	Literature published in peer reviewed academic journals
Acts and omissions	In relation to a potential offence, an *act* refers to what a registrant may have done to constitute that offence, whereas an *omission* is something that registrant did not do, but should have done, as part of the their professional duties
Adjudication stage	The stage of the fitness to practise process in which a fitness to practise panel hears evidence and makes a determination of what, if any, sanction is appropriate
Admonishment	See *Recorded Censure*
Advice	Some regulators can give official advice to a registrant where no misconduct has occurred
Aggravating factor	Any fact or circumstance that increases the severity of an act or an omission, or the culpability of the registrant
Calibration	Formal and informal processes that seek to ensure consistency of decisions across cases (see also Quality Assurance)
Case Examiner	An individual employed by the regulatory body who works at the investigation stage to gather evidence for fitness to practise cases
Case File	The information received from regulators about individual fitness to practise cases, used as data for this report
Case Law	A ruling by a court. In fitness to practise cases this is usually where a regulator has come to a determination on a case, and the registrant has contested the outcome, usually at the Court of Appeal or the High Court.
Code (of conduct)	All health professions regulators have a code of conduct that outlines the standards to which all registrants must adhere in order to maintain a position of good standing with the regulator. Departures from these standards can indicate misconduct
Conditions (of practice)	A sanction in which a registrant may continue to practise, but the scope of their practice may be restricted in some way, or they are obliged to undertake other measures to address deficiencies in their professional practice
Consensual disposal	The means by which regulatory panels and registrants reach agreement to conclude a case by deciding in private the outcome that the panel would most likely have reached if the case went to a public hearing
Determination	The official and recorded outcome of a fitness to practise panel
Engagement	Refers to the registrant's response to all stages of the fitness to practise process, including any written or verbal communications, sharing of relevant evidence, and attendance when requested at a panel hearing

Erasure	The removal of the registrant from the register held by the regulator,
Grey literature	Information produced on all levels of government, academia, business and industry in electronic and print formats not controlled by commercial publishing
Guidance documents	Documents published by regulators that describe their regulatory processes, but excluding those documents that form part of their statute as a regulator
Hearing	An adversarial legal proceeding, usually held in public, to determine the facts of a case based on the evidence, and to determine an appropriate sanction, if deemed necessary
Impairment	A registrant's lack of capacity to carry out their professional duties in accordance with the standards of the profession and in a manner that protects the public from harm and maintains public confidence in the profession
Insight	In relation to mitigating or aggravating factors, evidence that the registrant understands the consequences of their actions, as well the necessary steps needed to rectify identified deficiencies in their practice
Interim order	Suspension of a registrant or a restriction on their practice to protect the public for the duration of the fitness to practise process
Interviewees	Individuals with expertise and / or experience in the fitness to practise processes of regulators who were interviewed for this research
Investigation stage	The stage of the fitness to practise process in which evidence is gathered and a decision is made on whether the case needs to go to a public hearing. However, more minor sanctions, undertakings, or consensual disposal may be imposed or agreed at this stage
Legal advisor	A legal professional who provides impartial legal advice to fitness to practise panels
Misconduct	An act or omission that represents a serious departure from professional standards, to be determined through the fitness to practise process
Mitigating factor	Any information or evidence presented during the fitness to practise process regarding either the registrant or the circumstances that may result in a lesser sanction, or a decision at the investigation stage not to refer the case to a full panel hearing
Negligence	An act or omission that falls short of the standards expected of the registrant in circumstances in which the registrant has a professional duty of care
Outcome	The result of a fitness to practise process after a decision is made at any stage of that process
Panel	A group of individuals, representing registrants of the profession as well as lay people, who decide on the outcomes of cases at adjudication stage of the fitness to practise process
Professional Regulator (Health)	Bodies with a statutory responsibility to regulate one or more groups of health professionals.

Quality Assurance	Process to ensure that the fitness to practise procedures are of an appropriately high standard
Recorded censure	A term we use in this report to indicate a sanction in which a panel or case examiners determine that a practitioner can continue to practise but will have an official record of their departure from professional standards entered against their name in the register, for a specified period. Different regulators may use different terminology, and this may be dependent on the stage (investigation or adjudication) at which the decision is made and may indicate different levels of severity. Synonymous terms used include: *Warning* (GDC, GMC/MPTS, NMC, GOC, GPhC, PSNI) *Caution* (NMC, HCPC/HCPTS) *Admonishment* (GCC, GOsC) *Reprimand* (GDC)
Registrant	An individual who is registered with the regulator as having achieved the necessary competency and official qualifications to practise in that profession. This is a necessary (but not always sufficient) condition to hold a licence to practise.
Remediation	The process by which any professional deficiency is remedied in order to return the registrant to safe practice
Reprimand	See *Recorded Censure*
Sanction	The actions taken by a panel or case examiners, at either the investigation or adjudication stage of the fitness to practise process, in response to findings related to misconduct and/or impairment/unprofessional conduct
Seriousness	The severity of an act or omission that determines a) whether that offence, if proven on facts, amounts to misconduct, and b) if found, the level of sanction appropriate in response to the finding
Statute	The acts that established the regulator or the statutory instruments that set out their fitness to practise processes
Suspension	A sanction which removes the registrant's license to practise for a specified period
Thematic framework analysis	An interpretive process, whereby data is systematically searched to identify patterns within the data in order to provide an illuminating description of the phenomenon
Threshold (Guidance)	Relating to guidance, a statement of facts or processes that assist decision makers in determining the appropriate course of action or sanction relating to the severity of acts or omissions by distinguishing between the relative severity of acts or omissions
Undertakings	Measures agreed between the registrant and the panel or case examiners, that the registrant will undertake in order to address deficiencies in practice while continuing to practise
Warning	See *Recorded Censure*

List of Acronyms

FtP	Fitness to Practise
GCC	General Chiropractic Council
GDC	General Dental Council
GMC	General Medical Council
GOC	General Optical Council
GOsC	General Osteopathic Council
GPhC	General Pharmaceutical Council
HCPC	Health and Care Professions Council
NMC	Nursing and Midwifery Council
PSNI	Pharmaceutical Society of Northern Ireland
PSA	Professional Standards Authority (formerly the CHRE)
CHRE	Council for Healthcare Regulatory Excellence (now the PSA)
MPTS	Medical Practitioners Tribunal Service
HCPTS	Healthcare Practitioners Tribunal Service

Executive Summary

Introduction

This report presents findings from 'The concept of seriousness in fitness to practise' project commissioned by the General Dental Council (GDC) and the Nursing and Midwifery Council (NMC). The project was undertaken between December 2019 and September 2021, and investigated how seriousness in Fitness to Practise (FtP) cases is understood and applied by health professions regulators. The research addressed the following objectives:

- To develop an understanding of how the concept of seriousness in relation to misconduct is defined and applied by professional regulators, and to identify the considerations that influence that application.
- To achieve a clearer understanding of the similarities and differences in approaches across regulation and reasons for these.
- To describe the relationship between professional misconduct, enforcement actions and the statutory objectives of healthcare regulation.

Study design and methods

This project used a qualitative multimethod design to investigate how the concept of seriousness is understood and applied in all nine UK health professions regulators' FtP procedures. The research had 18 research questions (see p.19, table 1) in order to meet the project's objectives and was structured around six work packages (WPs):

1. Making detailed scoping and sampling plans for the project.
2. Analysis of legislation, policy, guidance, and relevant case law.
3. Analysis of Fitness to Practise case file information from the General Dental Council and Nursing and Midwifery Council plus published Fitness to Practise Panel decisions from the other UK health professions regulators.
4. Analysis of interviews with regulatory staff and decision-makers.
5. Analysis of further legal decisions, including from the Professional Standards Authority's Section 29 database.
6. Project management, delivery and dissemination.

Analyses of data collected in WPs 2, 3, 4 and 5 used thematic framework analysis, a systematised form of thematic analysis, to produce a comprehensive linked analysis of seriousness in FtP.

For WP2, Google Scholar and websites searches were used to identify 56 items of grey and academic literature published between 2017 and 2020 with relevance to issues of seriousness in FtP. In addition, 130 documents setting regulatory legislation, policy and guidance were identified from searches of regulators' websites. These documents were all coded, and from them, 139 potentially relevant case law decisions were identified for review.

In WP3, the GDC and NMC provided samples of case determinations and other additional documents. Additional data in this work package was accessed from all other regulators' websites. The General Optical Council (GOC) and General Osteopathic Council (GOsC) also provided additional material which had previously been published online. In all, over four hundred case determinations, plus additional linked material where available, were analysed.

For WP4, participants were recruited via regulatory bodies and other related organisations, either through discussion to nominate individuals or through the circulation of a call for participants. The 21 participants recruited included lay and clinical panel members and case examiners, regulatory lawyers, FtP Leads, and others with relevant expertise.

Material analysed in WP5 was accessed via the Professional Standards Authority's (PSA) website, and included notes from case review meetings and decisions in cases referred to the High Court under the Authority's Section 29 powers.

In addition to the project commissioners the GDC and the NMC, four regulators provided added input and support to the project as Associate Research Partners: the General Chiropractic Council (GCC), the General Optical Council, the General Osteopathic Council and the General Pharmaceutical Council (GPC). This support included providing access to additional material for analysis where determinations were no longer available online, providing additional information to the research team, and supporting participant recruitment. The General Medical Council (GMC) also provided support for participant recruitment.

Findings: recent literature

Findings relevant to the project from recently published literature centred on three key areas. Firstly, the aggravating and mitigating factors that influence decisions about seriousness in Fitness to Practise cases. In addition to factors such as registrants' levels of honesty, risk to patients, and insight, which have been well covered in earlier studies,[1] there was a focus in more recent works on contextual issues. These included consideration of registrants' health and personal circumstances, as well as the broader social and organisational context in

which the misconduct occurred, with a focus on issues such as pressurised work environments, bullying, and workplace cultures. A second theme within the literature reviewed was the importance of registrant engagement with Fitness to Practise processes and the impact that engagement and legal representation at hearings can have on sanction outcomes.

Finally, though most studies on FtP focus on a single regulator, we found some literature looking across professions. These pieces generally concerned doctors and nurses, and one focused on the different outcomes for the registrants involved in what has become known as the Bawa-Garba case. This case, and its implications for health professions regulation, was the subject of a number of pieces identified in the review, which identified some potential differences of approach between Medical Practitionars Tribunal Service (MPTS)and NMC panels in considering the case, particularly in the extent to which they followed criminal court rulings.

Findings: comparing Fitness to Practise procedures

From analysis of regulators' procedural and guidance documents, we identified key points at which Fitness to Practise processes and outcome options differ between regulators. Focusing particularly on key decision points, and the outcome options available to regulators at those points, we developed five models of FtP processes covering the nine UK health regulators, looking beyond differences in terminology used across the various systems. The major procedural differences centre on whether regulators find impairment or not at the adjudication or panel hearing stage of their process, and at which points they are able to issue recorded censures.

Findings: combined analysis of documentary and interview data

Regulatory guidance documents, relevant case law decisions, FtP case determinations and data from interviews with FtP staff, panel members and regulatory lawyers were analysed using a common coding framework (see appendix B). In this section, findings from across these sources of data are summarised in combination.

Determining and identifying misconduct and seriousness

Seriousness is used in two main ways in Fitness to Practise processes. Firstly, it is used to define misconduct; and secondly, if misconduct is found, to place that misconduct on a spectrum of seriousness to determine an appropriate sanction.

The definition of misconduct is based on case law decisions, and these decisions help panels to determine if misconduct has occurred. The terminology used to describe misconduct in case law has evolved over time, but key cases Roylance v GMC (1999) and Calhaem v GMC (2007), frequently cited in regulatory guidance documents, establish that acts or omissions must feature a degree of seriousness to reach the threshold of misconduct.

However, beyond that, case law does not clearly define seriousness in relation to misconduct, and decisions about what constitutes seriousness lie with Fitness to Practise panels. Interviewees noted that these decisions have an element of instinctiveness rather than being scientific, pointing to an element of subjectivity.

Decisions on seriousness are though, informed by parameters set out in regulatory guidance documents which contain some clear directions about some types of misconduct that carry a presumption of seriousness. These are broadly consistent across all regulators' guidance and are cases involving:

- Sexual misconduct
- Dishonesty
- Criminal convictions, especially those resulting in a custodial sentence.

However, when it to comes to situating an act or omission on a spectrum of seriousness, there is variance within and between regulators. Analysis comparing cases with seemingly similar basic content in terms of the type of misconduct, looking across a series of dishonesty cases involving the falsification of documents, shows that these resulted in a wide range of sanction outcomes. Therefore, even in cases where there is a presumption of seriousness based on the type of misconduct involved, our analysis of case determinations

shows how the outcome is shaped by the specific combination of factors in the individual case.

Decisions about seriousness are taken at various stages in Fitness to Practise processes, and especially during panel hearing at the misconduct, impairment, and sanction stages. These decisions involve panellists considering a variety of factors to locate cases on a spectrum of seriousness.

Harm and risk of harm

Protecting, promoting and maintaining the health, safety and wellbeing of the public is one of the statutory objectives set for UK health professions regulators. The extent of harm resulting from misconduct or the risk that harm could have resulted from it, is therefore a key issue in decisions about seriousness in relation to misconduct. Our analysis of case determinations identified various forms of harm that are considered within Fitness to Practise cases, namely:

- Physical harm
- Emotional distress
- Financial harm
- Abuse of trust

Within these broad categories, some cases analysed revealed nuanced ways in which these types of harm could be manifested.

Serious physical harm during the provision of care arose in cases featuring the provision of inappropriate or unsafe care, for example, including cases with incorrect prescriptions or the inappropriate management of a condition. Other cases featured failures to request assistance or senior review when a patient deteriorates or when a safeguarding risk is identified. These cases demonstrate that harm can arise from a registrant's failure to act as well as from actions they may take.

Emotional distress was identified in cases centring on the provision of care, but also in cases centring on dishonesty or other behavioural concerns. Emotional distress was also identified in relation to colleagues as well as patients and their relatives.

Financial harm was identified in cases involving theft from workplaces, for example, and the victims were typically the registrants' employers.

Abuse of trust is important in determinations of seriousness as it relates to the statutory regulatory objective to maintain public confidence in the professions. Abuse of trust cases, including breaches of confidentiality, were found to have significant impacts on patients.

We noted that discussion of harm in case determinations can be particularly extensive within sexual misconduct cases. At the impairment decision stage, consideration of harm moves from looking back at harm caused or the risk that it could have occurred, to looking at the risk of that harm recurring in future. Risk of repetition is a key factor influencing decisions about impairment. Overall, our analysis shows that Fitness to Practise panels take a broad view of harm when considering misconduct cases and their seriousness.

Registrant response

Analysis of case determinations and interviews with Fitness to Practise decision-makers clearly showed that a registrant's response to involvement in Fitness to Practise proceedings can be a key factor in determining the seriousness of the case, and the eventual outcome of it. Registrant engagement (i.e. responding to the regulator, co-operating with investigations and evidence gathering processes, and attending panels) was found to be especially important in decisions about impairment and sanction. An engaged registrant, particularly one attending a hearing, provided an opportunity for panel members to question them and their evidence, and to develop more confidence in considering any mitigation the registrant may offer in the form of reflection, insight, or evidence of remediation. Whether panels should draw adverse inferences from a registrant's absence from a panel hearing or a failure to engage with their regulator overall was an issue discussed by interviewees and noted in case determinations. There have been recent developments in case law on this issue in Kuzmin v General Medical Council [2019] EWHC 2129 which found that it is a professional obligation for regulated professionals to engage with their regulator. However, from our interview data, it is clear that this position had not been adopted by all panels.

Closely linked to registrant engagement, is whether registrants have legal representation at Fitness to Practise hearings. This was reported by interviewees to vary between professional groups, with doctors, dentists and pharmacists typically said to have legal representation while nurses, dental care professionals and pharmacy technicians were reported as having higher levels of self-representation. Legal advice and representation were seen as important in supporting registrants in navigating the complex Fitness to Practise process, and making them aware of the importance of full engagement with proceedings.

Attitudinal issues

Analysis of case determinations demonstrated that the identification of attitudinal issues within a case has a significant impact on decisions about seriousness. Attitudinal issues are mainly considered at the impairment and sanction decision points: panels are unlikely to find conditions an appropriate outcomes if an attitudinal issue is present, as such issues are often seen as not being remediable and as carrying a high risk of repetition. In the case files we analysed, panels, and particularly the NMC panel determinations in our sample, often distinguish between attitudinal issues and deep-seated attitudinal issues. Cases we analysed where an attitudinal or a deep-seated attitudinal issue was identified typically resulted in a sanction outcome of suspension or erasure across all regulators.

Environmental context

Environmental factors are considered by panels to place a registrant's conduct into a wider context. These issues were only considered in cases relating to professional practice, and mainly in cases from regulators of professional groups working in larger organisational settings. Several types of environmental issues were identified from the cases analysed as having been considered by panels:

- Interpersonal relationships
- Staffing and resources
- Workplace culture
- Supervision and management
- Organisational issues, including unclear or inadequate processes.

Environmental issues were more likely to be accepted as mitigation for misconduct where there was corroborating evidence available from other witnesses, and where there was evidence that the registrant had proactively raised concerns about the issues.

Misconduct in non-professional settings

Health professions regulators' Fitness to Practise procedures cover their registrants' conduct outside of their work, as well as their professional practice. From analysis of case determinations, we found that regulators' approaches to considering cases centring on conduct outside registrants' professional practice may vary. We identified variation in how consideration of the relevance of conduct to professional practice is recorded, but also potential differences in the way that regulators approach these cases. Some interviewees noted a distinct change in their organisation's approach, moving away from cases relating to

registrants' private lives if no impact on their professional practice has been found. Others felt that consideration of potential relevance to professional practice should be broader. In case determinations, we found examples of how panels draw connections between conduct in private life and professional practice. Comparison of a number of cases centring on incidents of violence in non-professional settings showed how aggravating and mitigating factors were taken into account in such cases, resulting in sanction outcomes ranging from no action to erasure.

Public confidence

Maintaining public confidence in the professions is a duty enshrined in health professions regulators' statutory objectives, and is one of the grounds on which registrants' fitness to practise may be found impaired. Impairment on this ground may be found even where a registrant is judged to have fully remediated and have insight, and to no longer present a risk to public safety. The threshold for impairment on this ground centred on the seriousness of the misconduct, and an evaluation of how allowing the registrant to continue to practise unrestricted may be perceived.

From our interviews, we found differing interpretations of the meaning of public confidence. Some participants saw the need to maintain public confidence in terms of the potential impact of misconduct on an individual member of the public's willingness to seek treatment from healthcare professionals. For others, maintaining public confidence could be about marking the seriousness of an incidence of misconduct so that regulation was seen to be active and effective. Others mentioned considering potential media coverage when making judgements about public confidence, and some referred to the idea of considering the views of an abstract 'reasonable-minded' member of the public. The range of different ways in which public confidence is interpreted by individual decision-makers suggests that the concept is nebulous and ill-defined.

Calibration and quality assurance

Given the individual nature of Fitness to Practise cases, each featuring a unique combination of factors, calibration and quality assurance of decisions are important but challenging. We found that these processes occur in a number of ways:

- Guidance and training to set parameters before decisions are made.
- Calibration through the input of legal assessors and between decision-makers during decision-making processes.

- Formal quality assurance processes to evaluate decisions that have been made, including through audits, either internal or commissioned from external organisations, and decision review groups.
- External audits and oversight by the Professional Standards Authority.

Seriousness across health professions regulation

From our analyses, we found that there may be differences between the types of cases heard by different regulators' panels. For example, those whose registrants are typically in close contact with patients on a one to one basis saw a higher proportion of cases centring on allegations of sexual misconduct or boundary violations within the samples of cases we analysed. This was noted in cases sampled from the GCC, the GOsC, and in HCPC cases involving physiotherapists. Such general trends in caseloads were also identified by interview participants.

Interviewees with experience of working across a number of regulators' panels differed in their views on how consistent or not approaches to cases are. Some suggested that there is a perception that the MPTS is more lenient in its approach to sanctions than other regulators, though others countered this suggestion.

It was also suggested by interviewees that different professional groups were considered to pose more or less risk to patients, and that this may be a factor in decisions. Moreover, it was suggested that the public may have different expectations of different professions. However, it was also recognised that attempting to clearly establish any such different expectations of professional groups and include these in FtP decision-making may be problematic.

Procedural differences, and particularly the different sanction options available to different regulators were also noted as important points of variation between regulators. Several participants noted that their organisation's restrictive legislative frameworks and Fitness to Practise rules present challenges in developing the ways that cases are dealt with, pointing to differences in the ways that regulators are able to operate. Participants in Fitness to Practise leadership roles consistently pointed to a need for regulatory reform.

Discussion

This research looked across FtP procedures and cases from the UK's nine health professions regulators to explore the concept of seriousness in fitness to practise. Reflecting on our findings in relation to the project's objectives, we look first at consideration of

similarities and differences in approaches across regulation, before moving to look at the relationships between professional misconduct, enforcement actions and regulatory statutory objectives. Finally, we consider how our understanding of seriousness in fitness to practise has developed, in terms of its definition and application by regulators, and the considerations that influence that application.

Similarities and differences in approaches across regulation

Mapping FtP procedures of the UK health professions regulators produced five models, with differences at four main points. These differences centred on whether a regulator can

- issue a recorded censure at the end of investigation stage;
- use undertakings or consensual disposal to resolve a case at the end of investigation;
- find impairment at the adjudication stage;
- issue a recorded censure if there is a finding of misconduct but no finding of impairment.

These procedural differences between regulators, arising from differences in the legislative frameworks they operate according to, may influence the way in which cases progress through FtP processes.

UK health professions regulators share the same statutory regulatory objectives, underpinning their approaches to FtP, and we found that regulators offer broadly consistent guidance on some specific types of behaviour that are likely to be treated as serious misconduct, including dishonesty, sexual misconduct, violence, and some criminal convictions. In other areas, regulatory guidance may differ, with the NMC in particular having redeveloped its guidance in recent years, including its approach to taking contextual factors into account and how it views misconduct that occurs outside the workplace. Such developments demonstrate that approaches to seriousness can change over time.

At case level, the individual nature of each misconduct case makes comparisons between regulators challenging, as outcomes can vary between a regulator's own panels even in cases featuring superficially similar basic concerns. However, in some areas we saw clear consistency between regulators, such as in cases featuring attitudinal issues.

This research also identified remaining questions about whether comparability and consistency between regulators is desirable. While procedural consistency may be desirable, it may also risk perpetuating legislative and procedural rigidity. Efforts to introduce regulatory reform should balance moves towards consistency with allowing flexibility for

regulators to respond to changes over time and to act in line with the demands of regulating a particular profession.

The relationship between professional misconduct, enforcement actions and the statutory objectives of healthcare regulation.

The overarching statutory objective of UK health professions regulators is the protection of the public, with subsidiary objectives being to: protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the professions they regulate; and to promote and maintain professional standards and conduct for the members of the professions they regulate. Fitness to practise matters pertain to all of these objectives and we found that decisions about seriousness are often explicitly linked to these regulatory objectives. Professional misconduct is seen as having the potential to present a risk to the public, or a risk that public confidence in the professions may be undermined. Decisions about impairment and sanction especially focus on weighing and mitigating these risks.

Consideration of any harm caused, and the potential for any future harm, are important in assessing risk to public and patient safety. The presence of any risk of future harm is linked to the imposition of more restrictive sanctions in order to mitigate that risk and to meet the regulatory objective of protecting the public.

Maintaining public confidence in the professions is a term drawn directly from the statutory regulatory objectives and repeated in regulatory guidance documents. However, there is little in the way of further explanation of this term or definition of it, and public confidence is an intangible notion. We found that FtP panel members apply this term in a variety of ways. Public confidence is an important concept in health professions regulation, but it remains nebulous, and may not be consistently interpreted.

Understanding how the concept of seriousness in relation to misconduct is defined and applied by professional regulators, and to identify the considerations that influence that application.

FtP panel decisions are informed by regulators' guidance documents and case law decisions, with some types of behaviour consistently identified as likely to be treated as serious, such as dishonesty, sexual misconduct, violence, and some criminal convictions. Beyond these categories carrying a presumption of seriousness, what constitutes misconduct and how serious that misconduct should be considered are matters for FtP panel members to determine. Even within those categories of misconduct presumed to be serious,

panels retain discretion to make the ultimate decision about the degree of seriousness in any individual case. Framed by regulatory guidance but without clearly defined thresholds, these decisions involve weighing a range of factors relating to the nature of the conduct and the registrant's response to the issues raised and the regulatory process, to reach a judgement about the risk posed by the registrant and if and how any such risk can be mitigated.

Decisions about the risk posed by registrants centre on the evaluation of the characteristics of each case, typically described as the aggravating and mitigating factors. As well as considering the risk of harm and any perceived risk to public confidence, other considerations include risk of repetition, informed by consideration of the registrant's response to the concerns raised and the regulatory process. Registrant response and engagement is known to be associated with FtP outcomes, however our findings suggest that some professionals groups may be more likely to have legal representation than others, and that legal representation can affect the way in which a registrant engages with FtP processes.

Environmental and contextual factors also feed into decisions about seriousness in FtP cases. The aspects of environmental context taken into consideration can be categorised as: interpersonal relationships, work environment, local culture, supervision and management, and organisational issues. However, it is clear that environmental issues are more likely to be accepted as mitigation where there is corroborating evidence from other witnesses or from the organisation itself. Evidence that the registrant had proactively raised concerns about the issues was also important. Consideration of environmental factors seems to be an area of change in how seriousness is looked at.

In weighing factors to make decisions about seriousness, decision-makers locate cases on a spectrum of seriousness. These decisions may be clear cut where a registrant's conduct obviously falls into a category where regulatory guidance sets out a presumption of seriousness, or where a case is very clearly not serious. However, decisions are far less straightforward at the mid-point of the spectrum, where a number of factors may need to be weighed and balanced.

Conclusion

This research has demonstrated the complex interplay between a wide range of factors that shape how seriousness is identified. There is no clear and concise regulatory definition of seriousness in fitness to practise, nor does one arise from this research. Rather, we have identified how decisions about seriousness are made within FtP cases and the considerations that underpin these decisions.

Implications and areas for development

Our findings highlight a number of areas which would benefit from further consideration by researchers and regulators, including working collaboratively on the following areas:

- **FtP Processes**. Differences in legislative frameworks may contribute to differences in FtP outcomes between professional groups, due to the availability of different outcomes, especially the use of recorded censures at different points and the use or not of impairment within FtP processes. Reform to achieve common basic processes may improve comparability and support consistency, but may also risk embedding further legislative rigidity. Further consideration of the intended, and potential unintended, consequences of reform may be worthwhile.
- **Public expectations.** Further investigation of legitimate or necessary differences between regulatory approaches arising from the different nature of the professions being regulated may also be useful. Our research suggests that further work to understand whether the public has different expectations of different professional groups could form part of this.
- **Contextual factors.** Beyond differences in legislative frameworks, there are also apparent differences in regulators' approaches to how some factors are taken into consideration in FtP cases, for example in relation to contextual factors. Monitoring and liaising between regulators around the development of new approaches to such factors may be useful. Developing an enhanced understanding of the barriers to individuals' ability to meet their professional obligations in challenging work environments could help to identify ways to support registrants in difficult circumstances.
- **Engagement and representation.** Registrant engagement and legal representation can impact on decisions about seriousness. Further work to monitor the impact of engagement and representation on outcomes, including any differences in types and levels of engagement and representation across professional groups may be worthwhile.
- **Public confidence.** The concept of maintaining public confidence is enshrined within the UK health professions regulators' statutory objectives, but our research found that FtP decision-makers have varying understandings of and ways of applying this concept. This is an area where further work to establish how meaningful this concept is, and to develop additional guidance around it, may be desirable.

1. Introduction

This report presents findings from the Cross Regulatory Seriousness project, commissioned by the General Dental Council (GDC) and the Nursing and Midwifery Council (NMC), and carried out between December 2019 and September 2021. The project investigated how 'seriousness' in Fitness to Practise (FtP) is understood and applied by health professions regulators in the United Kingdom. This qualitative mixed-methods study included analysis of documentary materials, FtP case decisions, and interview data. This report sets out the background to this work, its overarching objectives and detailed research questions, the study design and methodology, and the findings from across the project. Finally, it places these findings in the context of the existing literature in this field and identifies the implications from the research.

Research objectives:

- To develop an understanding of how the concept of seriousness in relation to misconduct is defined and applied by professional regulators, and to identify the considerations that influence that application.
- To achieve a clearer understanding of the similarities and differences in approaches across regulation and reasons for these.
- To describe the relationship between professional misconduct, enforcement actions and the statutory objectives of healthcare regulation.

1.1. Background

1.1.1. Fitness to practise and impairment

FtP procedures are a core element of the work of health professions regulators, albeit that only a small proportion of those who are regulated are subject to those procedures. Through these procedures, regulators receive and investigate complaints and referrals about the practice and conduct of health professionals. The purpose of FtP procedures is to establish whether a registrant has failed to meet the standards expected for their profession, and if so, whether the failing means that they are not fit to practise unrestricted. If a practitioner is deemed unfit to practise their profession unrestricted, this is usually referred to as "impairment". Decisions on impairment relate to the risks posed to patients and the public of continued practice, although "risk" in this sense is broadly defined, and includes both the specific risk to individuals receiving treatment, as well as the wider risk to the standards of the profession and the need to uphold public confidence in that profession. All regulators

apart from the General Chiropractic Council (GCC) and the General Osteopathic Council (GOsC) come to a judgement on impairment based on criteria set out in Dame Janet Smith's fifth report into the Shipman Inquiry[2] and confirmed in case law in CHRE v NMC and Grant [2011] EWHC 97. Ultimately, where concerns about FtP are confirmed, outcomes can include restrictions being placed on a professional's practice, or their suspension or erasure from their professional register.

As with all regulatory activities, the operation of FtP procedures is intended to support the achievement of the shared overarching objective for health professions regulators, as set out in the Health and Social Care (Safety and Quality) Act 2015, which is the 'protection of the public.' This objective is further broken down into three subparts focusing on: protecting, promoting and maintaining public health, safety and well-being; promoting and maintaining public confidence in the health professions; and promoting and maintaining professional standards.[3]

1.1.2. Regulatory reform

Operating FtP procedures is costly and resource intensive for regulatory bodies,[4] and being involved in FtP proceedings can be a stressful experience for complainants and for health professionals.[5-8] Proponents of regulatory reform have argued that the current system is too adversarial, and that many cases could be better resolved through discussion and agreement.[9] Improved communication by regulators, increased collaboration between the employment and regulatory spheres to support a quality improvement culture, and the development of nuanced means of addressing the real-world complexities associated with day to day clinical practice have also been highlighted as important.[10]

With these issues in mind, in recent years, regulators have sought to modernise their approaches to managing FtP matters, to try to ensure that their processes and actions are proportionate and appropriate, informed by the Professional Standards Authority's (PSA) principles of 'right-touch regulation.'[11] For example, regulators have increasingly sought to work with employers to resolve concerns locally where possible, as part of an 'upstream regulation' approach. Additionally, parliament has allowed some regulators the powers to use 'consensual disposal' methods to manage FtP concerns by agreeing a solution with the registrant concerned.[12] Those regulators with some form of power, such as undertakings, to dispose of cases through agreement with the registrant at the end of investigation stage are the GDC, the General Medical Council (GMC), the General Optical Council (GOC), the General Pharmaceutical Council (GPhC) and the NMC. Such developments aim to ensure that fewer concerns enter FtP procedures unnecessarily, and that of those that do merit regulatory consideration, only those which are especially serious or where there is dispute progress to a panel hearing. However, some variation between the precise forms of

consensual disposal available to regulators with those powers has been noted by the PSA.[13]

In this vein, both the GDC and the NMC have made a number of changes to their FtP processes. The NMC introduced Case Examiners in 2016, an employer liaison service, and has focused its attention on progressing only cases where there is dispute to FtP panels. The NMC's intention is that FtP procedures should contribute to building a culture of learning and development, and to focus on protecting and improving patient safety while also maintaining public confidence in the professions it regulates, in line with the over-arching regulatory objective.[14] However, in earlier research conducted for the NMC the term 'public confidence' was considered too subjective by stakeholders, who wanted clarity about how 'public confidence' and 'serious regulatory concerns' would be defined and identified by the regulator.[15] The NMC has also introduced a systematic approach to taking contextual factors in FtP cases into account, as part of its new strategic approach.[16]

The GDC's current corporate strategy includes an aim to focus its investigative activity on cases featuring serious concerns that warrant regulatory action.[17] This element of the strategy builds on intentions set out in earlier documents, such as the previous corporate strategy *Shifting the balance: a better, fairer system of dental regulation,* published in 2017.[18] That document stated the GDC's aim of clarifying the threshold for impaired fitness to practise by developing a clearer and more transparent understanding of what constitutes 'seriousness' in terms of breaches of its standards.[18] In addition, the GDC committed to ensuring that links to risks to patient safety and public confidence are embedded in its understanding of impairment.[18]

However, while regulators have pursued modernisation of their FtP processes and sought to refocus on serious cases and those involving dispute, their ability to make changes to FtP procedures themselves is limited as the constitution of those procedures is largely prescribed by regulator-specific legislation. Reform of the UK's health professions regulatory system has long been discussed,[19] and latterly reform appears more likely to come to fruition, with proposals recently published by the Department of Health and Social Care in a consultation document entitled *Regulating healthcare professionals, protecting the public*.[20] Some of the proposed reforms focus on FtP, including initiatives aimed at increasing consistency across regulators and offering greater flexibility by giving regulators more powers to amend their processes without the need for further legislative change. The proposed changes would: allow more cases to be resolved at case examiner stage, through a wider range of outcomes; allow regulators to set their own procedures; and introduce modified processes for the review of decisions made at the initial assessment and case

examiner stages of FtP processes.[20] Other changes would implement some of the recommendations from the Williams Review into gross negligence manslaughter in healthcare.[21] Importantly, the proposals envisage the implementation of a common three stage FtP process, common grounds for FtP action, common powers to conclude cases at the case examiner stage through an accepted outcomes process, and the extension of consideration of impairment to all regulators.[20] In line with this focus on creating a common legislative framework and FtP process across all the health professions regulators, this research takes a cross-regulatory approach to exploring how seriousness in FtP has been understood and applied by regulators.

1.1.3. Seriousness and FtP

As noted above, in recent years, both the GDC and the NMC have focused attention on more clearly conceptualising what constitutes 'seriousness' in the context of FtP. This shared focus on seriousness is the driver for this research, which builds on an earlier literature review undertaken by CAMERA for the GDC.[1] That review, published in 2018, found no shared definition of seriousness in relation to misconduct, due to the complexity, variety and individualised nature of FtP cases.[1] The review also highlighted that the consideration of a range of aggravating and mitigating factors was part of determinations of seriousness, including the registrant's honesty or dishonesty, any repetition of misconduct, the risk of harm to patients, and whether the registrant had shown remorse or insight into their conduct, or had undertaken remediation. Additionally, the review identified complex issues in FtP cases meriting further attention, including the relationship between individual registrants' behaviour and the maintenance of public confidence in their profession, and how conduct outside registrants' professional practice should be considered in FtP procedures.[1] However, little empirical research into how regulators understand and apply the concept of seriousness was identified through the earlier review, especially with regard to how panels reach their decisions in FtP cases.

The findings from this research will provide evidence to inform future policy development in relation to FtP processes, and will contribute to on-going discussions about the need for and potential impacts of legislative reform in health professions regulation.

2. Study design and methods

This project used qualitative analysis of several types of data to explore how the concept of seriousness is understood and applied in health professions regulators' FtP procedures. To meet the research objectives, our analysis focused on addressing a number of detailed research questions shown in table 1. This table also maps each research question to the project work package (WPs) that contributed to addressing them, as well as to the findings sections in this report that are relevant to each question, as the findings are organised around key themes and issues rather than by research question.

The overall study design is shown in Figure 1. The first stage of the project involved finalising the scope of the work and sampling approaches to be taken, with the major part of the project then organised into four further WPs that each focused on analysis of particular data types:

- legislation, case law, policy and guidance documents, literature review
- a review of FtP case determinations
- interviews with people with knowledge and experience of FtP work, especially decision-making
- a review of PSA reviews of FtP decisions and court decisions arising from these.

A final WP focused on project management and dissemination activities.

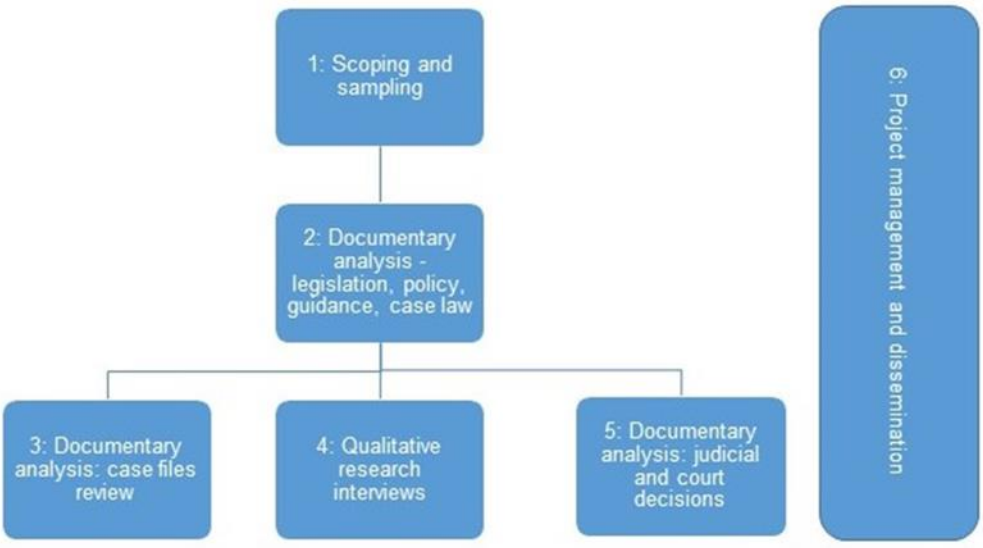

Figure 1: Study design

Table 1: Research questions mapped to research questions and report sections

Research questions	WP2	WP3	WP4	WP 5	Findings section(s)
1.1 What do regulators consider constitutes serious misconduct?	X	X	X	X	5.1, 5.2, 5.4, 5.6
1.2 What do regulators consider affects public confidence in the profession(s) they regulate?			X		5.1, 5.2, 5.6, 5.7
1.3 From documentary analysis, is this understanding clear across each part of FtP processes for the GDC and NMC?	X	X		X	5.1-5.8
2.1 Is seriousness a relative concept across regulation? In what ways is this manifest in (a) policy guidance and (b) case notes recorded by the different regulators?	X		X		5.9
2.2 (How) Is this reflected in case notes and judicial and court decisions?		X		X	5.9
3.1 How consistent is the application of sanctions between regulators? If there are inconsistencies/differences in approach, what are the reasons for these?		X	X	X	4, 5.9
4.1 Is there a common approach within and between regulators towards determining whether misconduct is serious enough to result in a finding of impaired fitness to practise?	X	X	X		5.2.4, 5.3.2, 5.4-5.7
5.1 Within each regulatory body, how are the decisions on seriousness calibrated?	X	X	X		5.8
5.2 What thresholds are (a) specified in policy guidance and (b) deployed in decisions about misconduct?	X	X	X		5.1, 5.2, 5.4, 5.6, 5.7
6.1 How do FtP panels come to a judgment about the impact of misconduct on public confidence in the profession?		X	X		5.7
6.2 What is the threshold at which misconduct is deemed to damage public confidence in the profession?	X	X	X		5.7
6.3 Does this differ between regulatory bodies?	X	X	X		5.7
7.1 Are clear links made between fitness to practise decisions and health regulatory objectives?	X	X	X		5.1-5.7
7.2 What arguments are made to establish these links?	X	X	X		5.1-5.7
7.3 Do these arguments differ at different stages of the process?	X	X	X		5.1-5.7
7.4 Is there between and/or within regulator variation? If so, what factors might influence this variation?	X	X	X		5.1-5.9
8.1 How is serious misconduct defined by the regulators for (a) the public and (b) members of the professions served by the regulator?	X	X			5.1
8.2 (How) Do the definitions of serious misconduct provide an explicit link to patient risk and public confidence?	X	X			5.1

2.1. Project Steering Group

Delivery of the project was supported by a Steering Group, whose membership consisted of the research team leads (Bryce and Gale) and representatives from the GDC and the NMC. The Steering Group met bi-monthly throughout the course of the project.

2.2. Associate Research Partners

Four additional health professions regulators have engaged with the project as Associate Research Partners (ARPs): the GCC, the GOC, the GOsC, and the GPhC. The ARPs have provided information to support the project, and facilitated participant recruitment and data collection. ARP representatives also took part in a learning event held in May 2021, at which emerging findings from the research were presented and discussed.

2.3. Data collection

2.3.1. Literature

At the beginning of the project, we undertook searches of Google Scholar and the websites of the UK health professions regulators and the PSA to identify relevant peer-reviewed and grey literature published between January 2017 and March 2020. The intention of this literature review activity was to update an earlier literature review on impairment and serious misconduct carried out by members of the research team in 2018, to provide updated background material as context for this research.[1] These searches identified 56 potentially relevant papers and research reports.

2.3.2. Legislation, policy document, guidance documents and case law decisions

UK health professions regulators' websites were searched to identify legislation, policy and guidance documents relating to FtP procedures. These searches resulted in 130 documents being included for analysis. Searches were undertaken between January and June 2020.

From regulators' guidance documents, potentially relevant case law decisions were identified and downloaded using the Westlaw UK database. In all, 139 case law decisions were initially identified though later analysis found that many of these were not specifically relevant to matters of seriousness.

All documents were uploaded into Nvivo12, a computer-aided qualitative data analysis software package, for analysis.

2.3.3. Case determinations

FtP case decision documents, or determinations, were accessed in one of two ways, depending on the source organisation.

2.3.3.1. General Dental Council and Nursing and Midwifery Council

Samples of case decisions from the GDC and the NMC were accessed through liaison with these organisations, as funders of the research. Sampling focused on misconduct cases, excluding cases concerned only with health issues or competence issues. Review hearings, for example to assess on-going suspension orders, were excluded. Sample sizes were calculated, based on consideration of the number of cases considered by the regulators' FtP panels over the most recent three year period for which data were available at point of sampling (GDC, 2017-2019, n=459; NMC, 2016-2019, n=3381), and also the feasibility of analysis during the study period. The samples drawn were 92 GDC cases, approximately 20% of its three-year total, and 180 NMC cases, approximately 5% of its three-year total. The decisions sampled were from the period January 2017 to December 2019, and were broken down to ensure coverage of four broad groups of outcomes:

- cases that concluded with registrants found to be impaired and being removed from practice, e.g. through erasure or suspension;
- cases that concluded with registrants found to be impaired but not removed from practice, e.g. conditions of practice;
- cases that concluded with no finding of impairment, e.g. no action;
- and, cases that concluded at the Case Examiner stage, and therefore did not progress to a full hearing.

As the project focused on seriousness, we weighted the sample towards the first two categories, with the third 'no impairment' category intended to provide a counterpoint of less or not serious outcomes for comparison. Table 2 gives the number of cases included in each category.

Table 2: NMC and GDC case determination sampling strategy

Outcome category	**GDC sample size**	**NMC sample size**
FtP impaired: removed from practice	27	60
FtP impaired: continue to practise	27	60
FtP not impaired	18	40
Closed at Case Examiner stage	20	20

A systematic random sampling approach was used to select cases, working backwards from December 2019 to draw every *n*th case meeting the sampling criteria until the agreed sample sizes were achieved. Case documents were then shared with the research team by the regulators. The GDC shared panel determinations and Case Examiner decision documents. The NMC shared these documents plus additional material from the Case Examiner stage, including investigation reports and decision letters sent to registrants.

2.3.3.2. Associate Research Partners and other regulatory bodies

We also sampled FtP case determinations published by the other UK health professions regulators. These samples were predominantly drawn from information put online by regulators, where case determinations are published for transparency. Prior to sampling, we reviewed the number of FtP cases that each regulator brings to the panel stage each year. These numbers vary considerably in line with the differing sizes of regulators' registrant bodies. For those organisations with larger caseloads, such as the GMC and the Health and Care Professions Council (HCPC), we sampled at least 50 cases. Where there were fewer than 50 cases available online, we sampled all that were available. Sampling again focused only on misconduct cases, and excluded review cases. Some regulators only put case determinations online for 12 months, and in some instances this limited the number of cases available for analysis. Where sampling from a large body of cases, we worked backwards from December 2019, sampling consecutive cases meeting our criteria. Where cases were available over a longer period, we only sampled those from January 2017 to December 2019. We liaised with ARPs to access additional, previously published, determinations where possible or to confirm that those available online were the only cases available. Table 3 shows the number of cases sampled for each regulator.

Table 3: Other regulators case determination sampling strategy

Regulator	**Number of cases analysed**
General Chiropractic Council	7
General Optical Council	50
General Osteopathic Council	42
General Pharmaceutical Council	17
Health and Care Professions Council/HCPTS	50
Medical Practitioners Tribunal Service	55
Pharmaceutical Society of Northern Ireland	3

2.3.4. Interviews

We completed 21 interviews with people working in FtP related roles, including FtP panel chairs and panel members, Case Examiners, regulatory staff in FtP leadership roles, regulatory lawyers, and legal assessors for FtP panels. We used a purposive sampling approach to select participants with knowledge and experience of FtP work, especially those with expertise relating to FtP decision-making, focusing our recruitment on those involved in the later stages of FtP procedures.

Table 4 describes, in broad terms, the roles of the participants, and shows the spread of organisations they work across. To protect participant anonymity, we have assigned numbers to each of the UK health professions regulators in a non-alphabetical sequence. Where the participant also worked in roles related to regulation or comparable disciplinary processes but not with a health regulator, this is noted as 'other'. Of the 21 participants recruited, 10 were female and 11 male. Their experience in regulatory work ranged from six months to several decades, and they were from a mix of clinical and lay backgrounds. Of those holding lay decision-maker roles, several had prior experience of working in policing, criminal law, or other relevant disciplinary fields.

Table 4: Interview participants' roles and spread across organisations

Participant ID	Role	Organisation(s)
P001	Case Examiner (lay)	1
P002	Case Examiner (clinical)	1
P003	In-house legal team	2
P004	Panel member (clinical)	1
P005	Case Examiner (lay)	2
P006	FtP Lead	1
P007	Case Examiner (clinical)	2
P008	Panel chair & member (lay)	1, 2, + other
P009	FtP Lead	3
P010	Chair/lay panel member (lay)	2, 6, 8, + others
P011	FtP Lead	2
P012	Panel chair & member (lay)	2, 5, 7 + others
P013	Panel chair & member (lay)	1, 4, 5, 7 + others
P014	Panel chair & member (lay)	4
P015	Panel member (clinical)	4
P016	Panel member (clinical)	4
P017	Panel Chair (clinical)	2
P018	In-house legal team	4
P019	FtP expert	Other
P020	FtP Lead	5
P021	Legal Assessor	2, 3, 5, 7 + other

Potential participants were identified either through discussion with regulators to nominate individuals in key roles or through the circulation of a call for participants, which was

distributed by a number of regulatory bodies to their staff and FtP panel-related associates on behalf of the research team. All potential participants were given an information sheet describing the study, and all provided informed written consent prior to being interviewed. Interviews were semi-structured, using a topic guide developed from our research questions to focus on concepts of particular interest (see appendix A). Interviews were conducted remotely, by video call, and were digitally recorded for transcription. Participants were offered the opportunity to review the transcript prior to analysis.

Interviews were conducted between February and June 2021, and took place during the Covid-19 pandemic. The pandemic did not impact on data collection, as the intention had always been primarily to undertake interviews remotely.

2.3.5. PSA case review notes and related court decisions

We used the PSA's website to access notes from case review meetings held to discuss FtP cases the outcomes of which the PSA decides to look at in detail. We identified 95 available sets of notes from this search, from January 2017 to December 2019. The PSA is able to refer FtP panel decisions to the High Court under its Section 29 powers, and we found 12 decisions between January 2017 and December 2020 that had been referred to Court under this process. We extended the sampling frame to include 2020 decisions in this instance as there is some time lag involved in this process and court decisions reached in 2020 were likely to relate to FtP cases from previous years. Due to the overlap in the sampling timeframes, some but not all of the High Court decisions included arose from PSA meetings included in the sample. Some of the earlier High Court decisions included had been referred by the PSA prior to January 2017. Table 5 shows the spread of these cases across the regulators, though it should be noted that in several of the cases the regulators either did not contest the appeals or actively supported the PSA's appeal case.

Table 5: PSA review meeting and associated court decisions samples

Regulator	Cases reviewed in PSA Case Meetings 2017-2019	High Court decisions available 2017-2020
GCC	2	0
GDC	4	1
GMC	14	3
GOC	1	0
GOsC	3	0
GPhC	1	0
HCPC	19	3
NMC	51	5
PSNI	0	0
Total	**95**	**12**

2.4. Data analysis

We used a framework analysis approach to provide an underlying structure to the project, linking the analysis of different data types together, and enabling the layering and integration of findings arising from those data. Framework analysis is a structured form of thematic analysis developed originally for the analysis of primary qualitative data, e.g. from interviews or focus groups,[22] and adapted for use with other data, notably the review and synthesis of qualitative materials,[23, 24] and has been used in applied health policy research.[25] This approach involves the development of a coding framework that is then used to code and categorise data, with the framework able to be amended or extended as the analysis progresses.

During the initial phase of the project, we developed a preliminary coding framework based on the project research questions, and on known issues and factors relevant to seriousness in FtP drawn from the literature, including our earlier review[1] and recent material identified for this study.

Documentary data collected during the project and interview transcriptions were uploaded into Nvivo12, a computer-aided qualitative data analysis software package, for analysis. Initially we coded legislation and policy documents, with the coding framework being revised and extended as necessary. In the next phase of work, the framework was used to code the samples case determinations and other case documents, and also the interview transcripts. Three members of the research team (ER, TP, and MB) carried out the coding and revisions to the framework were agreed through discussion between the team. The coding framework is included as appendix B. The final stage of the analysis involved looking across the coded data to consider patterns, concepts, and themes.

2.5. Ethical approval

Ethical approval for this research was granted by the University of Plymouth Faculty of Health Research Ethics and Integrity Committee (ref: 19/20 – 1269).

3. Findings: Literature review

Here, we present a short summary of the main features of recent literature reviewed in WP1 that have particular relevance to our emerging findings from the analysis of case documents and interview data. This information from the literature provides context to those further findings presented later in this report.

3.1. Aggravating and mitigating factors

Several papers focused on the aggravating and mitigating factors that influence FtP decisions. [1] Factors include a registrant's honesty or dishonesty, risk or any actual harm to patients, whether the misconduct was a single incident or part of a pattern of behaviour, and the response of the registrant such as any insight or remorse demonstrated.[1]

Other factors considered include contextual issues such as the registrant's personal difficulties or problems with health, as well as the broader social and organisational context in which the misconduct occurred. The Bawa-Garba case was cited as being instrumental in informing decisions over the extent to which organisational issues should be considered.[26] Organisational context, including bullying, pressurised working environments, and a lack of adequate supervision may impact on a registrant's conduct and performance in a variety of ways.[27] Sexualised workplace cultures have also been recognised as a potential factor in some cases of sexual misconduct.[28]

Gallagher and Dhokia have examined the extent to which panels consider aggravating and mitigating factors during FtP hearings.[29] They note three cases of appeal from 2008 which changed the way in which FtP panels were required to examine cases and determine the degree of impairment and suitable sanctions. The first case - that of Cohen v. GMC [2008] - found in favour of the registrant. Cohen argued that the FtP panel should have focused on his current and future fitness to practise, and not disciplined past misconduct through sanction. If mitigating factors had been taken into consideration, current and future fitness to practise would not have been found to be impaired. Two other appeal cases (Zymunt v. GMC [2008] and Azzam v. GMC [2008]) affirmed the principle that FtP panels must consider aggravating and mitigating circumstances, including any remedial action undertaken since the event in question, in their consideration of impairment, judgements on seriousness, and the imposition of sanctions. [29]

3.2. Registrant response to FtP involvement

The extent to which a registrant engages with the regulatory process, from initial complaint to the final hearing, has been recognised as vitally important to the severity of outcomes.[30, 31] Leigh et al examined a sample of FtP hearings from the HCPC and noted that, of all the registrants who were erased, none had attended their final hearing.[30] Not attending the hearing meant that registrants were not able to defend themselves against concerns raised and panels were more dependent on the statements of witnesses.[30] The registrant's credibility and reliability as a witness, demonstration of insight, remorse and regret, and any remediation which has taken place are also important aggravating and mitigating factors.[30] Caballero and Brown have statistically analysed MPTS and GMC data and found that engagement variables had the strongest associations with severity of outcomes. Doctors who did not have legal representation or did not attend final hearings were more likely to receive serious sanctions.[31]

Insight was considered to be an important factor as it was understood as an indication of how the registrant was likely to behave in the future. Remediation was thought to be a good indicator of this too, though it was noted that acts of remediation could occur without insight highlighting the importance of assessing remediation in the context of the professional's insight.[32]

Kirkham et al have analysed social worker regulation and argue that, within FtP proceedings, 'the search for truth is deprioritised in favour of obtaining acknowledgment of error on the part of the registrant.' [33] The authors argue that the focus on engagement and attendance may disadvantage some registrants who are unable to attend for reasons such as the cost of transport and accommodation, loss of wages, and caring responsibility.[33]

3.3. Consistency or variability between regulators

Very little research exists examining consistency or variability between regulators, focusing instead on the regulation of single professions or a single regulatory body. One piece of research comparing doctors and nurses found that nurses more frequently received a sanction of erasure than doctors, and that doctors received less severe sanctions, although the reasons for this were not clear.[28] The case of Bawa-Garba is also illuminating regarding the potential for different outcomes despite similar types of misconduct between professions. The Bawa-Garba case[1] involved a doctor (Bawa-Garba) and a nurse (Amaro)

[1] Bawa-Garba's case was heard by the Medical Practitioner's Tribunal Service and she was initially suspended from the register for 12 months. The decision was revoked by the Divisional Court on appeal from the GMC and Bawa-Garba was erased from the medical register.

An appeal by Bawa-Garba to the Court of Appeal found that the MPTS was best placed to determine what public confidence demanded in relation to the medical profession and restored the judgment of suspension

appearing before their respective regulators following the death of a child they were responsible for caring for. Whilst the nurse was erased from the register, the doctor was suspended and so eventually allowed to return to practice.

One key point in the decision-making process of both panels was in reference to public confidence which was determined in relation to three factors: deliberateness and recklessness, the fully informed member of the public, and the wastefulness of ending a career in order to satisfy a need for punishment. The MPTS judged that a sanction of suspension would not undermine public confidence in the profession because Bawa-Garba had not been reckless in her care of the patient, a 'fully-informed' member of the public would consider suspension rather than erasure proportionate, and Bawa-Garba was an otherwise highly competent doctor with an unblemished record. The focus here is on the 'fully informed' member of public, which suggests an appreciation of the nuance of medical care and systemic challenges. In its Indicative Sanctions guidance then in place, the NMC Conduct and Competence Committee is not directed to consider recklessness if negligence has already been established. That guidance was updated in August 2018.[34]

Hodson points to differences in legal representation to make sense of the different examinations and conclusions of each case. Bawa-Garba had legal representation, largely funded by crowd-funding from the medical community, but Amaro did not. Bawa-Garba's legal team used relevant case law in her defence, including Giele v GMC [2006] and Bijl v GMC [2001]. These cases were used to argue that public confidence refers to a "fully informed and reasonable member of the public", and that concerns for public confidence should not be carried to the extent of "feeling it necessary to sacrifice the career of an otherwise competent and useful doctor" purely to satisfy public demand for blame and punishment. In addition to this legal support, Hodson points out that from medical school onwards, doctors have a culture of belonging to a defence organisation, unlike nurses. [35] Other research has also noted the relationship between legal representation and FtP outcomes.[31]

Several papers have examined the implications of the Bawa-Garba case for future professional regulation.[35-37] A number of factors regarding possible differences were identified, including that the MPTS panel was considered to have diverged from the judgement of the criminal court by imposing suspension as a proportionate sanction, while the NMC panel was influenced by the comments of the sentencing judge. Whilst this case is

placed on Bawa-Garba's medical registration. The then Secretary of State for Health Jeremy Hunt commissioned a rapid policy review in relation to gross negligence manslaughter as it related to healthcare professionals. The Williams Report confirmed that there are no plans to introduce automatic erasure for gross negligent manslaughter (Hodson 2019:6).

not generalizable, it does highlight the issue of variability between regulators and the factors which may lead to that variation.

4. Findings: Comparing FtP Procedures

While all nine UK health professions regulators operate FtP procedures, sharing many key features, these processes also differ between organisations, largely as a consequence of differences in the legislation that governs the operation of each individual regulator. This section compares the procedures of the regulators based on information from guidance documents and on regulator websites.

For the purposes of clarity, any outcome by a regulator that results in the registrant being able to continue to practise without restrictions, but where a censure for their conduct is recorded on the register for a period of time, is referred to here as a "recorded censure". This term covers warnings, cautions, admonishments and reprimands as they are variously described by the regulators.

In order to compare the FtP procedures of the different regulators, it is useful to split the process between the investigation stage and the adjudication stage. This distinction exists in all regulators, which is to say that there is a discernible point at which a process of investigating a FtP complaint can be transferred to a process by which a committee or tribunal comes to a finding based on the facts of the case, and decides upon a relevant sanction. However, it is also important to note that the distinction between the stages is not absolute, as there are various judgements made in the investigation stage, and considerations of seriousness feed into these judgements.

4.1. Investigation stage

There is a high degree of similarity and continuity between regulators in the way they process cases at the investigation stage of fitness to practise procedures. Although the terminology changes between regulators, there is an initial triage or assessment phase of the process that determines whether the nature of the complaint falls within the remits of the regulator and therefore requires their further involvement. If this is the case, then there is an evidence gathering stage at the end of which investigators – either by committee or case examiners – make a decision on the final stage of the investigation process. For all regulators this final stage of investigation involves a judgement on whether there is a case to answer through a fitness to practise panel, and this decision is based on the realistic prospect test, i.e. is there a realistic prospect of the alleged facts being proved, and those facts leading to a finding of misconduct? Such a decision is based on two important aspects: whether there is a relevant body of evidence to support the complaint; and whether the complaint concerns an action serious enough to warrant action.

However, there is also some divergence between regulators at this stage of the process. For some regulators, there is only one of two decisions that can be made at the end of the investigation stage: either the case proceeds to a fitness to practise committee / tribunal, or it does not and the case is closed with no action (HCPC, GOsC, GCC).[38-40] However, for most regulators there are other decisions that can be made depending on the relative seriousness of the case. Even if a case does not pass the realistic prospect test at the end of the investigation stage, some regulators can still choose to issue a recorded censure to the registrant (GPhC, GDC, GOC, GMC, NMC)[41-51]. Such a decision is based on a judgement of whether it is in the public interest to proceed with such a case, and this is turn implies a judgement on the seriousness of the complaint. Precedent in case law has determined that judgements on seriousness in fitness to practise cases should consider whether the issue is remediable, whether it has been remediated, and whether a practitioner has shown insight (Cohen v GMC [2008] EWCH 581). For the majority of regulators, these factors influence whether it is deemed in the public interest to proceed and refer the case to a fitness to practise committee or tribunal, or whether a recorded censure will be sufficient to close the case at this stage (GPhC, GDC, GOC, GMC, NMC).[41-45, 50, 52-56]

Some regulators can also agree undertakings with a practitioner at this stage, or agree to other measures for consensual disposal (GPhC, GDC, GOC, GMC, NMC).[43-45, 48-50, 56] This situation arises where the practitioner does not contest the facts of the case, and a consensus decision on any remedial action can be agreed with the registrant to avoid the case going further. This is only considered in cases deemed less serious.

Even if case examiners or an investigating committee find that there is no realistic prospect of a future finding of impaired fitness to practise (or in the case of the GOsC or GCC, unacceptable professional conduct), some regulators may issue advice to the registrant if they feel there has been a departure from professional standards not serious enough to take the case any further (GPhC, GDC, NMC, GOsC, GCC).[41-43, 49-51, 53, 57, 58]

All regulators can impose an interim order (suspension or conditions of practice) and this can be instigated at any stage of the process, investigation or adjudication. This decision is based on an assessment of the risk to public and patients if the facts of the case were to be proved, rather than the seriousness of the alleged acts or omissions, i.e. a case could be deemed potentially serious, but may not require an interim order if there is no apparent risk to patients or public from continued practice.[40, 59-65]

4.2. Adjudication

There are some key differences between regulators at the adjudication stage of the fitness to practise process. The most notable difference is whether or not there is a decision on impairment as part of the process. For all regulators apart from the GCC and GOsC, if the facts of the case on misconduct are established, there is then a subsequent decision over whether a practitioner is currently impaired. For the GCC and GOsC, there is a single decision on whether the facts of the case determine unacceptable professional misconduct, which, as established in case law, has the same threshold as a finding of misconduct in other regulators (Spencer v General Osteopathic Council [2012 EWHC 2147]). It is also notable that neither the GCC nor the GOsC can give any sanction at the investigation stage, i.e. they cannot agree undertakings or issue an admonishment/warning/caution at any stage before unacceptable professional misconduct is found, and the same case law (Spencer v GOsC) is cited as preventing any such actions at the investigation stage.[40, 65]

The GCC and the GOsC are the only regulators that do not make a decision on impairment,[40, 65] but to what extent does this substantially differentiate their processes from the other regulators? The extent of this difference is largely determined by whether or not, for those regulators that do make a decision on impairment, they are able to issue a sanction in situations where misconduct is found on the facts of the case, but impairment is not. In this situation the GOC, GMC, Pharmaceutical Society of Northern Ireland (PSNI) and GPhC can issue a recorded censure in cases that are serious enough to constitute misconduct, but at the lower end of the spectrum of seriousness so as to determine that the practitioner is not currently impaired.[47, 65-68] Mitigating factors, such as insight and steps towards remediation, may come into play in such a decision. However, other regulators (HCPC, GDC, NMC) cannot issue any sanction at the adjudication stage unless impairment is found.[49, 69-71] The HCPC and the NMC can, however, issue sanctions specifically designated for cases of “minor impairment”. For the NMC this is a caution order, and the HCPC can refer a registrant for remediation.[49, 69, 71, 72]

In the case of the HCPC which like the GCC and GOsC cannot issue a recorded censure at the investigation stage, the adjudication process bears similarity with the GCC and GOsC, despite the fact that it seeks to determine misconduct and impairment separately, whereas the GCC and GOsC do not. However, the NMC can issue warnings and undertakings at the end of the investigation stage, whereas (see above), the GCC, GOsC and the HCPC cannot.

The GDC and NMC processes are notable in this respect because they can issue recorded censures at the end of an investigation stage, but cannot issue a recorded censure at the adjudication stage unless impairment is found. This leaves open the possibility, at least

procedurally, that a registrant involved in a less serious case may receive a recorded censure if it is closed at the investigation stage, but a more serious case may end up with no action taken, if it is referred to the adjudication stage, and then misconduct is found based on the facts, but the registrant is subsequently not found to be currently impaired. The likelihood of such a scenario would depend on the circumstances in which either of these regulators would find misconduct but *not* impairment at the adjudication stage of the process.

In summary, there are differences in the fitness to practise processes between the regulators in relation to the decisions taken around the seriousness of a registrant's acts or omissions. These differences revolve around whether: they can issue recorded censures or undertakings / consensual disposal at the end of the investigation stage; whether they find impairment separately from misconduct; and whether they can issue a recorded censure if misconduct is found, but impairment is not. This has informed the typology as indicated below, with five models of regulatory decision making (See Figures 1-5). Broadly speaking, these are ordered in terms of the number of points within the decision making process in which decisions on the seriousness of registrants' acts or omissions can result in a different outcome. This is important, because the greater the number of points in which judgements about seriousness can lead to different outcomes, then in theory the greater the range of options available to regulators to differentiate between the seriousness of a case.

Table 6: Summary of key features of regulators' FtP procedures

	Investigation stage		Adjudication stage		
Procedure / Regulator	Can issue recorded censure at investigation stage	Can issue undertakings / consensual disposal at investigation stage	Finds impairment at adjudication stage	Can issue recorded censure if misconduct found but not impairment	Model
General Optical Council	✓	✓	✓	✓	1
General Medical Council	✓	✓	✓	✓	1
General Pharmaceutical Council	✓	✓	✓	✓	1
General Dental Council	✓	✓	✓	✗	2
Nursing and Midwifery Council	✓	✓	✓	✗	2
Pharmaceutical Society of Northern Ireland	✗	✗	✓	✓	3
Health and Care Professions Council	✗	✗	✓	✗	4
General Chiropractic Council	✗	✗	✗	N/A	5
General Osteopathic Council	✗	✗	✗	N/A	5

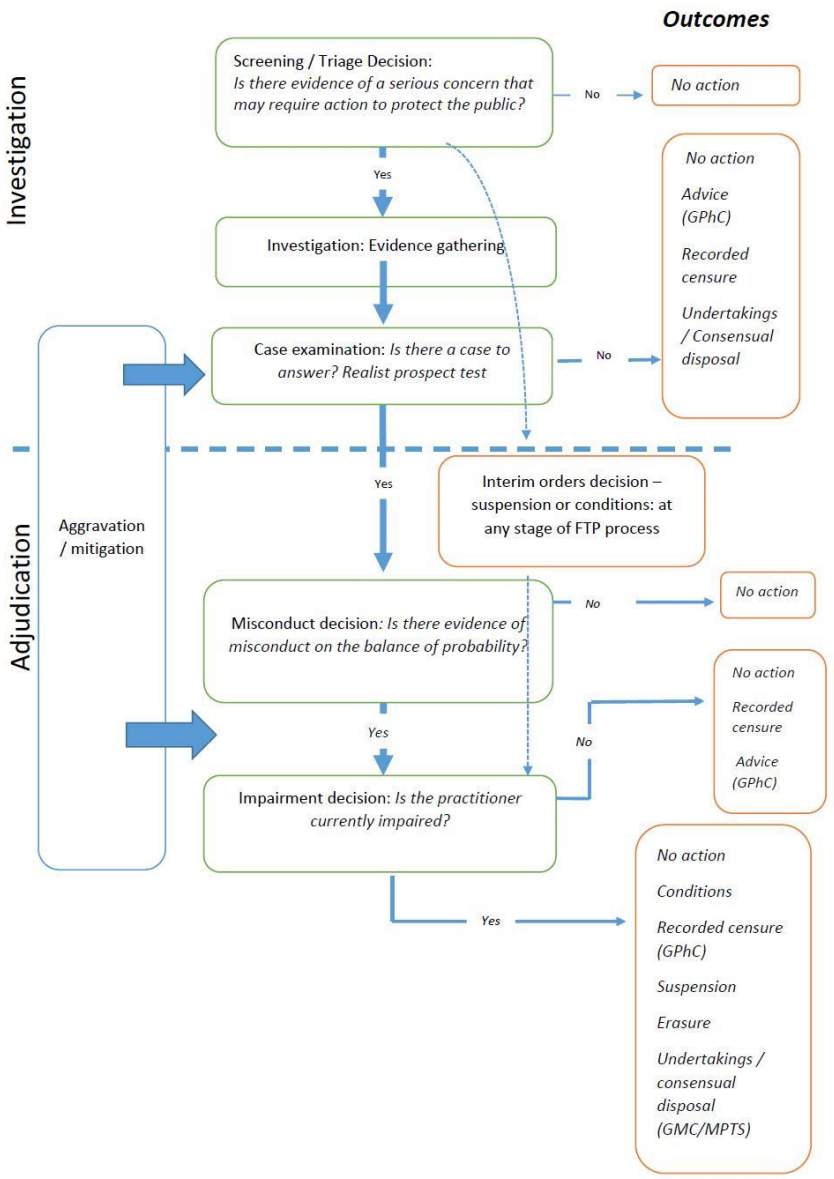

Figure 2: Model 1 - FtP process for the GOC, GMC, and GPhC

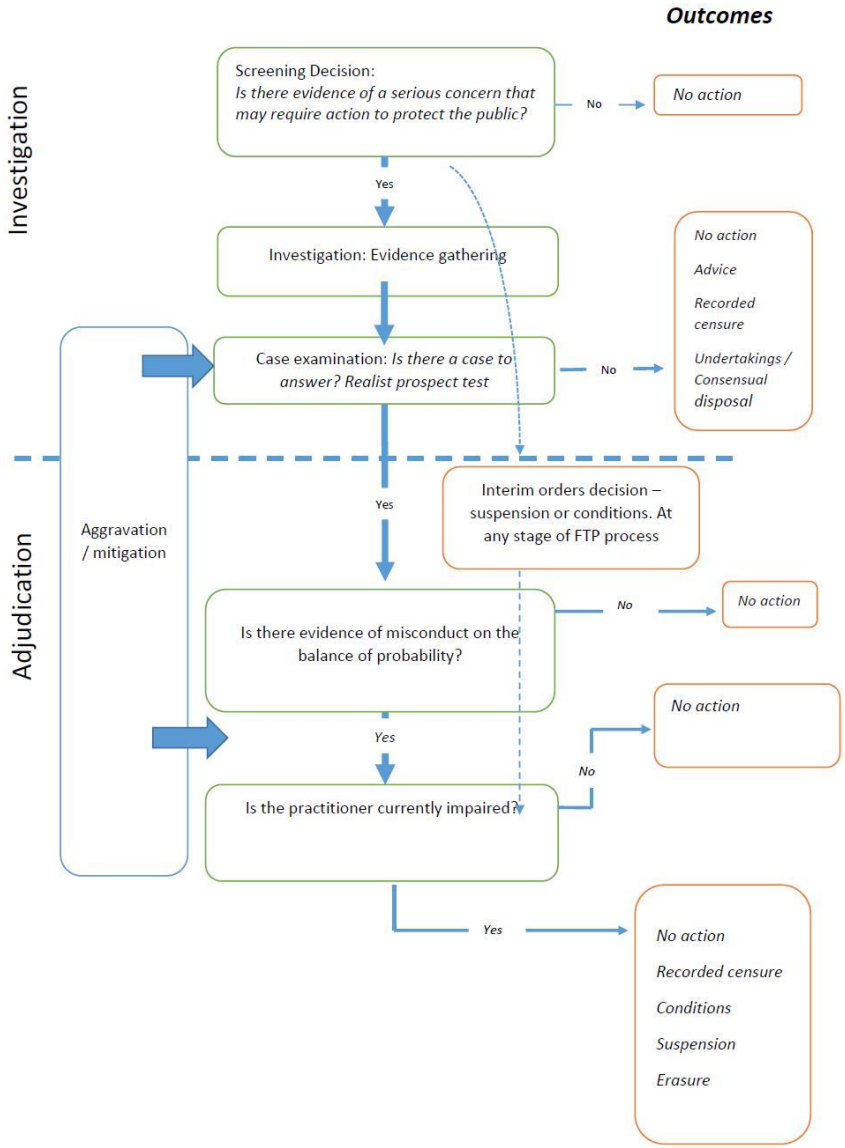

Figure 3: Model 2 - FtP process for the GDC and NMC

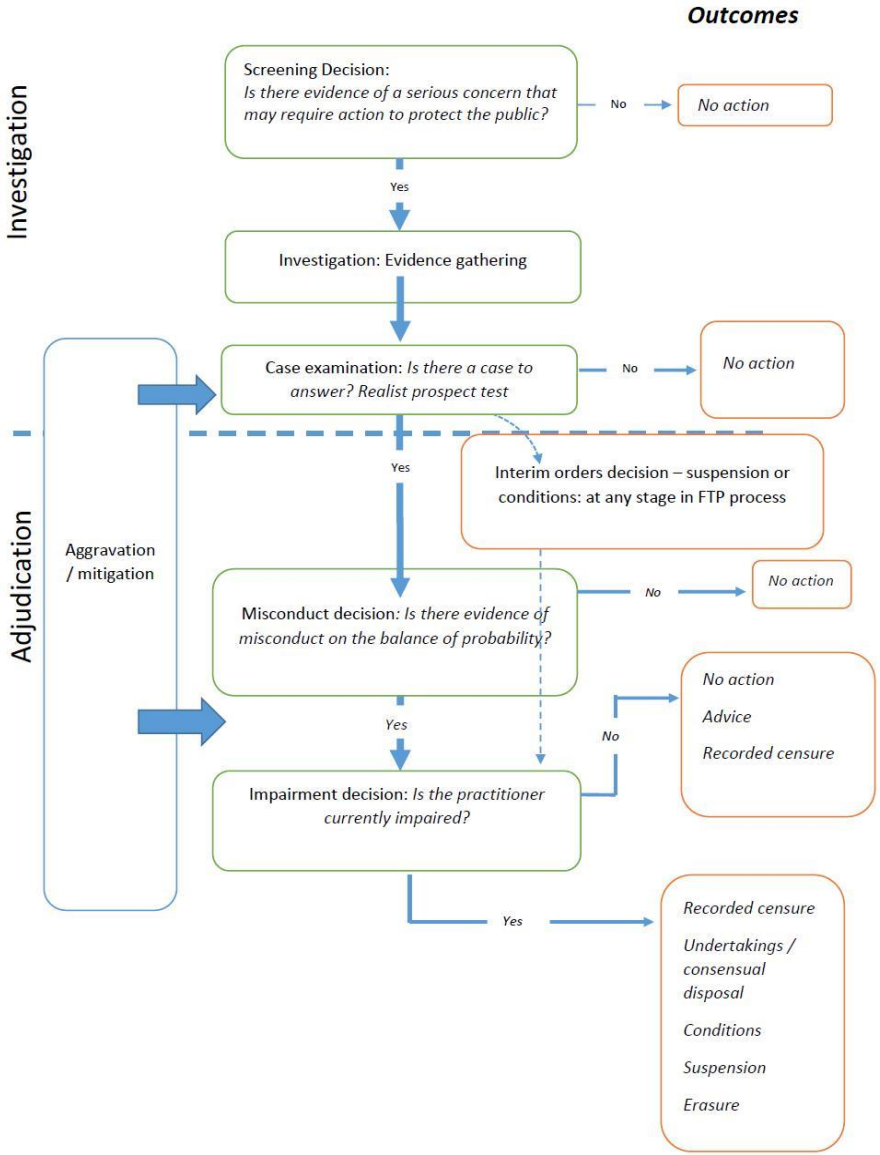

Figure 4: Model 3 - FtP process for the PSNI

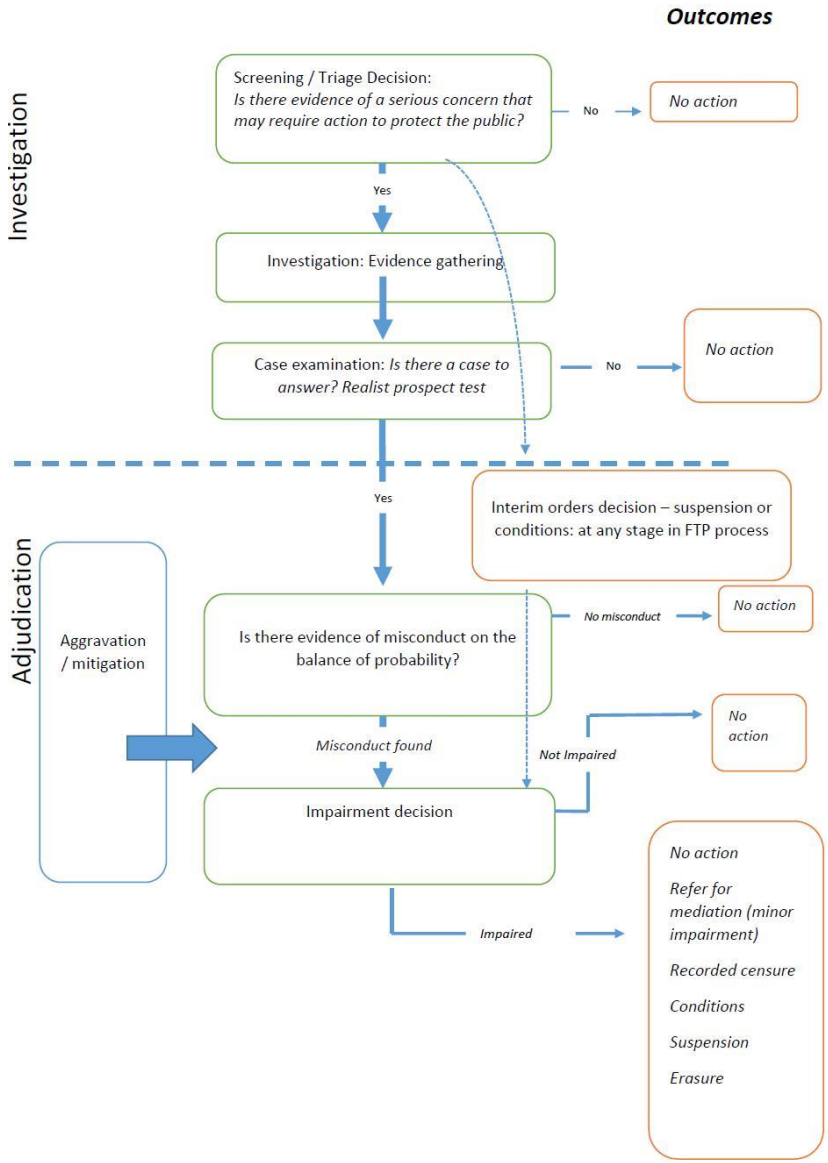

Figure 5: Model 4 - FtP process for the HCPC

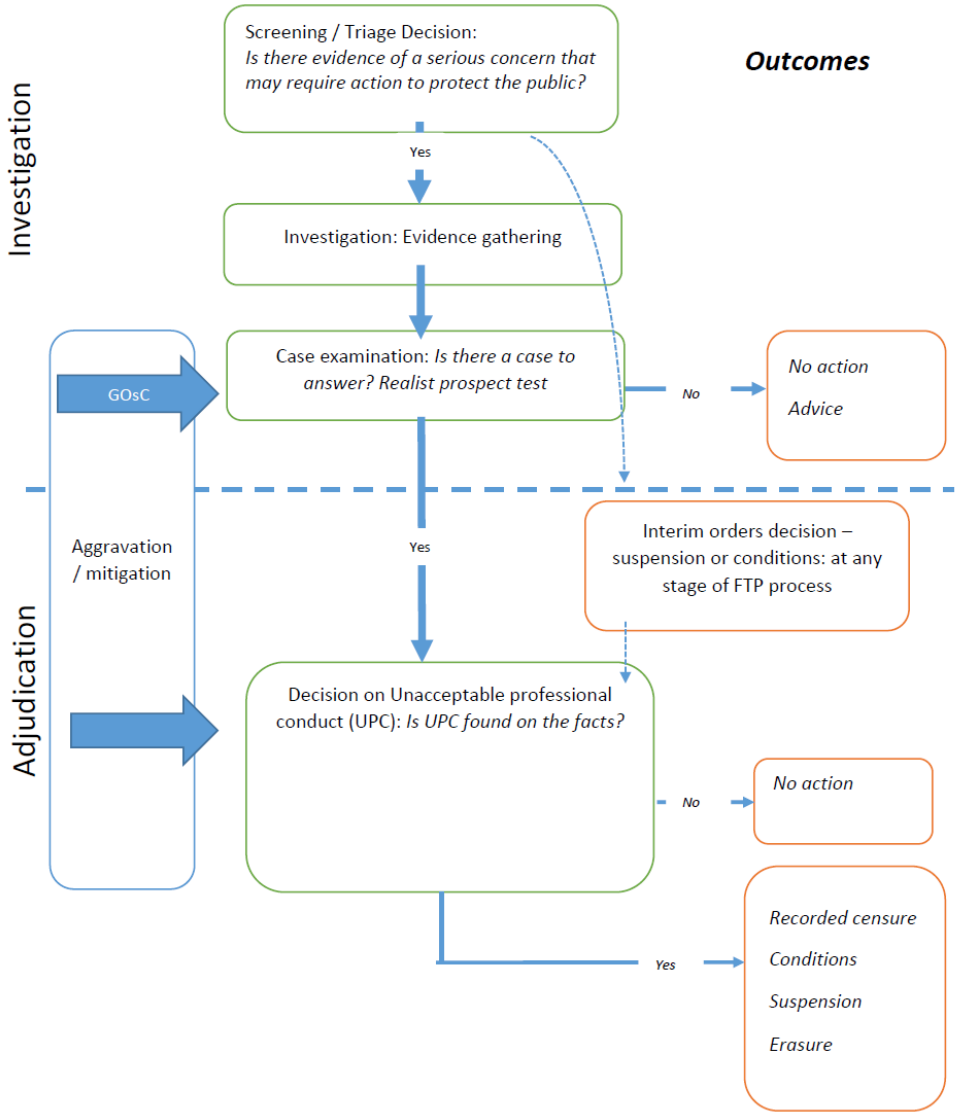

Figure 6: Model 5 - FtP process for the GCC and GOsC

5. Findings: combined analysis of documentary and interview data

Regulatory guidance documents, relevant case law decisions, FtP case determinations and data from interviews with FtP staff, panel members and regulatory lawyers were analysed using a common coding framework (see appendix B). In this section of the report, findings from across these sources of data are presented in combination.

Table 7 includes the total number of case determinations analysed, from the cases sampled at the panel hearing stage. The table also shows whether the registrant was present and/or represented at the final hearing, and whether misconduct was found or not. Some cases were excluded from the original samples drawn after initial review due to being incomplete or to falling outside our stated inclusion criteria. We excluded some review hearings, competency hearings, incomplete cases, or cases deemed to be private where large amounts of information was redacted from the determination. Of the NMC cases, 15 were excluded leaving a total of 140; GOC cases originally numbered 50 but 3 cases were excluded leaving a total of 47; 1 GPhC case was excluded due to replication leaving a total of 16; 1 PSNI case was excluded giving a total of 3; and 7 GOsC cases were excluded leaving a total of 35. In three cases, from the NMC and GOsC case determinations were incomplete but were included for analysis as there was enough information available to do so. This included 2 NMC cases which were missing impairment and sanction sections, and 1 GOsC case which was missing a sanction section.

Regulator	Case determinations analysed	Attendance	Representation	Misconduct	
				Found	Not found
GDC	70	48 (4 unknown)	40 (3 unknown)	63	7
NMC	140	84	69	118	22
GOC	47	29	31	43	4
HCPC	50	22	19	50	0
GPhC	16	10	7	16	0
MPTS	55	46	42	45	10
PSNI	3	1	2	3	0
GCC	7	5	6	7	0
GOsC	35	28	23	35	0

Table 7: Key features of cases included in analysis

Table 8 shows numbers of cases according to finding of impairment, including no impairment, impairment on the grounds of public protection only, impairment on the grounds of public interest only, and impairment on the grounds of both public protection and public interest, as well as relevant sanctions for each of these categories. This illustrates spread of sanction type against each type of impairment found in the cases analysed. It is important to note that these table are only presented to describe the sample of cases analysed for this research, and that we have not sought to produce any quantitative analysis of the features of these cases. The tables should not be used to make comparisons between regulators' caseloads as the sampling approach for this project was not designed to support such comparisons.

Table 8: Impairment categories and sanction outcomes by regulator

Regulator	Impairment and sanctions given for each category of impairment							
	No impairment	**Sanction**	**Public protection only**	**Sanction**	**Public interest (confidence and standards) only**	**Sanction**	**Public protection and public interest**	**Sanction**
GDC	10 No sanction section for this category	N W C S E	2	N W C 2 S E	9	N W 6 C 1 S 2 E	42	N W 4 C 13 S 15 E 10
NMC (2 cases incomplete and no impairment/ sanction recorded)	15 No sanction section for this category	N W C S E	0	N W C S E	32	N W 27 C S 4 E 1	69	N W 5 C 13 S 18 E 33
GOC	11	N 5 W 6 C S E	0	N W C S E	2	N W C S 2 E	30	N W C 4 S 12 E 14
HCPC	0	N W C S E	0	N W C S E	8	N W 7 C S 1 E	42	N W 4 C 5 S 7 E 26
GPhC	0	N W C S E	0	N W C S E	2	N W 1 C S 1 E.	14	N W C 2 S 7 E 5
MPTS	5	N 3 W 2 C S E	0	N C W S E	4	N 1 W C S 3 E	36	N W C 2 S 21 E 13
PSNI	0	N W C S E	0	N W C S E	0	N W C S E	3	N W C 1 S 1 E 1

Key: N = No Sanction, W = Warning or equivalent, C = Conditions, S = Suspension, E = Erasure

Table 9 contains numbers of each type of sanction across regulators, in cases where misconduct was found.

Regulator	Sanction				
	No sanction (where misconduct found)	**Warning or equivalent**	**Conditions**	**Suspension**	**Erasure**
GDC	10	10	16	17	10
NMC (2 cases incomplete and no sanction determined)	15	32	13	22	34
GOC	5	6	4	14	14
HCPC	0	11	5	8	26
GPhC	0	1	2	8	5
MPTS	4	2	2	24	13
PSNI	0	0	1	1	1
GCC	0	2	3	0	2
GOsC (1 case incomplete and no sanction determined)	0	14	1	10	9

Table 9: Sanction outcomes in analysed cases where misconduct found

5.1. Overview: determining and identifying misconduct and seriousness

Seriousness is used in two main ways in FtP processes. Firstly, it is used to define misconduct itself, and to distinguish misconduct from both deficient performance and the absence of misconduct. Secondly, it is used to place the misconduct on a spectrum of seriousness.

Defining the scope of misconduct is done in reference to case law decisions, which help panels to determine if misconduct has occurred within a case, and with reference to professional standards. Historically, in relation to medicine, the term 'infamous conduct in a professional respect' was used to mean 'serious misconduct judged according to the rules written or unwritten governing the profession' (*R v GCMER* [1930] 1 KB 562. This evolved into the term 'serious professional misconduct', which courts also left ill-defined. For example, Lord Mackay in *Doughty v General Dental Council* [1987] 3 All ER 843 referred to "conduct connected with his profession in which the dentist [or doctor] concerned has fallen short, by omission or commission, of the standards of conduct expected among [members of the profession] and that such falling short as is established should be serious."

The Medical Act 1983 (Amendment) Order 2002 (SI 2002/3135), which came into effect in November 2004, revised the term 'serious professional conduct' to simply 'misconduct'. Notably however, although the word 'serious' was removed from statute, subsequent case law has continued to use the term to characterise misconduct. For example, in *Meadow v General Medical Council* [2007] 2QB 462, the Court of Appeal (CA) found it 'inconceivable that misconduct…should signify a lower threshold of disciplinary intervention" (para 198) than serious professional misconduct. The case of *R (on the application of Remedy UK Ltd) v GMC* [2010] EWHC 1245 confirmed the need for a degree of seriousness to reach a definition of misconduct. Likewise, Roylance v GMC (1999) and Calhaem v GMC (2007), where both cases are frequently cited in regulatory guidance documents in relation to determining seriousness,[45, 65, 73-75] establishing that acts or omissions must feature a degree of seriousness to reach the threshold of misconduct.

Case law therefore determines that a finding of misconduct requires a degree of seriousness but does not clearly define seriousness in relation to misconduct beyond that. In law, therefore, the question of seriousness remains somewhat opaque, and decisions about what constitutes seriousness in terms of misconduct lie with regulatory panels. Interviewees highlighted the lack of precise definitions of seriousness, and several characterised the process of making decisions about seriousness as being instinctive, and a matter of judgement:

'*It's more art than science*…' (P003, In-house legal team, Org 2)

'*What it really boils down to is people's judgement, gut reaction, experience, we look at the whole thing in the round, looking at consequences and all those other things, but then you take a step back and look at what this person has done and you just say to yourself how bad was it. It's not really any more scientific than that*…' (P010, Lay Chair & FtP panel member, Orgs 2, 6, 8 & others)

Such comments point to an element of subjectivity in FtP decisions about seriousness, though these decisions are taken within the parameters set out by regulatory guidance documents.

It is in those regulatory guidance documents that the clearest directions about what types of conduct will be considered as serious in FtP procedures appear. Available online, these documents also provide information to registrants and the public about what regulators consider to be misconduct, although they vary in terms of accessibility. All the UK health professions regulators have guidance stating that they consider sexual misconduct to be serious.[38, 41, 43-45, 48, 49, 55, 57, 64-70, 76-81] Sexual misconduct is an umbrella term, encompassing rape, sexual assault, sexual abuse of children (including the creation or distribution of child abuse images), as well as other sexual misconduct with patients, relatives or colleagues, such as inappropriate relationships and boundary violations. Some regulatory guidance, such as documents from the GPhC and the GDC,[67, 70] clearly identifies sexual misconduct as undermining public trust or public confidence in a profession, positioning such behaviour as clearly counter to the regulators' objective to maintain public confidence in the health professions. The involvement of vulnerable people as victims in these cases or the presence of an abuse of trust are typically cited in these guidance documents as aggravating features in sexual misconduct cases, and there is also a presumption that these cases will be referred to an FtP panel, and that erasure is a likely outcome.

Cases involving dishonesty are another category of misconduct identified in regulatory guidance as likely to be considered serious. Guidance documents variously identify dishonesty as a failure to meet required professional standards, which set expectations for honesty, or as having the potential to undermine public trust in a profession.[48, 65, 68]

In addition, regulatory guidance also highlights cases involving criminal convictions as likely to be considered serious. Criminal convictions may encompass some cases of sexual misconduct or offences featuring dishonesty, such as burglary, robbery, theft, fraud, and forgery.[43] Other convictions highlighted in regulators' guidance documents as being

particularly serious include those arising from violent offences [43] or hate crimes. [43, 82] Convictions resulting in custodial sentences are marked as particularly serious.[83]

However, while some categories of conduct are described as being serious or likely to be considered as serious, there is a wide range of conduct that falls outside those specified categories but that may still be considered serious and fall within the scope of FtP procedures, resulting in a sanction. Indeed, even for those categories of conduct that are indicated as likely to be considered serious, there remain a range of potential sanction outcomes. Appendix C contains a table describing several cases featuring apparently similar cases of misconduct involving the falsification of documents, and therefore dishonesty, but shows how these cases were resolved with very different outcomes.

Decisions about what other acts or omissions by health professionals may be considered serious in relation to FtP, and about the outcomes in all FtP cases, involve decision-makers considering the individual circumstances of each case. Here, we come to the second main way in which seriousness as a concept is used in relation to misconduct. At various key decision points in the process – especially during FtP panel hearings when decisions are taken on whether acts or omissions constitute misconduct or unprofessional conduct, if a finding of impaired fitness to practise should be made, and any sanction outcome – a range of factors are considered, and the severity of the case decided according to its particular nature.

Essentially, through the process of considering the evidence available to them, decision-makers locate FtP cases on a spectrum of seriousness. The factors they consider as part of these decisions include: the nature of the acts or omissions constituting the misconduct; the extent or risk of harm presented by the misconduct; the registrant and their response to the situation; and any other aggravating or mitigating aspects of the case, including the wider context in which the acts or omissions occurred. Decisions about seriousness are especially concerned with questions of risk, and with ensuring that regulatory objectives are met. The next sections of this report explore in more depth how FtP decision-makers consider these factors to decide how serious a case is and how it should be resolved.

5.2. Harm and risk of harm

Protecting, promoting and maintaining the health, safety and well-being of the public is one of the objectives set for UK health professions regulators.[3] The extent of harm incurred as a result of a registrant's conduct, or the risk of harm presented by that behaviour, is therefore one of the key issues considered in FtP decision-making.

Where explicit thresholds are cited in regulatory guidance on FtP decision-making, harm is one of the factors that is mentioned as indicating seriousness. Such thresholds are seen, for

example, in guidance documents relating to referrals for full investigation or to FtP panels, in statements that conduct presenting 'an actual or potential risk to patient or public safety' should be referred. [38, 41] However, it is not always the case that harm is necessarily a marker of seriousness. For example, the NMC's guidance now draws a distinction between reckless or deliberate harm and harm that has arisen in other circumstances, and emphasises that it may not need to take regulatory action 'even where there has been serious harm' if there is no longer a risk to patient safety and the regulator is satisfied that the registrant involved has learned from the situation.[84]

At the FtP panel stage, analysis of case determinations shows that harm is considered at various stages of the proceedings. Firstly, the extent of harm caused, or the risk that harm could have been caused, is considered as part of an initial decision about whether a registrant's behaviour constitutes misconduct.

5.2.1. Harm and the provision of care

Misconduct occurring within a registrant's everyday clinical practice was identified from analysis of case determinations as the source of a range of types of harm to patients and service users. Examples of misconduct included the provision of inappropriate or unsafe care, failing to provide appropriate care, and failure to escalate treatment as necessary. Cases of inappropriate or unsafe care included incorrect prescriptions or the inappropriate management of a condition, and failure to store or dispense medications or therapies appropriately. Cases of failure to escalate included failure to request assistance or senior review when a patient deteriorates or when a safeguarding risk is identified. These cases illustrate how it is that misconduct can involve acts and/or omissions, such that a registrant's failure to do what is appropriate may be equally serious.

While these types of misconduct are broad enough to apply to all registrant groups included for analysis, with the exception perhaps of student registrants with the GOC, the precise form the misconduct took in such cases and the extent or risk of harm resulting from that misconduct varied greatly according to the different professions' responsibilities and activities. Cases in the sample analysed that involved the risk of or actual serious physical harm or death as a result of treatment featured doctors, nurses, pharmacists, paramedics, biomedical scientists, and operating department practitioners. Conversely, however serious the misconduct of physiotherapists, opticians, osteopaths, chiropractors, dieticians, hearing aid dispensers, radiographers, and practitioner psychologists, it did not cause serious physical harm or death in the sample of cases reviewed.

5.2.2. Types of harm

Within the cases determinations analysed, a number of distinct categories of harm were identified as having been taken into consideration by FtP panels, in addition to physical harm:

- Emotional distress
- Financial harm
- Abuse of trust

Within these broad categories, some cases analysed revealed nuanced ways in which these types of harm could be manifested.

In cases focused on issues arising from the provision of care, panels focus on whether or not physical harm has occurred, or was at risk of occurring, but also recognise emotional distress as harm. Examples of this in the cases analysed included: emotional distress caused to a mother whose child had died of meningitis who had been blamed by a doctor found to have missed symptoms (MPTS017); the distress and discomfort caused to nursing home residents neglected by a nurse found sleeping on duty (NMC045); and the emotional impact on patients and relatives resulting from inappropriate care provided by an oncologist (MPTS026).

Emotional distress was also identified in cases centring on dishonesty or behavioural concerns. For example, in a case where an osteopath communicated inappropriately with a patient, the patient was described as being uncomfortable, confused and upset, as well as vulnerable and intimidated (GOsC033). In the case of a nurse who spoke inappropriately to colleagues and nursing home residents, the NMC cited “potential for emotional harm in speaking to residents and Colleague A in an intimidating and abusive fashion” (NMC009).

Panels often consider the impact of misconduct on colleagues. Distress caused to colleagues by the misconduct was considered, for example in cases where a colleague was accused by the registrant of a theft they had committed (HCPC006), and where colleagues were collectively under suspicion for theft committed by a registrant (GOC045).

Financial harm is also identified by panels where it is relevant, including in cases involving theft from workplaces. Other examples in our sample included cases where pharmacies are unable to claim recompense for prescriptions (GPhC011), or the resources needed to carry out an investigation and audit following the falsification of test results by a biomedical scientist (HCPC034). In another case, the panel determination noted that the seriousness of the misconduct was increased by the financial ramifications for the NHS:

> "*This seriousness was increased by the context, that the items were medical equipment which was the property of the NHS, and the Registrant, suspecting that they may be stolen, attempted to sell them for personal financial gain. The items were of considerable value, £18,500 each. Members of the public were deprived of these items of life-saving medical equipment and there was also a potential cost to the public purse.*" (HCPC040)

Abuse of trust is an important part of determinations of seriousness, and panels will often recognise the diminution of trust in professionals as part of the impact of misconduct and as a form of harm resulting from it. This can result in patients' or relatives' trust being lost, or health professionals losing trust in a colleague as a result of their misconduct, which can impact on team work and patient care. Damage to trust could also include damage to an organisation's reputation with the public or its patients. Abuse of trust can have significant impacts on patients:

> "*The crossing of professional boundaries clearly undermined Relative B's trust and confidence in* [the registrant] *who had presented himself as a "friend" and supportive individual. Such conduct also undermined trust and confidence in the nursing profession more generally and, further, undermined the relationship with the District Nursing Service. As Patient A's main carer any further erosion in trust and confidence had the potential to impact upon the continuity of care to Patient A.*" (NMC051)

In cases involving breaches of confidentiality, such as the inappropriate accessing and sharing of patient records, much of the exploration of harm or the risk of harm focused on the abuse of trust involved. Again, the impact of such misconduct on trust in the health professions was highlighted:

> "*It noted that a Physiotherapist has privileged access to confidential and sensitive material regarding patients and any actions abusing that privilege have the potential to damage patients' trust in professionals."* (HCPC025)

These examples illustrate how panels draw clear links between misconduct cases and regulatory objectives, as the damage to trust is stated as having the potential to negatively impact on patients' and the public's confidence in the professions.

5.2.3. Sexual misconduct and harm

Panel determinations in cases of serious sexual misconduct often featured more extensive consideration of harm than other forms of misconduct, and victim impact statements were often included within the case determinations. Harms explored within sexual misconduct cases included physical harm, emotional and psychiatric harm to the victims and also damage to interpersonal relationships including with colleagues, and harm to trust, including the public's trust in professions and organisations. These cases provided insights into the nuances within broader categories of harm. This breadth and depth of exploration occurred across regulators in the most serious cases of sexual misconduct:

> *"S[ervice] U[ser] D said she had been left feeling shocked, violated, and that her "whole life had been broken", requiring her to undertake therapy. SUF had said that she could no longer visit a medical professional when unaccompanied. SUH had not returned for further physiotherapy due to her loss of confidence. SUC had described how her trust in medical professionals had been wholly undermined. SUJ had described feeling let down by the physiotherapy department..."* (HCPC032)

Again, the descriptions of harm resulting from sexual misconduct clearly link back to regulatory objectives, and particularly to the impact on patients' trust and confidence in health professionals.

The various different forms of harm identified by FtP panels within their determinations as contributing to the seriousness of these cases show that within FtP procedures harm is seen as complex and multi-faceted. Indeed, in one case this was illustrated by an NMC panel explicitly contradicting a description of 'no harm' recorded in NHS Datix forms used to log patient safety incidents, and assessing that in fact patients involved had experienced harm:

> "*In this regard, the panel was satisfied that despite the Datix forms recording that "no harm" was caused, any harm was neither long-lasting nor permanent. The harm experienced was very real to the patients at the time the incidents occurred*." (NMC038)

This demonstrates that FtP panels take a broad view of harm, looking beyond physical harm to encompass other impacts on patients, colleagues, organisations, and the public.

5.2.4. Harm and impairment

It is important to note that while the occurrence of harm, or the risk that it could have occurred, as part of the acts or omissions that a case centres on is an important element in an FtP panel's decision about whether those acts or omissions constitute misconduct, it is

not necessarily the case that evidence of serious harm or risk of harm within a case will lead to a finding of impaired fitness to practise and a sanction.

Decisions at the impairment stage, where the concept is used, focus on risk, and particularly the risk of future harm should the registrant be allowed to continue to practise unrestricted. This focus on risk, and on assessing the registrant's current fitness to practise, means that there can be cases where harm has occurred, even serious harm, but a finding of impairment will not be made:

> *"…the fact that somebody died does not mean this is automatically a serious case and is automatically impairment and sanction. There's a pressure to do that, which flies in the face of the intention behind FtP hearings, which is to protect the public and not to punish*." (P008, Lay Panel Chair & panel member, Orgs 1, 2 & other)

Participants suggested a finding of no impairment was more likely in clinical cases, where there was a greater prospect of the risk of future harm being mitigated through the demonstration of insight and through remediation. Conversely, in cases where a panel believes that a risk of harm remains then a finding of impairment, and a sanction deemed appropriate to mitigate that risk, would be made. This includes cases where the harm identified was a risk of damage to public confidence or trust in the profession, discussed below in section 5.7.

5.3. Registrant response

It is clear from analysis of case determinations and from interviews with FtP decision-makers that the response of a registrant to involvement in FtP proceedings can be a key factor in determining the seriousness of the case, and any sanction arising from it.

5.3.1. Registrant engagement

Interview participants identified registrants' engagement with regulatory processes as especially important in informing decisions about impairment. This was seen to be the case at the case examiner stage, where case examiners consider whether there is a realistic prospect that the registrant may be found to be impaired by a panel, and may have access to written submissions from the registrant:

> "*Then when considering current impairment obviously what's really critical for us is whether or not there's been a response from the registrant, insight, remorse, remediation etc., and again we don't decide yes your fitness to practise is impaired, just if there is a realistic possibility that it would be found impaired."* (P005, Lay Case Examiner, Org 2)

At the panel stage, registrants may appear in person, and again their engagement with the process was felt to be important to decision-makers. Panellists suggested, for example, that being able to question registrants presents an opportunity to corroborate their written evidence:

> "*But you're all left thinking well how deep is that, or is it something someone helped them write a week before, so the opportunity to ask the registrant questions and to try and explore that a bit more is hugely beneficial.*" (P013, Lay panel chair & panel member, Orgs 1, 4, 5, 7 & others)

The difference that can be made by an engaged registrant was emphasised by panellists, but there were also some who argued that negative inferences should not be drawn from an absent or disengaged registrant:

> "*Well I suppose human nature being what it is it does make a difference, but again all our professional practice is to be impartial, be fair […] to make sure that we're not unduly swayed by incorrect or misleading factors, some people are just charismatic personalities aren't they, or they've got the gift of the gab, so we have to cut through all of that and just look at the facts and what is presented in front of us. When I started in this role* […] *I had a Chair […] who quite strongly emphasised that if the applicant has not engaged that we should draw no adverse inference from that.*" (P014, Lay panel chair & panel member, Org 4)

The need not to draw adverse inferences from a registrant's absence was also noted in case determinations, which identified the gap that non-engagement creates in the evidence available to a panel:

> *"The Panel drew no adverse inference from the Registrant's absence, however his non-engagement did mean that he had placed no evidence before the Panel that was capable of contradicting or undermining the evidence relied upon by the HCPC."* (HCPC009)

Analysis of case determinations shows that the first discussions of engagement generally explore the attendance of the registrant and whether proceeding in their absence would be problematic, taking into consideration the efforts that have been made to contact the registrant. Panels are careful to establish that the registrant was appropriately informed, and to consider whether they may have requested an adjournment. Otherwise, hearings continue as it is considered in the public interest to do so, even though it is acknowledged that this may be to the detriment of the registrant:

> *"There is always some potential disadvantage to a registrant in proceeding in their absence, but this is a conscious choice and that potential disadvantage has to be weighed against the obvious public interest in getting on with this case and reaching a decision, so that is what we will do."* (GPhC008)

Decisions to proceed with hearings in registrants' absence are guided by case law. The cases most commonly cited by all regulators in this regard are R v Jones [2002] UKHL 5, GMC v Adeogba [2016] EWCA Civ 162, and Visvardis [2016] EWCA Civ 162. These cases and the guidance resulting from them generally focus on the need to balance the rights of the registrant with public safety and the wider public interest; there is a recognition of the impact that proceeding in the absence of the registrant may have on them and the need to proceed with 'care and caution.' One more recent case, Kuzmin v General Medical Council [2019] EWHC 2129*,* allows a panel to draw adverse inference from the non-attendance of a registrant, arguing that it is incumbent on regulated professionals to engage with their regulator. In the sample of cases analysed, this decision was only cited in one case (GPhC004) and introduced but rejected in another case (MPTS030), though it should be noted the decision dates from late in our sampling timeframe.

5.3.2. Registrant engagement and impairment

The impact made by registrant absence is evident in some case determinations, where the gap in evidence was cited as contributing to panels' decisions to find impairment:

> *The Committee noted that Ms X had not acknowledged her faults or shown insight into the seriousness of the deficiencies in her practice. She did not attend this hearing and the Committee could neither assess her level of insight nor any remediation she may have undertaken. The Committee concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. The Committee therefore determined that Ms X's fitness to practise is currently impaired.* (GDC001)

In these instances, without evidence from an engaged registrant demonstrating insight or remediation, the panels felt that a finding of current impairment was necessary in order for the regulatory objective to protect the safety of the public to be met.

Conversely, the presence of an engaged registrant can be important at the impairment stage, as evidence they present may allow them to demonstrate that they have effectively mitigated any risk that their misconduct may have presented. One interviewee explained that mitigating factors taken into consideration in FtP largely relate to the individual registrant:

> "*So the kind of aggravating factors tend to sit around the conduct, and the mitigating factors tend to sit around the person, not exclusively but they sort of balance themselves out in those ways*." (P003, In-house legal team, Org 2)

Impairment decisions focus on risk, and an engaged registrant can make a positive difference by seeking to show the panel that although they have committed misconduct in the past, they have sought to address the issues raised and no longer present a risk to the public:

> *"It also considered that, in addition to the steps you have taken to avoid a repetition of the same mistakes, you have demonstrated insight into the matters that have brought you before your regulatory body. You have attended this hearing, engaged fully with the process and you admitted at the outset your failings in relation to the prescription."* (GDC064)

However, it should also be noted that while engagement can make a difference to decisions in FtP panel hearings, that is not always the case, as in some cases a panel may determine that the misconduct was so serious that no mitigation would be possible:

> "*However, the Panel was satisfied that offences of this nature are particularly serious and that it would be difficult for any registrant to establish they were not impaired on the personal aspect of the test for impairment even if they did engage fully on the regulatory process.*" (HCPC005)

5.3.3. Engagement and sanction decisions

Analysis of case determinations also identified instances in which the registrant's engagement, or lack of engagement, was cited as a factor in the sanction decision. When making sanction decisions, panels consider the least restrictive sanction option first, starting with no sanction or warning, and then work up the 'sanction ladder' until they agree a sanction that they believe will mitigate any risk the registrant is considered to pose. The consideration of aggravating and mitigating factors is a key part of discussions around sanctions, and again the extent of the registrant's engagement, and whether they have demonstrated insight, remorse or remediation sufficiently to allay concerns can be important:

> "*How I approach it is I go through my aggravating and mitigating with my colleagues and we draw up our list and we look at that, and then we go back and quickly relook at what it is they've actually done and hold that up in the air and look at how bad it is. And the key concepts again are insight and risk of repetition leading directly from insight, if it's not dishonesty or sexual misconduct, which are automatically sort of*

shoved to the top, the sanction is based very, very much on the extent of people's insight." (P010, Lay panel chair & panel member, Orgs 2, 6, 8 & others)

Demonstrating insight, and that consequently the risk of repetition is reduced, through engagement can therefore influence the severity of the sanction outcome in a case.

The extract below shows how non-engagement can be a factor which influences sanction outcome:

> *The Committee then considered imposing conditions upon the Registrant's practice, but concluded that these matters are too serious for conditions to be the appropriate sanction. The Committee also determined that it would not be possible to formulate workable or practicable conditions that would adequately address the issues identified or uphold the public interest. There was also the difficulty of formulating appropriate workable or measurable conditions relevant to the Registrant's lack of meaningful insight, his absence from these proceedings, and his firmly stated intention not to engage with the regulatory body.* (GOsC003)

In this case, the registrant's non-engagement, and failure to demonstrate insight, contributed to the panel's decision that conditions would not be sufficient to mitigate the risk posed by the registrant or to uphold public interest.

As noted above, misconduct involving dishonesty is generally treated as serious by all regulators, though panels retain discretion over the ultimate outcome. The extract below shows how, in a dishonesty case, the possibility of suspension rather than erasure was dismissed by a panel, with the registrant's non-attendance at the hearing and non-engagement with their regulator cited as contributing to that sanction decision:

> *"The Panel's view was that if the Registrant had attended the hearing or engaged with the HCPC, the Panel might have been persuaded to give weight to the mitigating factors and give the Registrant an opportunity to demonstrate in the future that trust could safely be placed in him. Given the very limited engagement by the Registrant, the Panel considered that the mitigating factors carried little weight, when considered in the context of the seriousness of the Registrant's dishonesty."* (HCPTS003)

Analysis of case determinations therefore demonstrates how, across regulators, the degree of engagement with FtP proceedings shown by registrants, and perhaps especially, attendance at hearings can influence the outcome of those proceedings. Registrants' engagement and the evidence they provide informs panel decisions about risk of repetition, with a particular focus on insight, remorse and remediation, and is one element that can shape panels' views about the seriousness of the case.

5.3.4. Registrant engagement across professional groups

Table 7 shows how many of the registrants in our sample of case determinations attended their hearings and/or had legal representation. The levels in the sample vary between regulators, though it must be noted that the sample was drawn randomly and not intended to be representative. However, interview participants also noted that levels of attendance vary between professional groups, both between and within regulators in the case of those who regulate multiple groups such as the GDC and the HCPC.

Closely linked to the issue of registrant engagement, is whether registrants have legal representation at their FtP hearings. Interview participants reported that some groups of registrants are more likely to have legal representation than others. There are sometimes varying levels of representation between professional groups covered by the same regulator.

Doctors, dentists, and pharmacists, covered by professional indemnifiers, were reported as typically being represented when engaged with the FtP process. Other groups, such as nurses, dental care professionals, and pharmacy technicians were reported as having higher levels of self-representation. Participants also noted that some registrants are supported by representatives from professional bodies, for example the Royal College of Nursing, but that such representation may not be as high quality as legal representation from specialists. Some panel chairs reported that they make particular efforts to help guide unrepresented registrants through the hearing process:

> "*The question of representation or not, it usually is of enormous benefit but we get a very, very high number of unrepresented people, and we do bend over backwards to try and help them*." (P010, Lay panel chair & panel member, Orgs 2, 6, 8 & others)

Legal representation was seen as important by participants because legal advice could support and guide registrants through the FtP process, which is complex and legalistic. Legal advice was seen as important in aiding registrants to understand regulators' expectations, especially in terms of the need for registrants to demonstrate insight and perhaps to show evidence of remediation activities. Lack of legal representation was, therefore, seen to potentially have an impact in terms of the seriousness of the outcome for registrants who are perhaps unaware of how to present their case to best effect:

> "*I think registrants who don't have or can't have, unable to have, for many reasons legal representation are extremely disadvantaged, and it can make a difference certainly to our final decision*." (P004, Clinical panel member, Org 1)

> "*And that's where professions where the registrants have a lawyer to help them, if a process works so much better […] I'm sure you get a much better result or a quality of*

result, because things have been properly thrashed out." (P013, Lay panel chair & panel member, Orgs 1, 4, 5, 7 & others)

With legal representation therefore linked to outcome quality by those involved in FtP hearings and decision-making, through being seen to contribute to a rigorous and robust process in which evidence is appropriately presented and challenged, and with some professional groups seemingly having better access to legal representation than others, according to their economic status, there are questions over fairness and equity. While the decision to attend or not, and whether to obtain legal representation or not, rests with individual registrants, those individuals' decisions may be framed and shaped by wider issues. In the absence of legal advice, some registrants may not be aware that their engagement with the regulator and their attendance at a hearing can make a positive difference in their case. In addition, some interviewees suggested that levels of attendance may lower among registrants who qualified outside the UK, as they may not be as familiar with UK regulatory processes and expectations.

5.4. Attitudinal issues

Analysis of cases shows that assessment of attitudinal issues can have a huge impact on the determination of seriousness within a case decision. Predominantly, attitudinal issues are considered at the impairment decision stage, as the presence of such issues indicates a risk of repetition, and at the sanction decision stage, as panels are unlikely to find conditions an appropriate outcome if an attitudinal issue is present. A 'deep-seated attitudinal issue' being identified may also mean the difference between a suspension order and erasure as the outcome of a case.

5.4.1. Identifying attitudinal issues

The consideration of attitudinal issues varied between regulators, with some regulators in our case sample not referring to these issues at all, and others referring to them quite frequently. The approach taken, as recorded in the case determinations, also varied between panels, with some seeming to find an attitudinal issue quite easily and others setting out the process of decision-making in far greater detail. Some panels also refer to different types or grades of attitudinal issue, with a simple 'attitudinal issue' being less serious than a 'deep-seated' one, with the latter suggesting intractability. NMC panels in particular often make this distinction:

> *"Having heard submissions, the panel was satisfied that misconduct being "partly attitudinal in nature" is not necessarily indicative of a deep-seated attitudinal problem."* (NMC062)

> *"Whilst at the impairment stage the panel identified an attitudinal issue, it did not consider this to be deep seated or harmful."* (NMC104)

> *"The panel was in no doubt that there was evidence of a harmful attitudinal problem. There was, however, insufficient evidence to draw the conclusion that this was deep-seated."* (NMC006)

These extracts demonstrate that NMC panels are careful to delineate as precisely as possible the nature, and the risk implications, of any attitudinal problems they perceive, describing these in terms of their depth and harmfulness, in a clear assessment of seriousness.

Attitudinal issues, often identified in dishonesty cases, were frequently described by panels as being difficult to remediate:

> *"Dishonesty by its very nature is an attitudinal concern and is very difficult to remediate. Your lack of insight and remorse, and seeming lack of understanding of the significance of your behaviour, led the panel to conclude that there is a real risk of repetition."* (NMC026)

> *"The Tribunal acknowledges that dishonesty is always difficult to remediate, particularly if found to be attitudinal in nature."* (MPTS001)

As the latter extract indicates, it is not always the case that dishonesty is seen as an indicator of an underlying attitudinal issue – this is for the panel to determine. In another dishonesty case, although no evidence of an attitudinal issue was found, the registrant was not seen to have demonstrated sufficient insight into their behaviour, and the panel therefore remained concerned about the risk of repetition:

> *"The panel was of the view that there is no evidence that* [registrant] *has a deep-seated attitudinal problem; however there is very limited insight into the impact of her actions and the panel identified a significant risk of repetition of putting patients at risk of harm."* (NMC042)

This illustrates the multifaceted nature of decision-making in FtP cases, with the seriousness of a case being decided by weighing a number of elements, unique to each case.

A GOC panel, also considering a case featuring dishonest conduct, found that:

> *"Whilst, there were two distinct instances of dishonesty that indicated a behavioural pattern over a period of 4 months, there was no other evidence before the Committee of similar behaviour prior to these incidents or since. The Committee concluded that there was therefore no evidence of deep seated personality or attitudinal problems."* (GOC045)

This demonstrates again that although regulatory guidance highlights dishonesty as serious, panels operate their discretion to locate the particular acts of dishonesty on a spectrum of seriousness, depending on the characteristics of the individual case. The two cases cited above show that dishonest conduct in and of itself is not always seen as sufficient grounds to find that the registrant has an attitudinal issue.

These discussions in case determinations about what does not constitute an attitudinal issue also illuminate how panels weigh evidence to decide whether or not an attitudinal issue is present, and if so, whether there is risk of repetition. In the case from which the extract below is taken an NMC panel decided, based on testimonials from colleagues describing the registrant's positive approach and professionalism in their current role and on insight shown by the registrant, that their misconduct did not result from a deep-seated attitudinal problem:

> *"However, the panel had concluded that your conduct was not the manifestation of a harmful or deep-seated attitudinal problem. The testimonials provided to the panel present a picture of a caring and capable nurse who is dedicated to the nursing profession. The panel was satisfied that your insight is now sufficient."* (NMC039)

Attitudinal issues can be identified within the misconduct itself or within the registrant's response to local or regulatory investigations, including the final hearings:

> *"The panel concluded that whilst the charge itself relates to a single incident of misconduct the information before the panel indicates that* [the registrant] *only made admissions to the theft of the medication once faced with the CCTV evidence. Furthermore, the lack of engagement by* [the registrant]*, in the panel's view demonstrated an attitudinal problem."* (NMC004)

> *"You were particularly defensive when giving evidence and as set out above you relied on the evidence given by your expert witness in some instances. The Committee was often not able to rely on the truthfulness of your evidence. Your apparent lack of recognition of the risks that you continue to pose to patients and the*

wider public interest, and the harm that you have caused, including the effects of your dishonest conduct, is strongly suggestive of an ingrained professional attitudinal problem." (GDC020)

In these extracts, the way in which the registrants concerned had engaged with regulatory processes and the content of their evidence to the hearing, was seen as indicative of attitudinal issues. In particular, as a consequence of their attitudes towards the regulatory process, these registrants were considered to lack insight into their misconduct and its effects.

Where attitudinal issues have been featured within the misconduct itself, some of the following factors were identified as evidencing the attitudinal concern: repeated or prolonged dishonesty, awareness that certain behaviours are wrong but continuing the behaviour, persistent lack of insight, blaming others, and the registrant putting their needs ahead of the needs of patients:

> *"The panel noted that* [the registrant] *had left patients unattended or unsupervised on more than one occasion. The panel was concerned that* [the registrant] *had exhibited a pattern of behaviour which related to her putting her own interests, ahead of those of her patients. The panel considered that this represented a serious attitudinal problem rather than something that could easily be remediated or something that arose as a consequence of inadequacy in her knowledge and skills as a registered nurse."* (NMC049)

> *"In the Committee's view the Registrant has displayed no real insight into the seriousness of his misconduct and his persistent dishonesty provides evidence of harmful deep-seated attitudinal problems."* (GOC002)

In some cases, such as sexual misconduct, this determination is specific to the misconduct type:

> *"This case involves a fundamental abuse of power and violation of the rights of patients.* [The registrant's] *conduct demonstrates a deep-seated and harmful attitudinal problem, manifested by predatory behaviours involving sexual assaults on patients."* (NMC044)

5.4.2. Attitudinal issues and sanction decisions

Analysis of case determinations shows that attitudinal issues are an important consideration in sanction decisions, especially where a 'deep-seated' attitudinal issue is identified. Suspension or erasure are likely to be the outcome of cases where such an attitudinal issue

has been identified, and this is in line with the sanctions guidance given to panels in the case determinations analysed.

Our sample included 64 cases featuring 'attitudinal' or 'deep-seated attitudinal' issues, and of these 61 resulted in suspension or erasure. These cases were from seven regulators (the GCC, GDC, GOC, GOsC, HCPC, NMC, and MPTS). Of the three cases with other outcomes, one had a finding of no impairment and two resulted in conditions being imposed on the registrants' practice. None of those three cases were considered to feature 'deep-seated' attitudinal issues.

The extracts below show that attitudinal issues can be a key factor in leading panels to dismiss conditions of practice as an appropriate sanction option, as these are not considered to be sufficient to address such issues:

> *"So far as the factors identified in paragraph 106 of the Sanctions Policy are concerned, the Registrant lacks insight and there are persistent and general failings. Furthermore, the Panel has concluded that when the fundamental problem has a behavioural and attitudinal cause, there are no conditions of practice that could be imposed while allowing the Registrant to practise as an autonomous practitioner."* (HCPC018)

> *"Whilst the clinical failings in this case could possibly be appropriately addressed by way of conditions, the attitudinal deficiency relating to your serious and persistent dishonest conduct would not be capable of being adequately addressed with conditions."* (GDC020)

Attitudinal concerns can also be a factor in moving a panel from suspension to erasure:

> *"The Committee then considered whether a period of suspension would be appropriate. It took account of the factors at 34.1 of the ISG' It found there was a 'deep seated personality or attitudinal problem' and that there was no evidence of insight. It was satisfied that suspension of the Registrant's registration would not protect the public or satisfy the public interest."* (GOC028)

Again, it is the difficulty of effectively remediating attitudinal issues, and therefore the risk of repetition that registrants with such issues are seen to represent, that causes panels to see these issues as serious and to impose more restrictive sanctions.

5.5. Environmental context

In order to determine misconduct and its seriousness, environmental factors are considered by all regulators so as to place a registrant's conduct into a wider context. Analysis of case determinations shows that panels often note that conduct has fallen below professional standards, but it is the context of what occurred and the level of personal culpability assigned to the registrant that makes it serious and therefore misconduct.

A wide variety of contextual factors are examined by panels, but typically only in cases directly relating to registrants' professional practice. Consideration of these issues mainly arises in cases from regulators with registrants based in secondary care or similar large workplaces, such as the GMC and NMC. The professional role of the registrant is considered as it determines their autonomy, plus the impact of staffing, teamwork and support around them are also looked at where relevant. Other factors considered in the sample of cases analysed included organisational factors, such as poor senior leadership and a lack of clarity in local guidelines.

Key to judgements of seriousness is the extent to which panels consider environmental factors to be mitigation for misconduct, as part of determinations on whether the registrant's behaviour constitutes misconduct, and on impairment and sanction. While panels do, when relevant, recognise that environmental factors, such as short staffing, can lead to poor practice and impact patient care, they also focus on registrants' professional obligations.

Although outside the timeframe that the analysis here focuses on, during the interviews we noted that several participants with roles on FtP panels mentioned the Covid-19 pandemic while discussing how environmental factors are considered in FtP cases. The comments made were speculative but it was clear that panellists were anticipating that the circumstances of the pandemic may be relevant as contextual factors in future cases, because of its huge impact on the provision of health services and the demands placed on healthcare professionals.

5.5.1. Interpersonal relationships

In some cases analysed, difficulties in interpersonal relationships at work were recognised as causing problems within the work environment, and contributing to circumstances in which poor practice occurred:

> *"You told the panel that just prior to seeing Patient A for his appointment, you had overheard Dr 1 telling Dr 2 words to the effect of "I want to put my hands around the*

Practice Nurse's throat." You told the panel that you considered this "a threat" and it affected you. As a result, you were distracted at the time of seeing Patient A. […] You could not account for why you had done it other than you had been "under stress" and were distracted. The panel was of the view that, while giving evidence, your demeanour was calm and quiet, and that you answered questions in a considered yet open manner. This was is in stark contrast to that of Dr 1, who became more vociferous, argumentative and defensive under pressure." (NMC134)

In such cases, it is clear that panels were mindful of the impact of stressful working relationships on registrants' behaviour, accepting that, in these cases at least, individuals do not work in isolation and that a negative work environment can create the conditions in which misconduct occurs.

5.5.2. Staffing and resources

In addition to interpersonal relationships, other aspects of the work environment were identified in the sampled cases as having been relevant to how and why misconduct occurred. These included staffing levels and workload pressures:

> *"The panel noted the difficult circumstances on the ward at the time of the incident, when you were the sole nurse on duty."* (NMC128)

In the following extract, it can be seen that the panel were convinced that in circumstances where a care home was understaffed, that was mitigation for a registrant's failure to record that medication had been given. Therefore, the panel found no misconduct in relation to those charges:

> *"The panel further noted that these errors arose in the context of Mr X working in a busy nursing home, with only two nurses on duty during the day shifts, and only one nurse on duty at night. The panel had regard to the importance of record keeping in the nursing profession. The panel heard evidence that nurses conducting medication rounds in the Home were frequently interrupted by other staff. In such circumstances it is likely that mistakes would arise. In these circumstances, the panel did not consider that Mr X's failures to record that medication had been administered fell significantly short of the standards expected of a registered nurse. The panel determined that Mr X's actions in charges 5 and 8, were not sufficiently serious as to amount to misconduct."* (NMC142)

Examples of the work environment being taken into consideration by panels within the cases analysed predominantly came from NMC panels, though there were also examples of similar

issues being raised as mitigation by registrants with the GPhC, the HCPC, and the GDC. While this may be a consequence of sampling, and the NMC cases are the largest number in our sample, it is also in line with NMC policy.[14, 83]

5.5.3. Workplace culture

In some cases, the environmental issues identified related not to resource matters such as staffing but to workplace culture.

In one such case, a doctor was alleged to have used inappropriate language towards a colleague, and the panel took into account evidence suggesting that such language was not atypical of that used between colleagues at the clinic where the registrant and the complainant worked:

> *"The evidence suggested that there was a relaxed culture at […]. During lunch hours or when patients were not in attendance, the conversation might be described as louche; swear words were used and there was sexual banter. […]*
>
> *"The Tribunal does not find serious misconduct. The prevailing culture of louche language at […] militated against such a finding, even though Dr X was not normally an initiator of that language. […] Here he did initiate the language, but the Tribunal was not satisfied that it should make a finding that Ms B was upset by it. However it does find that the use of this language amounted to misconduct which fell short of serious. He had received formal advice from the GMC about his communications with staff in 2010 and 2013 and failed to heed that advice."* (MPTS024)

Here, the panel accepted that the prevailing workplace culture of 'louche language' was sufficient to mitigate against the registrant's own use of such language being found to be serious misconduct. However, due to the registrant's prior FtP history in relation to communications with colleagues, the panel did find that there was misconduct, although not serious. This example clearly shows environmental factors being considered as mitigating by a panel, holding the conduct back from crossing a threshold of seriousness. It also, though, shows that this acceptance of mitigation can be partial, rather than leading to full absolution.

In an NMC case, the panel again heard evidence that inappropriate language was part of a 'banter' culture in an operating department, but despite accepting this was the case, did not see it as mitigating the registrant's individual responsibility to conduct themselves appropriately:

> *"In reaching this decision, the panel took into account the evidence of Ms 1, your own submissions and the evidence Dr 5. The panel had little difficultly in concluding that*

the comment was an inappropriate one. You do not appear to challenge the allegation that it was said. It was the evidence of Dr 5 that this comment was part of the culture of theatre at the time. […] The phrases used by you were part of the theatre culture. However, it was clear to the panel that the use of this language, and banter, was wholly inappropriate given your role as mentor." (NMC071)

In another NMC case, rather than workplace culture being recognised by the panel as the backdrop to the conduct under consideration, the panel rather saw the registrant as actively contributing to creating a negative culture:

"*With regard to Ms X not ensuring that the HCAs were awake, the panel was of the view that she actively participated in a culture which put staff comfort above those of patient needs, by both allowing this to occur and not escalating the matter to management*." (NMC042)

In this instance, the registrant's role in contributing to a negative culture, and failing to seek to change it, was seen as part of their misconduct.

5.5.4. Supervision and management

The level of supervision and management support available to registrants is also sometimes considered by panels as a factor that can influence practice and behaviour:

"The Committee was left with the impression that the Pharmacy did not consistently provide Ms X with the level of support which she might reasonably have expected. […]

The Committee noted Ms X's evidence that she had learned from her experience and would act differently in the future. It recognised that she was at a relatively early stage in her career, and that the working environment and absence of suitable role models were likely to have had some influence over her decisions. Her references speak highly of her professionalism, as well as her technical competence." (GPhC005)

Taken in combination with other factors, such as the registrant's evidence suggesting insight into the issues raised, her relatively early career stage, and positive references, the lack of appropriate supervisory support in this example was accepted by the panel as a mitigating factor in this case.

Likewise, in the extract below, the panel recognised that lack of induction and lack of supervision by senior staff were relevant mitigating factors in relation to allegations about a doctor:

> *"The Tribunal considered the mitigating factors in this case. It took account of the unfavourable working circumstances of Dr X during the time of events giving rise to the Allegation; these included the lack of an adequate induction for his role and a lack of supervision by senior staff*." (MPTS049)

5.5.5. Organisational issues

Issues with organisational processes were also recognised in some cases by panels as mitigation. These issues included examples where local policies were unclear or inappropriate, problems with workplace technology, and where record-keeping systems were inadequate or unreliable:

> *"Dr B's evidence was that he thought people were honest, but the department needed to record things better. His evidence was that there was always the potential for someone to do something wrong. He did not cross-check every single form but did undertake random checks as he was aware of the potential for mistakes. Ms C also agreed that there was room for error in the system being used at the time. There are many examples of errors and unreliability in the system. The Tribunal considered that it is easy to see how mistakes and misinterpretations could have arisen given the inadequate record keeping and diaries."* (MPTS038)

In this extract, testimony from witnesses corroborating the claims made by the registrant were important, and the panel accepted that problems with local systems did offer some explanation for how mistakes were made, and mitigated the seriousness of the registrant's own actions.

In cases where issues relating to organisational processes were raised as mitigation by registrants, questions relating to the boundary between individual an registrant's responsibilities and the impact of environmental factors were also raised:

> *"Further, the panel recognised that at the time of the incident the Hospital was going through numerous changes of management roles and concerns had been identified by the CQC. However, it was of the view that you ought to have raised the issue with your line manager or another member of senior staff."* (NMC098)

> *"You told the panel that the Home was poorly run, understaffed, and with staff who had not been trained to manage patients with complex needs including dementia.*

You received no training, support or supervision and you said this was the case for all staff. […] You recognised that you should have left your employment at the Home earlier but you remained because you cared for your patients. You did, however, raise concerns with your manager and also made several referrals to safeguarding." (NMC124)

In the first of these two NMC cases, despite there being acknowledged issues with the organisation in which the registrant worked, the panel did not see this as sufficient mitigation for the registrant's behaviour and pointed to the registrant's failure to escalate issues to senior staff. In the second, as well as there being corroborating evidence for claims of organisational issues, the registrant had demonstrated insight into their position and actions at the time, and had also raised concerns about the organisational issues to managers and others. These examples illustrate that organisational failings do not excuse registrants from their individual professional obligations in the eyes of FtP panels, though such failings may be taken into consideration and help to contextualise a registrant's actions or inactions.

5.6. Misconduct in non-professional settings

Health professions regulators' FtP procedures cover registrants' conduct and behaviour outside of their work as well as their professional practice.

Decisions in cases relating to conduct outside of professional practice are guided by case law, principally R (Remedy UK Ltd) v GMC EWHC 1245 (Admin) which distinguishes between misconduct in the exercise of professional practice and 'morally culpable or otherwise disgraceful conduct outside or within professional practice' that 'is dishonourable or attracts some kind of opprobrium', and which may bring the profession into disrepute. A second case often cited in panels' determinations is GMC v Calhaem [2007] EWHC 2606 (Admin) which states that for a doctor's conduct to be misconduct 'it must be linked to the practice of medicine or [else it must be] conduct that otherwise brings the profession into disrepute, and it must be serious.' Though these decisions confirm that conduct outside professional conduct can constitute misconduct if serious, decisions on what actually reaches that threshold remain with FtP panels.

Analysis of case determinations shows that the ways in which regulators' FtP panels consider, or record consideration of, the extent to which misconduct that occurs outside of the registrant's work is material to their fitness to practise differ. GOC panels routinely consider and record this in such cases under a 'Material Relevance' heading in their determinations. For other regulators, there was considerable variance, including between

cases heard by the same regulator, as well as between regulators. There is typically some mention of relevance to professional practice, though this varies considerably from a thorough consideration of risk to future patients to more general consideration of the impact on public confidence in the profession. For example, the sample of HCPTS cases analysed included several cases in which registrants had been convicted of downloading and viewing child sexual abuse images. The registrants concerned were two paramedics, a chiropodist/podiatrist, and a clinical scientist. Only in the case of the clinical scientist was there any reference in the case determination to a possible risk to patients if the registrant was allowed to continue to practise unrestricted:

> "*The Panel therefore concluded that the Registrant's fitness to practise as a Clinical Scientist was at the time, and remained, impaired on public protection grounds, not least because in his work he would be expected to interact with the public, which would include children, but also because of the impact on patients of learning that a Clinical Scientist had behaved in this way."* (HCPC044)

In the other three cases, the panels considered only the risk of repetition and impact on public confidence in the professions when considering impairment and also at sanction stage, with no mention made of concerns relating to patient contact.

In making these decisions, panels are guided by regulatory guidance documents which, as noted in section 5.1 above, typically indicate that some forms of conduct are likely to be considered serious. This includes cases involving sexual misconduct, dishonesty, and criminal convictions, where these result in a custodial sentence or are for 'specified offences.' Some convictions relate to conduct that occurs outside a registrant's professional practice. NMC guidance,[83] cited to panels in some cases in our sample, states that if criminal offences were committed in a registrant's private life, and there is no clear risk to patients or the public then it is unlikely that the regulator would take action, unless the registrant received a custodial sentence or the matter involved a specified offence as set out in the NMC's guidance.

Some interview participants noted a shift in recent years in their organisation's stance regarding cases featuring allegations of misconduct occurring outside the registrant's work, with some organisation's now not seeking to pursue such cases unless the conduct involved serious criminal convictions:

> *"… whereas now there's very much a change, and I think rightly so, in favour of but does this affect your practice as a [registrant], because if you're off taking cocaine at weekends when you're not working, yeah ok we don't like that but if there's no*

> *evidence that that's ever impacted your practice why is that our concern, you are entitled to a private life whatever that may be*…" (P005, Lay Case Examiner, Org 2)

Not all were entirely in favour of this change in regulatory stance on such matters, with some expressing concerns that it had gone too far:

> "*So there was a deliberate shift away from it, but I do think the shift's gone a bit too far whereas it seems as though private life there's not the scrutiny about the kind of the factors that might make it relevant to public protection*." (P003, In-house legal team, Org 2)

In addition, the approach to such cases does not seem to be consistent between regulators. Whereas P003 cited above suggests that their organisation would not take action in a case involving drug use in a registrant's private life, without evidence of an impact on the registrant's practice, in one MPTS case in our sample, a registrant's conviction for possession of a controlled drug was found to be 'a serious matter' and misconduct:

> *Whilst it is appreciated the offence took place the day before* [the registrant] *was due to work, during and in the context of his personal life it cannot be fully detached from his professional life. The repetition of his behaviour which on the first occasion led to a caution and on the second occasion led to a conviction increases the seriousness of his conduct."* (MPTS040)

The panel argued that the '*significance of the fact that cannabis is a class B controlled drug should have had more resonance with [the registrant] as a doctor*.'

Analysis of case determinations shows that making decisions about whether misconduct in a registrant's private life has relevance to their professional practice, and therefore how serious it should be considered, can be challenging for panels. These decisions involve consideration of where the conduct occurred, whether the practitioner was registered at the time it took place, any impact on their professional practice, and any use of their professional knowledge as part of the conduct.

Examples within the sample of cases analysed included an NMC case (NMC038) in which the panel found that a registrant's theft and use of a disabled parking badge was a breach of the 'fundamental tenets' of the profession constituting serious misconduct. The panel noted that the seriousness of the conduct was linked to the registrant's professional practice, contrary to the registrant's representative's submissions, because the theft and subsequent use of the item took place in hospital carparks.

Consideration of any link between the registrant's conduct in their personal life and their professional practice often occurs at the impairment decision stage in panel hearings. For example, in cases concerning violence outside work, panels may consider whether there is a risk of the registrant becoming violent with patients:

> *"The Committee felt that there was a concern that the Registrant had the potential to react angrily to patients that he had access to under training."* (GOC011)

> *"Even though these matters occurred before the Registrant was registered as a Paramedic, his actions were such that they give rise to concerns as to how he would deliver services to vulnerable service users when in a position of trust."* (HCPTS030)

Where implications for professional practice are not identified within case determinations, there is typically discussion of the potential impact of the registrant's conduct on public confidence in the profession or the risk of harm to the public. Again, these matters are typically considered at the impairment decision stage.

> *"Whilst the Tribunal noted no concerns have been raised regarding* [the registrant's] *clinical practice, it considered that* [the registrant's] *actions which led to his conviction were capable of damaging confidence in the medical profession, particularly when he was aware that his actions and behaviour were already under scrutiny by the GMC."* (MPTS040)

> *"The Panel determined that the conviction of the Registrant related to very serious criminal offences and had clear implications in terms of the wider public interest in maintaining public confidence in the profession. The Panel determined that other practitioners would consider that the Registrant's actions were abhorrent and would attract public opprobrium."* (HCPTS024)

In such cases, impairment may be found on public confidence grounds alone, or in combination with a risk to the safety of the public. Further examination of how panels approach decisions about impairment, and public confidence in particular, is included in section 5.7 of this report.

Appendix D provides a table comparing seven cases all featuring violent conduct outside of the registrants' work. The cases span five regulators: the GOC, the GMC/MPTS (x3), the HCPC/HCPTS, the GOsC, and the GPhC. Identifying the aggravating and mitigating factors in the cases, and specific elements in each that were identified as markers of seriousness, the table provides further insight into how panels reach outcomes decisions in cases relating to conduct outside of registrants' professional practice. The outcomes in these cases range from no action through to erasure, and include four suspensions ranging from one month to

one year in duration. Although the MPTS case ultimately concluded with no action, the panel did find impairment on the grounds of public confidence and professional standards but concluded that the registrant's violent conduct, in which a member of the public was assaulted, had arisen in unusual circumstances that were unlikely to recur. In addition, the registrant was found to have shown insight, taken responsibility for his actions, and had undergone remediation through counselling. This combination of factors meant that the panel believed the risk of repetition to be low, and that the findings of misconduct and impairment in the case, being a matter of public record, were sufficient to meet the regulatory objectives of protecting public confidence and maintaining professional standards. At the other end of the sanction ladder in this comparison, the case which ended in erasure featured a student registrant with the GOC, whose violent conduct was aggravated by homophobia, with this considered by the panel to be evidence of a deep-seated attitudinal issue, and a major marker of seriousness in the case. The registrant had also shown limited engagement with FtP processes, and the panel considered that they had shown little insight into the impact of their conduct. The panel did not feel that suspension would be sufficient to protect the public or to protect the wider public interest and confidence in the profession, leaving erasure the only outcome able to achieve those aims.

Looking across these cases illustrates the varied factors that can shape outcomes in FtP cases occurring outside the registrants' workplace. These factors are similar to those considered in cases relating to registrants' professional practice, focusing on the aggravating factors of the case, and any mitigating factors, typically the registrant's response to the case, but also including the circumstances in which the conduct occurred.

5.7. Public confidence

As well as considering whether a registrant's fitness to practise is impaired because they present a risk to the public (discussed in section 5.2), panels also assess whether that registrant's fitness to practise is impaired on public interest grounds.

This second facet of impairment is considered even in cases where the registrant is judged to have fully remediated and have insight, and thereby no longer presents a risk. Therefore, a registrant's fitness to practise can be judged to be impaired on the grounds of public interest only. The threshold for this centres around both the seriousness of the misconduct, and on how the panel perceive a member of the public may respond if they were aware of the facts of the case.

In cases where impairment is found on the grounds of public interest only, the misconduct is often referred to as 'serious' within the case determination. In some cases, this is because of

the potential risk of harm to vulnerable individuals, or serious dishonesty. In case determinations, panels often argue that there is no risk of future harm to individuals, but the misconduct is serious enough to undermine trust in the profession. Trust is of great importance and misconduct is often found to breach that trust.

Analysis of case determinations shows that panels are often concerned about how the public would perceive the misconduct and may determine that, through their misconduct, the registrant has 'brought the profession into disrepute' (e.g. GDC014, GOC003, HCPTS0011, MPTS004, NMC065, PSNI004) or that the misconduct 'had the potential to damage the public view' of a registrant's profession (HCPTS0010).

The member of the public whose response is imagined is considered to be 'reasonable and well-informed' with certain expectations of professional behaviour. They should be able to trust registrants and would expect a finding of impairment if misconduct is serious enough. Failure to mark unacceptable conduct in this way may be seen, in the eyes of both the public and the wider profession, as regulatory acceptance of or leniency towards failures to adhere to professional standards.

In discussing how they apply the concept of maintaining public confidence in a profession in their decision-making, interview participants offered differing interpretations of its meaning. Some participants looked at the idea of 'maintaining public confidence in the profession' as meaning a need to ensure that allowing a registrant found to have committed misconduct to continue to practise unrestricted would not impact on members of the public's willingness to seek treatment from healthcare professionals:

> "*I think the way we look at public confidence more generally is a high threshold, we look at if we don't do anything here is the public at large, or would they feel that they can't trust professionals generally, and in our case [registrants] generally, so is it going to be something so awful that people might take risks with their own health and wellbeing by, for instance avoiding treatment because they just think [registants] have got carte blanche to do that awful thing so why on earth would I go to one*." (P011, FtP Lead, Org 2)

Some participants positioned themselves as the prospective patient when talking about applying this concept:

> "*I suppose the way I think of it is if I knew about this person having done such a thing would I think twice about going to see them. And going on from there, if I knew that*

this particular [registrant] was dishonest let's say, would it affect my view of all [registrants]." (P010, Lay panel chair & panel member, Orgs 2, 6, 8 & others)

This perspective situates the 'public confidence' concept as being about the potential impact of allowing a registrant to continue practising unrestricted on the willingness of individual patients to seek care from health professionals, if they were to become aware of the case. However, while stating this understanding of the concept, some participants recognised that it sets a high threshold and cast some doubt that FtP cases were likely to have such an impact in anything other than extreme circumstances:

"*I think one of the things that the [regulator] guidance has tried to do, and I think it's possibly rather too prescriptive in this particular area, is say that it needs to be something that's so serious that members of public may think twice about seeking [healthcare] services because of what you've done. Now those cases to my mind are so few and far between it's beyond belief, you're talking Harold Shipman…*" (P005, Lay Case Examiner, Org 2)

One suggested that such a threshold was too high, and that consideration of how to maintain public confidence should be a broader judgement about professionalism and registrants' adherence to professional standards:

"*That's a very high threshold, because there aren't that many instances of misconduct that would stop the public from accessing healthcare, we've only got to take Harold Shipman, has everybody stopped going to their GP, no, and that was a really significant case. I think the public confidence and professional standards one is more about the basis of somebody's professionalism*." (P007, Clinical Case Examiner, Org 2)

Some participants also highlighted the importance of regulation being seen to be done in terms of maintaining public confidence:

"*So I suppose I try and hold in my mind if it was my GP or dentist and they'd been found guilty of X would I think that there should be some sort of sanction against them to mark the seriousness of that*." (P015, Clinical panel member, Org 4)

Media coverage was mentioned by several participants when discussing how they thought about the concept of maintaining public confidence. References were made to the public learning, and forming a view about FtP cases and outcomes, as consumers of media reporting:

> "*It's a long-winded way of saying you stand back and you think what would your average member of the public think about that, I sometimes think of it as The Daily Mail test, which I shouldn't, if this appeared in the paper what would people think*." (P010, Lay panel chair & panel member, Orgs 2, 6, 8 & others)

However, participants also cautioned against using the anticipated tone of future media coverage as a barometer of public opinion, or a marker for how public confidence in healthcare professionals might be affected by FtP cases:

> "*That is a concept that panellists sometimes find quite difficult, me in the early days, but you're not writing your determination or reaching your decision on the basis of well how might this get written up in The Daily Mail, and that's quite challenging because some of our determinations are written up in The Daily Mail […] And it's a difficult balance to get right, and occasionally, I've never told a panellist off, but occasionally, that is the area which most often I might have to say just hang on a minute, this is what I think public confidence and public interest are, it's not the interest of the public…*" (P012, Lay panel chair & panel member, Orgs 2, 5, 7 & others)

Some participants also noted the idea of 'the well-informed' or 'reasonable-minded' member of the public as an abstract figure in considering whether public confidence would be undermined if a registrant was allowed to continue practising without restriction, but noted that this is difficult to apply meaningfully:

> "*We use the concept of the well informed member of the public a lot, the difficulty is if they're so well informed they're in the same position as we are as lay people on the panel, so there's no difference*." (P010, Lay panel chair & panel member, Orgs 2, 6, 8 & others)

> "[It is] *impossible to know what a reasonable minded member of the public informed of all the facts would actually make of this, […] you know if you were doing that exercise literally you'd have to say well how old is this person and where do they live, and what's their background, and what are their influences, and what social media do they read, it would really come down to that, so that is not the exercise we enter into*." (P014, Lay panel chair & panel member, Org 4)

Our participants' comments, explaining how they understand and apply the idea of maintaining public confidence in the profession, show that this is not a straightforward exercise. In contrast to the somewhat formulaic statements about maintaining public confidence in regulatory guidance documents, for panellists, and those working in FtP more

broadly, the process of making decisions about impairment of fitness to practise is complex and challenging, and there is no single approach to how such decisions are made.

In cases where the registrant is judged to have fully remediated and have insight, and thereby no longer present a risk, panels also judge whether the registrant is impaired on the grounds of public confidence only. The threshold for this centres around both the seriousness of the misconduct, and on how the panel perceive a member of the public may respond if they were aware of the facts of the case.

Definitions of public confidence, and therefore clear thresholds, are sparse and panels are often not explicit about what they mean by public confidence. However, there are examples taken from case decisions that illuminate what is meant by public confidence:

> "*In mitigation, the Committee recognised that you have been punished by the criminal justice system and have served your sentence. You were commended by your probation officer for the swiftness within which you completed the hours of unpaid work and on a voluntary basis you continue to work at the charity shop. In the Committee's judgment, the manager of the charity shop represents a reasonable and well-informed member of the public. His testimonial, as quoted above, carries considerable weight*." (GDC042)

Public confidence is usually examined as part of an impairment determination but may be explored when panels are determining misconduct. For example:

> "*The Committee finds that [the registrant's] conduct in making claims to NHS England which were inappropriate, misleading and dishonest, is serious and undermines public confidence in the profession. It is in no doubt that fellow dental professionals would judge [the registrant's] conduct to be deplorable*." (GDC025)

Thresholds for public confidence tend to align with seriousness more generally – risk or extent of harm, repetition, an abuse of trust, intent or attitudinal issues all make a finding of impairment on the grounds of public confidence more likely.

> "[The registrant] *had, at the time of these incidents, acted so as to place those in her care at unwarranted risk of harm and in so doing brought the midwifery profession into disrepute. The panel has concluded that she did so*." (NMC015)

At the stage of determining impairment, a lack of insight and remediation can also be considered to affect public confidence, as well as repetition of the misconduct since the original referral. Thresholds for a finding of impairment on the grounds of public confidence

are sometimes determined by imagining how a member of the public would respond if they discovered the panel had found the registrant unimpaired. If the panel imagines the member of public would be shocked, a finding of impairment on the grounds of public confidence is more likely.

Panels emphasise the importance of members of the public being properly informed, with an understanding of the misconduct which has occurred and wider contextual factors:

> "*In the panel's judgment, a properly informed member of the public, conversant with the limited scope of your misconduct, (which the panel considered fell at the lower spectrum of seriousness) the steps you have taken to address it, your remorse, the minimal risk of repetition and, crucially, aware that you have provided safe care to critically ill patients for a significant period since the events of [date], would not be concerned at the absence of a finding of current impairment*." (NMC119)

Even when a registrant is no longer at risk of repeating their misconduct or putting the public at risk, panels may find a registrant's fitness to practise impaired specifically on public interest grounds in order to mark the importance of maintaining public confidence. In such circumstances, the panel's aim is to send a message to other professionals and the wider public about behavioural standards required of professional registrants.

5.8. Calibration and quality assurance

Quality assurance and calibration of FtP decisions is important yet challenging, given the individual nature of FtP cases, which all involve consideration of a range of factors to establish the risk presented by the registrant concerned. Calibration takes place in a number of ways, both formal and informal, at various points in FtP procedures.

5.8.1. Guidance and training

Regulators' guidance for decision-makers are used as a calibration tool. For example, the GCC's *Guidance on Sanctions* states that it 'aims to promote consistency and openness in decision-making', and the GDC's *Interim Orders Guidance for Decision Making* similarly states that its purpose is 'to promote consistency and transparency' in decision-making. GMC guidance documents, including its *Guidance for Case Examiners – Rule 28, Guidance for FtP decision-makers on assisted suicide*, and *Interim Orders Tribunal Referrals*, contain similar statements as do multiple documents from the GOsC. Likewise, the GPhC's *Good decision-making, investigations and threshold criteria* guidance states that the guidance

'plays a significant part' in ensuring that decisions are fair and proportionate and is part of the organisation's efforts to ensure the quality and consistency of decisions.

In interviews, Case Examiners and FtP panel members explained that they actively refer to guidance documents, such as indicative sanctions guidance, to help them make decisions. FtP panel members also mentioned the importance of initial training, and periodic training updates, for keeping them updated on developments in FtP-related case law, maintaining their knowledge, and aiding the calibration of decisions on seriousness.

5.8.2. Calibration during decision-making

Some FtP panel members interviewed also noted the important role of the Legal Assessors, who are present when panels meet behind closed doors to deliberate and reach their decisions on whether a registrant's behaviour constitutes misconduct, whether their fitness to practise is impaired, and if so, what sanction, if any, to impose. Legal Assessors refer panels to relevant case law, and sometimes also note previous relevant panel outcomes, thereby offering a form of calibration during the decision-making process itself.

Other forms of informal calibration during decision-making came from the process of discussion between decision-makers. At both Case Examiner and FtP panel stages, interview participants described how working with colleagues to make decisions served to moderate those decisions. The composition of panels changes with each case, and participants described that working with different people brought different perspectives and experiences to the decision-making process:

> "*I really like the way these panels work because they mix you up, you don't work with the same team twice, occasionally you do work with someone twice which is lovely when that happens, but it's also lovely that you're constantly working with different people. So we all come with our different experiences*." (P008, Lay panel chair & panel member, Orgs 1, 2 & other)

In addition, many lay members of FtP panels interviewed sat, or had previously sat, as panellists for a number of different regulatory bodies, both in professions regulation and in other regulatory or disciplinary processes. These experiences, and knowledge of how forms of conduct are treated in a variety of fields, potentially mean panellists themselves have a role in informal inter-regulator calibration.

5.8.3. Internal quality assurance processes

From interview participants and regulatory guidance documents we identified formal quality assurance processes operated by regulators. For example, the GDC has a Quality

Assurance Group (QAG) to which cases can be referred for review. The GDC also operates a Decisions Scrutiny Group (DSG) that randomly samples cases from all stages of its FtP processes. The GOC [85] and GPhC [41] refer to internal quality assurances in their documents but without giving further detail about how these operate.

One participant emphasised the importance of having a clearly articulated policy basis underpinning FtP activity as this provided clarity from the outset about the aims of the FtP process. Otherwise, interview participants in FtP lead roles within regulators cited a number of quality assurance mechanisms within their organisations including internal audits, either regularly scheduled or organised to focus specifically on an arising issue or risk, informal peer review processes critiquing redacted decision documents, and enhanced checks on cases deemed higher risk. Audit processes mentioned included post-decision reviews but also regular monitoring of on-going cases, particularly to monitor risk.

Several participants mentioned that feedback on decisions can also arise when cases are reviewed or appealed following decisions at the Case Examiner stage, under processes such as the NMC's Rule 7A or the GDC's Rule 6. Some Case Examiners noted that their monthly team meetings were also a useful source of feedback and an opportunity for sense-checking decisions. These meetings did not focus on the details of specific cases and decisions but rather presented an opportunity to discuss types of case in hypothetical terms, and to consider themes or trends within cases.

FtP panellists discussed that they sometimes receive feedback on case decisions from the regulators concerned, and that regulators' approaches to providing such feedback can differ considerably, with some organisations seen by panellists with experience across multiple regulators as being more proactive and more challenging in this regard.

Participant reported that feedback generated from these processes could focus on the case outcomes themselves, though this was seen as less common, or on the way in which decisions have been written and explained. In addition, audit and review processes also produce information about any emerging issues or trends within cases that can then be explored further.

5.8.4. External review

Some participants reported that the organisations they work for also commission periodic external audits of their FtP decisions. However, the major source of external review discussed by interviewees was the PSA's reviews of FtP decisions.

Some participants in FtP Lead roles noted that they sometimes refer specific panel decisions to the PSA if they feel the outcome was not sufficient to protect the public, for example, and

explained that this mechanism was useful and meant they were not directly challenging panel outcomes themselves:

> "*So their ability to challenge decisions which we think are insufficient is really valuable because it's the most direct and easy way to get them challenged, otherwise we'd be in the business of having to challenge our own panels, and that's a very problematic position to be in*." (P011, FtP Lead, Org 2)

The PSA has the power to review every FtP hearing decision, and may refer decisions to the High Court. In the twelve court decisions arising from PSA appeals between 2017-2020 we reviewed, there were some apparent themes in the cases referred. Firstly, five of the cases appealed involved dishonesty, and concerns centred on whether this was fully recognised in panel decisions. Secondly, three of the appeals focused on misconduct that the PSA argued had not been properly recognised by panels as sexually motivated. Finally, overlapping with those groups of cases, in five of the cases, the original panels had made findings of misconduct but not subsequently found impairment, and the appeals centred on challenging those findings of no impairment.

In addition, the PSA provides feedback from its case reviews to regulators in the form of learning points. However participants' views on the value of that feedback were mixed, with suggestions that it can be somewhat piecemeal rather than identifying themes or trends.

5.9. Seriousness across health professions regulation

5.9.1. Seriousness and professional groups

Looking across sampled FtP cases from all the UK health professions regulators indicates some potential differences in the types of case heard by different regulators' panels. Broadly, in caseloads of regulators whose registrants, or subgroups of registrants, are typically in close physical contact with patients, particularly on a one to one basis, there were multiple cases centring on allegations of sexual misconduct involving patients or colleagues, or boundary violations. This was noted, for example, in the cases sampled from the GOsC and in HCPC cases involving physiotherapists. In the sample of NMC and GDC cases we analysed, for example, we noted a relatively high proportion of cases dealing with substandard practice.

Table 4 shows the percentage of some types of misconduct in relation to the total number of cases we analysed. For the sexual misconduct category, sexual misconduct towards colleagues or patients was included, whereas convictions for producing or viewing child

sexual abuse images, or sexual misconduct which took outside the work environment, were not included. For the 'theft of drugs' category, this referred to the registrant physically removing drugs from the workplace rather than inappropriate prescribing. Substandard care or practice included a wide range of issues related to professional performance including behavioural and communication issues but excluded scope of practice. Again, it should be noted that this table is provided only to describe the sample of cases analysed, as the samples were not drawn to be representative.

Table 10: Selected types of misconduct in analysed cases

Regulator	No. of cases analysed where misconduct found	Sexual misconduct towards colleague or patient and (%)	Substandard care or practice and (%)	Theft of drugs and (%)
GDC	63	0	38 (60%)	0
NMC	118	4 (3%)	83 (70%)	4 (3%)
GOC	43	2 (4.5%)	13 (27%)	0
HCPC	50	7 (14%)	15 (30%)	0
GPhC	16	2 (12.5%)	2 (12%)	0
MPTS	45	5 (11%)	11 (24%)	1 (2%)
PSNI	3	0	1 (33%)	1 (33%)
GCC	7	1 (14%)	3 (42%)	0
GOsC	35	4 (11%)	7 (20%)	0

These apparent differences could simply arise from the sampling approach used, as type of case was not used as a sampling criterion. However, similar differences between regulators' caseloads were also noted by some interview participants:

> "*The thing is though that each of the regulators tend to specialise in different areas of misconduct, so at the NMC it's medicines administration and that sort of thing, at GPHC there's a lot of substance abuse and dishonesty associated with drugs, at the GOC there's the sexual element of being in a darkened room with an individual person, and there's the clinical cases getting it wrong, it's easy to miss a diagnosis. So it's quite difficult to draw a parallel across the regulators when you're tending to deal with different types of misconduct*." (P010, Lay panel chair & panel member, Orgs 2, 6, 8 & others)

There were also suggestions that specific types of case may be seen as particularly serious where the concerns raised are linked to registrants' professional practice:

> "*I think there are some things which are more serious for different professions than others, so I'm really worried if a paramedic is drink driving because they drive ambulances, I'm really worried if pharmacists are drug addicts or have convictions for dishonesty, I think osteopaths and chiropractors tend to be at a higher risk of sexual misconduct simply because they see patients on their own […] So I think you can see that there are legitimately different approaches and levels of seriousness depending on the profession, and I wouldn't want to say that one sanction fits all*…" (P019, FtP expert, Other org)

Interviewees with experience of working as panel members across a number of different regulators generally felt that there was a broadly similar approach to considering cases in terms of seriousness, but again pointed to differences in caseloads. Other interviewees did suggest that theoretically regulators' approaches to seriousness are comparable, as seen in their guidance documents which consistently point to the same types of case, those featuring dishonesty, sexual misconduct, and some criminal convictions, as serious, but that there may be differences in practice. Others suggested that differences may occur between panel hearings of the same regulator, rather than between regulators:

> "*So between panels there are different ways that they look at it, between regulators, I think broadly speaking there is a consistency*…" (P021, Legal Assessor, Orgs 2, 3, 5, 7 & others)

Some panellists we interviewed suggested that there was a sense of a general difference in the application of sanctions between the MPTS in GMC cases and other regulators, with doctors perceived as receiving lighter sanctions through FtP processes than other registered health professionals. One FtP Lead participant noted that this perception also exists amongst the professional groups that they regulate:

> *"…they are really concerned by the fact that they perceive the GMC is more favourable towards its registrants than other regulators are towards theirs, so the perception is that if you're the doctor you get a slap on the wrist, and if you're the [registrant] you get struck off. And that's been reflected in some very high profile cases, so I can understand that, and it may just be that the GMC has over the years had more of a focus on remediation supporting professionals back into practice than others have*." (P011, FtP Lead, Org 2)

While this perception was reported by several participants working in the FtP field, all acknowledged that it was simply a perception. One participant, not linked to the GMC or MPTS, argued that this perception is not borne out by statistics looking at rates of erasure

across professions, and that variations may also reflect differences at earlier points in FtP processes. The perception may have been fed by high profile cases, such as Bawa-Garba, where registrants in different professional groups received different sanctions from their regulators in cases arising from the same events.

The tables in appendices C and D demonstrate the challenges of comparing across regulators even in cases sharing some basic core elements, due to the individual nature of each case, and the way that a range of aggravating and mitigating factors are weighed to reach decisions on risk, impairment and sanction. These tables also include some examples from the same regulator showing how each unique combination of factors can result in different outcomes, even where there are cases with apparently similar forms of misconduct.

In section 5.2, we noted that some professional groups present, at least in their clinical practice, a greater risk of serious harm or death resulting from their misconduct. Some interviewees also raised the related issue of whether, given different risk profiles, but also the different levels of responsibility and financial reward associated with different professional groups, public expectations of those groups are the same or differ. There were suggestions that expectations of those whose clinical roles entail less responsibility for patient safety may be lower than for example for doctors and dentists.

While differentiating between professional groups to explicitly identify some as a greater risk or to label their misconduct as more serious was recognised as a challenging and controversial idea by those who raised it, some participants also identified that understandings of seriousness in FtP do and have changed over time. It was noted for example, that the NMC's approach to dealing with cases relating to misconduct in non-professional settings has developed over recent years. Other examples cited included longer term changes, such as that in the past, cases could have been brought on the basis of registrants' sexuality when homosexuality was illegal. Seriousness, therefore, is not a fixed notion, and ideas about what should and should not be considered serious may develop over time in line with changes in wider society.

5.9.2. Seriousness, sanctions and procedures

Participants also offered their views on the use of particular sanctions, with several discussing the value of warnings and noting that these are used in different ways – in different circumstances, and at different stages of the process – by different regulators. While some saw a role for warnings as setting a marker that there had been misconduct, although further restrictions on practice were not warranted, others suggested that warnings could be seen as punitive.

Interview participants mentioned areas of apparent difference or inconsistency in relation to sanctions, both within and between regulators. Decisions about the length of suspension orders given to registrants were identified as one area where there may be inconsistency between panels:

> "*I find that panels can be quite different, and I've had a little bit of unease recently if I'm honest with one or two panels I've sat on, because what happens is so and so will say a year, somebody else will say six months, and the chair will say we seem to be about nine months in the middle, and unless anyone would live or die by it I suppose that's what often happens. Certainly I've sat on one or two recently where I thought we gave so and so a year's suspension which seemed a bit unreasonable, and this one seems worse and we're only six months, so that sometimes is a little bit difficult.*" (P015, Clinical panel member, Org 4)

Another panellist suggested that the reasons for decisions about the length of suspensions can involve considering the interests of the registrant and the impact that a lengthy suspension from their work may have on them, and noted that panels may impose shorter suspensions than they may think appropriate due to concerns about such impact:

> "*I think the sanctions are necessary but they're a very blunt instrument, sometimes they feel like a punishment and they're not designed to be a punishment, but how can you suspend somebody for six months not be a punishment, because they can't work for six months, how can that not be a punishment. And of course you weigh up all interests, including the registrant's own interest, and I've seen people really you'd want to suspend them for 12 months but you perhaps go with three because they're a single parent family, and you know how are they going to feed the kids for 12 months*." (P017, Clinical panel chair, Org 2)

It was also noted that the meaning, and therefore impact on registrants, of erasure varies between regulators as the time period before registrants can apply to re-join the register differs.

Panellists with experience of working in non-health professions disciplinary processes noted that the range of sanctions available in FtP processes can be more limited, as there is little use of financial penalties for instance, because of the non-punitive focus in FtP.

In relation to case outcomes, some participants pointed to the impact that differences in procedures and available sanction options, as described in section 4, may shape regulators' approaches and panels' decisions:

> "…*there's also a slight glitch with the MPTS because they can't do a non-restrictive sanction, so you see a lot of really torturous frankly unacceptably poor reasoning for a no public impairment finding because they want to impose a warning, and because they don't want to suspend.*" (P019, FtP expert, Other Org)

One participant noted that in their experience there was a clear difference in the progression of cases through FtP procedures with no impairment decision point (i.e. the GCC and GOsC) compared to other regulators' working with impairment as a criterion. They suggested that cases that would likely be closed at the end of investigation stage due to there being no realistic prospect of impairment being found are instead progressed to panel hearings.

Several participants noted that there are challenges presented by the legislative frameworks governing their organisations' FtP procedures, and that the rules in place make it difficult to close cases earlier and could pull cases through the system unnecessarily:

> "*The problem with seriousness is, it's assumed in the rules I think that cases must be serious otherwise they wouldn't be at the [regulator] anyway, and the problem with that is that loads of cases that aren't serious go a long way further forward, that makes us look like we don't know what we're doing when we do, but we're just bound to follow the rules as we're supposed to follow them*." (P006, FtP Lead, Org 1)

Participants in FtP leadership roles within regulators consistently pointed to a need for the reform of health professions regulatory legislation and highlighted the differences between regulators created by current rules:

> "…*certainly in discussions that I've been in with other regulators, they've introduced processes that I'd quite like for our processes but of course we can't do that unless we were to get legislative reform, in which case it might make us more agile, efficient, and potentially get to outcomes much more quickly that we don't need to go through this prescribed and elongated process that we currently have*." (P009, FtP Lead, Org 3)

> "*I suppose the first thing I noticed when I started at the [regulator] is that the rules to me are very outdated and that only allows us to do certain things in certain ways*." (P020, FtP Lead, Org 5)

It is clear that different legislative frameworks impact on the ways in which regulators, and their FtP panels, are able to resolve cases. The differing sanction options available to different regulators' panels are the most obvious manifestation of this, but variations earlier in their processes are also evident.

6. Discussion

This research has looked across FtP procedures and cases from the UK's nine health professions regulators to explore the concept of seriousness in fitness to practise, using analysis of regulatory guidance documents, case law, case determinations, and interviews with people working in FtP-focused roles. The research had three objectives:

- To develop an understanding of how the concept of seriousness in relation to misconduct is defined and applied by professional regulators, and to identify the considerations that influence that application.
- To achieve a clearer understanding of the similarities and differences in approaches across regulation and reasons for these.
- To describe the relationship between professional misconduct, enforcement actions and the statutory objectives of healthcare regulation.

Through analysis of multiple types of data, this project has explored various facets of how seriousness is identified within FtP cases. This research has provided insights into how and why decisions about seriousness are made, and at which points in the process those decisions occur. This discussion reflects on these findings in relation to the project's objectives, starting with consideration of similarities and differences in approaches across regulation, before moving to look at the relationships between professional misconduct, enforcement actions and regulatory statutory objectives. Finally, we consider how our understanding of seriousness in fitness to practise has developed, in terms of its definition and application by regulators, and the considerations that influence that application.

6.1. Similarities and differences in approaches across regulation

Our work mapping the UK health professions regulators' FtP processes resulted in five models, with the differences between these models focused on four main points. These differences centred on whether a regulator: can issue a recorded censure at the end of investigation stage; can use undertakings or consensual disposal to resolve a case at the end of investigation; find impairment at the adjudication stage; and/or, can issue a recorded censure if there is a finding of misconduct but no finding of impairment. These procedural differences between regulators, arising from differences in the legislative frameworks they operate according to, may influence the way in which cases progress through FtP processes, with interviewees, both panellists and FtP leads, pointing to the different options available across regulators as a factor in case progression or outcome. In this regard, the

matter of whether the regulator decides on impairment or not is important, and for those that do, the ability to impose a warning being dictated or not by a finding of impairment is also significant. The procedural rules regulators are required to follow at earlier stages of their FtP processes were also seen as restrictive, and as sometimes unnecessarily driving cases through to later stages of the system. Proposals for regulatory reform may address these issues if implemented and bring increased procedural consistency between regulators.[20]

As discussed further below, since 2015 UK health professions regulators have shared the same statutory regulatory objectives, embedded within their legislative frameworks. These shared objectives mean that their FtP procedures should in theory have the same broad aims, focusing on protecting the public and maintaining public confidence in the professions they regulate. We found that regulators offer broadly consistent guidance on some specific types of behaviour that are likely to be treated as serious misconduct, including dishonesty, sexual misconduct, violence, and some criminal convictions, particularly those resulting in custodial sentences.[1] In other areas, regulatory guidance may differ. Some regulatory guidance has developed over the course of this project, with the NMC in particular revising its approach to FtP cases and producing new guidance in several areas including its approach to taking contextual factors into account and how it views misconduct that occurs outside the workplace.[14, 16, 84] These developments demonstrate that regulatory guidance, and the perspectives on seriousness encapsulated within such documents, are not static and can evolve and shift over time.

At case level, the individual nature of each misconduct case makes comparisons between regulators challenging, as outcomes can vary between a regulators' own panels even in cases featuring superficially similar basic concerns due to the precise combination of aggravating and mitigating factors identified by the panel, and the response of the registrant. The ways in which such factors are taken into consideration by panels in making decisions about seriousness is discussed further below. However, in some areas we saw clear similarities in approach between regulators' FtP panels. For example, in cases in our sample where attitudinal issues or deep-seated attitudinal issues were identified, these cases typically resulted in a sanction of suspension or erasure, with very few exceptions.

Through this research, we have also identified questions about whether it is desirable or expected that regulatory approaches to FtP cases should be comparable, or whether differences in cultures, responsibilities and scopes of practice between professional groups necessitate different regulatory responses. It appears reasonable to suggest, as noted previously, that a greater degree of procedural consistency between regulators may be desirable, especially in terms of the points at which recorded censures can be issued and

the use of the concept of impairment, to achieve a more standardized approach to health professions regulation. However, it should also be noted that legislative, and consequently procedural rigidity is an issue that has prevented regulators from modernising processes previously. Efforts to introduce regulatory reform must therefore balance moves towards consistency with allowing flexibility for regulators to respond to changes over time and to act in line with the demands of regulating in a particular professional sphere.[20] Understanding what those demands are also necessitates a better understanding of public expectations of regulation, and we identified outstanding questions about whether the public's perception of and expectations of different professional groups may vary.

6.2. The relationship between professional misconduct, enforcement actions and the statutory objectives of healthcare regulation.

The overarching statutory objective of UK health professions regulators is the protection of the public, with subsidiary objectives being to: protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the professions they regulate; and to promote and maintain professional standards and conduct for the members of the professions they regulate. These objectives are shared by all UK health professions regulators, having been inserted as amendments to their governing legislation by the Health and Social Care (Safety and Quality) Act 2015.[3]

Fitness to practise matters pertain to all of these objectives, and our findings show that decisions about seriousness, especially about impairment and sanctions, are typically explicitly linked in panels' case determinations to these objectives, especially the protection of the public, through to protection and maintenance of public or patient safety, and the maintenance of public confidence in the professions. Professional misconduct is seen as having the potential to present a risk to patient or public safety, or a risk that public confidence in the professions may be undermined. Decisions about impairment and sanctions, as regulatory enforcement actions, involve weighing these risks in each individual FtP case.

Among these risks, consideration of any harm caused by a registrant's acts or omissions is particularly important. Our analysis shows that panels consider a range of types of harm: physical harm, emotional harm, financial harm, and abuse of trust. We identified nuanced forms in which harm is manifested within these broad categories, as emotional harm can include harm to colleagues as well as to patients, and abuse of trust can encompass damage to organisational reputations and damage to public confidence. Consideration of harm is important, as it very closely relates to the statutory regulatory objective to protect the safety, health and wellbeing of the public. Panels take into account the extent of any harm

caused, or the harm that could have resulted from the registrant's conduct. At the impairment stage, panels' attention shifts to whether it is likely that the harm would be repeated if the registrant continued to practise without restriction. This focus on current and future risk means that there can be instances in which harm, even serious harm, has occurred in the past but that the panel does not find a likelihood of repetition in the future. It is therefore possible that serious harm arising from misconduct does not necessarily lead to a finding of impairment or a severe sanction outcome. However, where a risk of future harm is identified, often due to a lack of demonstrable insight from a registrant or the presence of an attitudinal issue, the sanction outcome will be more restrictive in order to mitigate that risk and to meet the regulatory objective of protecting the public.

Maintaining public confidence in the professions is a term directly from the health professions regulators' statutory objectives that is repeated as a mandate for regulatory actions through FtP processes in regulatory guidance documents. Within those guidance documents, the term is used consistently between regulators but with little in the way of further exposition or definition. This absence of definition is understandable, given that 'public confidence' is abstract and intangible. However, interpreting its meaning and applying the concept within decisions about seriousness is therefore the domain of individuals and panels. Through our research, we found that there was considerable variety in FtP decision-makers' understanding and application of the concept at the individual level. Our analysis shows that panel members variously think about this in terms of individual patients declining to seek care from healthcare professionals, think about an abstract 'reasonably-minded' member of the public, or think in terms of the media coverage of potential case outcomes. Public confidence in the professions then, is a somewhat nebulous concept, and one which is not consistently interpreted by decision-makers though it plays an important role in decisions about seriousness at the impairment and sanction stages of FtP panel processes.

Where it is found that a registrant's professional misconduct presents a risk on the basis of one of the regulatory objectives, decisions about sanction focus on how to mitigate that risk in order to ensure that the regulatory objectives are upheld. The factors considered by panels when establishing the risk presented by a registrant and their conduct, and when deciding the appropriate sanction to mitigate that risk, are discussed further below as these considerations are central to understanding how seriousness is defined and applied by professional regulators.

6.3. Understanding how the concept of seriousness in relation to misconduct is defined and applied by professional regulators, and to identify the considerations that influence that application.

FtP panel decisions on seriousness are guided by regulators' guidance documents and case law decisions. As noted above, some types of behaviour are identified consistently in guidance documents as likely to be treated as serious misconduct, including dishonesty, sexual misconduct, violence, and some criminal convictions, particularly those resulting in custodial sentences.[1] Beyond these categories carrying a presumption of seriousness, what constitutes misconduct and how serious that misconduct should be considered are matters for FtP panel members to determine. Even within those categories of misconduct presumed to be serious, panels retain discretion to make the ultimate decision about the degree of seriousness in any individual case. FtP panels make judgements about seriousness at the misconduct stage, the impairment stage – where used – and the sanction stage. Framed by regulatory guidance but without clearly defined thresholds, these decisions involve weighing a range of factors relating to the nature of the conduct and the registrant's response to the issues raised and the regulatory process, to reach a judgement about the risk posed by the registrant and if and how any such risk can be mitigated.

Decisions about the risk posed by registrants centre on the evaluation of the characteristics of each case, typically described as the aggravating and mitigating factors. As well as considering risk of future harm and any perceived risk to public confidence, as described above, risk of repetition is also important in decisions about seriousness. In examining the risk of repetition in misconduct cases, the response of the registrant and the extent of their engagement with regulatory processes can be crucial in shaping the outcome of the case. Registrant engagement has previously been identified in the literature as important for FtP outcomes in GMC and HCPC cases.[30, 31] Our findings add further insights into how and why registrant engagement, especially attendance at panel hearings, can make such a difference. Panel members explained the importance of being able to question registrants and examine their evidence in person in informing their views of that registrant's insight into their conduct, and the extent of any remorse shown or remediation activities undertaken. These factors are key to panels' decisions about whether the registrant has effectively mitigated any risk posed by their past conduct, and strongly inform decisions about impairment and sanction.

However, the importance of registrant engagement to panel outcomes does raise some additional issues. Firstly, we found mixed views over whether panels should draw negative

inferences if a registrant does not engage with regulatory processes and does not attend their panel hearing, and there have been recent developments in case law on this issue. Engagement with their regulator, and attendance at hearing, can be viewed as part of registrants' obligations as professionals. However, there may be reasons for non-engagement and non-attendance, including a lack of understanding of regulatory processes, or financial reasons.[33] Moreover, closely connected to the question of registrant engagement, is that of whether registrants have legal representation at hearings. Again, lack of legal representation has been identified as being associated with more severe sanctions outcomes in GMC FtP cases.[31] Participants in this research stated that legal representation can be important in shaping outcomes, as expert barristers know how to present a case effectively to demonstrate any mitigating factors, and can explain the importance of engagement to their clients. However, our findings also suggest that some professionals groups may be more likely to have legal representation than others. Differences in levels of representation were attributed to coverage by professional indemnity and financial status. While the decision to secure legal representation or not rests with the registrant, it may be that decisions not to engage representation are shaped by financial restraints or by lack of knowledge of the regulatory process, and that this lack of expert advice and representation may in turn impact on the extent of registrants' engagement with regulatory processes. Further investigation comparing levels of representation across professional groups, and exploring registrants' choices in relation to engagement and representation, would inform further debate about whether it is reasonable to draw negative inferences from non-engagement or whether to do so may be unfair.

In recent years, and especially following the Bawa-Garba case,[35, 36] there has been considerable attention on the extent to which regulators and their FtP panels should take environmental context into account when considering FtP cases. We found that in cases about registrants' professional practice some regulators, especially those with registrants working in larger secondary care environments such as the GMC and NMC, panels often do consider the environmental context in which misconduct occurred. The aspects of environmental context taken into consideration can be categorised as: interpersonal relationships, work environment, local culture, supervision and management, and organisational issues. However, it is clear that environmental issues are more likely to be accepted as mitigation where there is corroborating evidence from other witnesses or from the organisation itself, rather than if issues are raised solely by the registrant. Moreover, panels also consider a registrant's response to issues within their working environment, for example the extent to which they had actively raised concerns with managers or sought to change their role. Panels also consider the extent of individual registrants' obligations as

professionals, and the extent to which any issues within their workplace can be seen as limiting those professional responsibilities. Again, this seems to be an area of change in how seriousness is considered, and the parameters of individuals' responsibilities in the face of organisational challenges may shift over time.

For some regulators, another area of change has been in how they approach cases involving conduct outside the workplace. The NMC's revised guidance on its approach to FtP cases provides a particular example of a shift to focus less on conduct issues in registrants' private lives, except in particularly serious cases marked by convictions for specified offences or resulting in custodial sentences.[83] Our analysis of cases involving conduct outside professional settings shows that approaches can vary even between decisions from the same regulator's panels. The key questions in these cases often centre on any link or relevance between the conduct and the registrant's professional practice, and any risk that the conduct presents, either in terms of a risk of harm or a risk that public confidence in the profession might be undermined. These are typically considered by panels at the impairment stage. However, there appears to be no consensus on how broadly or narrowly to draw connections between conduct in a registrant's private life and their professional practice.

In weighing various factors to make decisions about seriousness, decision-makers locate cases on a spectrum of seriousness. These decisions may be clear cut where a registrant's conduct obviously falls into a category where regulatory guidance sets out a presumption of seriousness, or where a case is very clearly not serious. However, decisions are far less straightforward at the mid-point of the spectrum, where a number of factors may need to be weighed and balanced.

6.4. Conclusion

Through an extensive qualitative exploration of the concept of seriousness in fitness to practise, this research has demonstrated the complex interplay between a wide range of factors that shape how seriousness is identified. There is no clear and concise regulatory definition of seriousness in relation to fitness to practise, nor does one arise from this research. Rather, we have identified how decisions about seriousness are made within FtP cases and the considerations that underpin these decisions. While identifying some areas of similarity and difference between regulators in their procedures and guidance, we have also found that at the level of individual cases there can be within regulator variation as much depends of the features of a specific case. Our findings do show that FtP panel decisions about seriousness are made in reference to statutory regulatory objectives, especially in

term of protecting the health, wellbeing and safety of patients and the public and maintaining public confidence. However, the concept of public confidence and how this is applied remains somewhat nebulous and open to interpretation by individual decision-makers.

6.5. Implications and areas for development

Our findings from this research offer considerable insights into how decisions about seriousness in fitness to practise operate, especially at the panel stage. It also demonstrates that there are a number of areas where further work could be undertaken, by researchers and regulators, including working collaboratively, to extend the knowledge base and develop practices in this area:

- **FtP Processes**. Differences in legislative frameworks may contribute to differences in FtP outcomes between professional groups, due to the availability of different outcomes, especially the use of recorded censures at different points and the use or not of impairment within FtP processes. Reform to achieve common basic processes may improve comparability and support consistency, but may also risk embedding further legislative rigidity. Further consideration of the intended, and potential unintended, consequences of reform may be worthwhile.
- **Public expectations.** Further investigation of legitimate or necessary differences between regulatory approaches arising from the different nature of the professions being regulated may also be useful. Our research suggests that further work to understand whether the public has different expectations of different professional groups could form part of this.
- **Contextual factors.** Beyond differences in legislative frameworks, there are also apparent differences in regulators' approaches to how some factors are taken into consideration in FtP cases, for example in relation to contextual factors. Monitoring and liaising between regulators around the development of new approaches to such factors may be useful. Developing an enhanced understanding of the barriers to individuals' ability to meet their professional obligations in challenging work environments could help to identify ways to support registrants in difficult circumstances.
- **Engagement and representation.** Registrant engagement and legal representation can impact on decisions about seriousness. Further work to monitor the impact of engagement and representation on outcomes, including any differences in types and

levels of engagement and representation across professional groups may be worthwhile.

- **Public confidence.** The concept of maintaining public confidence is enshrined within the UK health professions regulators' statutory objectives, but our research found that FtP decision-makers have varying understandings of and ways of applying this concept. This is an area where further work to establish how meaningful this concept is, and to develop additional guidance around it, may be desirable.

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8. Appendices

Appendix A: Interview topic guide

Interview Questions

1. **Introduction**
    a. Introduce self and role, research and funding, university.
        i. Including that we have reviewed guidance documents already
    b. Explain confidentiality, tape recording, expected length of interview, nature of discussion, reporting and data storage/archiving.
    c. Any questions?
    d. Written consent - check

2. **Background**
    a. Can you describe your role?

3. **Decision-making process**
    a. Can you please talk me through how you make decisions about misconduct cases?
    b. What tools/criteria/guidance do you use in decision-making? (inc. software/algorithms)

4. **Seriousness**
    a. Can you/How would you define 'seriousness' in relation to misconduct?
    b. How do you decide what is and isn't serious in misconduct cases?
        i. What criteria/guidance do you use?
        ii. Are there particular types of case that are 'serious' or particular factors in cases?
        iii. Are there 'thresholds' for when a case should be considered 'serious'?
    c. How do you weigh up aggravating and mitigating factors?
        i. What types of contextual factors are used and how are these judged?
    d. To what extent does the registrant's response and conduct during the investigation (and hearing) have an impact on your final decision?
    e. How much consideration, if any, do you give to organisational factors?
    f. How do you work as a team (panel) to make decisions?

5. **Impairment**
    a. How do you make decisions about whether a registrant's fitness to practise is impaired?
        i. Is there a threshold to help you determine this?

    b. Do you engage with the public/non-registrants regarding decisions about impairment (and seriousness), and if so how?

6. **Public confidence**
    a. What roles does the concept of public confidence have in how you make decisions about seriousness and impairment?
    b. How is the question of the impact of a registrant's behaviour on public confidence in the profession assessed?

7. **Patient risk/risk of harm**
    a. How does the question of risk of harm to patients or others inform decisions about seriousness and impairment?
    b. How are judgements about risk of harm made, and what factors are considered?

8. **Sanctions**
    a. How are decisions about sanctions made?
        i. What is the aim when applying sanctions?
        ii. What guidance/criteria are used?

9. **Consistency (internal & cross regulatory)**
    a. How do you ensure there is consistency between cases?
        i. What approaches tools, if any, do you use to determine this?
        ii. What quality assurance processes exist?
    b. To what extent, if at all, do you take into account the work of other regulatory bodies or changes they make in relation to FTP?
    c. What role does the PSA play in relation to consistency in FTP decisions and outcomes?

10. **Changes over time**
    a. How long have you worked here? How have things changed in that time in terms of how seriousness is determined?

11. **Legislation and case law**
    a. How do new case laws and new legislation affect fitness to practise cases? Are there any issues that come up?

12. **Service Improvement**
    a. Do you think there are any issues or problems in the Fitness to Practise process, relating to how seriousness is identified or decided? If so, what needs to change to improve it?

13. **Finally**
    a. Is there anything you would like to add or think I should have asked about Fitness to Practise and the regulatory process, in relation to the question of seriousness in particular?

End of interview

- **Remind that they can get in contact with any queries**
- **Ask if they'd like to see a copy of the transcript for information?**

Appendix B: Coding framework

Name	Description
Decision making	Content relating to regulatory & FTP panel decision-making processes
Aggravating and mitigating factors	Content relating to aggravating and/or mitigating factors that taken into consideration during regulatory decision-making processes
Environment or organisational factors	Content on aggravating and mitigating factors related to the environment or organisational culture that the registrant works in
Blame culture	Culture of blame within the organisation. Focus on blaming individuals rather than issues within the organisation
Changing nature of professional role	Professionals expected to take on an increasingly complex role
Economic factors	Content relating to economic factors (such as cutbacks) which may impact on registrant's ability to practise
Organisational culture of dishonesty	Content relating to normalisation of dishonest behaviour (e.g. fraud) within the workplace
Organisational culture of sexualised behaviour	Content relating to normalisation of sexualised behaviour in the workplace
Referrer or complainant dishonesty	Content relating to dishonesty in the initial referral and witness statements provided by referrer or complainant
Safe staffing	Content relating to staffing levels within the registrant's team or service and whether there was adequate staffing in place
Supervision or management	Content relating to the presence or level of supervision or management that is/was in place around a registrant, and whether this could be considered sufficient or insufficient; also content relating to perceived failings of management or supervisory processes

Name	Description
Witness credibility	Relating to credibility of witnesses and witness accounts
Work related stress	
Bullying	Registrant has experienced bullying in the context of the FTP issue
Workload	Content relating to the registrant's workload or their team or service's workload
Impact on registrant	
Nature of case or FTP issue	Content on aggravating and mitigating factors related to the nature of the conduct involved
Abuse of trust	
Area of practice	
Discrimination	
Financial gain or not	
Honesty or dishonesty	Content relating to the extent to which a registrant was acted honestly or dishonestly during events which led to complaint or referral
Media exposure	FTP case and registrant have received media coverage (e.g. Bawa-Garba) and impact on seriousness
On-going or recurrent behaviour	Content relating to whether the behaviour that led to complaint or referral was on-going or happened multiple times
premeditation	
Recklessness or risky behaviour	
Risk of future repetition	Content relating to the risk of future repetition of the misconduct as an aggravating factor
Risk or extent of harm	Content relating to whether the behaviour that led to the complaint or referral caused harm to patients, risked causing harm to patients, or whether there would be a risk of harm to patients if the behaviour continued or was repeated

Name	Description
Single incident	Content relating to whether the behaviour that led to complaint or referral was a single incident
Personal factors	
Acting under duress	
Character	Content relating to making judgements about the 'good character' of a registrant
Cultural background used as mitigation	Cultural background used as mitigating factor in FTP process (e.g. cultural differences in communication or misunderstanding sexual connotations)
FTP History	
Health	
Personal difficulties	
Stage of career	
Wider behaviour or performance	
Registrant response	Content on aggravating and mitigating factors relating to the registrant's response to the complaint or referral, and to subsequent investigation and FTP processes
Admit allegations	
Apology or remorse	Content relating to whether registrants apologise or otherwise show remorse for their actions or behaviour
Attendance at hearing	
Legal representation	
Candour	Content relating to whether the registrant has acted (or are perceived as acting) with candour (openness and honesty) in relation to investigations
Credibility	Registrant or witness is judged to be a credible or non-credible witness
Denial	

Name	Description
Diffusion of responsibility	Content relating to registrant blaming others for their own actions
Blaming target	Content relating to registrant blaming the target for their own actions (e.g. sexual misconduct)
Reducing perpetrator agency	Content relating to registrant reducing their own agency within their defence
Ingenuousness or disingenuousness	Remorse, insight or apology considered to be genuine or not
Insight or lack of insight	Content relating to whether registrants demonstrate (or are perceived as demonstrating) insight or show a lack of insight in relation to issues being investigated
Remediation	Content relating to whether registrants have undertaken remediation to address the issues being investigated (e.g. retraining, reskilling)
Uncooperative	
Calibration	Content relating to methods for calibrating decisions, e.g. case review meetings, risk assessment tools, monitoring processes
Complaint or referral	Content relating to initial complaint or referral to the regulatory body
Allegation	Relating to how allegation is presented in case decision
Proportionality of complaint or referral	Content relating to the appropriateness of complaint or referral, and likelihood of progression through FTP process
Proportionality of complaint or referral related to professional group	Content relating to likelihood of professional group (e.g. social workers and paramedics) receiving more complaints or referrals than other professional groups
Source of complaint or referral	Content relating to who made the initial complaint or referral
Colleague	
Registrant's employer (organisation)	

Name	Description
Self-referral	
Service user or member of the public	
Consistency	
Determination	Relating to the panel's decision regarding whether allegations are proved or not
Proportionality	
Sanctions	Content relating to sanctions that can result or have resulted from FTP procedures
Advice	Content relating to the issuance of advice by a regulatory body to a registrant as a result of an FTP process, e.g. that they should reflect on a specific element of professional guidance.
Conditions	Content relating to the imposition of conditions by a regulatory body/FTP panel on a registrant's practice, which restrict their right to practise or adds specific requirements
Erasure	Content relating to the imposed erasure or removal of a registrant from their professional register; sometimes referred to as being 'struck off'
Mediation	
No sanction	Content relating to circumstances in which FTP investigations or panel hearings conclude with no sanction for the registrant
Punitive effect	
Regulator preference	
Reprimand	
Suspension	Content relating to the suspension of a registrant's registration, removing their right to practise for a set period of time
Interim suspension	
Undertakings	Content relating to the agreement of undertakings between a registrant and their regulatory body, which

Name	Description
	restricts their right to practise or adds specific requirements (e.g. cannot practice particular procedures, or with certain groups of patients unaccompanied)
Voluntary erasure	Content relating to agreement between registrants and their regulatory body which sees the registrant voluntarily give up their professional registration
Warnings	Content relating to the issuance of an official warning to a registrant about their practice or conduct, which are typically public and which may also be called reprimands, censure, or similar.
Stages of decision making	
Transparency	
Equality and diversity	
Key concepts	
COVID 19	
Deficient performance	
Harm	
Impairment	Content referring to impairment or registrants' fitness to practise being impaired
Definitions	Content giving definitions of impairment
Misconduct	Content relating to misconduct (parent code)
Categories	
Boundary violations	Content relating to registrant behaviour that is, or could be, considered to violate appropriate professional boundaries between registrants and patients
Clinical misconduct	
Communication	Content relating to registrants' communication skills
Consent	
Criminal conviction	

Name	Description
Drugs or alcohol	
Dishonesty	
Abuse of Trust	
Breach of confidentiality	Content relating to registrant's breach or patient's or client's confidentiality
Breach of duty of candour	
Falsifying records	
Fraud	Content relating to fraudulent behaviour by registrants
Motivations for dishonesty	
Self-gain	
Unintended	Dishonesty was unintended (e.g. expense claims)
Providing false information	
Research misconduct	
Working alone	Dishonest act is committed solely by the individual
Working with others	Dishonest act is committed with others (e.g. friends, relatives, fellow trainees)
Exploitation	
Hate crime	
Inadequate insurance	
Not reporting FtP concerns	
Patient harm	
Professionalism	
Scope of practice	
self-prescribing	
Sexual misconduct	Content relating to sexual misconduct by registrants
Categories	

Name	Description
Abuse or attacks	
Comments	Sexually suggestive comments are made
Groping	
Inappropriate relationship	E.g. with service user, patient or relative
Pornography	
Involving children	
Involving colleagues	
Involving patients	
Involving vulnerable adults	
Motivations for sexual misconduct	Content relating to motivations given for sexual misconduct
Blurred boundaries	E.g. colleague becomes patient
Sexual misconduct as abuse of power	Sexual misconduct occurs as an abuse of power
Sexual motivation	
Predatory behaviour	
Target of sexual misconduct	Content relating to the primary target of sexual misconduct
Involving children	
Involving colleagues	
Involving patients	
Involving vulnerable adults	
Social media	

Name	Description
Substandard care or practice	Content relating to substandard clinical care or clinical practice
Unregistered practice	
Violence	
Definitions	Content providing definitions of misconduct or comparable terms (e.g. unprofessional conduct, deficient professional conduct)
Morality	Content relating to the morality of registrants' behaviour or to regulatory judgements about registrants' moral standing
Non-work or private life	Content relating to how regulators consider conduct or behaviour that occurs outside registrants' work/practice within FTP cases, processes or policies
Nexus or overlap	Content relating to the nexus, or overlap or intersection between a registrant's activities outside their work and their practice or their status as a registered professional
Risk	
Seriousness	Content referring directly to seriousness in relation to fitness to practise cases or processes or policies
Definitions	Content giving definitions of seriousness
Not serious	
Thresholds	Content describing thresholds at which misconduct becomes serious; or thresholds for sanctions within serious cases
Vulnerability	
Referrer	Content relating to the source of a complaint or referral
Registrant	Content relating to registrants about whom allegations of misconduct are made
Place of qualification	

Name	Description
Professional group or job role	Content relating to registrants' professional group or job role
Protected characteristics or demographics	Content relating to registrants' demographic characteristics, especially those deemed protected by Equality Act 2010
Setting	Content relating to the type of practice setting in which the registrant works
Regulatory framework	
Adversarial	
Case Law	
Changes to FTP processes	Content relating to longitudinal changes to FTP practices and attitudes e.g. shifting from criminal to civil standard of proof in 2008
FTP structures and processes	
Case Examiners	
Background	
Training	
Committees or panels	
Professional expertise	Content relating to panel members with professional expertise in the same field as the registrant
Decision-making process	Content relating to how regulators make decisions regarding FTP cases. Distinct from parent node 'Decision-making' which should include factors which may affect a FTP decision, rather than the process itself
CE decision-making process	
Factors taken into account for progressing or not progressing a case	Not the same as aggravating and mitigating factors which relate to sanctions, this is about the factors that are taken into account in terms of whether a case is escalated
Panel decision-making process	
Panellists	

Name	Description
Background	
Training	
Lawyers	
Legal assessors	
Support provided for registrant	Content relating to processual and/or emotional support provided for the registrant by the regulatory body
Guidance refs	
Interim orders	
Legislation	
Professional Standards Authority	
Professionalism	Content relating to professionalism as a concept, as opposed to misconduct relating to professionalism
Standards or codes	
Regulatory objectives	Content relating to regulatory bodies' core objectives in relating to their overall work and to fitness to practise processes in particular
Deterrent	
Issues with regulation	Content relating to problems identified with the process of regulation, particularly the fitness to practise process, and impact on service users, public, registrants, and organisations
Maintain public health, safety and wellbeing	
Maintaining public confidence in profession	Content referring to the concept of 'public confidence in a profession', or potential damage to this public confidence, and/or the maintenance of this public confidence as a motivation for regulatory policies or activities
Trust	
Patient safety	Content referring to the risk of harm to patients as a motivation for regulatory policies or activities

Name	Description
Promote health, safety and wellbeing of public	
Promote, raise or maintain professional standards	Content referring to ideas about raising professional standards as a motivation for regulatory policies or activities
Protect the public	Content relating to the role of regulatory bodies in protecting the public, in broad terms, and this being a motivation for regulatory policies or activities
Regulator representation	Relating to representation of regulator's position during case hearing
Regulator statistics	Content relating to descriptive statistics around FTP processes
Proportionality of complaint or referral related to prfessional group	Content relating to likelihood of professional group (e.g. social workers and paramedics) receiving more complaints or referrals than other professional groups
Regulatory reform	Content relating to suggested changes to regulatory processes to improve impact and function
Regulator collaboration	
Shipman	

Appendix C: Comparison of cases involving falsifying documents

Case no.	Registrant characteristics	Misconduct	Seriousness	Registrant response	Impairment	Aggravating and mitigating factors	Case law	Guidance	Panel determining comments	Sanction
MPTS 013	Locum consultant in endocrinology and diabetes -full apology made -full admissions to the Allegation and the fact that he accepted his dishonesty amounted to serious misconduct. -no history of such behaviour. -testimonials show that there have been no issues over probity, honesty or clinical competence either before or since the dates of the Allegation. -misconduct was entirely out of character. -working successfully as a Locum Consultant.	Uploaded falsified certificate to portfolio in order to gain entry to specialist register	-Serious breach of standards -Honesty and integrity – fundamental tenet -Would be considered deplorable by fellow practitioners and members of the public -Motivation – for own benefit to obtain entry to specialist register	-Attended hearing -Legal representation -Lied in local meeting and blamed family members -Lied further outside regulatory investigation -Accepts dishonesty amounts to serious misconduct -Full admission -Full apology -Reflection shows insight	**Protect the public – no real risk of repetition** **Public confidence** – if portfolio entries not accurate, stops process working -Expectation of honesty and integrity from doctors - No risk of harm to patients - Attempts to flout system reduces confidence in which it is held by profession and public and more generally puts patients at risk -Sustained dishonesty	**Aggravating** -Significant departure from professional principles -Dishonesty in professional context to gain entry onto specialist register -Sustained dishonesty -Blamed others **Mitigating** -Good character -Exemplary professional service -Apology, regret, remorse -Full admission -Accepted serious misconduct	Nicol J in Ali Abbas v GMC [2017] EWHC 51: "a finding of dishonesty is of particular significance, especially if it is persistent and combined with a lack of insight. In such circumstances, 'nothing short of erasure is likely to be appropriate' - see Naheed v GMC [2011] EWHC 702 (Admin) at [22] per Parker J. Plainly, the individual circumstances of the case must be considered and there can be no universal or inflexible rules in this context.	**Dishonesty** -Outside clinical responsibility particularly serious -can undermine trust public place in profession **Suspension** -deterrent effect -appropriate where there may have been acknowledgement of fault and low risk of repetition -So serious that action must be taken to maintain public confidence but falls short of being incompatible	-Tribunal was satisfied that a period of suspension is necessary to send a clear message to the registrant, the profession, and the wider public, that dishonesty constitutes behaviour unbefitting a registered professional. However, the Tribunal took into account the fact that there is a public interest argument in not keeping otherwise good and competent doctors from treating patients for any longer than necessary for the purposes of maintaining public confidence and professional standards.	Suspension – 1 month. Review not required

					- Therefore, finding of impairment necessary	- Insight -No risk of repetition -Testimonials and references	As Blake J. said in Atkinson v GMC [2009] EWHC 3636 (Admin) at [13], 'erasure is not necessarily inevitable and necessary in every case where dishonest conduct by a medical practitioner has been substantiated. There are cases where the panel, or indeed the court on appeal, have concluded in the light of the particular elements that a lesser sanction may suffice and it is the appropriate sanction bearing in mind the important balance of the interests of the profession and the interests of the individual. It is likely that for such a course to be taken, a panel would normally require compelling evidence of insight and a	with continued registration		

							number of other factors upon which it could rely that the dishonesty in question appeared to be out of character or somewhat isolated in its duration or range, and accordingly there was the prospect of the individual returning to practise without the reputation of the profession being disproportionately damaged for those reasons.'			
MPTS 019	**Registrant characteristics** -Positive testimonials -No clinical concerns -Clinical competence cannot excuse or mitigate dishonesty -English not first language	**Misconduct** Deliberately amended certificate from foreign ministry of health in order to gain entry onto specialist register	**Seriousness** -Breach of fundamental tenet – honesty and integrity -Considered deplorable by fellow practitioners -deception was deliberate and intended to assist in	**Registrant response** -Attended hearing -No legal representation -Acknowledged misconduct deceitful and dishonest -Inconsistencies in evidence before tribunal	**Impairment** **Protect the public** -Little evidence of insight or remediation -Recognises full insight will take time to develop -Registrant provided	**Aggravating and mitigating factors** **Aggravating** -Motivated by personal gain -Put own interests ahead of those of regulator -Deliberate plan to deceive regulator	**Case law** -PSA v GMC & Igwilo [2016] EWHC 524 which states: "The purpose of the Specialist Medical Lists and the GMC's regulation of them is to protect the public interest, including the safety of	**Guidance** **Erasure** -Any of the following factors being present may indicate erasure is appropriate -a. A particularly serious departure from the principles set out in Good Medical	**Panel determining comments** -Lack of insight and remediation, therefore suspension would not meet the need to protect patients or wider public interest -Undermined public confidence	**Sanction** Erasure

	-Good character -20 year career without referral		achieving specialist registration -deception was recurrent	and in correspondence with regulator -Intention of deceiving regulator -Registrant considered misconduct serious but not shocking	contradictory evidence -Concerns about credibility and candour -Misconduct not repeated -Misconduct atypical of prior good character -20 medical career without referral -Low risk of repetition but lack of insight, remediation – risk of repetition can be ruled out **Public confidence** -Honesty and trustworthiness, acting with integrity and within the law are cornerstones of the profession and public expects practitioners to meet	-Very little insight or remediation -Did not take opportunities to admit misconduct before being found out **Mitigating** -Admitted all aspects of allegations -No previous finding of impairment -Unblemished career -Positive testimonials -Single incident, although over extended period	patients, and in the case of forensic psychiatrists, to maintain the standards of expert evidence submitted in court cases. Dr Igwilo applications had not met the required standard for the Specialist Register of Forensic Psychiatrists on two previous occasions. He responded to the guidance given by the GMC as to how he might improve his prospects of success by using deception and deceit to try to obtain inclusion in the list when he was unable to do so by legitimate means. Such conduct jeopardised the integrity of the Specialist Medical List system, and the GMC's ability to regulate it.	Practice where the behaviour is fundamentally incompatible with being a doctor -b. A deliberate or reckless disregard for the principles set out in Good Medical Practice and/or patient safety -h. Dishonesty, especially where persistent and/or covered up j-. Persistent lack of insight into the seriousness of their actions or the consequences. -Although it may not result in direct harm to patients, dishonesty related to matters outside the	-Put patient safety at risk -Reckless disregard for principles -lack of credibility within evidence -little evidence of remediation -no acknowledgment of extent of dishonesty -no real insight -remediable but lack of insight and justification of misconduct interferes with ability to remediate	

					professional standards -Failure to be honest with regulator is a serious breach of standards Forging of certificate attesting to professional qualification has the potential to put patients at risk -impaired on grounds of public confidence and professional standards			doctor's clinical responsibility (eg providing false statements or fraudulent claims for monies) is particularly serious. This is because it can undermine the trust the public place in the medical profession. -Health authorities should be able to trust the integrity of doctors, and where a doctor undermines that trust there is a risk to public confidence in the profession. -Evidence of clinical competence cannot mitigate serious and/or persistent dishonesty. -Dishonesty, if persistent and/or covered up, is		

								likely to result in erasure. ’		
HCPC 009	**Registrant characteristics**	**Misconduct** -Submitted two bogus training certificates to potential employer	**Seriousness** -Reasonable and honest people would consider actions to be dishonest -Planned and required degree of sophistication of carefully doctored certification intended to dupe a potential employer -Put registrant and work colleagues at risk	**Registrant response** -Challenged by HR and denied all knowledge of wrongdoing, later resigned -Not in attendance and made no submissions -Panel treated all allegations as denied	**Impairment** **Protect the public** -Dishonesty may be attitudinal in nature so more difficult to remedy -No engagement and no evidence submit So no evidence of remedy -High risk of repetition -No evidence accepts extent of failings -No evidence of insight **Public confidence** -Colleagues placed at risk of harm	**Aggravating and mitigating factors** **Aggravating:** -Pre-planning and sophistication -Not an isolated incident, dishonesty persisted over 2 months -Public placed at risk of harm -Failure to engage in reg proceedings -No evidence of insight, remorse or remediation -Very serious misconduct **Mitigating:** **-**No previous reg. findings	**Case law**	**Guidance** **Dishonesty:** **-**Undermines public confidence in profession and can sometimes impact patient safety -Likely to lead to more serious sanctions -Can have a significant impact on trust placed in those who have been dishonest and public safety -Serious of dishonesty = seriousness of sanction -However, there are different degrees of dishonesty e.g.:	**Panel determining comments** -Dishonesty not isolated -Put the public at risk -Lack of insight -No evidence of remediation or willingness to remediate -Therefore current risk of harm to public and public interest -Public interest in retention of experienced professional -Erasure proportionate to misconduct	**Sanction** Erasure

					-Public confidence undermined by risk of harm and dishonesty -Professional standards undermined if no finding of impairment, especially given seriousness of findings so far			-single incident or recurrent -duration -passive or active role -early admission of dishonesty		
NMC106	**Registrant characteristics** -Long unblemished career -Caring and compassionate nature (from testimonials)	**Misconduct** Submitted falsified training certificates to locum agency Failed to disclose current local investigation	**Seriousness** -Training completed but no valid certificate, therefore did not place patients at risk of harm -Opportunistic (as opposed to pre-meditated) -Motivation – self-gain (employment) -repeated acts of dishonesty	**Registrant response** -Attended hearing -Early admissions -Apology and remorse -Insight – awareness of impact on reputation of nursing profession, breach of tenets and dishonesty -Positive testimonials provided by patients re. good	**Impairment** **Protect the public** -No risk of harm -Whilst could have remediated more, remediated enough that panel could not conclude registrant was liable to repeat misconduct **Public confidence** -Acts brought profession into disrepute and	**Aggravating and mitigating factors** **Aggravating** -Repeated dishonesty -Motivation – attempt to gain employment **Mitigating** -Early admissions -Full engagement -Remorse -Insight	**Case law**	**Guidance** -Lower end of the spectrum of impaired fitness to practise where panel wishes to mark unacceptable and must not happen again	**Panel determining comments** -Dishonesty at the lower end of the spectrum -Misconduct the result of poor spontaneous judgement rather than a deep-seated attitudinal issue -No patient harm, early admissions, apology, evidence of genuine remorse -Engaged with regulator since referral	**Sanction** Warning – 2 years

				character and practice, commitment and caring approach -Remediation - two incidences in long career -Clinical ability never questioned prior to incidents -Provided satisfactory answers regarding how to handle in the future	breached fundamental tenets of honesty and integrity -Serious nature of the misconduct -Repeated dishonesty -Public confidence would be undermined if impairment not found -Impairment on grounds of public confidence only	-2 incidents were opportunistic and set against a background of long, unblemished career -No other regulatory findings -No further issues since -Caring and compassionate nature -Willingness to continue to remediate in the future			-Insight into past misconduct -Efforts to remediate -No adverse findings before or since -Had salutary impact on registrant -Suspension disproportionate considering insight, remorse and remediation -Public interest satisfied by caution order -In the public interest to retain experienced professional	
NMC026	**Registrant characteristics** -Clinical competence not called into question -Testimonials – colleagues speak highly of clinical abilities	**Misconduct** Submitted falsified training certificates to locum agency	**Seriousness** -Considered deplorable by other registered professionals and amounts to serious professional misconduct -Honesty – bedrock of profession and public expect	**Registrant response** -No insight -No remorse -Admission at outset of hearing to one charge but this would have been difficult to deny due to	**Impairment** **Protect the public** -Lack of insight and remorse, lack of understanding of significance of behaviour, therefore risk of repetition	**Aggravating and mitigating factors** **Aggravating** -Level of sophistication and planning -Lack of insight and remorse **Mitigating**	**Case law**	**Guidance** **Suspension** -this sanction may be appropriate where the public interest can be satisfied by a less severe outcome than permanent removal from the register.	**Panel determining factors** -Misconduct not at lower end of spectrum -Nature of case attitudinal rather than clinical -Clear breach of fundamental tenet but misconduct not	**Sanction** Suspension – 6 months

			honesty and integrity -by breaching fundamental tenet, put reputation of profession at risk -Patients not at risk of harm	overwhelming evidence -No understanding of why what you did was wrong and how it would impact negatively on profession -No evidence of remediation -Dishonesty by nature is attitudinal and so difficult to remediate	-Impaired **Public confidence** -Impairment on grounds of public interest	-Positive testimonials re clinical practice -No previous regulatory findings -Single incident in 17 year career		This is more likely to be the case when the following factors are apparent: -a single instance of misconduct but where a lesser sanction is not sufficient -no evidence of repetition of behaviour since the incident	fundamentally incompatible with remaining on the register -Suspension for six months reflects gravity of misconduct and gives time to develop insight into seriousness of behaviour -Public interest – period of suspension will make seriousness of misconduct but also allow an experience and clinically competent professional to return to practise.	

Appendix D: Comparison of case involving violent conduct in non-professional settings

Case code	Registrant	Misconduct	Seriousness	Registrant response	Impairment	Aggravating and mitigating factors	Case law	Guidance	Panel determining comments	Sanction
GOC011	Student registrant	-Criminal conviction violence aggravated by homophobia towards acquaintance in non-professional context -Punched 2-3 times -Verbal abuse -Community order	-More severe conviction as aggravated by homophobia	- Self-referred to regulator - Accepted culpability in police interview and prepared to offer apology to victim - Did not attend hearing - No legal representation - No engagement with regulator - No intention of returning to studies	-Grant – a,b, c engaged -Concern there is potential for registrant to react angrily towards patients -Potential for insight and remediation but no engagement and so no evidence -Recognised self-referral, admission to police and offer of apology but no apology sent to regulator and no engagement in process -Therefore risk of repetition and registrant impaired	**Aggravating** -Violence involved striking a woman several times, causing injury -Only stopped because others intervened -Used abusive language -Aggravated by homophobia -No insight or remorse, no remediation -Limited engagement with reg process **Mitigating** -No prior fitness to practise history -Self-referred -Pled guilty -Isolated and spontaneous act -Would have apologised if bail conditions allowed	The Committee recognise that this was the most severe sanction but had regard to what was said in Bolton v Law Society "…The reputation of the Profession is more important than the fortunes of any individual member."		- Aggravated by homophobia assault – evidence of deep-seated attitudinal issue -Not willing to respond positively to conditions – no intention to return to practice, limited engagement with process -Suspension – no evidence of insight, risk of repetition, deep-seated attitudinal problems, patients not protected by suspension, nor wider public interest and public confidence -Registrant's conduct which gave rise to his conviction is fundamentally incompatible with remaining on the register -Offence involved violence.	Erasure

									-Persistent lack of insight into seriousness of the impact of the offence on safety of patients and reputation of profession. -Serious departure from council's standards for optical students	
MPTS 009	**Registrant characteristics** -Consultant -Misconduct investigated at work. Duties restricted until counselling completed. Duties resumed	**Misconduct** -Two separate assaults on the same woman in a domestic context -First assault involved two punches in the face with bruising -Second assault involved slapping the face -Victim did not wish to pursue criminal charges	**Seriousness** -Repetition of assault -First assault caused injury	**Registrant response** -Misconduct admitted and found proved -Demonstrated insight -Cooperative throughout investigation -Detailed supportive testimonials from colleagues	**Impairment** -No concerns about patient safety -Maintained professional standards throughout -No further incidents since period of misconduct -Developed insight at early stage -Understands impact on victim, colleagues, and profession -Took full responsibility for actions -Remediation – counselling -Impressive efforts to remediate -Low risk of repetition	**Aggravating and mitigating factors** **Mitigating:** -Engagement and co-operation with the regulator's investigation -Full and frank admissions at every stage of these proceedings -Genuine expressions of apology and remorse -Previous good character with no previous Fitness to Practise concerns -Exemplary testimonials from colleagues -Developed insight -The lapse of time since the misconduct with no repetition. **Aggravating:** -There were two acts of violence	**Case law**	**Guidance** **Suspension** Some or all of the following factors being present would indicate suspension may be appropriate. a. A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical	**Panel determining comments** -Period of conditional registration would not adequately reflect the serious nature of the misconduct. -The Tribunal considered that conditions would not send the appropriate message to the registrant, the profession and public about what is regarded as behaviour unbefitting a registered professional. -No evidence of repetition since original misconduct. -Risk of repetition low. -Has insight.	**Sanction** Suspension – 2 months

					-**Member of public would not require finding of impairment on grounds of public protection** -Breached fundamental tenet and brought profession into disrepute -**Impairment on grounds of public confidence** necessary because of gravity and circumstance of misconduct and because repeated over a significant time	over a period of time -The first assault involved a punch which caused significant injury		register would not be in the public interest. f. No repetition of similar behaviour since incident. g. has insight and does not pose a significant risk of repeating behaviour	-Admitted misconduct, -Has engaged with proceedings -Genuine remorse, accepted culpability, genuine insight and remediation. -Exemplary testimonials, examples of registrant de-escalating stressful situations. Period of suspension will send out a signal to the doctor, the profession and public, that violence, which was repeated, is unacceptable and is regarded as behaviour unbefitting of a registered professional. -registrant is a valuable doctor with leadership roles extending across, [specialties].	
MPTS 010	**Registrant characteristics** Consultant -Unusual stressors – no accommodation, living away from	**Misconduct** -Assaulted and verbally abused member of the public -Arrested and admitted responsibility for pushing	**Seriousness** The Tribunal determined that if a member of the public were to know that a doctor has received a conditional	**Registrant response** -Attended hearing -Legal representation -Self-referred -Admitted allegation	**Impairment** -Has insight -Visibly upset by behaviour. -Genuine remorse. -Took full responsibility for actions	**Aggravating and mitigating factors** **Mitigating:** -No actual harm	**Case law**	**Guidance** -Where a doctor's fitness to practise is impaired, it will usually be necessary to	**Panel determining comments** -Unusual combination of professional and social stressors -Can taking no action meet overarching	**Sanction** No action

	home, loss of professional post	-Guilty of assault by beating -Conditional discharge – no conviction	discharge for assault by beating, contrary to section 39 of the Criminal Justice Act 1988, they would be shocked.	-Admits misconduct	-Open and candid in evidence -Robust understanding of impact of actions in victim and profession. -Remediation – sought out counselling of own volition -The Tribunal found the risk of repetition to be low as this combination of circumstances is highly unlikely to arise again. -Finding of impairment necessary to promote and maintain public confidence and standards			take action to protect the public. But there may be exceptional circumstances to justify a tribunal taking no action. -The Tribunal accepted the evidence of the professional witnesses that the registrant's combination of stressors was highly unusual and rare, noting that the probability of the simultaneous combination of these events is incredibly unlikely. The Tribunal determined that these individual stressors when combined amounted to exceptional circumstances	objective? A (risk of harm) – not relevant, B (public confidence) – finding of impairment sufficient to meet public confidence limb, C (professional standards) – misconduct and impairment both a matter of public record (impact on reg). If comes before reg. again, has lost previous unblemished record, no action sufficient to maintain standards. Suspension purely punitive so not imposed	

MPTS 039	Registrant characteristics -Consultant - Overwhelmed by work	Misconduct Reached into motorist's car and grasped him by the neck On hospital grounds Conditional caution for common assault	Seriousness	Registrant response -Self-referral -Full admissions -Attended hearing -Legal representation -Apology and remorse -Attended anger management course	Impairment Remediation – modified workload and responsibilities, anger management course Took responsibility for actions Comprehensive insight Single incident Mitigating factors – workload, loss of support at work, pressures at home, Positive testimonials No personal impairment. Remediation, insight, low risk of repetition. Public interest - conditional caution for assaulting a member of the public on hospital grounds. – actions caused alarm to those who witnessed it. Considering the wider public interest, the Tribunal were satisfied that any	Aggravating and mitigating factors -**Mitigating** -Full admissions of wrongdoing from the outset and has fully co-operated with all investigations -Offered apology to victim, expressed feelings of shame and remorse and has accepted full responsibility for the assault -Misconduct was a momentary loss of control -Victim was not physically injured -No previous violent behaviour or repetition since the incident -Unblemished 28-year career - Comprehensive insight into behaviour -Remediation – completion of relevant courses -Registrant under considerable pressure professionally and personally -Registrant is working on ongoing strategies to ensure he maintains the correct work-life balance and does not repeat such	Case law **Registrant's representative: considering** the case of Giele v GMC [2005] EWHC 2143 (Admin), Justice Collins made clear that the public interest includes retaining the services of a doctor with considerable abilities and commitments. He submitted that in the case of Mehta, the Court held that it was proper for the Tribunal to take into account the fact that the doctor was a skilled and valuable practitioner in deciding that its finding of misconduct and impairment was sufficient for the maintenance of public confidence without further sanction.	Guidance **Length of sanction**: The following factors will be relevant when determining the length of suspension: a the risk to patient safety/public protection b the seriousness of the findings and any mitigating or aggravating factors c ensuring the doctor has adequate time to remediate	Panel determining comments -Substantial weight attached to professional testimonials -Exceptional and committed consultant valued by colleagues and patients -The Tribunal accept that the uncontested testimonials demonstrate that the registrant is an exceptional doctor who is wholly committed to his work, his colleagues and his patients and that he has shown insight and extensive remediation. Those factors of themselves, did not warrant the Tribunal to make a finding that there are exceptional circumstances in this case. The Tribunal was satisfied that the registrant's acceptance of a conditional caution for common assault is not	Sanction Suspension – 1 month

					member of the public witnessing the incident would be concerned about such behaviour displayed by anybody, but particularly such behaviour by a member of the medical profession. Taking this into account, it considered that limbs b and c of the over-arching objective are engaged Far below standard – therefore public confidence and professional standards impairment	behaviour in the future. **Aggravating**: -Conditional caution after committing a physically violent offence; -Assault was on a member of the public and took place on hospital grounds -Assault took place while he was on duty -Independent witnesses to the misconduct were alarmed by his behaviour.			fundamentally incompatible with his continued registration because of the mitigating factors set out above. The Tribunal determined to suspend registration from the medical register for a period of one month. The Tribunal considered that a longer period of suspension would have a purely punitive effect on the registrant. Rather than marking the seriousness of his departure from the behaviour expected of a doctor, it would be a potential risk to patients, as highlighted in the uncontested testimonials, should the registrant be unavailable to treat them for a prolonged period.	

HCPC 014	Registrant characteristics Paramedic	Misconduct -Police called to altercation between registrant and person A at person A's house -Registrant pleaded guilty to actual bodily harm -Community order, restraining order and court costs. --Mandatory rehab course.	Seriousness -Took place outside work -Related to registrants personal life -Alcohol involved -Difficult personal circumstances -There was evidence that the Registrant, during a violent argument, caused injury to Person A. -The police were contacted firstly by multiple people regarding the incident. -The Panel considered that this was behaviour which fell significantly short of that which the public is entitled to expect from a registered professional.	Registrant response -Self-referred -Attended hearing -Legal rep. -Fully engaged	Impairment -Took place outside work -Related to registrants personal life -Drinking alcohol at the time -Difficult personal circumstances -Pleaded guilty and self-referred -Complied with conditions of sentence -Apologised and expressed remorse -Accepts that she broke person A's toe in altercation -Isolated incident -Accepts she should not have drunk alcohol at the time -Fully appreciated the significance of conduct on wider public -Fully engaged in proceedings -Given evidence of insight and remediation	Aggravating and mitigating factors **Aggravating:** no aggravating features beyond the circumstances of the conviction. **Mitigating**: -This is an isolated incident, and the Registrant has had a previous unblemished employment record and there are no clinical concerns -The Registrant was dealing with difficult personal circumstances at the time of the incident -The Registrant has taken a proactive and responsible approach by her early guilty plea and reporting of the matter to the regulator. -The Registrant fully completed the requirements of her sentence within a short space of time -The Registrant has demonstrated insight and remorse and the risk of repetition is low.	Case law	Guidance	Panel determining comments The Panel noted the insight demonstrated by the Registrant and the steps she has taken to address the issues that led to the offending behaviour. The Panel considered a Suspension Order would be disproportionate, as the conviction was not at the higher end of seriousness and was an isolated incident during difficult personal circumstances. In light of the Registrant's insight and the length of time these proceedings had been ongoing, the Panel considered that a Caution Order of 1 year was appropriate to mark the seriousness of the behaviour. The Panel considered that this was the proportionate balance to protect and	Sanction Caution – 1 year

					-Positive testimonials -Low risk of repetition **-Not impaired on personal component** -Serious misconduct – caused harm and member of public called police with concerns regarding registrant's behaviour. -Breached fundamental tenets and brought profession into disrepute -**Impaired on grounds of public confidence**				uphold proper standards of conduct and behaviour and to enable the Registrant to return to practice	
GOsC 035	**Registrant characteristics** Registered osteopath	**Misconduct** -Aggressive behaviour towards acquaintance -Registrant assaulted victim on two occasions -Victim left shaken and distressed	**Seriousness** -Outside professional context -Researching techniques related to professional practice so misconduct not wholly unrelated to professional practice	**Registrant response** -Did not attend hearing -No legal represent. -Panel had regard to written submissions -Registrant denied assault -Panel determined registrant's account was 'inherently unlikely'	**Impairment** -Not determined	**Aggravating and mitigating factors** **Mitigating:** -Single incident on a single day -Previously good character -Excellent testimonials from a wide range of people which speak to general integrity and good character -No similar behaviour since misconduct **Aggravating:**	**Case law** **Reg rep:** Remedy – a finding of serious professional misconduct (in the context of GMC proceedings) could arise as a result of behaviour which does not occur within the actual course of a person's professional conduct	**Guidance**	**Panel determining comments** Serious matter with potential to reflect badly on profession as a whole. Isolated nature of incident and numerous positive testimonials, not fundamentally incompatible with remaining on the register	**Sanction** Suspension – 12 months with review

						-Acted with violence -Unprovoked assault caused significant distress to victim -No significant insight, behaviour remains unexplained			Not in public interest to remove from register Period of suspension proportionate to mark seriousness of misconduct and to send a message that behaviour is unacceptable	
GPhC 017	**Registrant characteristics** Registered pharmacist	**Misconduct** Conviction of assault by beating and criminal damage	**Seriousness**	**Registrant response** -Attended hearing -Admitted allegations -Legal representation -Remorse -Learnt to manage anger and stressful situations -Self-referral -Pleaded guilty	**Impairment**	**Aggravating and mitigating factors** **Mitigating**: -no previous fitness to practise history -acknowledged his guilt at the first opportunity at court -co-operated with investigations -admitted the facts and concedes fitness to practise is impaired -no repetition of the behaviour underlying the convictions **Aggravating:** -The assault was a series of blows including kicking to the head -The magistrates regarded the offences as so serious that a sentence of imprisonment,	**Case law** **Regulator representative:** CHRE v GDC and Fleischmann [2005] EWHC 87 (Admin): "where a practitioner has been convicted of a serious criminal offence...he should not be permitted to resume his practice until he has satisfactorily completed his sentence." **Legal Assessor:** the principle of the case of Fleischmann had been made clearer by the later case of Obukoff v GMC [2014] EWHC	**Guidance**	**Panel determining comments** The Committee concluded that a period of suspension was the appropriate and proportionate sanction in this case, even though it could have a substantial impact on the Registrant. -This sanction was necessary to mark the gravity of the convictions, taking account of the aggravating and mitigating factors and the Registrant's limited insight at this stage. -The period of suspension	**Sanction** Suspension – 9 months with review.

						albeit suspended, had to be imposed.	408 (Admin). The principal element of criminal justice sentencing that regulatory committees should have regard to was not the ultimate date when it could be said the sentence had expired but whether any rehabilitative steps the Registrant had been ordered to complete within that period had in fact been completed satisfactorily.		would also allow the Registrant to complete the rehabilitation requirements imposed by the magistrates and any other steps he wished to undertake to prevent a re-occurrence of inappropriate behaviour. The Committee took account of the case of Fleischmann and felt bound by it in determining the length of the period of suspension.	