Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK Health and Social Care: Insights into sexual misconduct and dishonesty

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Foreword

This research is the most ambitious project yet undertaken to use the information contained in the Professional Standards Authority's database of fitness to practise determinations from the nine statutory regulators we oversee. We are grateful to Professor Searle for having proposed this ground-breaking approach to us and are confident that her work has real interest and value.

Professor Searle and her colleagues have analysed the determinations from 6,714 final fitness to practise hearings, these being the cases involving registrants of the Nursing and Midwifery Council, the General Medical Council, and the Health and Care Professions Council. Using the coding that is applied to determinations when they are received for review by the Authority, and applying cluster analysis, they have shown how the different kinds of departure from professional standards group together for the different professions. They have also analysed in more depth cases involving sexual boundary violations, and cases involving dishonesty.

In doing so, Professor Searle offers us a rich and fascinating discussion of the complex and subtle interplay between individual professionals, teams, workplaces, gender and culture. Three different types of perpetrator emerge from the discussion: the self-serving bad apple, the individual who is corrupted by the falling standards of their workplace, and the depleted perpetrator struggling to cope with the pressures of life. The analysis of these types places our understanding of misconduct in the sector within the academic literature on counterproductive work behaviour, and suggests a range of preventative and supportive approaches specific to each.

The data on which the analysis is based has been collected in pursuit of a regulatory process, yet the findings of this analysis clearly have much wider implications for many stakeholders. We look forward to discussing the findings widely, and how they can be used to support preventative interventions in future by regulators, employers, and others.

The report points to areas for future research, including a recommendation for a more targeted look at the fairness of sanctions across the different professions. The report also gives the Authority helpful guidance on how we might continue to enhance the ability of our data to be used for future research.

We are extremely grateful for the engagement with colleagues at the NMC, GMC and HCPC in this study, which was invaluable. I also acknowledge the important contribution of Douglas Bilton, our Assistant Director for Standards and Policy, who has done so much to shape the quality and relevance of our research.

Harry Cayton CBE

Chief Executive
Professional Standards Authority

Executive Summary

This report outlines the results of a sequential mixed methods analysis examining 6,714 individuals' fitness to practise (FtP) cases from three distinct groups - doctors, nurses and midwives, and allied professionals working in the UK health and social care context. FtP is a process for handling complaints about professionals in order to determine whether someone is fit to practise. The most serious of these cases are referred to a formal panel hearing. We used the determination documents that record the decision taken in formal hearings in our analysis to consider the prevalence and difference in misconduct cases across and within each profession. From our multi-method analysis, we: 1) identify the most prevalent forms of wrongdoing; and 2) examine in further details three forms of misconduct whose existence and prevalence undermines trust in professionals and confidence in institutional systems. From our analysis we improve understanding of how and why professional wrongdoing occurs.

Specifically, our analysis shows eleven frequent forms of wrongdoing, with comparative quantitative cluster analysis for each profession offering exploration of the commonalities and differences. Applying Robinson and Bennett's (1995) taxonomy, we offer a meta-level perspective on these wrongdoings and their interconnections to reveal fundamental similarlities between misconducts across these professions. Then, using quantitative analysis, we examine three types of FtP dimension to explore in further detail these misconducts. We include the most prevalent, dishonesty and theft, common to all three professions, and add further insight by specifically analysing qualifications dishonesty where

the target for perpetrator action is the organisation. We also explore differences across these three professions for arguably the most severe form of wrongdoing, sexual misconduct. Each of these forms of wrongdoing are self-gratifying actions which are diametrically contrary to that expected from a health professional.

Our qualitative analysis is two-stage, identifying the perpetrator profession and gender differences, specifically their different target(s) and location(s) of these wrongdoings. We highlight differences in both the recording of misconduct and also the form and severity of sanctions used. Importantly, we distinguish three different types of perpetrator: first, a category of instrumentally-focused perpetrators (bad apples) operating as sole agents; the second group is characterised as follower-based action in which individuals' wrongdoing has a clear social dimension emanating from learning and transfer from key others, and involves the normalisation of misconduct, and thus the erosion of perpetrators' moral compasses (corrupting barrels); the final category is typified by a different set of antecedent processes, and central here is the accumulative erosion of individuals' resources through stress or resource depletion, and therefore misconduct emerges through omission and error (depleting barrels). The latter category is not found for qualifications fraud.

Through gaining a more nuanced multi-dimensional perspective of wrongdoings, we offer recommendations to aid regulators and employers to improve their detection of perpetrators and how to ameliorate the occurrence of these behaviours within health organisations. We

outline key roles and organisations which appear far more frequently and could particularly benefit from targeted resources. We discuss education and training of professionals and the public that might also offer a further means to enhance detection and reduce their occurrence. We also identify ways that regulators and the Professional Standards Authority might improve their reporting and categorisation of FtP cases that would allow more support for subsequent analysis of professional misconduct, and so improve our ongoing understanding of how and why wrongdoing occurs. We contend such advances are important in this unique and sensitive health and social care context, in which service users are particularly vulnerable and where wrongdoing by one professional can have pernicious consequences in eroding confidence in the wider professions, regulators and employers. Signalling trustworthiness and restoring confidence for all three professions through systems that can better detect, monitor, and sanction perpetrators keeps service users, employees, and the public safe.

1. Introduction

In the context of health, the relationship between the professional and a service user is unique due to the intimate nature of the procedures and treatment provided, and the high stakes for the service user (Dixon-Woods et al, 2011). The type of relationship is enshrined in professional oaths (e.g. the Hippocratic Oath) and codes of conduct (Merrison, 1975) which exhort these professionals to aid the sick without causing them further injury or harm. In this way, those working in professional health roles are positioned as particularly trustworthy and virtuous; the social contract for these services is predicated on trust and confidence (Dixon-Woods et al., 2011). Yet instances of professionals' misconduct challenge, at a fundamental level, such taken-for-granted notions.

a. Twin assurances of trust

In the UK, healthcare operates by virtue of a social contract supported by twin assurances of trust and confidence (Dixon-Woods et al., 2011). In the unusually high stakes of healthcare, trust is a salient concern, due to a number of factors. These include multi-stranded service user vulnerability arising from: i.) temporal constraint (i.e. treatment needed now); ii.) variations in the speciality skills and expertise of health professionals, which then can, iii.) reduce the number of viable alternatives for individual service users. The user therefore trusts a health professional not to further exacerbate their exposure to risk, nor increase their level of dependency through exploitation for self-gain, or undermine their sense of self-determination (Barnard, 2016). Besides this potential vulnerability, user confidence arises and is assured by controls that operate from two institutions - the healthcare

regulator (Dixon-Woods et al., 2011) and the professional's employer. There are four key forms of controls evident here. They include: i.) Input controls which check and restrict entry to professions and health organisations to only those with the key knowledge, skills and experiences, and attitudes (Cardinal and Sitkin, 2010); ii.) Process controls which stipulate how tasks should be undertaken and the way professionals are to be monitored, often formalised in terms of regulations or human resources, health and safety, and other work-based formal procedures (Snell, 1992); iii.) Output controls which involve practice to achieve performance goals and associated metrics pertaining to what is done (Snell, 1992); iv.) Finally, normative controls which concern the enforcement of accepted and regulated norms, legalistic mechanisms, and enshrined values (Sitkin and George, 2005). These regimes of regulation provide oversight in terms of formal monitoring and the sanctions given to those who do not comply (Dixon-Woods et al., 2011), and are often reinforced further by informal peer norms (Lawrence and Robinson, 2007). Research shows controls both complement and can enhance trust (Weibel et al., 2016).

FtP cases question the competence and integrity of the individual professional, but also raise a challenge towards a profession and institutions (Muzio et al., 2016). Indeed, history shows how earlier self-regulatory models have had to be abandoned in the wake of earlier health scandals (Dixon-Woods et al., 2011). Importantly, investigation of how and why wrongdoing occurs can help identify 'control vulnerabilities' which regulators and organisations can focus their efforts on and thus restore trust and confidence.

b. Introduction to counterproductive work behaviours: four approaches

Professional misconduct is one example of Counterproductive Work Behaviours (CWB): a voluntary form of action which violates significant norms for the organisation, threatens the wellbeing of organisations, the employees that operate there, and/or those receiving service from them (Robinson and Bennett, 1995). Wrongdoing occurs where professionals lack the motivation required to comply with normative expectations or prescribed codes of their roles (e.g. regulator's professional standards; health and safety procedures), or where they seek to exploit either vulnerable individuals or organisational systems for their own self-gain (e.g. deliberately falsifying qualifications; stealing property).

Research into CWB has distinguished two forms of action - instrumental or premeditated actions, and those which are more impulsive (Berkowitz, 1993). In categorising these types of behaviours, two organisation-level dimensions have been identified. These involve: property deviance which involves the misuse of the organisations' resources, such as inappropriate use of IT systems, from those which are termed 'production deviance' and concern how job tasks and work roles are to be done (Hollinger, 1986), such as poor record keeping or failure to record patient histories correctly. These types of misconduct contravene the formal output and process controls (Weibel et al., 2016). In contrast, a second category focuses on interpersonal actions, such as being verbally aggressive or sexually harassing a patient (Robinson and Bennett, 1995). Robinson and Bennett's (ibid.) accepted workplace misconduct taxonomy also includes a severity continuum, which distinguishes more serious interpersonal-

level aggressions, such as sexual harassment and other forms of physical abuse, from that targeted at property, such as theft from the organisation. These distinctions for wrongdoing allow a fine-grained examination of FtP charges, if we differentiate the targets of misconduct, to discern whether actions undermine confidence in the health system through patient directed actions compared to those directed at colleagues. Further, efforts to understand wrongdoing in organisations have distinguished four approaches which involve different antecedents and processes.

i. Individual differences (bad apples)

One of the most established perspectives on misconduct considers wrongdoing from a functionalist, trait-based approach. This positions these behaviours as atypical of the norm and perpetrated by outliers (bad apples) (Kish-Gephart et al., 2010) motivated by a deliberate need for some form of self-gain. Attention here is on the detection and removal of such individuals from entry into an otherwise-sound system. The literature highlights three conceptually and empirically distinct personality trait dimensions which are associated with deviant individuals: Machiavellianism; Narcissism; and Psychopathy (O'Boyle et al., 2012). These are evident in a health context with cases such as the Shipman inquiry (Smith, 2004). While traits appear an important component of CWB, evidence suggests contextual factors, including the culture and leadership of these organisations, can help to moderate their prevalence (O'Boyle et al., 2012).

More contested individual difference studies have considered the issue of gender (Andreoli and Lefkowitz, 2009), with some arguing misconduct is more prevalent

amongst men (Kish-Gephart et al., 2010). This is especially the case in caring contexts in which the prevailing view is of women as more caring and ethical in their decisions (Gilligan, 1977). Certainly, meta-analysis suggests females are less likely than males to engage in CWB where their job role involves some consistency with their gender (Ng et al., 2016), such as that found for a nurse working in a hospital.

Moreover, evidence indicates that sexual misconduct is one in which abuse is more likely to be perpetrated by males (O'Donohue et al., 1998), and motivated by the need for power (Popovich and Warren, 2010), as well as personal sexual gratification (Pina et al., 2009). In addition, research shows the victims of such abuse are more likely to be lower status female employees targeted by higher status male perpetrators (O'Donohue et al., 1998). There is also evidence that certain types of location are more prevalent in such abuse cases, with increases found in workplaces with strongly hierarchal structures, marked skews in staff sex ratios, weekend work, and easy access to private spaces (O'Donohue et al., 1998). These conditions can often be found in large health and social care organisations. Further, research reveals that those with a proclivity for sexual misconduct are likely to become active where they see other male employees behaving similarly (Willness et al., 2007).

Although there is some compelling evidence of trait-based antecedents to misconduct (Dalal, 2005), there are also strong external factors that moderate, for instance, the role of job satisfaction in unethical behaviours (Kish-Gephart et al., 2010). Alternative explanations suggest a compelling role of social learning and self-regulation failure in professional misconduct.

ii. Social learning (corrupting barrels)

Accordingly, a different perspective on wrongdoing draws on social learning theory (Bandura, 1976) to highlight attention on the role of social contexts ('bad barrels') (Kish-Gephart et al., 2010) in the creation and perpetuation of deviant norms at both interpersonal and organisational levels (Treviño et al., 2014). Evidence shows how in the healthcare context colleagues can critically influence the ethical behaviour of doctors and nurses, with such impacts amplified in the unethical practices of those who are considered successful (Deshpande et al., 2006). Research into social learning has found that social norms change following exposure to others' unethical behaviour, with marked impacts for those who identify with the unethical group (Cialdini and Trost, 1998). The social learning involved comprises two elements: descriptive norms, which identify what most people do in particular situations; and injunctive norms, which indicate the specific behaviours most people endorse or reject. Research on tax compliance, for example, showed how lower contributions followed identification with a particular social group who provided information (Wenzel, 2004). Critically, evidence confirms how professionals can become corrupted after exposure to others' wrongdoing (Welsh et al., 2015). Conceptual work has highlighted the different ways that such misconduct can emerge, with Robinson et al., (2014) showing not only a direct impact as the target for others' actions, but vicariously following observation of others' actions, and also ambiently, through working in organisations which are characterised by collective deviance of co-workers. This spillover from different levels of exposure has yet to be empirically tested.

iii. Ego-depletion theory (depleting barrels)

A further perspective is one of wrongdoing through omission rather than the instrumentality outlined in the previous two cases. Critical to this approach is the culmination of exhaustion and the toll of accumulated stresses and strains in eroding individuals' self-regulatory resources and ability to maintain their otherwise good behaviour (Baumeister et al., 1998). Studies show how actively trying to inhibit one's negative responses draws on a limited and exhaustible reservoir of resources (Baumeister et al., 2006). Extant research indicates that this is a dynamic degradation, which can comprise continuous efforts at self-control, such as in the vigilance required to control temptations (Muraven and Baumeister, 2000); or efforts to respond to high levels of stress (Fox et al., 2001, Fina et al, 2015); or to manage negative emotions (Kiefer and Barclay, 2012); or simply from ongoing poor quality of sleep (Spector et al., 2006). For example, research confirms that sleep loss can result in escalating levels of misconduct and increases in aggression, with more marked impacts found in those with lower trait self-control. These studies show how accumulated emotional exhaustion creates depersonalisation and dis-identification (Bolton et al., 2012), and moral disengagement (Fida, et al, 2015) in which individuals can actually excuse their wrongdoing, or see it as a justified means of revenge (Tripp et al., 2007). Conversely, such behaviour reduces in frequency when job satisfaction improves (Andreoli and Lefkowitz, 2009). This approach to wrongdoing highlights how external environments can have an insidious and accumulative influence in overwhelming and eroding the good intentions of individuals. Further, and importantly in this context, they also reveal that such outcomes are not universal: they emerge as a by-product of diminished abilities to self-manage and inhabit their negative responses which can have clear consequences for colleagues within a workplace – they are contagious, creating chain reactions from others. Clearly, delivering a 24-hour health service has inherent shift requirements that can create sleep problems for some, but with the accumulative exposure from years of working in inherently more stressful professional roles, such as accident and emergency, it is easy to see how some individuals, either more prone or over-exposed, can experience ego-depletion.

iv. Ecosystem perspective (bad cellars)

The final perspective is generated through wider 'ecosystems' and environments, such as large-scale changes in demographics, or through technological or regulatory systems which threaten traditional jurisdictions between professions and produce wrongdoing (bad cellars) (Muzio et al., 2016). Here, dimensions such as the ethnicity of perpetrators can offer insight into the cultural dimensions of misconduct, evident in different prevailing cultural attitudes to cheating and faking (Miller et al., 2015). Further, studies indicate race and gender as predictors of incivility in some cases (Cortina et al., 2013). There are also clear differences in attitudes pertaining to acceptable behaviour, including, for example, sexual behaviour towards women (Edwards et al., 2014; Rontundo, et al., 2001). The health and social care workforce is one in which workforces have been internationally more mobile, yet few have examined the cultural dimensions to wrongdoing, which may be due to a lack of education about cultural differences, or stem from groups which might be perpetrating misconducts.

2. Method

a. Context

The Professional Standards Authority for health and social care (PSA) is responsible for protecting the public by overseeing nine statutory bodies that regulate 32 health and social care professions in the UK[2]. These nine regulators have four main functions: registration, quality assurance of higher education, setting standards, and fitness to practise (FtP). FtP is a process for handling complaints about professionals in order to determine whether someone is fit to practise. It is not designed to be a punitive process, although regulatory sanctions may have a punitive effect. FtP charges arise from concerns about any of the four aspects of professionals' behaviour which risk the safety of patients (service users) and undermine the public's confidence in that profession. The most serious of these cases are referred to formal panel hearings. The decisions in these cases are recorded in 'determination documents' which are then passed to the Professional Standards Authority (PSA) who have a statutory responsibility to oversee the cases and the decisions made.

b. Data sample

We used 6,714 FtP determinations from the PSA's database[3] from three regulators: the General Medical Council (GMC) (n=633), who regulate medical doctors; the Nursing and Midwifery Council (NMC) (n=4,852), responsible for nurses and midwives; and the Health and Care Professions' Council (HCPC) (n=1,229), regulating a range of 16 healthcare professions, including clinical psychologists, paramedics, chiropodists, occupational therapists, and social workers.

c. Procedure

We used sequential mixed methods to systematically examine these three groups of registrants' professional misconduct. For each FtP hearing, we used the determination document which includes incident details and pertaining evidence in a quasi-legal format. The documents vary in the level of detail/evidence and complexity and can include testimony from victims, perpetrators, colleagues, and managers[4]. From these documents we extracted the details of the confirmed charge types and the resultant sanctions. For the purpose of clarity and in line with our three stages, these methods are outlined further alongside their discrete results in the next section.

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[2] 'Further information about the Professional Standards Authority can be found at www.professionalstandards.org.uk'

[3] The database currently in use by the PSA holds circa 15,000 determinations from all nine regulators, and the sample related to cases that occurred between 2014 and 2016.

[4] In the case of Arinayagam (Ariyanagam v GMC [2015] EWHC 3848 (Admin)) the Court suggested that a model determination would be one in which the panel set out its conclusions on each of the paragraphs of the charge sheet; provided an adequate summary of the background to the allegation; summarised its view of the witnesses' evidence; commented on the quality of the evidence provided by the registrant; and then explained in some detail why some allegations were found not proved and others were found proven. We acknowledge that a determination is not a comprehensive account of all of the information considered by a panel

3. Quantitative Analysis - Mapping the Territory of Professionals' Wrongdoing

a. Procedure

The types and frequency of misconduct were examined and mapped for three professions (doctors; nurses and midwives; and allied professionals) through separate hierarchal cluster analysis carried out separately for each profession to explore the interrelationships between FtP charges (Köhn and Hubert, 2006). The FtP charges were categorical, and so the binary appropriate to employ was Jaccard's coefficient measure of the clustering (Aldenderfer and Blashfield, 1984). This approach avoids the use of joint absences in calculating these similarities. We clustered using the complete linkage cluster method (Dolnicar, 2003) which provides a higher quality of extraction by including charges on the basis of their similarity to all of the members of that cluster. The proximity of the cases was calculated and a dendrogram was created for each group (see pages 18-20). The dendrogram can be considered a family tree which shows a taxonomy of relationships between charges for each profession. Following best practice, the patterns of these clusters were interrogated and the data set separated to see if they were replicable (Ketchen and Shook, 1996).

b. Results

i. Descriptive statistics

The data comprised 17,301 FtP charges which had been categorised by the PSA under 40 different types of professional misconduct. Of these, 72.3% (12,599) were from nurses and midwives, 18.3% (3,230) from allied professionals, and 9.4% (1,472) from doctors. It is important to note that misconduct was found in a small proportion of each of these professions, (0.26% of GMC registrants[5] , 0.34% for HCPC[6], and 0.7% for NMC[7]). Differences are evident in the percentages between these professions, however HCPC does include a broad range of different professions. In comparing the types of FtP charges, similarities and differences are evident (see summary in table 1), with no significant difference found between the mean number of charges for each professions (Mean= GMC - 2.33; HCPC - 2.63; and NMC - 2.6). Each charge was represented across all the professions in varying proportions, except for manslaughter, which was found only in nurses and midwives. In order to compare differences in the volume of FtP charges by profession, they are expressed as a percentage of the total misconduct for that profession. While the PSA uses a categorisation system with 40 headings, included in the table in Appendix A, it is clear that half are largely redundant, and collectively receive less than 1% of the charges. (A complete table of the frequency of charges is included in Appendix A).

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[5] Information on total no of licenced doctors obtained from http://www.gmc-uk.org/doctors/register/search_stats.asp
[6] Information obtained from http://www.hpc-uk.org/aboutregistration/theregister/stats/
[7] Information obtained https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/nmc-register-2013-2017.pdf

The most prevalent form of misconduct is poor or inaccurate record keeping, especially amongst nurses and midwives and allied professionals, but it is also common among doctors (see table 1). The most frequent form of misconduct for doctors is theft and dishonesty, which was comparably widespread across all three (see table 1). Clear comparability is evident in the proportions of the most frequent charges across registrants of the three professions (see table 1), with six FtP charges found to account for between 43 and 60% of all the charges. Using Robinson and Bennett's (1995) taxonomy of wrongdoing, five of the most prevalent charges are in the production deviance category (labelled category 2 in table 1) and impact on patient safety. These include failures to undertake adequate care activities, including lack of competence and substandard care, poor and inadequate record keeping and referring, and inadequate communication. A further typical charge is theft, which is part of Robinson and Bennett's (1995) interpersonal aggression category (labelled category 5 in table 1). This last charge is serious for health professions as it breaches behavioural standards of care, but more importantly, societal norms. There are a further five charges which dominate FtP cases and which reflect varying degrees of prevalence in the registrants of the three professions. Together with the aforementioned six, they account collectively for between 72-76% of all of the professions' misconduct charges (see table 1). Significantly, these results confirm that women are perpetrators too, reflecting that incidents of wrongdoing are related to the sex ratios for these professions. The occurrence of female perpetrators in a context of care is at odds with both the values of a health professional, but also prevailing views of woman as being more ethical (Kish-Gephart et al., 2010).

Table 1: Summary top proportional charges by profession[8]

Misconduct Category[9] and Charge		GMC (Doctors)				NMC (nurses and midwives)				HCPC (Allied Profs)			
		#	%	%male	%female	#	%	%male		#	%	%male	%female
5	Dishonesty/Fraud/Theft	183	12.43	38.89	13.89	1298	10.3	22.19	57.53	303	9.38	50.94	45.28
1	Adverse Health	144	9.78	48.28	23.45	443	3.52	20.09	67.95	71	2.2	36.62	53.52
5	Conviction	125	8.49	48.41	19.05	517	4.1	37.52	53.58	158	4.89	51.9	39.24
2	Poor record keeping	117	7.95	34.75	14.41	1666	13.22	18.49	62	387	11.98	39.02	49.1
2	Substandard care	98	6.66	45.45	12.12	1267	10.06	17.76	60.22	296	9.16	44.26	43.92
5	Sexual misconduct	92	6.25	51.61	6.45	127	1.01	60.63	21.26	70	2.17	72.86	12.86
2	Poor performance	86	5.84	32.18	20.69	716	5.68	14.53	46.09	371	11.49	38.01	47.71
2	Failure to examine	75	5.1	30.26	14.47	935	7.42	18.29	59.57	279	8.64	44.09	46.24
2	Poor communication	75	5.1	32.89	19.74	902	7.16	16.52	52.55	292	9.04	41.44	42.47
3	Qualification dishonesty	71	4.82	38.89	13.89	365	2.9	22.19	57.53	53	1.64	50.94	45.28
2	Prof boundaries failure	55	3.74	55.36	8.93	265	2.1	35.47	36.23	131	4.06	49.62	35.11

[8] The gender information for this table has been extracted from the PSA data base and therefore has not been checked and validated. Please see later note table 2 – which indicates that gender may not be accurately recorded.

[9] Using Robison and Bennett (1995) category of wrongdoing: 1 - individual health, 2 - production deviance - individual focus
3 - property deviance, 4 - political deviance, 5 - interpersonal aggression

ii. Cluster analysis findings

Results from the cluster analysis reveal some commonalities and differences in the interrelationships of wrongdoing between the professions. The figures have been overlaid with Robinson and Bennett's (1995) taxonomy of wrongdoing to offer a further meta-level perspective. We have added to their four catergories of production political and property deviance, and personal aggression: a further individual health and addiction category to capture the diversity of FtP charges.

Figure 1: Key for cluster analysis

There are some clear similarities to the clustering of wrongdoing in FtP charges across these three health professions. Examining the aforementioned more frequent top 11 charges (bold outline to label) indicates how many of these charges coalesce, most notably for production deviance (coloured green), with many similar groupings of misconduct, such as failure to examine associated with substandard care and poor communication. In doctors

and allied professionals this cluster also contains poor record keeping. Amongst nurses and midwives and allied professionals it also includes the associated charge of poor performance and failure to refer. Further, for allied professions it is also associated with theft and dishonesty (see later in the report, section 5a and b). These results indicate such professionals are likely to breach the trust of patients and the social contract with the public, but they will also undermine the ability of others to do their subsequent work. The impact on co-workers is two-fold, both involving the often covert monitoring of the perpetrator, and then amieolorating its impact through either doing the task that was required or correcting what has been done. Examples of dishonesty for nurses and midwives' clusters include poor record keeping and inadequate prescribing, which highlight the risks such individuals pose to patient safety. In contrast, dishonesty amongst allied professions is linked to conviction and drugs, which suggests it has a very different profile to that found in the other professions, but nonetheless is equally likely to undermine confidence in regulators and employers of such individuals.

As we will outline in more detail later (see section 3 and figures 2-4, 5), sexual misconduct similarly shows strong associations with professional boundary failures and inappropriate allegation charges. There are also commonalities regarding the cluster for personal agression amongst doctors and nurses and midwives, which include verbal and physical aggression and rough handling of patients. More worrying for allied professions, this physically and verbally aggressive behaviour is associated with the aforementioned clustering of three charges for

In contrast, charges of qualifications' fraud show two sets of patterns (see section 5a-d for further analysis of this charge). Amongst doctors it is associated with failures to comply with both GMC requirements and with employing organisation's rules and procedures, while in nurses and midwives and allied professionals it is linked to convictions and police cautions. These results indicate the value of having strong input and process controls for both regulators and employing organisations and having serious consequences.

Finally, the prevalent profession-crossing adverse health charge shows a strong similarly detrimental clustering with alcohol abuse. However, amongst both doctors and nurses and midwives it is also associated with charges of drugs and police cautions, and in the case of doctors, even convictions. These results again indicate how professionals' misconduct might be detected through attending to associated concerns, such as the use of alcohol, especially since extant research has identified the role of alcohol as a means of managing the stress and burnout from working in health and social care (Monroe, et al., 2013; Piko, 2006).

Figure 2: Cluster analysis FtP for doctors

Dendrogram using Complete Linkage
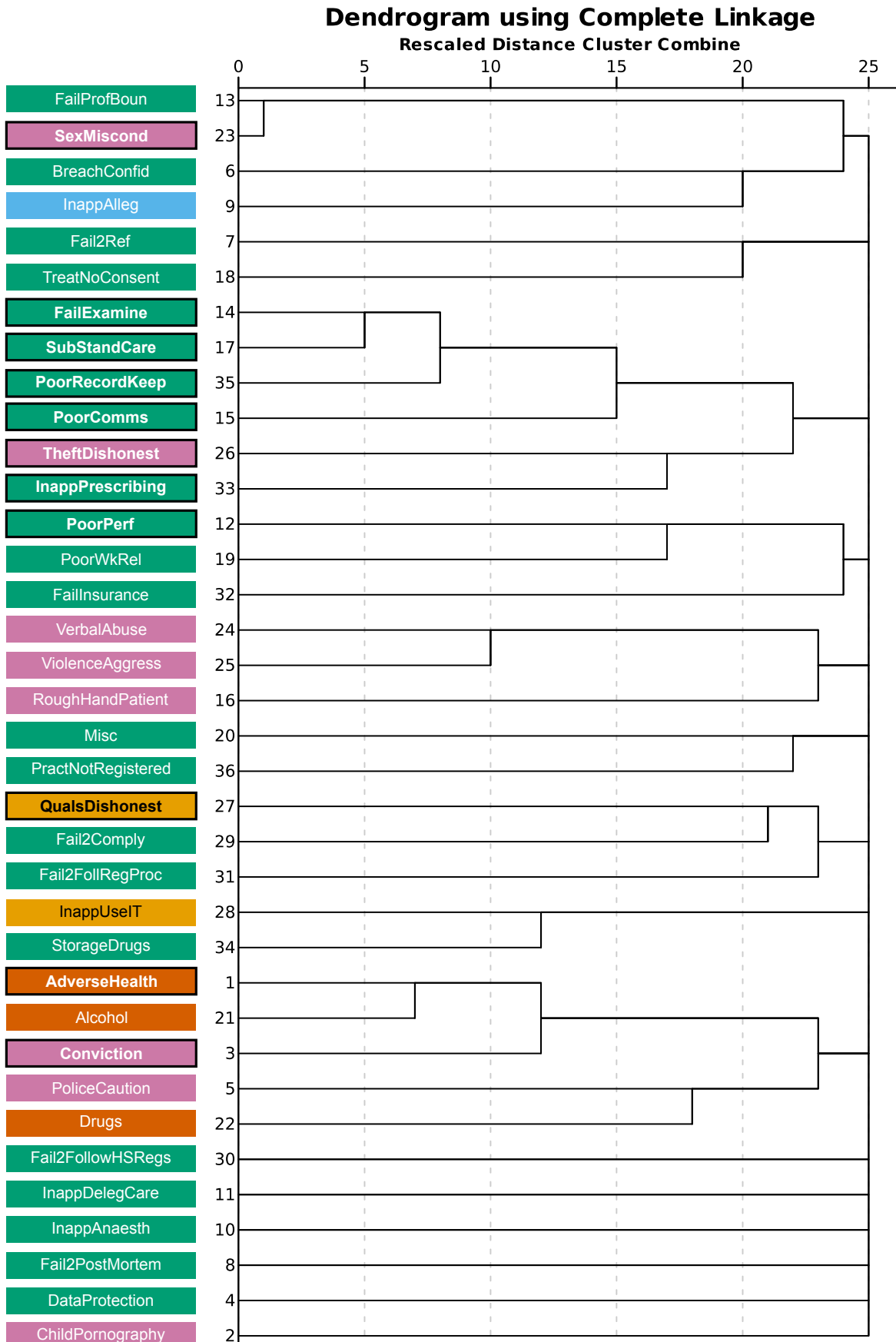
Rescaled Distance Cluster Combine

Figure 3: Cluster analysis FtP for nurses and midwives

Dendrogram using Complete Linkage
Rescaled Distance Cluster Combine

Dendrogram using Complete Linkage

Rescaled Distance Cluster Combine
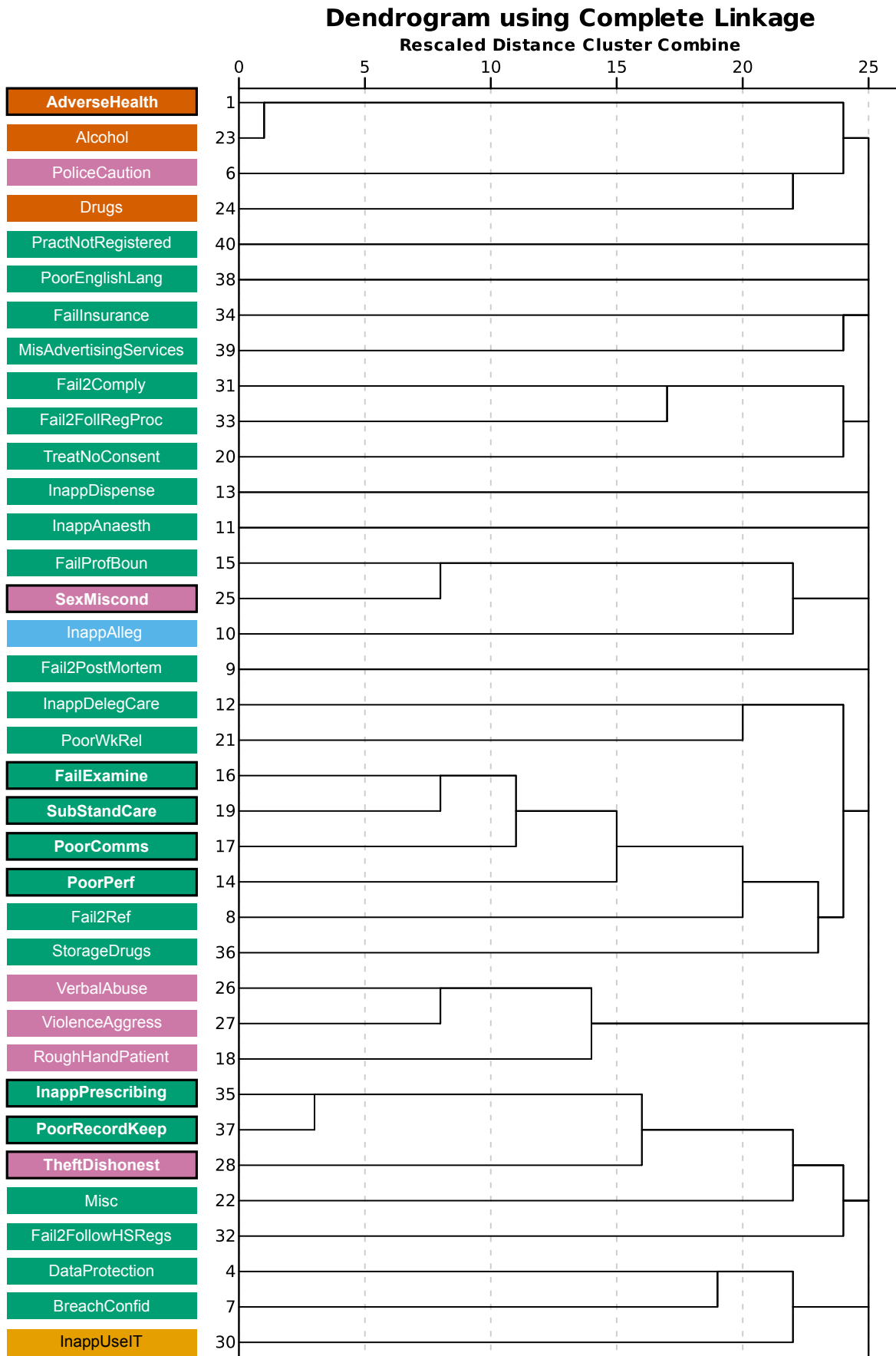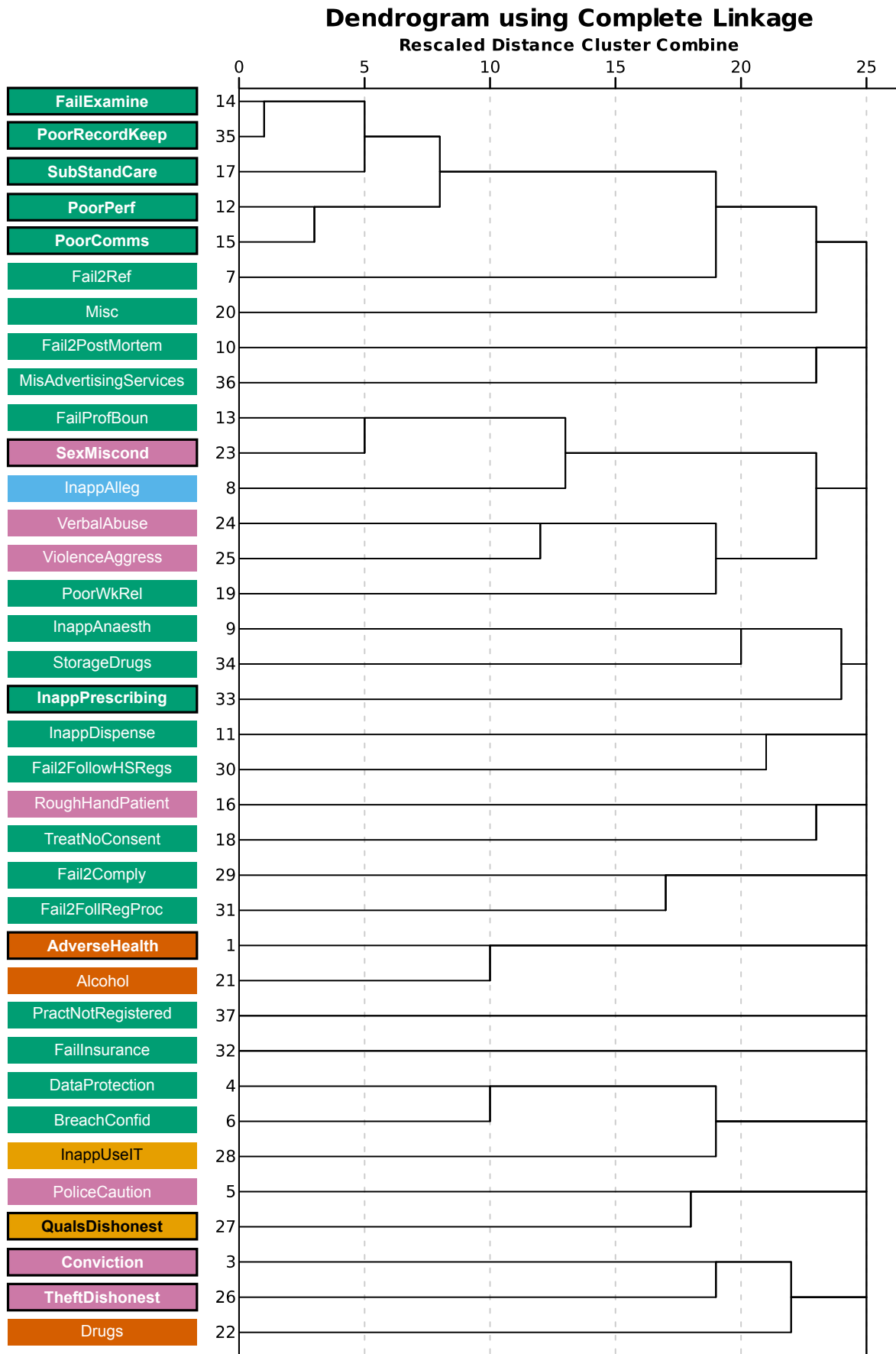
4. Focus on Sexual Misconduct

a. Characteristics of sexual misconduct

Within this second group of charges, sexual misconduct emerged as a more pervasive form of wrongdoing. It is arguably amongst the most severe of all interpersonal aggressions (Robinson and Bennett, 1995). There were 289 charges in the FtP database for these three regulators, of which 44% were perpetrated by nurses and midwives, 31.8% by doctors and 24.2% by allied professionals. Collectively, it accounted for 9.43% of all misconduct charges for these three professions, yet some significant differences are evident for these three professions. First, in looking at the overall statistics and the proportion by profession, sexual misconduct appears to be more frequently evident as a misconduct amongst doctors, than any other profession (see table 1). Scrutiny of cases with this as the only FtP charge showed similar ratios, again with doctors dominating (18.48% of single charges) compared to other professions (allied professionals 11.48%; nurses and midwives 7.87%). Second, a clear gender bias is found in perpetrators, with men dominating each profession (see table 2), echoing past research findings (e.g. Bradley, 1994; Pina et al., 2009). Further, this form of misconduct does not follow the job-sex ratios that occur in some of the other FtP charges (see table 1), as here men remain key perpetrators. Women are found to be abusers, but this is largely confined to allied professions or nursing, and not to doctors (see table 2).

The results of the cluster analysis of the FtP charges for each profession reveal the same strong relationships in this form of wrongdoing with sexual misconduct clustered with the charge of failure to maintain professional boundaries, and a less strong sister misconduct of 'inappropriate allegations' which equates to Robinson and Bennett's (1995) 'political deviance' (see figure 5 – for extract from figure 2-4).

Figure 5: Extract by profession from cluster analysis (figure 2-4) for sexual misconduct
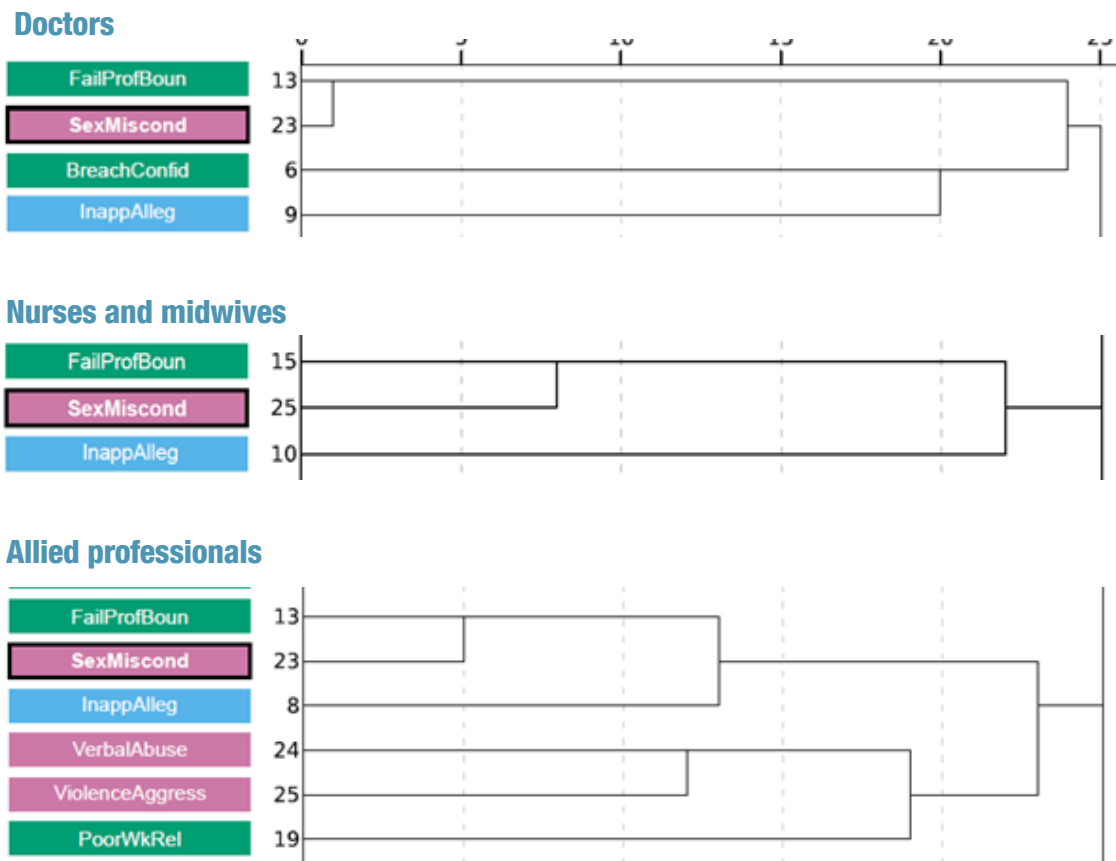
Extant research shows 'problems respecting others' boundaries' is a consistent finding (McDonald, 2012; O'Donohue et al., 1998; Pina et al., 2009). In looking at the cluster for doctors, their cluster extended to comprise the further charge of 'breaches of confidence', while for allied professionals three further interpersonal-related misconducts were included: poor working relationships, verbal aggression, and physical aggression. This suggests that sexual misconduct is quite different (and more violent)

for allied professionals than the other two groups. In the context of health, sexual misconduct is a distinct type of wrongdoing that fundamentally challenges accepted notions of professionals' integrity and trustworthiness for targets and the public (Begany and Milburn, 2002; Bradley, 1994; Hall, 2011; Smirles, 2004).

b. Qualitative analysis of sexual misconduct

Process

A two-stage coding process was used to analyse 289 determination documents (the record of decision making within an FtP case). First, the sexual misconduct cases were reviewed and 24 historical cases removed as there was insufficient information to allow further coding. Then we qualitatively coded the remaining 265 cases for ecological factors including: location of the incident(s); charge details, including target type and incident location(s); and perpetrator information concerning profession, gender, and main place of work. Next, from each profession a random-stratified purposeful sampling process was applied (Suri, 2011) that enabled retention of single and multiple charges (Hirzel and Guisan, 2002). This process ensured we captured major variations and retained 'common cores' in our subsequent analysis (Patton, 2002:240). We added more detailed codes to this second group, which included triggers (e.g. sexual motivation; home or work pressures) and charge details to capture type(s); breadth, frequency of incidents, and impact on targets; perpetrator information to allow for the capture of multiple culprits; and the sanctions of regulators. We ensured consistency in this coding by first having two researchers independently select and code pilot cases. The coding was then compared, and any differences resolved. Coding of this charge was undertaken until data saturation was achieved, as shown by no new perspectives and explanations emerging from the data, nor any further variations being found between cases (Morse, 1995). The coding used only the pre-identified

dimensions and was based on explicit reading level of the materials, i.e. the researchers did not make implications and instead relied only on the evidence presented and 'findings proved' in the document. In order to draw the key findings and conclusions from the coding, we moved from these deductive 'first-order codes' to inductive 'second-order themes' (Brown and Coupland, 2015), thematically grouping different codes based on the most commonly occurring (frequency counts) and discernible patterns (individual, social and organisational) to allow us to move to higher level illustrative themes. We illustrate these themes using exemplar quotes, while anonymising confidential information pertaining to identification of either perpetrator or victim. Further, for illustrative and comprehensibility purposes, we group together our qualitative findings according to profession and coded by gender, offence location, and targets in table 2. This approach is designed to support our analysis and created a base for more in-depth thematic qualitative analysis.

Table 2: Gender, location and target coding[10]

Coded Cases		Doctors		Nurses and midwives		Allied Profs	
		#	%	#	%	#	%
		79	29.8	121	45.7	65	24.5
Gender	Male	78	99	96	79	56	86
	Female	1[11]	1	25[12]	21	9[13]	14
Offence Location	At work	55	70	58	48	40	62
	Outside work	18	23	46	38	17	26
	At and outside work	6	8	17	14	8	12
Target	Solely Patient(s)	55	70	61	50	35	54
	Solely Colleague(s)	12	15	42	35	18	28
	Patient and colleague	4	5	2	2	3	5
	Colleague and other	0	0	1	1	1	2
	Other	8	10	15	12	8	12

Thematic Analysis sexual misconduct

To better understand the characteristics of sexual misconduct cases amongst these professions, in-depth thematic analysis was applied to a sub-sample of cases[14] until data saturation was reached (n=59). Analysis showed that regarding sexual misconduct, individual perpetrators acted alone with a strong bias towards male perpetrators across the registrants of the three regulators, which supports past research findings (Pina et al., 2009; Sansone and Sansone, 2009). However, the indirect complicity of others was apparent in colleague-on-colleague wrongdoing, through an individual's (conscious or unconscious) role in the creation of propagation of a sexualised informal organisational culture (Kish-Gephart et al., 2010). Supporting the results identified by the cluster analysis, sexual misconduct frequently occurred alongside another charge 'failure to maintain professional boundaries', an association which is logical and has been highlighted elsewhere (Muzio et al., 2016). Interestingly, we found key differences by profession and workplace environment, so we split our discussion into each profession, to better consider the emergent themes in terms of profession specificity or workplace environment.

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[10] This table does not include the historical cases which were removed from the qualitative analysis
[11] Confirmed 1 female perpetrator 48
[12] Confirmed 25 female perpetrators
[13] Confirmed 9 female perpetrators
[14] The random sub-sample extracted for the nursing and midwifery group contained only nurses, thus this is report in terms of nurse behaviour. It would be important to check midwife cases to ensure generailisability. It is lilkey there may be sdifference due to the type of task and situations midwives are involved in.

i. Doctors

The aforementioned link between sexual misconduct and failure to maintain professional boundaries was clearly found in 17 of the randomly selected and stratified sample of 24 doctor cases, but further multiple charges were also evident, most commonly poor/lack of communication and dishonesty. A relatively high number of cases (n=8) involved family doctor (GPs) perpetrators, a finding which concurs with prior research (Sansone and Sansone, 2009). The vast majority of incidents occurred at least in part, at perpetrators' workplaces (n=20), with relationships developed further via text or email contact. In every case, doctors targeted those who were the opposite sex. In most cases (n=16) patients were targeted, with two also targeting colleagues, and three involving only colleagues. Significantly, and echoing past findings, all of the colleagues targeted were subordinate females (O'Donohue et al., 1998). The other targets were members of the public and an external contractor. These incidents of misconduct occurred on multiple occasions whether against multiple targets, namely patients, or a single victim – this perhaps suggests such behaviours were not impulsive.

i.i. Patients - Intimacy and inappropriate relations

A theme evident in several of the patient cases was doctors developing inappropriate consensual relationships with patients, a not entirely unusual situation (Galletly, 2004), but given the clear power imbalance in doctors' favour in this relationship

(Popovich and Warren, 2010), one that illustrates an exploitation of patients. There were examples of further exploitation in the targeting of those considered 'vulnerable' due to either their mental state (e.g. patients suffering anxiety or depression) or life circumstances, as the next quote illustrates:

'There was clearly an imbalance of power in your relationship with Patient A in that you were an educated professional, 14 years her senior, in the position of dispensing necessary medical advice and treatment to her and her daughter' (D1).

Indeed, the power and status of the doctor was often highlighted in unrequited interactions:

'At the time of approaching each of the patients, Dr X knew, because of his position, important and personal things about them. You submitted that Dr X was seeking more than a professional relationship and there was going to be an imbalance of power in the relationship' (D2).

The dominant documented motivation for this form of wrongdoing was sexual motivation. However, other triggers that were identified included the nature of close consultation resulting in over-familiarity, or a therapy-based or mental health support context. Indeed, the 'intense emotional involvement' between doctors and patients has been noted as a trigger in sexual misconduct or in the overstepping of boundaries (Bradley, 1994:40), and is used as a means of justifying doctors' actions. Further examples of such action were

evident where doctors engaged in sexual relationships with patients or former patients who they now considered to be colleagues rather than patients:

'You maintained during your evidence that the boundaries between you and Patient A were blurred because, at the time, you viewed her as a colleague rather than as a patient…She worked in the NHS, and there had been some prior contact between yourselves regarding medication…not related to her as a patient but in her professional role' (D3).

Importantly, FtP panels did raise questions in such cases over whether doctors held a genuine ambiguity around defining that relationship, or whether this was merely an attempt to deflect blame, through casting some doubt on allegations. This concern is evident in the following quote:

'The panel found your responses to be convoluted and, to an extent, evasive. It seemed   to the panel that your various explanations for different scenarios were intended to 'muddy the waters' ' (D3).

Nonetheless, where a relationship developed, they occurred in settings where the doctor had been alone with the patient, and where they had taken an active role to pursue and develop this relationship, with the determination sometimes noting their subsequent remorse or regret and an acknowledgement that professional boundaries had been compromised.

i.ii. Exploiting blind trust

The instances of doctor-patient relationships appeared relatively similar to each other in their development. In contrast, clear differences were apparent in non-reciprocating patient misconduct cases, giving rise to concerns that this was an abuse of implicit or 'blind' trust. Here doctors' actions were discounted as they were deemed to be looking after and examining patients in terms of their best interests (benevolence), as well as being trusted because they 'knew more' than the patient (competence), combined with a sense that doctors are those who behave morally (integrity). Such cases left patients often reticent to raise concerns about this behaviour or even to fully recognise it themselves. These instances appear to concur with Bradley's (1994:40) category of 'impulsive sexual gratification' by doctors. Strikingly, patients, although unsure, did sense something 'is not right' after an abusive consultation and where more clear cut 'indecent assaults' occurred, as the next quote shows:

'The Panel noted Patient A's persistent doubts as to whether she was being "over-sensitive" and whether she could be entirely sure that "any boundaries had been crossed". However, these doubts were expressed in the context of her strong belief that doctors must know what is and what is not appropriate… The Panel considered that these uncertainties demonstrated Patient A's level of trust in doctors and her self-doubt about her capacity to judge when the proper boundaries had been crossed, rather than any lack of confidence in her recall of

what actually took place. For example, in relation to the events, in cross-examination Patient A stated that she didn't doubt what had happened, but only whether it was or wasn't standard procedure' (D4).

Similarly, another determination stated:

'When asked why she had not initially identified the consultant involved she told the Panel that she did not want to complain if this was a normal examination' (D5).

These findings reflect a 'dark side' of excessive or 'blind' trust from targets who reduce their vigilance, monitoring and safeguarding behaviours due to the type of health professional – here a doctor – and thus might be considered to somehow 'invite' wrongdoing (Gargiulo and Ertug, 2006) from opportunistic or deviant perpetrators. In other cases, there was a clear pattern with a 'gradual transition from appropriate to inappropriate examinations' (D4). Critically, these types of cases involved the targeting of relatively young female patients who had limited experience of health consultations, and were thus perhaps particularly vulnerable due to their uncertainty about the appropriate nature of such consultations. This suggests that better patient education about appropriate examinations would be a fruitful means to both build confidence to allow the speedy reporting of such abuses, and to create greater transparency which would reduce the ambiguity such perpetrators utilise.

i.iii. Colleagues – work climate

The cases that involved perpetrators targeting colleagues tended to include multiple targets, comprising multiple incidents involving subordinate or junior female colleagues. In two cases, specific references were made to contributing organisational environmental factors. For example:

'You did accept that on occasion you would put your hand on colleagues' backs, arms or shoulders, if they had done the same to you…Sister xx stated that…the ward was a "touchy feely environment" and "people will do that, it's what we do". The Panel finds that this [squeezing bottom] is not an act open to misinterpretation and it is of the view that this was the culmination of increasing familiarity with colleague A' (D6).

Further, the dimension of cultural differences in the working environment was identified as a contributory factor in some cases:

'You explained the incidents alleged by Ms B and Ms C, in part, by reference to the informal, friendly environment… It has also noted that English is not your first language and that you may not have appreciated the connotation associated with your comment, and therefore the indirect sexual innuendo may not have been intentional' (D7).

'Informal' sexualised cultures have been shown to precipitate these types of misinterpretation (Willness et al., 2007).

i.iv. Impacts and sanctions

The most evident impact for targets, i.e. patients or colleagues, following such incidents was mental harm. This supports the view of this form of misconduct as severe in its impact with accompanying feelings of depression, anger, humiliation, guilt, and an enduring loss of trust in the profession (O'Donohue et al., 1998). Thus, given the severity of the impact, from a lay perspective it is surprising that a range of sanctions are applied, from being struck-off, to placement on restrictive practice, or suspension. Further, where remorse or regret was demonstrated and an acknowledgement of wrongdoing was expressed, more lenient sanctions appear to be given to perpetrators, and particularly to those who used their period of suspension to address their behaviour.

ii. Nurses[15]

24 cases were randomly selected in a stratified sample of nurses and midwives' sexual misconduct, all of which involved just nurses and of which 21 involved male perpetrators and three female perpetrators. In all but one of the cases (which involved a male perpetrator and victim), the victims were again of the opposite sex. As seen before, nurse perpetrators acted alone. As with the doctor cases, of the 21 male sexual misconduct cases, 13 also involved a failure to maintain professional boundaries and four contained a conviction. 11 of the 21 cases occurred at the perpetrator's workplace and ten involved an 'outside work' element. Six cases were identified as occurring in organisations specifically designed for mental health related issues. Past research has indicated mental health as a more prevalent context for such misconduct, which may relate to the vulnerability of these patients (Sansone and Sansone, 2009), and this is also a context in which nurses' relations with patients may be different (Reid, et al., 1999). In contrast to doctors, there were striking differences with targeting colleagues being far more typical in nurses' cases of sexual misconduct. In 12 of the 21 male cases, the primary target was a colleague and in 9 of these cases, the colleague was a subordinate. Unsurprisingly, almost all cases were documented as being sexually motivated. 4 of the 12 colleague-related cases involved multiple targets and eight involved targeting a single colleague. Generally, the colleague targets report these incidents themselves. Those that occurred 'at work' frequently involved discrete locations around the workplace, such as in a staff room or discrete ward locations.

ii.i. The 'banter' climate – organisational culture

A clear theme running through these colleague incidents was the influence of organisational culture in the development of sexual misconduct towards colleagues. Several cases identified climates of 'banter'

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[15] There were no male or female midwives in this sample.

or flirtatious 'joking' behaviour as facilitating this wrongdoing, emphasising the power of group norms (O'Boyle et al., 2012). In many such cases, those targeted explained that they had tolerated inappropriate behaviour, as it was common within their organisation or in the department in which they worked, with senior management often unaware, as the following example demonstrates:

'There is an evidential dispute as to whether there was a culture of sexually explicit conversations between radiographers within the workplace. The Registrant asserts that such conversations were commonplace. The Panel has seen evidence from xx [manager] who disputes this assertion, although she did accept that she was not in the staff room, where such conversations are likely to take place. However, there is credible evidence within the HCPC bundle that such inappropriate conversations did take place within the workplace' (N8).

The normalisation of explicit sexual talk lead to inappropriate behaviours being tolerated until a more severe level or when an unspoken 'line' was crossed, for example:

'There is banter, and there is a line. Of which I feel he overstepped with me. Yes I put myself in the position of which I take full responsibility for… I do however feel in hindsight that what entailed after that was indeed not banter and not ok.' (N9).

Exemplified in this quote is how victims can feel in some way responsible for perpetrators' actions (Smirles, 2004). Indeed, we know from other research that such incidents appear more frequent in contexts where such behaviours go unchallenged (Willness et al., 2007). In retrospect, many victims reveal feeling uncomfortable in the presence of perpetrators, even prior to the incident, for example:

'From the very beginning I felt very uncomfortable in the Registrant's presence. I found the Registrant to be flirty but not in a particular pleasant way. I found him 'creepy'. He made it very clear that he was in a high position within the Trust and I found him quite domineering. He made me feel uneasy. It was never particularly what he said but it was the way he said it" (N10).

The strength of pervasive organisational/group norms in normalising this antisocial behaviour and inappropriate talk is demonstrated clearly in the frequency with which female colleagues of male nurse perpetrators appeared to often ignore their intuitions to their own detriment. This exemplifies the insidious and under-examined issue of power in sexual harassment (Cleveland, & Kerst, 1993), which is often legitimised through both wider societal gender-based power relations/hierarchies and through formal positions of power in organisations. Popovich and Warren (2010:50) thus contend that 'while perhaps unrecognized at one level, this basis of power may trigger a negative reaction on the part of the person/ victim, who, while not understanding why, feels uncomfortable about certain behaviours exhibited by the alleged harasser/social agent'.

ii.ii. Patients - abuse of power

There were 11 cases of nurse sexual misconduct towards patients; three of these cases involved targeting multiple patients, and eight cases consisted of targeting a single patient. In all cases, failure to maintain professional boundaries was also recorded. Indeed, boundaries were explicitly used as a mitigating factor by one perpetrator:

'You said that when you trained as a nurse, your courses had not addressed professional boundaries and that you had not been made aware of what was expected of you' (N11).

However, cases which targeted patients involved some of the most severe sexual misconducts analysed, with abuses of power or exploitation as central components. This was evident in the severity of the sanction applied, with most such registrants struck off the register. Nine of these 11 incidents occurred outside work, of which several involved mobile phone communication in this inappropriate relationship. These cases tended to involve vulnerable patients (e.g. those with mental health issues; drug and alcohol abuse problems, etc.), as the following quote shows:

'Patient A was suffering from clinical depression, a borderline personality disorder and a history of alcohol dependency and was taking medication but was also subject to psychotic episodes. The patient was described as being very vulnerable and at risk of exploitation… [the registrant] had full responsibility for her care' (N12).

While patients often reported these incidents, it was more often colleagues or other organisational members who alerted authorities as they became aware. It therefore appears that nurses are more vigilant to misconduct regarding those impacting on patient safety, proactively reporting instances, rather than being aware of concerns about their own or their colleagues' safety. This may be indicative of how sexualised cultures can skew employees' awareness.

ii.iii. Female nurse sexual misconduct

Female nurse perpetrators of sexual misconduct were far less common (n=3). Here patients were the targets, and these misconducts were reported via colleagues or others within the organisation. Importantly the triggers identified were more varied than those found for male perpetrators, and included home and work pressures, lack of organisational support and other mitigating circumstances, for example:

'It is Mrs X's case that when the relationship became sexual she intended to disclose the fact to the Trust but did not because of Service User A's controlling behaviour…Mrs X asserts that she felt totally unsupported by the Trust....very substantial personal mitigation that the NMC did not dispute, namely Mrs X, having begun a relationship with a former service user quickly found herself in a violent and abusive relationship in which she felt trapped' (N13).

Although fewer in number, female sexual misconduct appears more complex in nature and different in character

to that perpetrated by male cases, including additional personal triggers. The aforementioned case highlights that patients can also be controlling, abusive and manipulative in their interactions with professionals working in health and social care and thus suggests that easily and confidently reporting patient abuse must be possible for health professionals.

ii.iv. Impacts and sanctions

In contrast to doctors, sanctions against nurses appeared to be more severe, with a larger proportion struck off because of their misconduct (n=13). It is unclear exactly why this might be the case. One explanation could be because male nurses were carrying out more 'clear cut' sexual misconduct against colleagues (e.g. groping), rather than for example, starting an inappropriate consensual relationship with a patient. Nonetheless, in all of the cases, the victims experienced mental harm.

iii. Allied professionals

The vast majority of the randomly selected stratified sample of HCPC sexual misconduct cases also were perpetrated by men (10 of the 11 cases), of which four were carried out by paramedics, three were physiotherapists, two were radiographers, and one was a social worker in a mental health setting.

iii.i. Mobile settings and electronic communication

These instances tended to occur 'at work', but given the mobile nature of these roles, this often meant at the home of patients or in private treatment spaces. These individuals were all repeat offenders, with over half involving multiple targets, either patients (n= 6) or patients plus a colleague (n=1). Colleagues and others outside the organisation made up the remaining cases (n=4). While there was little commonality in cases where colleagues were targeted, those involving patients, while varied in nature, often featured the targeting of relatively young (e.g. teenage) females. Moreover, in both patient and colleague targets, perpetrators actively built rapport prior to subsequent assaults/inappropriate behaviour. This behaviour included the use of text, email or social media to develop relationships. For example, keeping secrets (A37) was evident in the case of a senior male perpetrator's abuse of two junior female victims.

iii.ii. Impacts and Sanctions

As with the aforementioned doctor and nurse cases, the most frequent impact on targets was mental harm. With regard to female perpetrators, the case (n=1) involved a service user, with home life issues being the central trigger. Similar to nurses, a relatively high number of perpetrators were struck off the register following their actions.

iv. Comparative assessment of reporting and sanctions for sexual misconduct

The analysis of sexual misconduct cases presented some inconsistencies with case recording. First, the gender of perpetrators is often not specified, especially in the cases of doctors (41.3%, compared to 14.29% of nurses, 18% of allied professions). Further, inconsistency of data

input shows the misallocation of gender in recording with scrutiny of the determination document clearly a different gender (e.g. for each profession, 33, 34, and 35). As a result, there is likely to be more a more marked skew towards male perpetrators in table 2. Second, the charge of 'Failure to Maintain Professional Boundaries' (charge no. 15) has not always been recorded alongside charges of sexual misconduct. This potential coding omission is a concern as it is evident in the determination documentation that boundaries have been either implicitly or explicitly crossed. Furthermore, in any case of health professionals' sexual misconduct, by its very nature professional boundaries have been crossed (e.g. for each profession 36, 37, 38).

Our analysis also suggests differences in the sanctions administered for sexual misconduct cases between these three professions, most strikingly in relation to nurses and allied professionals compared to doctors (see table 3). For example, while there were 24 cases of doctors and nurses sexual misconduct thematically analysed, it appears that nurses were more often struck off the register than doctors (see table 3). Further, table 3 reveals that doctors were also more likely to receive lesser sanctions (suspensions, caution or other discipline) than nurses. As highlighted earlier, further analysis would be required to ascertain if this is a result of the actual types of sexual misconduct carried out by nurses versus doctors, or whether it is an actual bias towards doctors. Preliminary analysis suggests that nurses' cases are perhaps more 'clear cut' and explicit than that found in doctors with the groping of colleagues or sexual relations with patients outside of the workplace. Doctors, on the other hand, often involved incidents which are arguably more complex, with consensual relationships developing between doctors and their patients more slowly over time, or where patient abuse was clouded by patient doubt over the appropriateness of consultations, which is more difficult and lengthy for panels to investigate. The equity of treatment is particularly important in this form of misconduct.

To a lay reviewer, some charges against doctors might appear to need review. For example, in one case (D6) of a doctor who was investigated for inappropriate behaviour to a subordinate colleague, inappropriate touching behaviour was not considered to be sexually motivated; instead the case documentation noted the 'touchy feely' environment and 'increasing familiarity' which was evident in the workplace. As there was remorse/regret expressed by the doctor no further sanction was applied. However, evidence shows such perpetrators abuse the power and status derived from their professional roles (Cleveland & Kerst, 1993; Popovich and Warren, 2010), with these positions used to intimidate or groom targets, which therefore begs the question of why sanctions are not harsher. This is arguably particularly important in the case of doctors who are already powerful authority figures, and thus able to sexually exploit their patients' blind trust. The literature highlights how such abuse is akin in form and impact to that of parent-child abuse (Galletly, 2004). In addition, actions which appear to condone the wrongdoing of those with high status might be triggers influencing vicarious and ambient others. It is evident that doctors' deployment of remorse or regret may play a key role in the sanctions that panels apply.

Table 3: Sanctions for sexual misconduct charges

		25		
		GMC	NMC	HCPC
Effects of charge on perpetrators/ sanction	Suspension / Discipline / Caution	11	7	5
	Struck off register permanently	5	9	3
	Struck off register temporarily	1	4	2
	Interim suspension / Restrictive Practice	0	2	0
	Remorse/Regret, Nothing	7	2	1
	Police Caution / Imprisoned	0	0	0
	Voluntary removal from register	0	0	0

In the FtP cases, there was clear guidance that where there was an understanding of the inappropriateness of their actions and regret or remorse shown by perpetrators, the sanction given was less harsh. It is, however, not possible from the current analysis to consider whether doctors are more insightful about their wrongdoing than nurses, or whether they 'know the right things to say' in order to better reduce their punishments. Further research in this area is thus required.

Summary

The exploitation of naïve younger women for sexual gratification, or more vulnerable (e.g. mental health) patients, is one clear way that perpetrators violate trust. Our analysis indicates different tones to sexual abuse, with the cluster analysis suggesting a more violent dimension to allied profession perpetrators, while the detailed qualitative nurse sample analysis indicated more severe wrongdoing. These findings all show the importance of more research into this form of wrongdoing

to further examine such distinctions between these professions, and also to check whether such incidents are different for midwives compared to nurses. A key issue is whether these perpetrators derive – or exploit – the greater autonomy or status that emerges from their job title in order to abuse (Osgood, 2017; Restubog et al., 2015). Further analysis is needed to examine cases where violence was used to discern if this is a different category of sexual violence, and checking the severity of actions. In addition, a perpetrator dimension which was not checked, but could be pursued in future research was the ethnicity of both perpetrator and target. Further analysis is prudent in the wake of high profile prosecutions in the context of health and social care (Jay, 2014; Lampard & Marsden, 2015). Given the significance of this form of abuse in undermining both trust and confidence in both professions, as well as institutions, it is an area that requires ongoing attention to ensure regulators and employing organisations are attentive to changes in perpetrator profiles.

c. Further quantitative analysis of sexual misconduct

Process

The NHS staff survey includes specific questions on sexual aggression and the actions that employers undertake, so we decided to examine all of the sexual misconduct cases to examine the relationship of charges with these organisational survey results (see figure 6).

Figure 6: extract from the NHS staff survey

Each of the determinations for this charge were reviewed and the incident location identified for 265 cases. We also coded the employment locations of perpetrators resulting in a data set of 242 usable FtP cases.

Results

The determination documents normally included details of the employer and the incident locations, with 236 employers identified. From this some key hotspots for sexual misconduct are evident (see table 4) with increased incidents of sexual misconduct. These locations correspond with prior literature on identifying how family doctors' practices and organisations focusing

on mental health are more frequent locations for such incidents (Sansone and Sansone, 2009).

Table 4: Types of employment locations for sexual misconduct cases

Employment location type	#	% of total cases
Hospital	122	51.69
GP surgery consulting room	31	13.14
Care home	21	8.90
Private consulting room	17	7.2
Local authority (inc. youth and adoption)	15	6.36
Mental health	14	5.93
Ambulance trust	13	5.51
Prison	3	1.27
	236	

Next, we explored the relationships between such incidents and the responses to harassment questions in the annual NHS staff survey. In total we identified 63 cases in which an NHS trust location could be found. These included 49 trusts in total, with a further between 201-319 trusts across England locations for this period (the number changes by year) in which no incidents were found. The number of sexual misconduct instances per trust ranged from 0 (in the majority of trusts – the exact number was more difficult to establish as above) to 3 (4 trusts). 39 trusts had a single incident, and 6 trusts two incidents. The types of NHS trusts involved in sexual misconduct included: 21/154 acute hospital trusts, 19/57

mental health/learning disability trusts, 2 community trusts, and 5 ambulance trusts. Thus this shows two distinct types of employment context in which sexual misconduct is more prevalent: we found that ambulance trusts are clearly over-represented (there are only 10 in the country), and that this form of misconduct seems to be far more common in mental health / learning disability trusts than within acute trusts.

There is a considerable spread of incidents over a number of years, with a single incident reported in 2000, and a further one in 2005, but almost all those in the data set were from 2008 onwards, with the majority occurring between 2012 and 2014. This gives some cause for concern about the reliability of the data, as it does not seem realistic that there was a sudden peak during these years, and fewer cases on either side. It is almost certainly that these are the years for which the best data was available. However, as there are so (relatively) few cases overall it would not be helpful to discard cases just because they do not fall within this period. It also means that focussing on individual years of cases is not entirely feasible, so we focused on surveys from 2010 onwards. Unfortunately, the NHS staff surveys do not use precisely the same questions every year. In particular, we determined that probably the most relevant for our analysis is the "effective action following incidents" variable, which describes the extent to which a trust takes effective action if abuse or similar is reported. This was included in the survey until 2011, and then again in 2014 (but not since). Given this, and the aforementioned issues described, the strategy employed in the analysis was to compare trusts with and without charges on staff survey data from

2011 (just before the majority of the incidents took place), 2014 (towards the end of this period), and the change in between. In each case a non-parametric comparison was undertaken between trusts with recorded incidents and those without using a Mann-Whitney test, and a non-parametric correlation between the number of incidents and staff survey scores. This analysis confirms significant ($p < .05$) correlations between number of charges that occur and:

• Change in % working extra hours: the more extra working increases, the more incidents of sexual misconduct occur;
• Physical violence from patients, and bullying/harassment/ abuse from patients, in both 2011 and 2014, and the changes in between: the more there is aggression from patients, the more sexual misconduct cases there are;
• Physical violence from colleagues, in 2014 only: the more there is aggression from co-workers, the more sexual misconduct cases there are;
• Quality of communication between staff and managers, in 2014 only: the better the quality of communication, the fewer the sexual misconduct incidents there are;
• Percentage of staff having equality and diversity training, in 2014 only: the more staff that have been trained, the fewer sexual misconduct incidents there are;
• Discrimination against staff, in both 2011 and 2014: the more reports of discrimination there were, the more sexual misconduct incidents occurred.

The Mann-Whitney tests revealed the same relationships, with nothing additional being found. There were no significant relationships with effective action following

incidents, engagement, job satisfaction, or perceptions of work pressure. Clearly we have to guard against

type I errors, and there is no good evidence for causal links, but the fact that all of the significant aforementioned relationships in the direction we would have hypothesised suggests that this is not likely to be a major issue. However, we do need to be careful of the trust type differences that occur throughout the data. In particular, ambulance trusts are notoriously different from most of the NHS (staff survey scores tend to be more negative). If we exclude ambulance trusts from the analysis, then all of the significant relationships listed above disappear. This suggests they may be driven largely by the differences between ambulance and other trusts, and we may not be able to conclude that there is a definitive link between survey scores and misconduct events. These results do however show that there may be value in more careful attention and monitoring of the following NHS survey dimensions: increased % working extra hours, raised levels of physical violence from patients and from colleagues, and elevation in reports of discrimination against staff. In contrast, organisations which are found to have a high quality of communications and greater proportions of staff receiving equality and diversity training appear to have lower instances. As many of the organisations in table 4, such as nursing homes, and local authorities, etc., are not subject to the same annual survey, it has not been possible to assess these relationships. Furthermore, while such organisations do have Care Quality Commission assessment this is not at the same frequency as the NHS staff survey, and therefore it will be more challenging to assess the use of such data to enhance hot spot detection.

d. Recommendations on sexual misconduct cases[16]

• Sexual misconduct codings

Following our analysis it is evident that failures to maintain professional boundaries are not always included in coding of these cases of sexual misconduct, despite the fact that failures to maintain professional boundaries is explicitly recorded or implicitly involved in every instance of sexual misconduct. For subsequent analysis of these important cases, it would be useful if data was accurately and routinely reported, including the gender and ethnicity of both perpetrators and targets, whether targets were patients or co-workers.

• Enhancing detection and amelioration of sexual misconduct

The analysis of sexual misconduct and the unfolding of this form of wrongdoing clearly shows the value of addressing workplace verbal and physical behaviours, namely boundaries, on an ongoing basis, to not only enhance detection but ultimately to reduce instances of sexual misconduct. Given the analysis of the NHS staff survey, it is clear more scrutiny should be given to those workplaces in which employees are noting more interpersonal aggression, including both racial abuse and sexual harassment.

Furthermore, as some professions and locations were shown to have more frequent incidents, namely ambulance trusts, mental health/learning disability trusts, and GPs' practices, it is important that the boundary dimension is

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[16] This analysis was carries out by professor J.F. Dawson

included in input controls for these locations. Including this dimension in recruitment and selection assessments would have the combined impact of ensuring all new recruits are aware, but also to deselect from these locations those who find professional boundaries a challenge. It should also be a dimension that is included earlier in medical careers, as this is a form of wrongdoing more closely associated with the abuse of power by male doctors. Similarly, it might be beneficial to include this in the early identification and de-selection of paramedics.

It could be further reinforced into other subsequent HR procedures, especially in the aforementioned 'hotspots', significantly in induction and ongoing training as a means of reducing the ambiguity on which such wrongdoing thrives, to not only deter perpetrators but also to alert employees to the warning signs and thus make workplaces safer. This is a topic which is particularly important in the content of awareness training, to highlight how women are treated differently. The tentative evidence from some cases indicate that health professionals from other cultural contexts can at times misunderstand cues and signals and arrive at different inferences when operating in contexts which are more sexualised and "touchy feely" than they may be used to. Again, for these individuals, greater awareness of differences in physical boundaries between cultures can help reduce their ambiguity. This issue would benefit from more rigorous study enhanced by the better collection of ethnicity and gender data pertaining to perpetrators and targets. While it is clear that there are cultural dimensions to norms, the behaviour of co-workers appears to be equally important in individuals' choices of action (Westerman, Beekun,

Stedham, & Yamamura, 2007). In addition, there is behaviour concerning physical aggression against more vulnerable others, and therefore contrary to wider shared societal norms, especially for those working in health and care. If national cultures are indeed a critical factor we would expect to see clear correlations with misconduct. But cultural differences are an overly simplistic indication of wrongdoing (Ralston et al., 2014), and may serve as a convenient excuse for those with low moral standards to abdicate responsibility for their actions. With specific research into this issue we would be able to determine which scenario is more likely and create more targeted information for both organisations and regulators about these key input controls. This would effectively reduce the number of potential perpetrators and thus protect vulnerable service users and workplaces. Targeted training resources could also be focused on those coming from outside the UK, who therefore might have some acculturalisation difficulties to ensure that they are aware of key differences in norms around what constitutes sexual abuse and harassment in the UK context. Alternatively, if culture was not found to be a factor, we could provide evidence for the FtP panel to better interrogate and challenge such individuals and ensure that due sanctions are applied.

More generally, our analysis showed various procedures which appear to be of particular concern; for example, discussing what is an appropriate and inappropriate 'consensual' relationship with patients, and those surrounding interactions with vulnerable patients. Boundary training should also be tailored to the specific issues that appear to be particular triggers in different professions,

including the. intimacy which can develop through in-depth consultations between doctor and patient. Further attention needs to be given to organisational climates, and specifically to the normalisation of flirtatious and sexualised talk as a trigger for inappropriate behaviour. This should also include physical touching between colleagues, and also aggression and violence within the allied professions health workforce. Evidence suggests that men and women have different perceptions of what constitutes harassment (Rotundo et al., 2001) and so efforts which raise awareness can be of broader value.

Specifically, Human Resources policy could be used more effectively to clarify the appropriate use of virtual and social media and mobile phone communication to avoid instigating or facilitating sexual misconduct across all the professions. Social media or text communication appeared to play an important role in grooming and relationship building, and thus efforts to reduce ambiguity are helpful to both deter perpetrators and make staff more aware. Evidence clearly shows the value of transparent processes and policies to enable service users and co-workers to challenge perpetrators (O'Donohue et al, 1998). We would further recommend that additional research is undertaken in contexts which have had repeat incidents of sexual misconduct to identify any specific factors behind ongoing professional wrongdoing. For example, is it in the same locations or professional groups in which such wrongdoing is occurring? What steps have been taken to ameliorate the initial and then subsequent sexual misconducts? Are the forms and types of wrongdoing the same, or are they changing?

• Sanctions and punishments for doctors

More scrutiny is required to examine the differences in sanctions that have been found between the professions for sexual misconduct. Specifically, this type of wrongdoing is significantly more prevalent amongst male doctors, and yet from a lay perspective they appear to have less severe sanctions applied to them when compared to the other professions. Furthermore, mitigating circumstances of cultural misunderstanding are used for some non-UK-national doctors. It is therefore suggested, as above, that further study should be undertaken to examine the cultural and ethnic dimensions of both perpetrators and targets in order to establish whether distinct forms of training need to be devised and delivered. Extant research clearly shows the severity of the harm this form of wrongdoing (with its inherent abuse of power) causes to victims (Galletly, 2004). Doctors are powerful authority figures in both health organisations and wider society and such misconduct is a fundamental abuse of patient and co-worker trust, requiring far more scrutiny and attention. Doctors can act also as powerful role models for others. More consideration is thus required to examine whether the antecedents for this profession are different, or whether the sanctions and other regulatory interventions are sufficient to deter wrongdoing. Further attention should include investigation into the composition of different professions' discipline panels, ensuring that there is gender balance.

5. Focus on Dishonesty

Dishonesty in terms of CWB is characterised as a form of property deviance (Robinson and Bennett, 1995). It has two distinct forms which are differentiated in the FtP charges; These include theft in the form of taking property belonging to another person or an organisation, and theft in terms of misrepresentation involving fraud or dishonesty about qualifications. The next section examines these two types of wrongdoing.

Significantly, our qualitative analysis of this charge reveals striking similarities between these two forms of dishonesty. The relationship between the evidence of misconduct outlined in the determination documents and the charges made is central, though we found some inconsistencies within and between regulators in the charging, which we will highlight further below for each type.

Dishonesty is considered a severe form of wrongdoing, as such actions go against generally accepted societal norms of behaviour. It is also the anathema of the type of conduct expected by those working with vulnerable service users. It requires a level of personal aggression towards the victim (Robinson and Bennet, 1995) and perpetrators increase the level of risk for patients and other service users. These actions undermine confidence in and the reputation of both regulators and employing organisations. We now examine them separately.

a. Characteristics of dishonesty/theft amongst health professionals

There are 1,784 charges of dishonesty/theft in the FtP database, of which the majority of cases are found amongst nurses and midwives (72%), with allied professions accounting for 17% of cases, and doctors, 10.4%. However, in examining the proportional frequency of misconducts, it is the most common type of wrongdoing amongst doctors (12.4%), and comparably frequent, at 10.3% for nurses and midwives and 9.4% for allied professions (see table 1). Perpetrators tend to follow gender sex ratios for the profession with men (38.9%) dominating the doctors, women dominating the category of nursing and midwifery (57.5%), and more balanced results found amongst allied professionals.

The cluster analysis results identified two patterns: one amongst allied professionals, and one for doctors and nurses and midwives (see figure 7). In the allied professionals group, dishonesty/theft is accompanied by actual criminal convictions and drug associated charges. Therefore, transgression is associated with serious criminal behaviour. The second grouping contains both nurses and midwives and doctors, revealing theft as part of suite of production deviance behaviour. Specifically clustered with theft is poor record keeping and prescribing behaviours, which indicates the increased risk to patients and service users from such individuals. Furthermore, in the charges that cluster nurse and midwife cases, their cluster also includes a failure to follow regulatory requirements,

while for doctors their additional associated production deviances are substandard care, failure to examine, and poor communication. Therefore, dishonesty/theft and its associate behaviours impacts on the quality of health care patients receive and the adherence to regulatory requirements. These results indicate the importance of utilising process and output controls pertaining to the monitoring of record keeping and prescribing behaviour, and in the case of doctors, also their referral activities as a means of detecting potential perpetrators.

## b. Qualitative analysis of dishonesty theft

Process

A random-stratified purposeful sampling process was used to select 72 cases, which included single and multiple charges. These cases were then coded using the same coding schemes as outlined above for sexual misconduct. This included coding for ecological factors

Figure 7: Extract by profession from cluster analysis (figure 2-4) for dishonesty theft
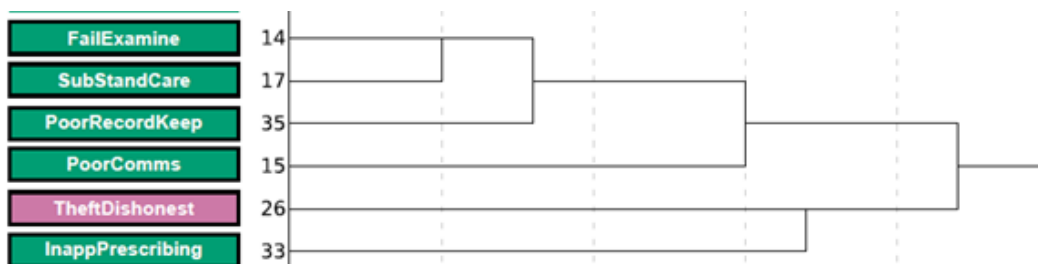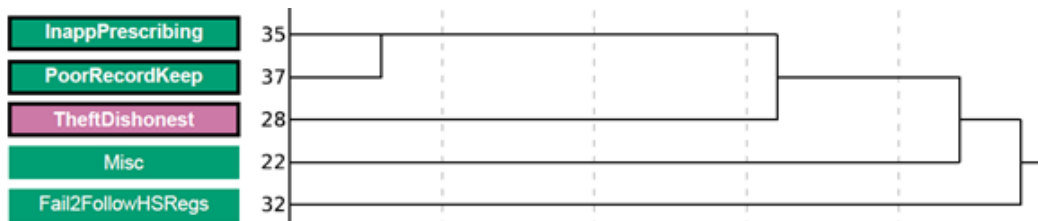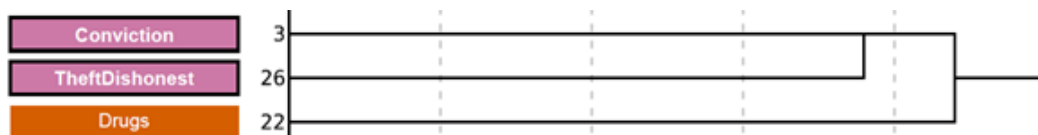
comprising: the location of the incident(s); the charge details, including target type and incident location(s); and perpetrator information concerning profession, gender, and main place of work. We also coded triggers (e.g. motivation, home or work pressures) and charge details to capture type, breadth, frequency of incidents and impact(s) on target(s), perpetrator information to allow for the capture of multiple culprits, and the sanctions of regulators. We used the same process as our previous one to assure consistency of this coding. We can now report themes, contrasted by profession, and illustrate these using anonymised exemplar quotes from determination files.

Thematic Analysis of Dishonesty/Theft

To better understand the characteristics of dishonesty cases amongst these professions, we applied in-depth thematic analysis to this random sub-sample of cases (n=72, of which 13 were doctors, 38 were nurses and midwives, and 21% were allied professionals) until data saturation was reached (see table 5 for a summary). In our thematic coding we sought to test out gender differences in perpetrators: we found that perpetrators follow the sex-ratios for their profession, so males dominated amongst doctors, while females dominated for nurses and midwives. In allied professional cases, just over half were male perpetrators working in a medical setting, such as a paramedics or biomedical scientists, and just under half were female cases from a social work context (see table 5). The chief target for this form of dishonesty was patients, with only some focusing on colleagues. We found this type of wrongdoing to be undertaken mainly within workplaces, with self-gain the key motivation for individuals and also groups operating across different locations. Critically, this collaboration suggests a level of planning and sophistication to such actions. We found both single and multiple targets were selected for these activities, with clear evidence of repetitive offending behaviour for some, while others appear to be isolated and more spontaneous forms of transgressions. We found peers played an important part in reporting such wrongdoing, especially amongst nurse and midwife cases. Furthermore, this type of misconduct was accompanied by additional charges, including 'poor / inaccurate record keeping and/or history taking', 'inappropriate / inaccurate dispensing of medication – pharmacy', and 'poor performance / lack of competence'.

It is important to note that from our investigation of these cases, some contained instances of qualifications' fraud which had not been captured within the PSA coding process. This may arise from some ambiguity in the PSA codes about how particular kinds of qualifications' fraud should be categorised. As a result, the dishonesty/ fraud (section 5c and d) will only include new insights rather than merely reiterating the themes identified in the dishonesty/theft (section 5c and d), which in fact contains several incidents which would be much better categorised as dishonesty/fraud. Nevertheless, the lack of consistency in the charge recorded does create a limitation in the data used in the cluster analysis and in the subsequent stratified sampling randomly identifying pertinent cases for qualitative analysis.

Table 5: Gender, location, and target coding for dishonesty/

Dishonesty /Theft Coding		GMC Doctors	NMC Nurses and midwives	HCPC Allied
Coded Cases / Saturation	Number of cases	13	38	21
Additional Charges Present	Yes	6	29	9
	No	7	9	12
Gender	Male	11	12	11
	Female	2	26	10
Offence Location	At work	11	35	15
	Outside work	2	3	6
Breadth of Targets	Multiple	7	18	4
	Single	6	20	13
Frequency of Charge	Multiple	6	18	8
	Single	7	20	13
Primary Target	Self-gain	8	18	13
	Self – self harm – alcohol or self-abuse	0	2	1
	Service Users - Patients	3	13	5
	Multiple (Internal)	2	3	1
	Multiple (Internal and External)	0	2	1
Actors Involved	Single perpetrator	11	35	19
	Multiple Perpetrators – Different workplaces	2	3	1
	Multiple Perpetrators – Same location – same department	0	0	1
Who detected / reported	Unknown	6	13	2
	Service users - Patients	1	2	0
	Service users – outside organisation	2	3	2
	Internal – Colleagues - Peers – same level / subordinates	1	7	2
	Internal – HR / Finance	1	2	3
	Self	0	1	2
	Internal – Others within the org / Senior orgl members / line mang	0	6	6
	Multiple (Internal)	2	2	3
	Multiple (internal and external)	0	2	0
	Multiple (external)	0	0	1
Self-Regulation	Unknown	1	5	1
	Solely work related	4	4	2
	Solely home/personal related	5	15	7
	Combination of home/personal and work	3	14	11
Effects of charge on victim	No actual harm but posed threat to one of target	9	19	7
	Not applicable – no harm	3	15	9
	Physical harm / Mental Harm / Sexual Harm	0	2	5
	Professional harm e.g. disciplined, sacked	1	2	0
Effects of charge on perpetrators/ sanction	Suspension / Discipline / Caution	3	8	1
	Struck off register permanently	2	9	5
	Struck off register temporarily	2	4	4
	Interim suspension / Restrictive Practice	3	10	3
	Remorse/Regret, Nothing	2	4	3
	Police Caution / Imprisoned	1	3	1
	Voluntary removal from register	0	0	4

i. Doctors

Most of the dishonesty/theft cases that were coded for doctors involved perpetrators who were acting alone (7 of cases sampled), with a larger proportion of male doctors committing offences, particularly within a GP setting. The primary purpose of theft for a large number of cases was self-gain (8 of cases sampled), and given the nature of their role, this has the potential to affect service users. Staff were also potentially impacted vicariously as secondary targets, or through trying to monitor and detect wrongdoing. In the coded cases, we found no mention of actual harm being caused, but such incidents still pose a risk for the profession and for employers. More importantly, these cases revealed poor and vulnerable systems for monitoring or checking, which presented opportunities for perpetrators', who could remain undetected for a significant length of time. For most of these cases it was unclear who had detected the issue, whilst for some, internal stakeholders including HR/Finance, Service Users – Colleagues (collectively 6 of cases sampled) – Peers at the same level, and external Service Users outside the organisation were all important information sources.

i.i. Embellished records and falsified information

A key form of theft found was the distortion or falsification of information by doctors, which is more indicative of fraud than theft (8 of cases sampled), as we mention above. These acts included falsifying information for conference presentations and in their authoring of academic papers, or falsely representing qualifications or assessments (see section 5d). The actions undertaken appear deliberate for the purpose of self-gain. They indicate the need to audit and verify important information with third parties, such as those found in re-registration.

i.ii Groups of theft perpetrators and coercive others

We found evidence of group perpetrated theft deception (2 of sampled cases), with regards to falsified information, especially among those who had trained together. For example, a doctor deliberately falsified another's qualifications to open a medical account to obtain materials that they were not trained to use. A faked certificate was developed, motivated by financial/self-gain:

"Having found that Dr X acquiesced to the creation of a false account with XX and to the creation of the false certificate, the Panel considered that Dr XX must have acquiesced in this course of action for a purpose. The Panel was of the view that, on the balance of probabilities, it is more likely than not that the purpose was to generate an additional line of credit through which to obtain supplies from XX" (D16).

A further theme to dishonesty cases was one of external coercion, either from patients or fellow doctors. In instances involving patients, this action was to access drugs, and highlighted the challenges of interacting with difficult, abusive, aggressive, and manipulative service users. In the case of pressure from fellow doctors, the focus tended to be on cheating, such as in obtaining qualifications (e.g. D.40). This latter group highlights the apparent miscategorising of misconducts.

i.iii. Role of culture as a mitigating circumstance

A feature of several cases was the use of national culture as a mitigating circumstance in a dishonesty/theft case (2 of cases sampled). While the ethnicity of perpetrators was not included in our analysis (or officially recorded in determinations), we found examples, including deception concerning immigration status or other mitigating circumstances offered, which indicated that the doctor was unfamiliar with UK clinical norms. The difference in prevailing norms and extenuating personal circumstances were coupled together as a factor in professional misconduct, as the following extract highlights:

"You were practising in an environment which, by your own account, was something you had not previously encountered in the Ukraine and had limited acquaintance with the norms of UK clinical practice. You had background concerns about your parents' illness and your own financial position and you were working to pass professional exams. In your written statement to the panel, you stated that you acted in panic and at a time when your life seemed to be collapsing". (D17)

By contrast, only two FtP charges involved language problems, suggesting that communication was not a barrier to such individuals, or that language problems are underreported in the doctor's FtP charges.

i.iv. Mis-categorisation of dishonesty

As we have noted above, we found further dishonesty coding was often omitted from the PSA coding process, as in some forms of organisational-level deception (e.g. qualifications fraud). This may be due to ambiguity in the coding used by PSA. It is recommended that PSA reviews its coding system to allow for the distinguishing of theft from fraud pertaining to efforts to enter or progress in the organisation. There are clear differences in the targets for these two actions.

i.v. Impacts and Sanctions

As with many cases of professional misconduct in health and social care environments, the impact reported in dishonesty cases was an increased risk to service users. Those who showed remorse (2 of sample cases), attended their hearings, and demonstrated significant CPD training, appeared to receive less severe sanctions. Doctors also appeared more likely than nurses and midwives or allied professionals to receive short-term, suspension or interim suspensions (7 of sample cases) and not permanent sanctions (only 2 permanent from this stratified sample of cases) from their regulator. This type of sanction is much harsher for nurses and midwives than doctors (who received no sanction for their dishonesty), as shown in the following cases:

"Your evidence was that you received a phone call from a private hospital operated by XX [names organisation] offering you a day's private work at the time when you were on sick leave and knew that your on call obligations at XX [names organisation] were already covered. You accepted the offer, and went to that private clinic on XX [date] to undertake that day's

work before traveling on to XX to resume your full-time duties there. Your wife testified that, during a phone call with you that evening, you told her what you had done and that you should not have done it" (D14).

Compare this example with a similar case involving a nurse:

"[You] were absent on sick leave from X having reported enteric symptoms, during a time when there were concerns of a Norovirus outbreak. You were aware that you should not have worked as a nurse for 72 hours after you were last symptomatic, yet you did work nursing shifts during this period" (N15)[17].

Further research is required to ascertain if there is a clear trend of discrepancies in sanctions between different professions. We acknowledge that we were just using the determination documents and panels may have had more insight into the circumstances than is captured in these documents; however, we would recommend this area be the subject of further investigation specifically into the parity of sanctions between professions.

ii. Nurses and midwives

In examining dishonesty amongst nurses and midwives we found that the gender profile for offenders was different to that noted in sexual misconduct cases, with larger numbers of female perpetrators (26 of the cases sampled were female). There were some more instances

of multiple perpetrators which comprised family/friend relationships, with evidence of husband and wife, partner, siblings and friends involved in their dishonesty (3 of cases sampled). There was also a higher number of convictions for this group, which confirms the cluster analysis. A higher proportion of these offences took place within the workplace (35 of cases sampled), with self-gain as the primary target (18 of cases sampled), and due to these actions, as with doctors, potential harm was caused to service users/patients (4 of cases sampled). As before, the recurring motive is one of personal gain.

ii.i. Bank and agency workers

A key facilitator of theft in the nursing and midwifery context is evidently organisational resource pressures, which are evident in both the way that nurses are hired and where they are placed within a work setting. Bank nurses are often used in supporting already busy and understaffed settings. In addition, such contexts are often those without sufficient resources to provide proper monitoring of staff; therefore, opportunities to undertake additional paid roles arose, which offered individuals further financial gain. They were also workplaces in which errors might only be detected after the instigator had long since left. As per best practice, bank organisations should have completed pre-checks on individuals verifying their qualifications and identifying and not placing those with gross misconducts. Yet often such checks do not appear to have been adequately undertaken, with failures to verify why nurses and midwives had left their previous employment. This is

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[17] This example is extracted for comparative purposes but as in several cases, the nurse was not disciplined for dishonesty theft but for dishonesty qualifications fraud .

illustrated in the following quote:

"Mr X applied for the position of staff nurse at the nurse through an agency X Associates. … X was offered the position subject to a CRB check and satisfactory references. Checks were made on his PIN and it became apparent that he was subject to an interim conditions of practice order. In addition, one of his references came back indicating that he was dismissed for gross professional misconduct and had been referred to the NMC. It is alleged that he failed to inform the home at the time of applications that he was under NMC investigation and subject to a conditions of practice order" (N 18).

There were further examples of nurses and midwives who had lied about their grades of pay and their references to obtain employment (4 of cases sampled). The next example demonstrates the levels of deception that some individuals are undertaking. In this case the individual implied prior agency work:

"As a result of his false representations, Mr X's application for employment at (employer name) was successful and he was employed at an enhanced rate of pay, due in part to his falsely representing that he had been employed by a company, X Healthcare, which was in fact his own company" (N19).

The lack of checking by employers, especially for qualifications, created tangible risks for patients, such as the misconduct of a nurse dispensing over 1,400 prescriptions when he/she was not qualified to do so (N28).

ii.ii. Group-level dishonesty

In this profession we also found examples of group-level dishonesty which, as noted already, tended to include qualifications fraud; however, these additional charges were sometimes not coded as such by PSA, but in the category 'Dishonesty/fraud/theft'. Such incidents involved family members, including sisters, partners, and friends in their dishonest misconduct. However, the group level also operated among strangers. As the extract below illustrates, a senior nurse coerced junior nurses to complete references for people they did not know, which constitutes the falsification of their level of clinical skill. Such deceptions show false grounds for employment and increased risks to patients from such individuals:

"You provided false employment references in respect of a number of individuals when you possessed no knowledge of their current clinical skills. You further represented that the individuals had worked at the Trust and that you had observed and assessed their practice. You abused your position as a registered nurse and breached the trust placed upon you by your colleagues, the Trust and the public. In addition, you used your superiority … in order to request junior nurses to provide employment references for individuals about whom they possessed no knowledge" (N21).

ii.iii. Dishonesty by omission

This category focuses on those for whom dishonesty theft is not necessarily intentional, but instead occurs due to

individuals' cognitive resources being overwhelmed (Hobfoll, 1989). Analysis of the FtP cases identified three distinct sources that overwhelmed this category of nurses and midwives: work–based pressures, home-work spillover, and addiction and ill-health.

Work-based pressures

Our analysis found that external work-related pressure from organisations on resources was a significant contributory factor in theft amongst nurses and midwives; more so than for doctors. Scrutiny of the sampled nursing cases showed how resource-depleted organisational environments resulted in shortages of nursing staff. In such contexts, theft appeared a more common occurrence, with inadequate staffing reducing monitoring, but also creating a more pervasive issue of staff operating beyond their capacity. This appears to have two implications, as the quote below shows: professionals being unable to adequately recuperate, and being forced by this additional workload to check or undertake others' incomplete work:

"In your statement you stated, 'The reason I ended up doing the shift on 31 October was to help the patients in need at the Nursing home and I was called only that morning to come and help due to a big shortage of staff. Although I initially did not want to work that day and agreed only to work that morning shift, I agreed to carry on, as the home could not find anyone to do the shift later. Can I remind that if I did not work on that day later, the house would have been at risk of serious shortage of Nursing [sic] staff and had to fulfil all these duties with one staff'." (N22).

In such contexts it becomes clear why nurse and midwife theft misconduct often includes further associated charges of poor record keeping and performance, inaccurate dispensing of medication, sub-standard care, and failures to examine. Further, such impacts are unlikely to be confined to just one individual. They also appear amongst previously promoted senior professionals with additional staff responsibilities. Given such stressful environments, the deleterious effects on communication and the quality of working relationships are apparent, and endorsed by prior research (Fox, et al., 2007; Fox et al., 2001; Spector & Fox, 2005; Spector et al., 2006). The net result is service users' exposure to substandard care by professionals who are clearly overwhelmed by these work situations both personally and professionally. Antecedents of such misconduct point to low levels of supervision that failed to adequately support stressed staff. Cases also included underlying conflicts with colleagues. Indeed while some cases included further verbal abuse charges, case details implied poor working relationships. It is therefore likely that important signals might be found in NHS staff survey data. As the example below illustrates, the case reveals a downward spiral occurring in an organisation in which nurses and midwives with line management responsibilities become overwhelmed:

"You said that your error would not happen again. You said that on that night, the Home was understaffed and that you were working with staff who did not like you. You said you tried to call the health care assistants for help to carry out tasks; however, they would not answer their buzzers. You said that the healthcare assistants at the Home refused to take

instructions from you and as a result, you would end up completing their work for them. You said that you now know how to manage staff and how a registered nurse must behave, and at the time it was difficult to manage the team because it was an unsupportive environment" (N23).

Home-work spillover

Coding identified further self-depletion occurring due to individuals managing complex and challenging home/work interfaces. These nurses and midwives were overburdened but while the source was different, the impact in terms of theft and production deviance was the same. The spillover into work from something that had happened at home is illustrated in the extract below:

"I don't know why I said to my physio that somebody had beaten me up, it was suppose it stupid to say that a nine year old had beaten, do you know what I mean, play fighting and that's it, that's it in a nutshell…(sic). I have been in previous relationships where I have been beaten and maybe, maybe because I don't know, maybe just because I don't know, I don't know why I have done this, I am really really sorry, it got taken out of my hands all so quickly, it moved so fast, it just wasn't what I expected (sic)." (N42).

Drug dependence and illness

A further source that left nurses and midwives depleted in their work related to personal health and addiction issues. Drugs charges are shown in the cluster analysis (see figure

6) and was noted in 4 of cases we sampled in more detail. Examples included a drug dependent nurse or midwife stealing a prescription pad (e.g. N43), or using their status as a health professional to access workplaces in order to steal drugs. The example below indicates this type of deception:

"Attended work in her uniform when she was not on duty, she attended ward G5 when she had no reason to attend that ward, she asked for medication purportedly for ward F4 when she had no connection with ward F4, she passed herself off as a bank nurse when she was in fact a midwife and she asked for medication that was not required in her role as a midwife" (N20).

Similarly, a trigger situation for theft was related to nurses and midwives returning to work after periods of absence (4 of cases sampled). These individuals had either physical illnesses or mental health issues that required appropriate monitoring. Examples included lack of sleep or ongoing health problems as a factor in depleting normal self-regulation. The failure to adequately support and monitor vulnerable staff members implies a level of organisational complicity and culpability, and raises the question of whether if these individuals were of sound mind, would they have acted any differently.

ii.iv Impacts and Sanctions

As with cases involving doctors, the coding showed the impact of nurses' and midwives' wrongdoing related most to concerns about increased threat (19 of cases sampled)

rather than harm to service users. Again, remorse and attending hearings appeared important in demonstrating individuals' due awareness of the seriousness of the matter (32 of cases sampled). Nurses and midwives were found to be more likely than doctors to receive permanent rather than temporary sanctions from their regulator (9 compared to 2 of cases sampled).

iii. Allied Professionals

In looking at allied professionals' dishonesty in the form of theft, our analysis reveals that the majority of perpetrators acted alone (13 of cases sampled). There were still some examples, however, of multiple perpetrators (4 of cases sampled), with this group having a distinct family relationship dimension as it involved marital partners. Primarily these theft cases comprised paramedics and social workers. Equal numbers of male and female perpetrators were found; however, the random sample included a greater number of female social workers. Male perpetrators typically were found within a medical setting, i.e. paramedics or biomedical scientists. The majority of these offences were committed at work (15 of cases sampled). The offences that were committed outside of work related to family and health issues as the subsequent examples will illustrate. This is a group where many work tensions are evident. In addition, the coding indicates issues of vulnerable work systems, lack of supervision, and resource pressures which allowed opportunists to thrive.

iii.i. Deliberate deceivers vs vicarious social learning

Examples of this form of pre-meditated deception included deliberately misleading a prospective employer regarding experience and qualifications, providing their own reference claiming it was written by another (A29), or extracting money from a vulnerable service user (A44). In many instances, however, the fraud charge was not coded. Conversely, we found the importance of social interactions in workplaces in the learning and normalisation of theft for perpetrators. Examples emerged of observation and informal talk through which individuals were exposed to inappropriate behaviours, such as how to 'work the system', leading to the vicarious exposure and adoption of wrongful actions (Robinson et al., 2014). The cases suggest more widespread deviation of professional norms within local authority departments in particular. This resulted in deviant practices being adopted and accepted as simply careless errors, in contexts with poor or vulnerable systems that could be deliberately or vicariously exploited for financial gain as the next quote shows:

"The Panel's finding that this was a careless error… the Registrant did not act for monetary gain, and this was an important factor to take into account… In making an expenses claim on the basis of diary entries, although in this case an incorrect claim, the Registrant had been following the practice which had been advised by Witness 1 generally to other social workers working at X". (A24)

While an assumption could be made of individuals intentionally trying to claim mileage, motivated by financial/self-gain, many such cases suggest these simply arose from careless unintended error. Conversely, other examples identified weaknesses in systems that were

being manipulated for personal gain. Research has shown how such behaviours can be the result of perpetrators seeking revenge, intending to obtain a payback from the organisation (Restubog, et al., 2015; Wang, et al., 2016).

iii.ii. Self-regulation and lack of training

Within the allied professionals group, and not unlike nurses and midwives, there was a pattern of self-regulation triggers, highlighted by cases involving mental health issues, family illness/death, or dependence on drugs and alcohol (16 of cases sampled). An important category particularly affected by such stress was newly qualified staff who, due to poor supervision and inadequate managerial support, were overwhelmed and socialised into bad practices (3 of cases sampled). Conversely, there were corresponding issues for senior staff in inadequately staffed organisations:

"At the time of the events that led to these proceedings she had only been in post a few months and during this time her deputy had taken time off in lieu. The supervision session with 'X', Case F's social worker, had been the first with her. 'X' was recently qualified and in the normal course of events the Registrant's deputy would have been responsible for the supervision of 'X'. All these factors had weighed with the Registrant and with the anxiety of criticism of her decision had contributed to the Registrant in taking the action that she had". (A26)

iii.iii. Impact and sanctions

As indicated above, this was a group in which the level of harm to service users appeared relatively high in comparison to the other professions (see table 5) (5 of cases sampled). The use of suspension and caution was thus far lower than for the other professions (4% compared to +20%), in favour of more severe sanctions. Like nurses and midwives, those in the allied professions were more likely to be permanently struck-off than doctors (23% of allied professional cases sampled, compared to 15% of doctor cases sampled).

In this final set of analysis, the other form of dishonesty, that related to qualifications and fraud, is briefly considered but only in terms of its distinctive features, since as we note above, so much of the dishonesty/theft cases we analysed actually contained fraud and often fraud surrounding qualifications or experience. As we note elsewhere, this may arise from ambiguity within the PSA coding system about how to categorise different kinds of dishonesty.

c. Characteristics of dishonesty (fraud/qualifications) amongst health professionals

489 charges were found for this form of dishonesty in the FtP data, with most cases occurring among nurses and midwives (89%), with doctors accounting for 17% of cases, and allied professionals 13%. The proportional frequency, however, revealed such misconduct as more common to doctors (4.8% of FtP charges for this profession), in comparison to nurses and midwives' misconduct (2.9% of FtP cases) and allied professions (1.64% of their FtP) (see table 1). The sex ratios for this form of wrongdoing indicate that men (38.9%) dominate doctor fraud misconduct, while in nursing there is a female skew (57.5%), and it is more balanced amongst allied professionals. In addition, the cluster analysis outlined in figure 6, shows two distinct patterns (see figure 8). Like the allied professionals, groupings of misconduct for nurses and midwives included convictions. Therefore, this form of transgression is associated with behaviour that is more widely considered to be criminal. Those who seek to fraudulently enter an organisation or fake their qualifications thus appear more likely to also engage in illegal activity (see figure 8). In contrast, for doctors this form of fraud is linked to failures to comply with their regulator's and employer's rules and

Figure 8: Extract by profession from cluster analysis (figure 2-4) for qualifications fraud[18]
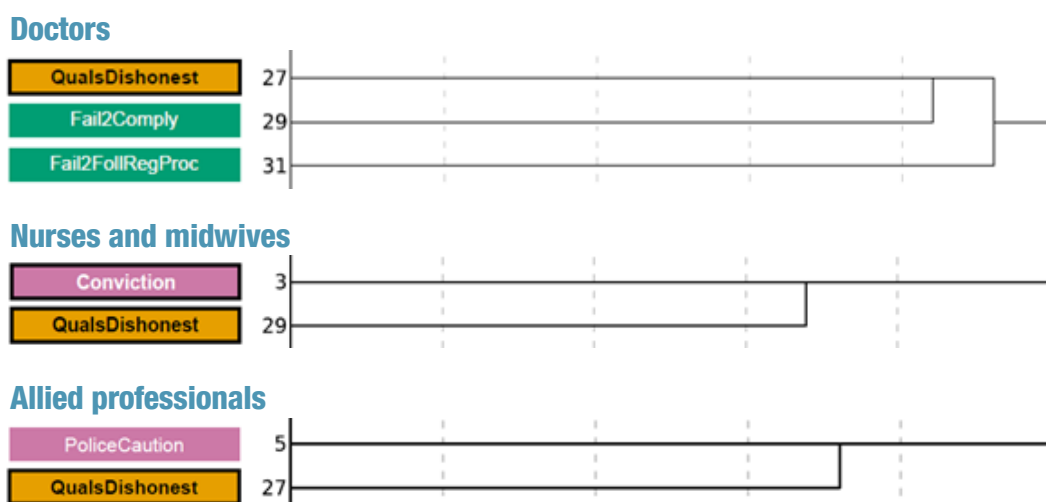
[18] N.b. Allied Professions cluster is already shown in figure 6 as it included both forms of dishonesty and is discussed in detail there

contrast, for doctors this form of fraud is linked to failures to comply with their regulator's and employer's rules and procedures. Analysis from all three professions attests to the value of strong input controls in organisations. It also indicates the value of recording this specific form of wrongdoing accurately and comprehensively.

b. Process of thematic analysis

A random-stratified purposeful sampling process was used to select 21 cases, of which 24% of these cases involved doctors, 28% nursing and midwifery professionals, and 48% allied professionals. These cases included those with both single and multiple charges and were coded using the same coding schemes as outlined earlier for dishonesty (see table 5). The sampling was directed by the relative frequencies and the differences implied in the allied professional profile, and saturation was reached after relatively few cases[19].

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[19] This is also influenced by the instances of this type of misconduct already analysed in section 5a and b; therefore, we avoid providing repetitive examples in this section.

Table 6: Gender, location and target coding for dishonesty qualifications fraud

Qualifications Dishonesty Coding		GMC Doctors	HCPC Allied Professionals	NMC Nurses and midwives
Coded Cases / Saturation	Number of cases	5	10	6
Additional Charges	Yes	4	8	4
Gender	Male	4	5	0
	Female	1	5	6
Offence Location	At work	3	3	5
	Outside work	2	5	1
Breadth of Targets	Multiple	0	8	5
	Single	5	2	1
Frequency of Charge	Multiple	2	5	3
	Single	3	5	3
Primary Target	Self-gain	4	6	2
	Self – self harm – alcohol or self-abuse	0	0	1
	Service Users – Patients	1	0	3
Actors Involved	Single perpetrator	5	8	6
	Multiple Perpetrators – Same location – same department	0	2	0
Who detected / reported	Unknown	5	1	0
	Internal – Colleagues - Peers – same level / subordinates	0	2	2
	Internal – HR / Finance	0	5	0
	Internal – Others within the organisation / Senior Organisational Members / line managers	0	0	2
Self-Regulation	Solely work related	2	4	1
	Solely home/personal related	3	6	2
	Combination of home/personal and work	0	0	2
Effects of charge on victim	No actual harm but posed threat to one of target	1	6	6
	Not applicable – no harm	4	2	0
	Physical harm / Mental Harm / Sexual Harm	0	2	0
Effects of charge on perpetrators/ sanction	Suspension / Discipline / Caution	1	3	1
	Struck off register permanently	1	5	2
	Struck off register temporarily	1	1	0
	Interim suspension / Restrictive Practice	1	0	2
	Remorse/Regret, Nothing	1	1	0
	Police Caution / Imprisoned	0	0	1

Qualifications fraud - Strategic Dishonesty

A central theme of those formally charged with this form of wrongdoing was their strategic decision to deceive. We found manipulations of job applications for each profession as illustrated below to fake competence, inflate previous salaries, and conceal restrictive practices. In addition to accessing health organisations directly, agency working also offered a means for such individuals to more easily gain access to health and social care organisations, and for their lack of competence to remain undetected for longer. The following quotes illustrate these actions for each profession:

"You underwent an assessment of your professional performance and your performance was found to be unacceptable in the areas of assessment, clinical management and working with colleagues. There was found to be cause for concern in the area of record keeping… Your case is that you did not tell the interviewing panel that there were no longer restrictions on your practice, you just told them that the Conditions imposed by an Interim Orders Panel had ended. The evidence of Dr XX and Dr YY was different. They both told the panel that they understood from you that there were no longer any restrictions on your right to practise. Dr XX made a note at the time of the answer you gave to the effect that there were "no ongoing restrictions". The panel prefers the evidence of the two interviewers to your own evidence". (D27)

"The panel considered that 'X' knowingly misrepresented herself by failing to tell her employers that she was not qualified to prescribe and by signing and issuing prescriptions when not qualified or permitted to do so". (N28)

"The Panel concluded that the Registrant had deliberately misled 'X' as to his experience and qualifications and provided a reference which was not written by either, as claimed. This was done pre-meditatively and deliberately with an intent to deceive. He hoped thereby to induce 'X' to employ him when they might otherwise not have done so. The Panel concluded that these misrepresentations and supporting actions were dishonest". (A29)

We further found examples as noted in the earlier section 5a and b, dishonesty/theft cases with the same types of qualifications' fraud; however, these were not formally recorded in the PSA coding. These included examples of individuals and groups of doctors (section 5b i.i., i.ii. and i.iv) and individuals and groups of nurses and midwives (section 5b), with their actions being miscategorised as dishonesty/theft charges.

i. Doctors

In reviewing doctors' FtP in this domain, 4 out of the 5 of sampled cases included motives pertaining to individuals' own self-gain (4 of sampled cases) or making job applications (4% of cases).

i.i. Forms of doctor fraud: lying and playing the system

The typical forms of wrongdoing involved lying on job applications (3 of these sampled cases), altering salary bands, and failing to disclose restrictive practice conditions. From a lay perspective, our analysis suggests some leniency might be shown to doctors who perpetrate fraud despite their significant wrongdoing, which includes knowingly working (seeing patients and prescribing) while not registered, and falsely using others' IDs, especially if patients were not harmed (e.g. D45). Further scrutiny of the doctor sample confirmed social learning components for such organisational fraud (1 of sampled cases), which included systemic 'playing the system' regarding the over-claiming of competence and qualifications, as the following example illustrates:

"The candidate clearly added points on his self-assessment question 4, regarding publications. When given the opportunity to clarify, he admitted that he had none. [S/he] Said he had been 'advised' by his supervisor" (D31).

As noted with theft charges, cultural differences were put forward by doctors as a mitigating factor in 60% of these sampled cases.

i.ii. Impact and sanctions

Reviewing impact suggests that while such wrongdoing might have no direct harm, it nevertheless poses a threat to the health system in terms of, for example, inexperienced or incompetent individuals treating patients.

Sanctions against perpetrators ranged from no action to being struck-off permanently. In contrast to nurses and midwives and allied professionals, the sanction of permanent removal appeared to be less frequently applied in our sample (for doctors, 1 of the sample compared to 2 of the nurses and midwives and 5 of the allied professional sample). Given the obvious increased financial rewards for fraud for this profession, it was somewhat surprising that greater sanctions were not applied to those who could arguably do greater harm to service users and to institutions.

ii. Nurses and midwives

Salient features of the nurse and midwife sample included sole perpetrators who had further charges of misconduct in these cases (4 cases in the sample), with half of the cases analysed involving multiple targets, including patients (5/6). However, the earlier dishonesty/theft charge analysis clearly showed examples of individual and collective dimensions to qualifications fraud, though many were not captured in the PSA coding. Peers and other senior staff were significant sources in reporting wrongdoing (4 of these 6 sample cases). Complex home/work dimensions were also involved in a majority of these cases (4 of the sample), and actual harm was not specifically identified.

ii.i. Forms of nurses and midwives' fraud: false reporting and playing the system

Not unlike doctors, a recurring theme among nurses was deliberate deception about their level of qualifications or

skills (e.g. D46), level of wellness, or recording tasks as completed when they had not, such as prescribing (5 of cases). These actions targeted patients (3 of cases), but co-workers were indirectly affected as attention was diverted from their own work to monitor and detect cheats. Further examples included not disclosing convictions or performance investigations (2 of cases). All of these cases highlighted the value of routine audits, such as from HR or finance (3 of sampled cases) to detect such behaviour, and in co-workers having time to notice cheating and challenge perpetrators, who might then offer further inconsistencies (N15). As the following quote shows, erratic activities can be an important trigger for concern and investigation:

"Noticed to be leaving room frequently, didn't complete paperwork and then collided under the influence of alcohol with a police car" (N47).

The frauds that related to skills and abilities underscored the value of rigorous qualification checking of applicants, which could be supplemented by simple work sampling exercises in recruitment to verify such skills (Searle, 2003). Failures to check were evident from both employing organisations and agencies. The sample also included one who sought multiple workplaces (1 of cases). This case involved dishonesty pertaining to nurses and midwives, with an individual working erroneously in two jobs whilst sick, which placed patients at further risk. Further declines in performance of nurses and midwives would logically follow such cases, as staff would not only be tired from their primary work, but would also have insufficient restorative time to be operating effectively in their second job. Bank agencies have a critical role to play here in enabling these dual employments.

ii.ii. Collective deceptions

The collective dimension of fraud here involves perpetrators in the same locations and departments abusing their positions of power and authority in two key ways: through creating false references, and by directly coercing others to undertake the same (see section 4 ii. ii N. 21). Such forms of behaviour fundamentally undermine confidence in input control systems, and raises concerns about re-accreditation, which may also use fakeable third-party endorsements, and could arguably do greater harm to service users and institutions.

iii. Allied Professionals

As with the other two professional groups, the qualitative coding of qualifications' fraud revealed deliberate attempts to omit or inflate qualifications to get jobs which they were not qualified to do. There was evidence of such individuals omitting mention of illegal activity, including a failure to disclose police cautions and convictions, and particularly a failure to report current FtP charges. The outcome of such cases showed clear risks to service users due to incompetence. A number of these perpetrators were from outside the UK and this was used as a mitigating circumstance. However, better recording of ethnicity would allow more detailed investigations into the frequency of such occurrences.

e. Summary

Qualitative analysis of the charges of dishonesty from both sections 5 b and d reveals four distinct category types that cross each profession. First, we found devious individual and group perpetrators who deliberately selected and exploited vulnerable workplaces. For example, and not unlike in the sexual misconduct cases, the perpetrators who were doctors tended to be GPs working in isolation, while for allied professionals the more dominant perpetrator groups were paramedics and social workers operating autonomously in mobile working environments. In contrast, nurses and midwives tended to be located in either a hospital or nursing home in predominantly static team environments (unless 'bank' /agency nurses). We found dishonesty was more apparent in fluid working contexts, whether through travelling to visit the service user, or by virtue of locum and bank working. These cases were often associated with other production deviance in nurses and midwives and doctors, and home/work stresses for nurses and midwives and allied professionals. Input and process control plays a vital role in reducing the prevalence of this type, with spot checks of records an important means of alerting organisations to these individuals further potential wrongdoing.

Second, a small but significant social learning group emerged, exploiting weak systems in understaffed organisations, which limited means of detecting and correcting their nefariousness. Indeed, we found evidence that supervisors might be central or even complicit in informal transfers, skewing workplaces to make theft and fraud more normal (Moore, Detert, Trevino, Baker, & Mayer, 2012). Here two networks were apparent – amongst doctors, it was those who trained together, while for the two other professions it was family or relationship bonds. Again, the use of process controls would be an significant means of detecting wrongdoing and then searching through these networks to identify further misconduct. Judicious use of sanctions against ring leaders and those assisting would further create clear disincentives.

A third category exhibited similar behaviour but arose from the omission of specific training. Training needs that were identified included acculturalisation for non-UK trained staff from cultures with different norms about dishonesty, and the inadequate induction of newly qualified staff who simply did not know their employers' policies and practices. In addition, there was an evident need to explicitly train supervisors to better support and monitor the adherence of their staff to key processes. This category of staff and their employing organisation might be identified through the examination of organisational survey results, such as those found in the annual NHS staff survey.

The final category that was identified was that of overwhelmed and stressed professionals (Spector et al., 2006). Critically, this group included previously promoted nurses and midwives and allied professionals for whom theft appeared to be more of a symptom of their inability to cope with current demands. It was part of a suite of wider production errors of those working in particularly resource-strapped organisations and is therefore likely that such misconduct could be more widespread in such contexts.

f. Recommendations

• Disrupting intentional deceivers

Reducing the risk of devious individuals and perpetrator groups requires awareness of those who have deliberately sought to exploit vulnerable workplaces to steal or de-fraud. Detection of instrumental perpetrators requires both input and process control-based strategies. Input controls involve systematic checking of qualifications and references, and could be further supplemented by the verification of key skills through job sampling. Further input controls might also be used at an earlier stage before training to assess the moral values (Skarlicki, van Jaarsveld, Shao, Song, & Wang, 2016) of those seeking to work in this area, or they could be a dimension included in recruitment to de-select those with low moral identity.

Where fraud has been detected, social network analysis would assist in the identification of both leaders and groups of perpetrators whose removal would act as a deterrent to others. Evidence from this analysis shows the value of reviewing family and friendship groups within organisations, and training colleagues across institutions where dishonesty is found.

It is important that fraud is taken as a serious form of wrongdoing, which is likely to be related to other production deviances. Process controls, in the form of spot audits within organisations, especially of higher risk-related activities like accurate prescribing of medicine and adequate record keeping, are further means of detecting early symptoms of potential wrongdoing. Output controls, as reviews of performance management, might also be used with supervisors asked to identify inconsistencies between stated and actual levels of skill. These processes clearly place a further burden on organisations in terms of additional time and action by supervisors, and support from HR.

It is therefore recommended that attention be focused on known weak spots highlighted in the analysis. This includes staff working in more mobile roles or for an agency, such as locums, agency nurses, social workers, and paramedics. We also see evidence of contexts experiencing a high frequency of cases including: care homes, and those involving social work, and paramedics. Further systematic research into this topic is suggested to examine sites with high and repeated instances of theft and fraud. This would involve more systematic collection of workplace locations by the PSA.

• Training and line manager support

Two key groups could benefit from more training: first, newly qualified staff could receive better training during induction regarding employers' expenses policies; and second, more acculturalisation training could be offered for non-UK trained staff to make UK cultural norms clearer. The latter would at least remove this as a potential defence, though the use of culture as an excuse for dishonesty is problematic: extant research shows differences in ethical norms and standards of behaviour arise from individuals' choices of reference in their ethical decision making. While national culture has been highlighted as a factor, local peers appear to be equally important in individuals' choices to undertake wrongdoing (Westerman, Beekun, Stedham, & Yamamura, 2007).

There also remain important challenges to simplistic societal-level perceptions of wrongdoing (Ralston et al., 2014). This analysis has shown recognition of the clear part local, social, and organisational factors play in creating and sanctioning misconduct. Large organisations with mobile professionals make detection harder and therefore require more awareness and attention from adequately trained and ethical supervisors to help ensure effective monitoring and correction of their staff members. To assess the significance of culture, systematic recording of demographics of both perpetrators and targets would improve understanding of the national and social dimensions of wrongdoing. This is a topic requiring a more precise analysis of cases, to check whether this is a genuine matter of inadequate acculturalisation, rather than those with lower moral values abdicating responsibility for their dishonesty. With better insight, more effective training could also be undertaken with FtP panels to challenge the use of this defence.

• Resource constrained organisations

In the case of theft, we do find support for an overwhelmed and stressed (Spector et al., 2006) dimension to wrongdoing. This group includes those where a change has occurred in the behaviour of previously successful professionals, with good performance shifting to misconduct, or those returning to work following a period of ill-health. For individuals in these groups, theft appears to be a symptom of their inability to cope with demands and resources, and thus it is part of a suite of wider production errors. Further systematic analysis of these cases should consider whether these actions arise due to resource conservation pressures

(Hobfoll, 1989), from moral disengagement (Moore, 2015), revenge behaviours (Aquino, Tripp, & Bies, 2006) undertaken by those with low moral identity, or poor supervision (Skarlicki et al., 2016). Extant evidence shows wider injustices are likely to be present in such workplaces (Thornton & Rupp, 2016), and implies that these cases are important for regulators to help organisations with potentially deeper safety concerns (Petitta, Probst, & Barbaranelli, 2015).

• Accurate recording of dishonesty

Given this misconduct is amongst the more frequent across all three professions, our analysis suggests the actual levels may be higher than currently recorded. The current analysis shows how such wrongdoing is linked to other transgressions, which include illegal activities, and also non-compliance. Therefore, a more reliable approach to coding of these types of misconduct is required from the PSA.

Furthermore, the potential difference in the sanctions applied to doctors raises concerns about consistency across professions. Differences in the sanctions applied between the different groups of professions may well create tension regarding the distributive justice of regulators. Leniency to some groups might encourage others from that profession to behave similarly, or create tensions between different professions in the same workplaces. This could then potentially increase the levels of moral disengagement of key groups. It is thus recommended that the training of FtP panels considers the equity of sanctions applied both across and within professions.

6. Professional Misconduct: Conclusions and Further Research

The analysis of three health professions shows shared patterns in the types and frequency of wrongdoing that occur. First, at a meta-level, the most frequently occurring charges are very similar, with multiple charges (more than two) found in 85-88% of cases. Further commonality was evident in the types of misconducts, dominated by categories of production deviance and interpersonal aggression (Robinson and Bennett, 1995). Collectively the same eleven misconduct charges were the most frequent in these professions. The patterns within the cluster analysis also indicated cross-profession similarities, most notably for sexual misconduct, which consistently strongly associated with the failure to maintain professional boundaries. There are also important misconduct synergies for dishonesty, with theft directly linked to qualifications' fraud in allied professionals, yet the two were distinct amongst nurses and midwives and doctors. Further qualifications' fraud synergies revealed how those duplicitously entering an organisation were also likely to commit illegal actions or not obey regulator or organisational rules. In addition, we found associations in the NHS staff survey results for training levels and hours worked and the locations of sexual misconduct. This is the first time such analysis has been undertaken. It suggests the value to organisations and regulators of using these surveys to better target misconduct detection and amelioration efforts.

Bad apples

In our analysis of misconduct, we found examples of a typical group of 'bad apple' perpetrators (Kish-Gephart et al., 2010; Muzio, et al., 2016), characterised by premeditated and strategic wrongdoing often involving either multiple offences against the same targets, or across multiple targets. We found important hotspots in which multiple cases of sexual abuse had occurred, and types of location in which both sexual misconduct and dishonesty were found including GP surgeries, care homes, and ambulances, and for distinct roles including locums, agency staff, and social workers. Analysis of targets attested to this group's exploitation of naïve younger women or the more vulnerable (e.g. mental health facilities, care homes) patients for sexual gratification, or patients in their homes or care homes for dishonesty. These perpetrators abused their power and positions in health and social care organisations (Cleveland & Kerst, 1993; Popovich and Warren, 2010) to exploit their workspace for their own gains. Their actions showed premeditated actions to groom or intimidate targets, and/or to fake qualifications and references. An important target dimension is blind trust in these professionals, especially for doctors, who are powerful authority figures. The literature highlights how sexual abuse by this group is comparable in form and impact to parent-child abuse (Galletly, 2004). Our analysis, however, indicated different tones to sexual abuse according to profession, with cluster analysis showing a more violent dimension to allied professional perpetrators, while the detailed qualitative analysis of the nurses and midwives sample showed these could be more severe attacks. These all indicate the value

of further research using interviews rather than secondary data to examine and understand these differences. This is especially important in the more violent forms of assault by those in caring professions.

Clearly, opportunistic individuals can seek out in a premeditated way locations and victims to deliberately steal and defraud from. The trauma of events surrounding the calling of an ambulance, or the cognitive confusion of those in care homes, coupled with mobility of professionals working in agencies could result in wrongdoing remaining undetected for a long time, especially in locations where supervision is limited or staff shortages leave little resource for monitoring. Analysis highlights the significance of input controls with this perpetrator group, but these require time to check and verify qualifications and references, as well as routine audits to check skill certificates.

Bad Barrels - Group Norms and Organisational Climate

In addition to the single perpetrators, we also found evidence of 'bad barrels' (Muzio, et al, 2016), arising in workplaces with poor climates, which included inappropriate sexual talk/behaviour within an informal organisational climate, or collectives which supported faking qualifications and references for staff members. These might be networks forged in training among doctor perpetrators, but family and those from the same location were more apparent links in the other two professions. This evidence challenges previous understandings of lone individuals and instead shows the social learning

and corrupting factors in developing skewed and more nefarious local norms. Extant study has revealed how incivility can be a precursor (Meier and Gross, 2015), with prior conceptual work identifying three distinct exposure routes: from the direct learning of being a target, to vicarious exposure of witnessing such incidents and seeing what then follows, and finally as a consequence of being employed within a workplace in which bad things happen (Robinson et al., 2014). Significantly our analysis has revealed how NHS staff survey results offer new ways to detect such compromised workplaces and to alert regulators about places in which professional misconduct is more likely to occur. Significant survey topics included not only direct questions about exposure to sexual harassment, but also increases in hours worked and reduced training levels. All of these are indicative of an organisation in which additional pressure and strain is occurring for individuals and groups of professionals. Our study of targets for sexual misconduct showed the same for both single and groups of perpetrators e.g. younger and subordinate women. In the case of theft, more research is required to explore who collective groups target. The accurate recording of demographics for both perpetrators and targets would enhance such research. Clearly organisations without adequate levels of supervision are unable to monitor and supervise staff, and therefore detecting and correcting individuals or groups of perpetrators is harder. More examination is needed as to how far austerity-constrained contexts might also exacerbate the moral disengagement of staff. Also, an examination of who is instigating and following in these groups would also be a useful topic for more in depth consideration to examine influence (Moore and

An important antecedent is this collective ambiguity, which could be addressed through better use of process controls and training to make conduct expectations transparent to all staff (Weibel et al., 2016). Transparency of policies and procedures can play a central role in providing clear guidance to deter perpetrators and reduce ambiguity for staff and service users regarding what is acceptable workplace behaviour. Further, social media is a key area where more attention and clarity is required from organisations and regulators. Extant research shows that it can be particularly effective in reducing instances of sexual harassment (Pina et al., 2009; Willness et al., 2007). Gender specific boundary training is one way to increase vigilance and responsiveness of 'warning signs' for female targets, and to facilitate conversations to promote better learning of what constitutes harassment for women. In contrast, training of newcomers and those with different backgrounds appears critical in enhancing knowledge to reduce incidents of theft. Further scrutiny of organisations in which multiple incidents have occurred would allow greater insight into how and why such toxic workplaces emerge, and recording employment and misconduct locations would allow such workplaces to be more easily detected. In addition, recording the training location and ethnicity of perpetrators would allow more transparency to understand the eco-system dimensions in transgression (Muzio et al., 2016), by revealing whether some types of wrongdoing occur more among some groups than others. One's moral identity is an important dimension to include in such work to help identify whether there are different norms of acceptable behaviour present within groups and workplaces (see Rotundo, et al., 2001).

Depletion

A third group, different from the instrumental nefarious actions of bad apples and without the contagion of social learning, suggests the influence of stress and strain in misconduct. Critically, recent research shows that stress increases individuals' moral disengagement, which then increases their subsequent levels of deviance (Fida et al., 2015). We find evidence in our qualitative analysis of stressed health professionals making poor judgements, which at times is exacerbated by the intimate and emotional nature of health consultation and treatment, or from relentlessly witnessing ongoing traumas. Our small sample and thus tentative findings suggest that depletion appears a particularly important antecedent to one key group, the female sexual abuser. However, it is also apparent in dishonesty cases with previously well-performing individuals unable to cope, or with those recovering from ill-health. Home/work conflict appears to play an under-appreciated role. Previous research also shows more pronounced long-term work-stress effects for women (Langballe et al., 2011; Ndjaboue et al., 2017). Significantly, this study suggests that a workplace that is overburdening is likely to impact on more than just one individual. However, further investigation is required into resource concerns and their potential role as an antecedent to professionals' wrongdoing.

This report has demonstrated the value of looking at different professions working in the same sector to reveal the wider organisational and social influences that could devolve into professional misconduct. Yet changing an organisation's ethos, or ridding the system of 'bad apples', is difficult, especially in the politicised context of health care resourcing. Regulators and employers face difficulties in refocusing on 'bad barrels' without undermining public confidence. Nonetheless, our results indicate the inherent danger in not recognising and attending to these collective dimensions of professional wrongdoing, including the role of group norms affected by direct, but also vicarious and ambient learning; the perverse efforts of some to obtain more power; and the impact of stress and strain from coping with resource pressures. All of these all play a part in creating environments which can facilitate or even trigger misconducts. This cross-profession study has inherent value to regulators, as it identifies these more insidious environmental consequences in causing stress, and the social dimensions of learning that extend within and across professions, setting in motion chain reactions that might increase levels of wrongdoing. Certainly if regulators are to achieve their goal of trust-based regulation (PSA, 2015), more awareness and attention is required towards the social and organisational dimensions that may critically undermine the ability of professions to continue to meet required standards.

Trust building

This report highlights the necessity of more effective and consistent use of control systems in detecting and deterring perpetrators, but also signals the trustworthiness of these systems (Weibel et al., 2016). There are some interesting discrepancies in the charges that are recorded and in the type of sanctions in the treatment of perpetrators, especially for doctors. While regulators' internal controls try to ensure consistency, our case analysis shows inconsistencies in the type of misconducts being recorded by PSA and in the level and type of sanctions administered by regulators; specifically, the use and duration of being struck-off.

Further education of the public and more vulnerable service users (e.g. young people, those with mental health issues) may be an underutilised tool to reduce the blind trust in the integrity and competence of health professionals, and to increase service users' confidence to challenge professionals. We need a holistic approach involving healthcare professionals and organisations, regulators and the public, to reinforce and more effectively challenge the boundary failures that appear inherent in wrongdoing. Dishonesty and sexual violation are behaviours which fundamentally threaten trust in the healthcare context. They have far reaching consequences for victims (Pina et al., 2009), but their impacts extend beyond them, challenging trust and confidence in entire systems delivering health and social care. Through better research of registrants across these three regulators, three distinct profiles have emerged which can be tackled separately in a more tailored, evidence-based approach for improved understanding of the sources of such behaviour. Through such insights the prevalence of wrongdoing can be tackled, especially wrongdoing which has a severe impact on victims and perpetrators, but also for wider healthcare professionals and the public.

References

Aldenderfer, M. S., and Blashfield, R. K. (1984). *Cluster Analysis.* (Vol. 44). London Sage University

Andreoli, N., and Lefkowitz, J. (2009). Individual and Organizational Antecedents of Misconduct in Organizations. *Journal of Business Ethics, 85*(3), 309-332.

Aquino, K., Tripp, T. M., & Bies, R. J. (2006). Getting Even or Moving On? Power, Procedural Justice, and Types of Offense as Predictors of Revenge, Forgiveness, Reconciliation, and Avoidance in Organizations. *Journal of Applied Psychology, 91*, 653-668.

Bandura, A. (1976). *Social Learning Theory.* Englewood Cliffs NJ: Prentice Hall.

Barnard, D. (2016). Vulnerability and Trustworthiness. *Cambridge Quarterly of Healthcare Ethics, 25*(02), 288-300.

Baumeister, R. F., Bratslavsky, E., Muraven, M., and Tice, D. M. (1998). Ego depletion: Is the active self a limited resource? *Journal of personality and social psychology, 74*(5), 1252-1265.

Baumeister, R. F., Gailliot, M., DeWall, C. N., and Oaten, M. (2006). Self-Regulation and Personality: How Interventions Increase Regulatory Success, and How Depletion Moderates the Effects of Traits on Behavior. *Journal of Personality, 74*, 1773-1802.

Begany, J. J., and Milburn, M. A. (2002). Psychological predictors of sexual harassment: Authoritarianism, hostile sexism, and rape myths. *Psychology of Men & Masculinity, 3*(2), 119-126.

Berkowitz, L. (1993). *Aggression: Its causes, consequences, and control.* New York: Mcgraw–Hill Book Company.

Bilton, D., and Cayton, H.Professional standards Authroity (2015). *Rethinking Regulation* Retrieved from London http://www.professionalstandards.org.uk/docs/default-source/psa-library/rethinking-regulation.pdf?sfvrsn=2

Bolton, L. R., Harvey, R. D., Grawitch, M. J., and Barber, L. K. (2012). Counterproductive Work Behaviours in Response to Emotional Exhaustion: A Moderated Mediational Approach. *Stress and Health, 28*(3), 222-233.

Bradley, J. J. (1994). Inappropriate personal involvement between doctors and their patients. *Journal of the Royal Society of Medicine, 87*(Suppl 22), 40.

Cardinal, L. B., and Sitkin, S. B. (2010). A Configurational Theory of Control. . In S. B. Sitkin, L. B. Cardinal, and K. Bijsma-Frankema (Eds.), *Control in Organizations: New Directions in Theory and Research.* Cambridge, England, : Cambridge University Press.

Cleveland, J. N., & Kerst, M. E. (1993). Sexual harassment and perceptions of power: An under-articulated relationship. *Journal of Vocational Behavior, 42*(1), 49-67

Cortina, L. M., Kabat-Farr, D., Leskinen, E. A., Huerta, M., and Magley, V. J. (2013). Selective Incivility as Modern Discrimination in Organizations. *Journal of Management, 39*(6), 1579-1605.

Dalal, R. S. (2005). A meta-analysis of the relationship between organizational citizenship behavior and counterproductive work behavior. *Journal of Applied Psychology, 90*(6), 1241.

Deshpande, S. P., Joseph, J., and Prasad, R. (2006). Factors impacting ethical behavior in hospital. *Journal of Business Ethics., 69*, 207–216.

Dixon-Woods, M., Yeung, K., and Bosk, C. L. (2011). Why is U.K. medicine no longer a self-regulating profession? The role of scandals involving "bad apple" doctors. *Soc Sci Med, 73*(10), 1452-1459.

Dolnicar, S. (2003). Using cluster analysis for market segmentation-typical misconceptions, established methodological weaknesses and some recommendations for improvement. *Australasian Journal of Market Research, 11*(2), 5–12.

Edwards, S. R., Bradshaw, K. A., & Hinsz, V. B. (2014). Denying rape but endorsing forceful intercourse: Exploring differences among responders. *Violence and Gender, 1*(4), 188-193.

Fida, R., Paciello, M., Tramontano, C., Fontaine, R. G., Barbaranelli, C., and Farnese, M. L. (2015). An integrative approach to understanding counterproductive work behavior: the roles of stressors, negative emotions, and moral disengagement. *Journal of Business Ethics, 130*(1), 131-144.

Fox, S., Spector, P. E., and Miles, D. (2001). Counterproductive Work Behavior (CWB) in Response to Job Stressors and Organizational Justice: Some Mediator and Moderator Tests for Autonomy and Emotions. *Journal of Vocational Behavior, 59*(3), 291-309.

Galletly, C. A. (2004). Crossing professional boundaries in medicine: the slippery slope to patient sexual exploitation. *Medical Journal of Australia, 181*(7), 380-383.

Gargiulo, M. and Ertug, Gokhan. (2006). The Dark Side of Trust. In R. Bachmann and A. Zaheer (eds.) Handbook of Trust Research (pp.165-186). Glos: Edward Elgar Publishing.

Gilligan, C. (1977). In a Different Voice: Women's Conceptions of Self and of Morality. *Harvard Educational Review, 47*(4), 481-517. doi:10.17763/haer.47.4.g6167429416hg5l0

Hall, K. (2011). Professional boundaries: Building a trusting relationship with patients. *Home Healthcare Nurse, 29*(4), 210-217.

Hirzel, A., and Guisan, A. (2002). Which is the optimal sampling strategy for habitat suitability modelling. *Ecological Modelling, 157*(2–3), 331-341.

Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist, 44*(3), 513-524. doi:10.1037/0003-066X.44.3.513

Hollinger, R. C. (1986). Acts against the workplace: Social bonding and employee deviance. *Deviant Behavior, 7*(1), 53-75.

Jay, A. (2014). *Independent Inquiry Into Child Sexual Exploitation in Rotherham: 1997-2013*: Rotherham Metropolitan Borough Council.

Ketchen, D. J., and Shook, C. L. (1996). The Application of Cluster Analysis in Strategic Management Research: An Analysis and Critique. *Strategic Management Journal, 17*(6), 441-458.

Kiefer, T., and Barclay, L. J. (2012). Understanding the mediating role of toxic emotional experiences in the relationship between negative emotions and adverse outcomes. *Journal of Occupational and Organizational Psychology, 85*(4), 600-625.

Kish-Gephart, J. J., Harrison, D. A., and Trevino, L. K. (2010). Bad Apples, Bad Cases, and Bad Barrels: Meta-Analytic Evidence About Sources of Unethical Decisions at Work. *Journal of Applied Psychology, 95*(1), 1-31.

Köhn, H. F., and Hubert, L. J. (2006). Hierarchical cluster analysis. *Wiley StatsRef: Statistics Reference Online*.

Lampard, K., & Marsden, E. (2015). Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile: Independent report for the Secretary of State for Health. *London Department of Health, available online at https://www.gov. uk/ government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL. pdf*

Langballe, E. M., Innstrand, S. T., Aasland, O. G., and Falkum, E. (2011). The predictive value of individual factors, work-related factors, and work–home interaction on burnout in female and male physicians: a longitudinal study. *Stress and Health, 27*(1), 73-87.

Lawrence, T. B., and Robinson, S. L. (2007). Ain't Misbehavin: Workplace Deviance as Organizational Resistance. *Journal of Management, 33*(3), 378-394.

McDonald, P. (2012). Workplace Sexual Harassment 30 Years on: A Review of the Literature. *International Journal of Management Reviews, 14*(1), 1-17.

Mehra, A., Kilduff, M., and Brass, D. J. (1998). At the margins: A distinctiveness approach to the social identity and social networks of underrepresented groups. *The Academy of Management Journal, 41*(4), 441-452.

Meier, L. L., and Gross, S. (2015). Episodes of incivility between subordinates and supervisors: examining the role of self-control and time with an interaction-record diary study. *Journal of Organizational Behavior, 36*(8), 1096-1113.

Merrison, A. W. (1975). *Committee of Inquiry into the regulation of the medical profession.* London: HMSO

Miller, B. L., Agnich, L. E., Posick, C., & Gould, L. A. (2015). Cheating Around the World: A Cross-national Analysis of Principal Reported Cheating. *Journal of Criminal Justice Education, 26*(2), 211-232. doi:10.1080/10511253.2014.98614 8

Monroe, T. B., Kenaga, H., Dietrich, M. S., Carter, M. A., & Cowan, R. L. (2013). The prevalence of employed nurses identified or enrolled in substance use monitoring programs. *Nursing research*, *62*(1), 10-15.

Moore, C. (2015). Moral disengagement. *Current Opinion in Psychology, 6*, 199-204. doi:http://dx.doi.org/10.1016/j.copsyc.2015.07.018

Moore, C., and Gino, F. (2013). Ethically adrift: How others pull our moral compass from true North, and how we can fix it. *Research in Organizational Behavior, 33*(0), 53-77.

Morse, J.M. (2016). The Significance of Saturation. *Qualitative Health Research,* (5), 147-149.

Muraven, M., and Baumeister, R. F. (2000). Self-regulation and depletion of limited resources: Does self-control resemble a muscle? *Psychological Bulletin, 126*(2), 247.

Muzio, D., Faulconbridge, J., Gabbioneta, C., Greenwood, R. (2016). Bad Apples, Bad Barrels and Bad Cellars: A 'Boundaries' Perspective on Professional Misconduct. In D. Palmer, R. Greenwood, K. Smith-Crowe (Eds.), *Organizational Wrongdoing.* (pp. 141-175). Cambridge, UK: Cambridge University Press Cambridge.

Ndjaboue, R., Brisson, C., Talbot, D., and Vézina, M. (2017). Combined exposure to adverse psychosocial work factors and medically certified absence for mental health problems: A 5-year prospective study. *Journal of Psychosomatic Research, 92*, 9-15.

Ng, T. W. H., Lam, S. S. K., and Feldman, D. C. (2016). Organizational citizenship behavior and counterproductive work behavior: Do males and females differ? *Journal of Vocational Behavior, 93*, 11-32.

O'Donohue, W., Downs, K., and Yeater, E. A. (1998). Sexual harassment: A review of the literature. *Aggression and Violent Behavior, 3*(2), 111-128.

O'Boyle Jr., E. H., Forsyth, D. R., Banks, G. C., and McDaniel, M. A. (2012). A meta-analysis of the dark triad and work behavior: A social exchange perspective. *Journal of Applied Psychology, 97*(3), 557 - 579.

Osgood, J. M. (2017). Is revenge about retributive justice, deterring harm, or both? *Social and Personality Psychology Compass, 11*(1).

Patton, M. Q. (2002). *Qualitative evaluation and research methods*: SAGE Publications, inc.

Peters, S., and Bilton, D. (forthcoming). 'Right Touch' Trust: thoughts on trust in healthcare In R. H. Searle, A. Nienaber, and S. B. Sitkin (Eds.), *Routledge Companion to Trust* Abingdon, Oxon: Routledge

Petitta, L., Probst, T. M., & Barbaranelli, C. (2015). Safety Culture, Moral Disengagement, and Accident Underreporting. *Journal of Business Ethics*, 1-16. doi:10.1007/s10551-015-2694-1

Piko, B. F. (2006). Burnout, role conflict, job satisfaction and psychosocial health among Hungarian health care staff: a questionnaire survey. *International journal of nursing studies*, *43*(3), 311-318.

Pina, A., Gannon, T. A., and Saunders, B. (2009). An overview of the literature on sexual harassment: Perpetrator, theory, and treatment issues. *Aggression and Violent Behavior, 14*(2), 126-138.

Popovich, P. M., and Warren, M. A. (2010). The role of power in sexual harassment as a counterproductive behavior in organizations. *Human Resource Management Review, 20*(1), 45-53.

Ralston, D., Egri, C., Furrer, O., Kuo, M.-H., Li, Y., Wangenheim, F., . . . Palmer, I. (2014). *Societal-Level Versus Individual-Level Predictions of Ethical Behavior: A 48-Society Study of Collectivism and Individualism* (01674544). Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=bth&AN=96646534&site=ehost-live

Reid, Y., Johnson, S., Morant, N., Kuipers, E., Szmukler, G., Thornicroft, G., Bebbington, P., Prosser, D. (1999). Explanations for stress and satisfaction in mental health professionals: a qualitative study. *Social psychiatry and psychiatric epidemiology, 34*(6), 301-308.

Rest, J. (1986). *Development in judging moral issues.* Minneapolis, MN: University of Minnesota Press.

Restubog, S. L. D., Zagenczyk, T. J., Bordia, P., Bordia, S., and Chapman, G. J. (2015). If You Wrong Us, Shall We Not Revenge? Moderating Roles of Self-Control and Perceived Aggressive Work Culture in Predicting Responses to Psychological Contract Breach. *Journal of Management, 41*(4), 1132-1154.

Robinson, S. L., and Bennett, R. J. (1995). A Typology of Deviant Workplace Behaviors: A Multidimensional Scaling Study. *Academy of Management Journal, 38*(2), 555-572.

Robinson, S. L., Wang, W., and Kiewitz, C. (2014). Coworkers Behaving Badly: The Impact of Coworker Deviant Behavior upon Individual Employees. *Annual Review of Organizational Psychology and Organizational Behavior, 1*(1), 123-143.

Rotundo, M., Nguyen, D. H., and Sackett, P. R. (2001) A Meta-Analytic Review of Gender Differences in Perceptions of Sexual Harassment. *Journal of Applied Psychology 86*(5): 914-922.

Sansone, R. A., and Sansone, L. A. (2009). Crossing the line: Sexual boundary violations by physicians. *Psychiatry (Edgmont), 6*(6), 45.

Searle, R.H. (2003). *Selection and Assessment: A critical text.* Basingstoke, UK: Palgrave McMillan

Skarlicki, D. P., van Jaarsveld, D. D., Shao, R., Song, Y. H., & Wang, M. (2016). Extending the multifoci perspective: The role of supervisor justice and moral identity in the relationship between customer justice and customer-directed sabotage. *Journal of Applied Psychology, 101*(1), 108-121. doi:10.1037/apl0000034

Smirles, K. E. (2004). Attributions of Responsibility in Cases of Sexual Harassment: The Person and the Situation. *Journal of Applied Social Psychology, 34*(2), 342-365.

Smith, J. (2004). *The Shipman Inquiry fifth report.* London: HMSO

Spector, P. E., Fox, S., Penney, L. M., Bruursema, K., Goh, A., and Kessler, S. (2006). The dimensionality of counterproductivity: Are all counterproductive behaviors created equal? *Journal of Vocational Behavior, 68*(3), 446-460.

Suri, H. (2011). Purposeful Sampling in Qualitative Research Synthesis. *Qualitative Research Journal, 11*(2), 63-75.

Thornton, M. A., & Rupp, D. E. (2016). The Joint Effects of Justice Climate, Group Moral Identity, and Corporate Social Responsibility on the Prosocial and Deviant Behaviors of Groups. *Journal of Business Ethics, 137*(4), 677-697. doi:10.1007/s10551-015-2748-4

Treviño, L. K., den Nieuwenboer, N. A., and Kish-Gephart, J. J. (2014). (Un) ethical behavior in organizations. *Annual review of psychology, 65*, 635-660.

Tripp, T.M., Bies, R.J., Aquino, K. (2007). A Vigilante Model of Justice: Revenge, Reconciliation, Forgiveness, and Avoidance. *Social Justice Research,* 20 (1), 10-34.

Weibel, A., Den Hartog, D. N., Gillespie, N., Searle, R., Six, F., and Skinner, D. (2016). How Do Controls Impact Employee Trust in the Employer? *Human Resource Management, 55*, 437-462.

Welsh, D. T., Ordóñez, L. D., Snyder, D. G., and Christian, M. S. (2015). The slippery slope: How small ethical transgressions pave the way for larger future transgressions. *Journal of Applied Psychology, 100*(1), 114-127.

Wenzel, M. (2004). An analysis of norm processes in tax compliance. *Journal of Economic Psychology, 25*(2), 213-228.

Westerman, J. W., Beekun, R. I., Stedham, Y., & Yamamura, J. (2007). Peers Versus National Culture: An Analysis of Antecedents to Ethical Decision-making. *Journal of Business Ethics, 75*(3), 239-252. doi:10.1007/s10551-006-9250-y

Willness, C. R., Steel, P., and Lee, K. (2007). A meta-analysis of the antecedents and consequences of workplace sexual harassment. *Personnel Psychology, 60*(1), 127-162.Aldenderfer, M. S., and Blashfield, R. K. (1984). *Cluster Analysis.* (Vol. 44). London Sage University

Appendix

Regulator Acronym	GMC	%	HCP	%	NMC	%
Dishonesty/Fraud/Theft 28	183	12	303	9	1298	10
Adverse Health 1	144	10	71	2	443	4
Conviction 3	125	8	158	5	517	4
Poor/inaccurate record keeping and/or history taking 37	117	8	387	12	1666	13
Substandard care/treatment 19	98	7	296	9	1267	10
Sexual misconduct 25	92	6	70	2	127	1
Poor performance/Lack of competence 14	86	6	371	11	716	6
Failure to visit/ examine/assess/diagnose/follow up 16	75	5	279	9	935	7
Poor/lack of communication 17	75	5	292	9	902	7
Dishonesty re qualifications/ 29 professional memberships/convictions/registration	71	5	53	2	365	3
Failure maintain approp prof. boundaries 15	55	4	131	4	265	2
Miscellaneous 22	55	4	128	4	453	4
Inappropriate/failure in prescribing/administration of medication 35	52	4	42	1	1154	9
Alcohol 23	46	3	61	2	208	2
Violent / aggressive behaviour 27	20	1	52	2	261	2
Verbal abuse 26	18	1	35	1	251	2
Poor working relationships 21	17	1	58	2	150	1
Drugs 24	16	1	25	1	131	1
Failure to follow regulatory body's advice/procedures 33	15	1	33	1	136	1
child proography	14	1	15	0	32	0
Failure to refer 8	14	1	75	2	274	2
Breach of Confidentiality 7	12	1	86	3	83	1
Inappropriate allegations 10	12	1	52	2	104	1
Police caution 6	11	1	31	1	124	1
Failure comply with conditions 31	9	1	8	0	35	0
Treating without consent 20	9	1	12	0	47	0
Failure to have appropriate Indemnity Insurance 34	6	0	0	0	2	0
Practising whilst not registered 40	6	0	7	0	14	0
Poor storage of drugs 36	4	0	8	0	122	1
Inappropriate anaesthesia 11	3	0	3	0	3	0
Inappropriate delegation of care 12	3	0	13	0	73	1
Data Protection Violations 4	2	0	27	1	25	0
Failure follow Health & Safety Regs/Infection Control 32	2	0	12	0	118	1
Insufficient knowledge of English language 38	2	0	0	0	14	0
Rough handling of patients 18	2	0	10	0	209	2
Inappropriate use of employer's computer/IT systems 30	1	0	15	0	9	0
Failure undertake conclusive post mortem/ scrutinise cremation forms9	0	0	0	0	1	0
Inappropriate/Inaccurate dispensing of medication - pharmacy 13	0	0	1	0	17	0
Manslaughter 5	0	0	0	0	6	0
Misleading advertising of services 39	0	0	10	0	42	0
charges	1472		3230			
total	633		1229		4852	6714
%	9.4		18.3		72.3	100
overone charge	413		855		2435	
% over1	65.24		69.57		50.19	
mean	2.33		2.63		2.6	

Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK Health and Social Care: Insights into sexual misconduct and dishonesty

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