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Making impact in healthcare contexts: Insights from a mixed-methods study of professional misconduct

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Abstract

The scarcity of public sector healthcare resources and the vulnerability of service users make the conduct of health professionals critically important. Health regulators, in delivering their core objective of patient protection, use empirical evidence to identify professionals' misconduct, improve their understanding of why misconduct occurs, and to maximise the effectiveness of regulatory actions that safeguard public trust in the healthcare system. This paper outlines the contribution of comparative academic analysis of three professions in the UK (doctors, nurses & midwives, and allied health professions) based on 6714 individual cases of professional misconduct. Three dynamic strands of ongoing impact are identified: 'dialogue', that creates an international multi-stakeholder community of interest; 'knowledge generation', which advances conceptual and empirical understanding of counterproductive work behaviour through sequential quantitative and qualitative study; and 'dissemination', where practical learning is utilised by regulators, employers, and other academics.

Introduction

The intimate nature of healthcare work and the inherent vulnerability of service users to healthcare experts make the conduct of health professionals delivering these services critically important. Health professionals are often trusted by the public above others (Edelman, 2020). The form of the relationship and the behaviour of health professionals towards their service users have been the focus of considerable attention (e.g., Currie et al., 2018; Dixon-Woods et al., 2011; Muzio et al., 2016; Yeung & Dixon-Woods, 2010). Ethics and formal assurances that their actions will not harm patients are central in the training of health professionals, such as those found in the doctors' Hippocratic Oath, and supplemented by other professional codes of conduct (Merrison, 1975). A further means of protecting the public is through regulation. Professional Standards Authority for Health and Social Care (PSA) oversees the ten UK regulated professions involved in providing health and social care. It has three objectives: protecting patients and reducing their exposure to harm; promoting standards for professionals; and maintaining public confidence in these professions (PSA, 2018). Central to these objectives is the individual regulators' control of their profession's register, ensuring only those with the correct level of approved initial training and receiving ongoing professional development are included, and that these individuals adhere to standards that assure their Fitness to Practise. As part of their remit, Professional Standards Authority undertakes research to understand and improve regulation (PSA, 2017).

This paper explores the impact of a Fitness to Practise study (Searle et al., 2017), commissioned by Professional Standards Authority, to compare misconduct across three professions – doctors, nurses and midwives, and allied health professions. We outline three contributions of this primary research on professional misconduct that Professional Standards Authority regarded as "groundbreaking" (Searle et al., 2017). First, we show the role of psychologically informed conceptual and empirical study in advancing understanding of the scale and main types of misconduct (and thereby risk to patients) from these three professions. We show its value in providing a taxonomy to reduce Professional Standards Authority's 40 Fitness to Practise categories (see table 1) into a more cognitively manageable and theoretically coherent set of domains (through simple quantitative analysis of 6714 determination cases comprising 17301 elements, to derive the ten most frequent Fitness to Practise categories). Second, we

expand understanding of the most prevalent form of misconduct, deception, which includes theft and fraud activities. Using stratified random sampling to identify our cases, we conducted comparative qualitative thematic analysis of these professions to provide empirical support for three explanations of misconduct that are found in the psychology literature, each involving distinct antecedents and processes: individual 'bad apples', social learning ('corrupted barrels'), and depleted environment ('poor cellars'). Third, we consider the impact of this work, via three streams that connect academia with practice – dialogue, knowledge generation, and dissemination (see figure 1).

We begin by briefly reviewing key psychological perspectives on misconduct, focusing on the taxonomies of counterproductive work behaviour that underpinned this project. Next, we consider the context of our work (health and social care) and its regulation in the UK, before moving on to the methods and key results. Our selected results (published in full in Searle et al., 2017) include a quantitative examination of Fitness to Practise, and a qualitative analysis of the most pervasive form of misconduct, deception. We then provide our discussion, including impact reflections and limitations, followed by our conclusion.

Professional Misconduct

Professional misconduct is a form of counterproductive work behaviour (Robinson & Bennett, 1995). In the health and social care context, misconduct violates important organisational and professional norms, and in so doing threatens the well-being of organisations and other employees. Further, misconduct exploits the trust placed in a professional by service users, who may, therefore, be exposed to further harm (Francis, 2013; Smith, 2004); it damages the reputations of regulators and other professionals, and diminishes public confidence in health professions and institutions. Accordingly, better understanding of the types of misconduct behaviours, their antecedents, and how they can be deterred, is of significant value to regulators and health and social care employers, and indirectly to the public.

Scholars from a variety of fields, including psychology, sociology, and law have sought to explicate how and why counterproductive work behaviour occurs. This can be condensed into two approaches: 1) distinguishing counterproductive work behaviours; and 2) explaining why they occur.

The first approach concerns separating counterproductive work behaviours from other actions (Dalal, 2005; Griep & Vantilborgh, 2018; Spector & Fox, 2002). As part of this, scholars have distinguished between instrumental, or premeditated actions, and those whose origins are more impulsive (Berkowitz, 1993). A counterproductive work behaviour dichotomy has focused on their targets, defining organisation focused deviations (Hollinger & Clark, 1982) as those concerning the misuse of an employer's assets (property deviance) such as sabotage or theft, and those regarding deviations of norms and specified procedures (production deviance). Interpersonal directed deviance, by contrast, are those behaviours directed at another person (Bennett & Robinson, 2000; Robinson & Bennett, 1995) range from mild 'political' actions to more severe forms of interpersonal aggression including stealing, or physical and verbal abuse. While there is significant correlation between these two forms of counterproductive work behaviour (organisational focused and interpersonal directed deviance) (Berry et al., 2007; Dalal, 2005), recent meta-analytic study shows them as distinct (Marcus et al., 2016). Building on Robinson and Bennett's (1995) work, Spector et al. (2006) devised a five-factor model that separated *withdrawal* (a subtle form of organisation directed action involving delivering less work than that which was contracted) from *production deviance* (non-compliance with normative expectations or prescribed codes, such as a regulator's professional standards or health and safety procedures); and *theft* (self-gain through deliberately falsifying qualifications or expenses, or stealing) from *sabotage* (defacing or destroying organisational property) and *interpersonal abuse* (comprising harmful physical and verbal behaviours towards other people). Another model includes 11 different factors (Gruys & Sackett, 2003), for example, drug and alcohol use as distinct from the misuse of time and resources. However, inherent in the construction of such models is the omission of actions that either did not meet the overarching taxonomy (Robinson & Bennett, 1995), or had low rates of occurrence; this restricts the inclusion of important, yet far rarer behaviours, such as murder (Marcus et al., 2016). Therefore, an important concern for practitioners is how far these conceptual models actually capture behaviours that are important within *their* contexts.

The second approach covers three explanations of *why* counterproductive work behaviour occurs through study of its antecedents. The first explanation concerns the identification of atypical

individuals, the inherently 'bad apples', who are regarded as operating premeditatively for self-gain (Kish-Gephart et al., 2010). Conceptual and empirical psychological analysis of individual counterproductive work behaviour has coalesced on personality traits, termed the 'dark triad', which includes Machiavellianism, Narcissism and Psychopathy, and entails self-focus, ruthlessness, and a lack of empathy. Here, misconduct behaviours are often driven by self-gain and tends to involve deception (c.f., Grijalva & Newman, 2015; O'Boyle et al., 2012). The second explanation concerns social dimensions by outlining how collective 'bad barrels' are created when individuals are exposed to, and learn, deviant norms and behaviours from others (Bandura et al., 1996). Meta-analytic trait research indicates that contextual factors have a significant moderating role, with study revealing the negative impact of authority and culture (O'Boyle et al., 2012; Spector, 2011). Through this route, exposure to deviant others produces a pernicious effect, corrupting individuals within the same workplace by shifting their norms and 'spreading' moral disengagement that is important to the production of their subsequent counterproductive work behaviour (Welsh et al., 2015).

More recent studies regarding why these behaviours emerge have foregrounded a third explanation directly related to the impact of an environment, constituting stress-emotional influences. This 'poor cellars' explanation contends that situational factors can deplete, or overwhelm individuals, causing them to alter their usually appropriate behaviour (Fox et al., 2001; Spector et al., 2010; Spector & Fox, 2002). Explanations here emphasise the significance of some trigger event or context (Sackett & DeVore, 2001), that leads to increased negative emotions, such as those caused by breaches to the psychological contract, perceived injustices, job stressors, or constraints to job performance (Spector & Fox, 2002). However, research shows that not everyone responds in the same way to these negative work experiences (Zaghini et al., 2016). Critically, this situational explanation suggests a time and context limitation on an otherwise "good worker" that results in such actions being temporary; these distinctions are important as they suggest the need to distinguish those who should be permanently removed from a register of professionals, from those for whom their Fitness to Practise can be reformed by working in a better environment. These social and contextual explanations for counterproductive

work behaviour are therefore particularly important for regulators, as they indicate relational and environmental influences that extend beyond a single individual to multiple professionals.

Research-informed practice: Our approach

Empirical evidence is therefore important in understanding areas for regulators to focus on as they try to transition from reactive to 'right touch' regulation, which requires 'upstream' predictive insights through identifying areas of heightened risk (Bilton & Cayton, 2015). Accordingly, in this paper, we examine the impact of a research project that compared the prevalence of different types of wrongdoing for three professional groups in the UK (doctors, nurses and midwives, and allied health professions – spanning data from the respective individual regulators of these groups). Our project sought to explore the similarities and differences regarding misconduct across these professions to provide a better understanding for UK regulators and healthcare managers, therefore through the insight the potential to improve detection, deterrence, and amelioration of misconduct consequences. Our study therefore addressed one overarching research question:

> *Research Question 1: What does academic analysis of Fitness to Practise cases reveal about the types of misconduct prevalent in health and social care in the UK?*

In this paper, we provide an overview of the study's findings (Searle et al., 2017), to address research question 1, and raise an additional research question on impact:

> *Research Question 2: How can academic analysis help regulators and organisational managers prevent misconduct in health and social care?*

Context of this project

Professional Standards Authority for Health and Social Care is the body responsible for protecting the public by overseeing ten regulators responsible for policing health and social care professionals in the UK. These ten regulators create and manage the 'registers' for their profession which involves the entry standard and its ongoing maintenance through continual education and training of a

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professional, their conduct and performance. Fitness to Practise is a process that regulators are required to follow when concerns are raised (for instance, by members of the public, an employer, or other health professionals) about the safety of a professional's practice. Under Section 29 of the National Health Service Reform and Health Care Professions Act 2002 ("the 2002 Act"), Professional Standards Authority reviews each regulator's Fitness to Practise decisions, via a summary document supplied from an individual regulator, termed a 'determination document', which results from a legal hearing where there is one (i.e., not all cases lead to a legal hearing and therefore not all cases have a determination document). Determination documents are held on a Section 29 database while the individual regulator includes and maintains the complete case record, which will comprises fuller records of the hearing proceedings than are contained within a determination document, as well as additional information related to misconduct cases (PSA, 2016; 2017). Following Professional Standards Authority's awareness of the trust research of the lead author and an invited presentation about trust in regulation, Professional Standards Authority funded a comparative analysis of Fitness to Practise across three professions. Our project focused on Fitness to Practise determination documents and their categorisation.

Method

In this study, 6714 incidents that resulted in a determination document were analysed across three regulators via access to Professional Standards Authority's Fitness to Practise determination database: the General Medical Council (n=633), which regulates medical doctors; the Nursing & Midwifery Council (n=4852), responsible for nurses, nursing associates, and midwives; and the Health and Care Professions Council (n=1229), regulating a range of 16 healthcare professionals termed 'allied health professions' (e.g., clinical psychologists, paramedics, chiropodists, occupational therapists, and social workers)[1]. The Fitness to Practise determination categories assessed comprise 40 categories that ranged from alcohol and substance abuse, to aggression and theft (see Table 1). We used a sequential mixed-methods analysis, which enabled a systematic exploration of these groups' misconduct (Bryman, 2006).

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[1] After 2 December 2019 social workers left HCPC and now have their own regulator.

Analysis of the 6714 Fitness to Practise incidents included two iterative phases. First, simple quantitative analysis (frequency counts and percentages) identified the prevalence of Fitness to Practise determination categories by profession to enable comparisons to be drawn on the most frequent forms of counterproductive work behaviour. Our results provided the basis for the subsequent stratified random sampling (Singh & Tarray, 2014) of Fitness to Practise incidents for each profession. Therefore, the second phase involved randomly selecting a sample using the criteria identified by the earlier analysis to allow further examination of the most frequent counterproductive work behaviour – deception. The sampling resulted in 72 incidents (13 doctors, 38 nurses and midwives, and 21 allied health professions) being selected for further qualitative analysis of the Fitness to Practise determination documents. We sampled both single and multiple category incidents, and matched the gender characteristics in our case sampling (gender was recorded in the dataset, but we found frequent use of the 'not specified' label for some professions). Our coding categories were comprehensive and informed by a literature review that crossed psychology, health, and organisational studies, to capture: *ecological* factors including target type and incident location(s); *perpetrator* information concerning profession, gender, and main place of work. We also coded potential *triggers* (e.g., motivation, home or work pressures) and *category details* to capture type, breadth, frequency of incidents, and impact(s) on target(s), as well as the *sanctions* taken by regulators (see full report, Searle et al., 2017).

In our findings section, we summarise key results of the sequential mixed method before considering the impact of such empirical evidence for our research commissioner, Professional Standards Authority, as well as wider stakeholders.

Findings

Quantitative analysis to outline Fitness to Practise concerns

Our dataset of 6714 individual incidents contained 17301 Fitness to Practise categories across the three professions. It provided, for the first time, important comparative insights (see table 1). In this

section, we provide an overview of the three key results on the most prevalent counterproductive work behaviour category, deception; full results can be found in the report (Searle et al., 2017). Our analysis utilised a simple colour coding system to show how these 40 categories could be collapsed into Robinson and Bennet's (1995) organisation-focused property deviance (yellow), and production deviance (green), individual-directed interpersonal abuse (red) and political tactics (blue). As drug and alcohol abuse were also categories identified in Gruys & Sackett's (2003) taxonomy, we extended their argument by adding 'adverse health' to a category which captured actions not aimed at others and which impeded the safety of individual professionals' work (brown). By using this simple presentation device, we revealed the dominance of production deviance across these professions, as well as showing how such activities might be clustered together.

Demographics

Although nurses and midwives are the dominant profession regarding Fitness to Practise incidents (72.3%, n= 4852), it was clear that this merely reflected their larger registrant size (see table 1). Comparison of the number of cases of nurse and midwife misconduct against the total number of registrants across the three professions, indicated similar Fitness to Practise levels (0.23% of Doctors , 0.95% for Allied Health Professions, and 0.7% for Nurses & Midwives), and no statistically significant difference in the mean number of Fitness to Practise categories for these professions (Mean for Doctors = 2.33; Allied Health Professions = 2.63; and Nurses & Midwives = 2.6).

We found that women dominated Fitness to Practise incidents, but again this arose from their dominance in nursing (72% of all the incidences), with males being the more prevalent gender in cases for medical doctors (see table 1). Further the use of 'not specified' gender was a more frequent occurrence in cases involving doctors. Nonetheless, these results refute any assertion that women working in a health context are more ethical (Gilligan, 1977) or less likely to undertake counterproductive work behaviour (e.g., Kish-Gephart et al., 2010). Further, the results indicate some important divergence in the types of misconduct undertaken, such as the dominance of males in sexual misconduct.

Deception is top Counterproductive Work Behaviour

Analysis showed ten dominant Fitness to Practise determination categories that were common across all professions (see table 2). Applying a literature-informed lens to these categories revealed further similarities, with two key forms of activities most prevalent. First, frequency analysis showed that five of the top Fitness to Practise determination categories included some form of *production deviance,* (Robinson & Bennett, 1995) in terms of not following standard care practices, and therefore such professionals placed their patients at heightened risk due to shortcomings in the adequacy of their care. These Fitness to Practise concerns entailed low competence and sub-standard care, poor and inadequate record-keeping and referring, and inadequate communication – straddling Gruys & Sackett's (2003) 'unsafe behaviour' and 'poor quality behaviour' categories.

In contrast, the second form includes two common Fitness to Practise determination categories that together relate to *deception* (17% = Doctors; 11% = Allied Health Professions; 14% = Nurses & Midwives); they comprise either interpersonal or organisational focused theft and fraud (Robinson & Bennett, 1995). These forms of counterproductive work behaviour are significant to regulators as such actions are breaches of trust placed in professionals by vulnerable people, patients, employing organisations, and the public. Our analysis provided evidence to recalibrate regulators' attention regarding counterproductive work behaviour through deriving the ten most frequent Fitness to Practise determination categories, and showing that collectively they account for between 72–76% of all of these professions' misconduct cases (see table 1).

Table 1: Frequency of Fitness to Practise charges by regulator

Professional Standards Authority Misconduct Category	Doctors	% of Doctor cases	Allied health professions	% of Allied health prof cases	Nurses & midwives	% of Nurses & midwives cases
Theft	183	12	303	9	1298	10
Adverse health	144	10	71	2	443	4
Conviction	125	8	158	5	517	4
Poor/inaccurate record-keeping and/or history-taking	117	8	387	12	1666	13
Substandard care/treatment	98	7	296	9	1267	10
Sexual misconduct	92	6	70	2	127	1
Poor performance/lack of competence	86	6	371	11	716	6
Failure to visit/ examine/assess/diagnose/follow up	75	5	279	9	935	7
Poor/lack of communication	75	5	292	9	902	7
Organisational fraud	71	5	53	2	365	3
Failure to maintain appropriate professional boundaries	55	4	131	4	265	2
Miscellaneous	55	4	128	4	453	4
Inappropriate/failure in prescribing/administration of medication	52	4	42	1	1154	9
Alcohol	46	3	61	2	208	2
Violent/aggressive behaviour	20	1	52	2	261	2
Verbal abuse	18	1	35	1	251	2
Poor working relationships	17	1	58	2	150	1
Drugs	16	1	25	1	131	1
Failure to follow regulatory body's advice/procedures	15	1	33	1	136	1
Child pornography	14	1	15	0	32	0
Failure to refer	14	1	75	2	274	2
Breach of confidentiality	12	1	86	3	83	1
Inappropriate allegations	12	1	52	2	104	1
Police caution	11	1	31	1	124	1
Failure to comply with conditions	9	1	8	0	35	0
Treating without consent	9	1	12	0	47	0
Failure to have appropriate indemnity insurance	6	0	0	0	2	0
Practising while not registered	6	0	7	0	14	0
Poor storage of drugs	4	0	8	0	122	1
Inappropriate anaesthesia	3	0	3	0	3	0
Inappropriate delegation of care	3	0	13	0	73	1
Data protection violations	2	0	27	1	25	0
Failure to follow health & safety regs/infection control	2	0	12	0	118	1

Counterproductive Work Behaviour						
Insufficient knowledge of English language	2	0	0	0	14	0
Rough handling of patients	2	0	10	0	209	2
Inappropriate use of employer's computer/IT systems	1	0	15	0	9	0
Failure to undertake conclusive post mortem/scrutinise cremation forms	0	0	0	0	1	0
Inappropriate/inaccurate dispensing of medication – pharmacy	0	0	1	0	17	0
Manslaughter	0	0	0	0	6	0
Misleading advertising of services	0	0	10	0	42	0

Key

Colour	Counterproductive Work Behaviour type (following Robinson & Bennett, 1995)
	Production deviance
	Deception
	Interpersonal aggression
	Political deviance
	Individual health

The most pervasive theft behaviours involved deceiving a variety of human targets, including both service users and colleagues, as well as instances of stealing goods or misappropriating expenses from employing organisations (12% = Doctors; 9% = Allied Health Professions; 10% = Nurses & Midwives). The second less pervasive deception behaviour was solely organisation-focused and concerned falsifying qualifications or immigration status (5% = Doctors; 2% = Allied Health Professions; 3% = Nurses & Midwives) (see tables 1 and 2). Although less common misconduct, this organisational fraud is significant for regulators, as professionals who engage in such activity can expose their patients and service users to harm, through operating without due competence and the correct training. Such actions are likely to be motivated by self-gain, with fake qualifications offering the means to upgrade work roles and therefore the means to receive higher salaries. They present concerns about the basis of key standards for a professional, creating a lack of confidence in some formal qualifications, or undermining the basis of revalidations; employers and the public are likely to have reduced trust in those who cheat the system (Gino et al., 2010; Holden et al., 2017). Further

statistical analysis showed a small difference in characteristics of qualification fraud by profession, with its statistically (Fisher's exact test) higher prevalence among doctors[2]; this result is perhaps unsurprising as medicine offers the greatest potential for economic gain. Further subtle differences in the scope of Fitness to Practise activity in this area were found between professions – while most qualification frauds across these professions were single instances (75–79%), 33% of cases involving doctors included a further form of wrongdoing (33%) (see Searle, et al., 2017). To provide regulators with further evidence that could be used to enhance detection or means of deterrence, we used qualitative analysis within and between these professions.

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[2] Further posthoc odds ratios for qualifications fraud show doctors as having 2.8 times higher likelihood of this form of misconduct than allied health professions, and 1.55 times higher odds compared to that of nurses and midwives. In contrast, nurses and midwives have 0.55 times the odds of qualifications fraud than allied health professions. This shows qualifications fraud is more likely among doctors than either of the other two professions.

Table 2: Summary of top Fitness to Practise charges by profession with gender

Misconduct category	Doctors				Nurses & midwives				Allied health professions			
	#	%	% male	% female	#	%	% male	% female	#	%	% male	% female
Theft	183	12.43	38.89	13.89	1298	10.3	22.19	57.53	303	9.38	50.94	45.28
Adverse health	144	9.78	48.28	23.45	443	3.52	20.09	67.95	71	2.20	36.62	53.52
Conviction	125	8.49	48.41	19.05	517	4.1	37.52	53.58	158	4.89	51.90	39.24
Poor record-keeping	117	7.95	34.75	14.41	1666	13.22	18.49	62.00	387	11.98	39.02	49.10
Substandard care	98	6.66	45.45	12.12	1267	10.06	17.76	60.22	296	9.16	44.26	43.92
Sexual misconduct	92	6.25	51.61	6.45	127	1.01	60.63	21.26	70	2.17	72.86	12.86
Poor performance	86	5.84	32.18	20.69	716	5.68	14.53	46.09	371	11.49	38.01	47.71
Failure to examine	75	5.1	30.26	14.47	935	7.42	18.29	59.57	279	8.64	44.09	46.24
Poor communication	75	5.1	32.89	19.74	902	7.16	16.52	52.55	292	9.04	41.44	42.47
Organisational fraud	71	4.82	38.89	13.89	365	2.9	22.19	57.53	53	1.64	50.94	45.28
Prof. boundaries failure	55	3.74	55.36	8.93	265	2.1	35.47	36.23	131	4.06	49.62	35.11

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Qualitative analysis: Uncovering three explanations

The utilisation of further qualitative analysis of deception Fitness to Practise cases provided examples of the three counterproductive work behaviour explanations that exist within the psychology and organisation literature: 'bad apples' (individual factors), 'corrupted barrels' (social learning), and 'poor cellars' (situated depletion). We analysed Professional Standards Authority's Fitness to Practise case determination documents, which comprise summary hearing details and categorisation of the type of incident. All of our qualitative coding was conducted using these summary determination documents and was thus constrained by the information they contain (discussed further in limitations section). As before, and due to space restrictions, we focus on the dominant Fitness to Practise category, deception (see full Searle et al., 2017 report for further details). In table 3 we provide illustrative quotes for each deception type (Theft; Organisational Fraud) by theoretical explanation.

Across both forms of deception, Fitness to Practise categories involved instances where individuals had set out deliberately to deceive, by exploiting employing organisations or individuals ('bad apples'); cases indicated the normalisation of dishonest working practices (social learning – 'corrupted barrels'); and other suggested the depletion of an individual's ability to self-regulate, most notably due to high stress that arose from work and/or personal factors which depleted the work environments ('poor cellars'). As such, these findings advanced regulators' awareness of the scenarios in which deception, in terms of theft and organisational fraud, occurs, and provide clues about its antecedents. For example, professionals' counterproductive work behaviour typically showed learned and organisation-targeted theft practices such as 'double jobbing', rather than interpersonal directed theft, such as rifling through patients' or colleagues' bags. These actions point to a more pervasive decline of professionals' standards directed towards their employing organisations, rather than actions that directly threaten patients. However, such misconduct has indirect consequences through removing resources to support patients' care (Button et al., 2009; 2014). They suggest an insidious normalisation of fraud, especially when it occurs against large organisations (Brooks et al., 2017).

Table 3: Examples of qualitative deception coding by theoretical explanation

Misconduct category	Individual 'Bad apples'	Social learning ('Corrupted barrels')	Depleted environments ('Poor cellars')
Theft	"Your evidence was that you received a phone call from a private hospital offering you a day's private work at the time when you were on sick leave and knew that your on-call obligations were already covered. You accepted the offer, and went to that private clinic to undertake that day's work before travelling on to resume your full-time duties. 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" (Doctor case)	"The Panel's finding was 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" (Allied health professions case)	"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" (Doctor case)
Organisational fraud	"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" (Allied health professions case)	"The candidate clearly added points on his self-assessment, regarding publications. When given the opportunity to clarify, he admitted that he had none. Said he had been 'advised' by his supervisor" (Doctor case)	"Noticed to be leaving room frequently, didn't complete paperwork and then collided under the influence of alcohol with a police car" (Nurse case)

Our analysis provided qualitative evidence for regulators to better target prevention strategies (table 3). In addition to illuminating specific elements of Fitness to Practise, the results of the qualitative analysis indicated differences between the three professions, in terms of who was involved, proposing the different strategies that may advance perpetrator detection and to ameliorate the consequences. They reflected differences in the specific social contexts, norms, and pressures that were present in different professionals' working contexts. For example, we found depletion among nurses and allied health

professions typically arose from the strain of working on the frontline of healthcare in under-staffed organisations, which resulted in mistakes or the skipping of due process. This finding indicates a more widespread Fitness to Practise concern related to that of the 'corrupted barrel' or 'poor cellar' rather than a matter that would be confined to just one registrant, and therefore raises concerns about the current separation in the UK of regulators who focus on work locations (Care Quality Commission) compared to these single-profession regulators. Doctors, on the other hand, were found to be under pressure from Continuing Professional Development (CPD) requirements to uphold their revered positions. Counterproductive work behaviour was directed at duping key systems, such as CPD, which is a process necessary for continuation on the register and these professional's revalidation. Our findings revealed further fraudulent activity in misrepresenting ongoing Fitness to Practise. They also highlight the spillover consequences of under-resourced workplaces and are of specific value to regulators in proactive upstream identification through revealing how staff surveys might be deployed to detect workplaces of concern, rather than waiting for Fitness to Practise to be detected.

Discussion

Our findings illuminate the merit of comparative analysis of different professionals working within the UK health and social care sector in advance understanding of counterproductive work behaviour. We asked two research questions in this paper: what does academic analysis of Fitness to Practise cases reveal about the types of misconduct prevalent in health and social care in the UK?; and, how can academic analysis help regulators and organisational managers prevent misconduct in health and social care? In sum, we provide answers to these questions through discussion of three elements: the discernment of weak points and inconsistencies in healthcare organisational systems and processes; reflections on impact; and uncaptured misconduct and avenues for further research.

Weak points and inconsistencies in healthcare settings

The initial project comparatively explored counterproductive work behaviour, leading to the identification of the ten most frequent forms of misconduct within this context. In doing so, it revealed similarities and differences between three health and social care professions, especially the dominance of fraud and theft behaviours in these professions. The project applied psychological theory to regulator

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datasets, usefully identifying three explanations for these behaviours that revealed individual, social and environmental triggers. Our analysis additionally identified small, but important, differences between these professions related to qualifications fraud and theft which indicated weak organisational systems (Reason, 2000). This information can be used to develop targeted preventative action from regulators and employing organisations.

Our analysis showed striking similarities across qualification fraud cases through their recurrence at the same points of entry – organisational recruitment systems. In addition to detecting these weak gateways into an employing organisation, our analysis highlighted the high prevalence and thus normalisation of 'gaming the system' within each profession. For example, we found evidence of premeditated fraud and deception by doctors in deliberately faking their own references, which could be positioned as evidence of 'bad apple' cases. In contrast, within the nursing profession, qualification fraud was more likely to include collective and coercive activities that utilised nurse networks to facilitate the faking of references by others. This difference in the modus operandi between professions' counterproductive work behaviour pertaining to fraud, is important implying the merit of different approaches to detection, particularly a greater emphasis towards unravelling the social actor networks that are central in these types of frauds, rather than assuming these events are isolated incidents (Free & Murphy, 2015). Through this evidence, systemic issues can be revealed that might be central to their ongoing operation, and consequently implying the value of a more holistic approaches to their amelioration. Notably, we highlighted the significant merit of focusing on recruitment systems, specifically the strengthening of reference-checking processes, and in greater scrutiny of employment agencies and the professionals who use such routes to enter into these workplaces.

A further weak organisational system for theft was expense procedures. Our qualitative analysis suggested the shortcomings of organisational induction processes, and communication processes concerning organisational policies around expenses. Without clear education about how to properly complete expenses, organisations are leaving themselves open to such fraud. Identifying the similarities across these different professions in the form of deception being undertaken, is of value in enhancing detection. Further, these findings highlight policy and practice areas where greater scrutiny is required

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by other professional groups, most notably from Human Resources, or Finance and Audit, as a means of improving the controls and scrutiny to improve detection of these counterproductive work behaviours.

For regulators, our evidence suggests value in systemic-level alerts that could be used to share knowledge about vulnerable institutions in which misconduct is likely to occur due to the elevated organisational risks that can arise in very large and often critically understaffed workplaces. It is likely that concerns about recruitment and expenses policies will not be confined to just one profession or organisation, and so identifying local hotspots could be an important means of restoring public trust within health and social care regulation more widely. They also alert regulators about upstream educational interventions as a more effective means to challenge negative norms and routines that we see emerging in these professions.

Reflections on Impact

In addressing our research questions and reflecting on the impact of the project, it is important to recognise, first, that it emerged from an ongoing relationship between the authors and Professional Standards Authority. In this way it shows the relational dynamics that are central to fostering research-practice links, with prior conversations significant for the development of trust between the different parties about the topic of interest and the key questions that the parties seek to address. Extant study has identified prerequisite good academic-practitioner knowledge exchange as requiring "good social relations, mutual empathy, and some sort of common ground" (Rynes et al., 2001). Without the basis of trust, commissioners may fail to understand the rigour required for academic publication, and academics in turn may over-complicate the analysis and evidence beyond that really required by those facilitating database access. Unsurprisingly, without this trust these relationships often fail (Anderson et al., 2001). Here, an iterative process developed between the two parties, not only of knowledge about the topic of counterproductive work behaviour, but also to enhance academics' understanding concerning regulation, its key foci, and the distinct health workplace contexts.

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Second, impact in this context is multi-levelled. Here, we chart three dynamic and interconnecting streams of activity: 'dialogue', that creates and sustains an international multi-stakeholder community of interest; 'knowledge generation', which focuses on the production of new empirical evidence pertinent to commissioners, but also of value to the wider community of interest; and 'dissemination', which concerns the distribution of the "groundbreaking" report, initially through face-to-face interactions and then through other means, that can elucidate practical learning about counterproductive work behaviour to diverse audiences (see figure 1). Our illustrative diagram, Figure 1, in fact spans four timeframes: those prior to the commissioning; processes related to the production of the study and its resultant report; those immediately and shortly following the report's publication; and finally into the future.

Figure 1: Three strands of impact for PSA report

Dialogue   Knowledge generation   Dissemination
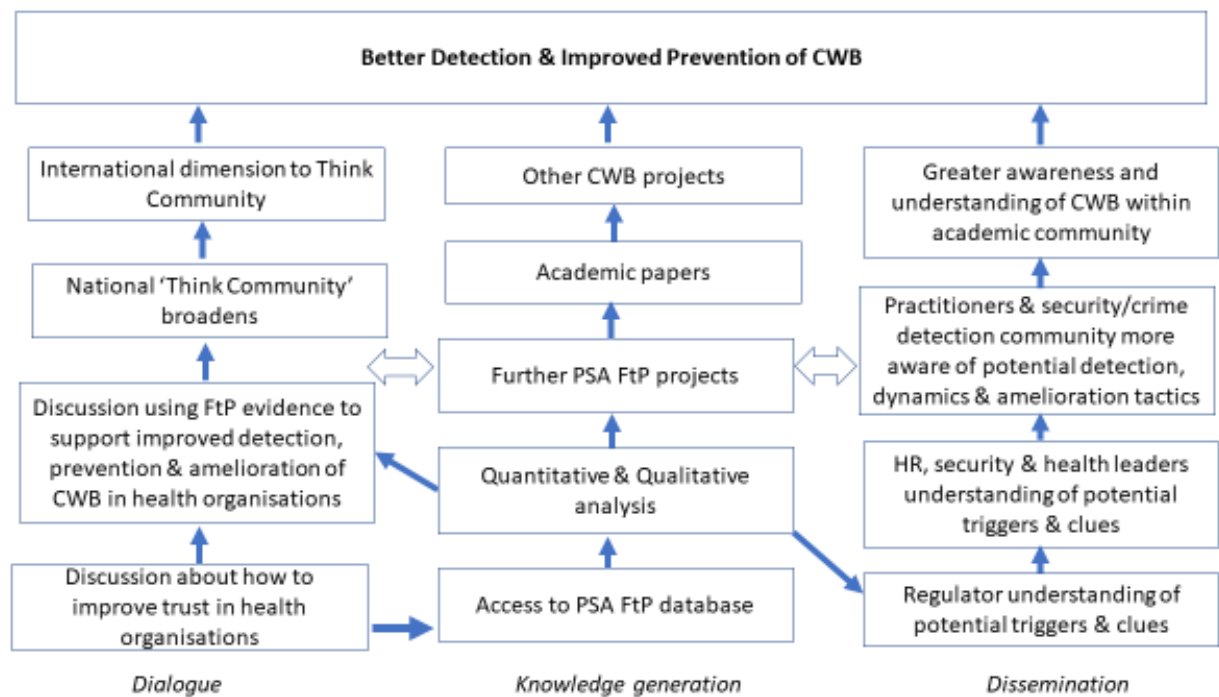
Dialogue

Focusing first on dialogue, it appears to be of central importance for impact– in this case, involving knowledge exchange between an academic partner (the authors) and a practitioner, the main regulator for the health context (Professional Standards Authority), in the areas of trust and regulation. Through positive dialogue between the two main parties, an ongoing partnership was formed (Hughes

et al., 2020), that offered a strategic-level bridging mechanism to promote work psychology insights to wider audiences (Anderson, 2007). The prior exchanges were necessary to the initial development of trust-building, and to reach a sufficient level to result in the commission of the initial and subsequent projects. Into the dialogue, the three key regulators (General Medical Council, Nursing & Midwifery Council, Health and Care Professions Council) were added, which then extended to involve other parties through the building of an international 'think-community' of interest in this topic. This was achieved via various events facilitated by Professional Standards Authority in their annual academic conference, but also further events on Fitness to Practise, such as a 2018 Edinburgh event for the judiciary. Given the topic, this spanned different professions, regulators, industries, and specialisms – for example, human resources, police and security professionals, justice and legal groups, as well as networks of management and academia.

Knowledge Generation

The second dynamic, 'knowledge generation', is often the central concern for academics (Rynes et al., 2001). The Professional Standards Authority project was the first to provide empirical evidence in the form of comparative insight and analysis of counterproductive work behaviour for three professions in the UK's health and social care context. The report has provided health regulators with a significant means to collectively maintain public trust, through improving awareness of the different risks, in identifying the distinct antecedents and consequences for three different ways that misconduct can arise. In particular, Professional Standards Authority found the antecedents of professional misconduct particularly illuminating, illustrated through the apple metaphors. First, we showed the role of individual actors ('bad apples'), and how individual status pressures (namely for doctors) and self-gain motivations were prominent foundations for theft and fraud (Murphy & Free, 2016). Second, we demonstrated how fraud and theft occur through social learning ('corrupted barrels') (Bandura, 1976) that normalises new behaviours. Third, by identifying the part played by depleted environments ('poor cellars') in fostering unjust and negative organisational contexts that overwhelm and diminish individuals' self-control, especially among less autonomous groups, of

nurses and allied health professions (Fox et al., 2001; Shoss et al., 2016). Recent Google analytics showed over 958 downloads of the report from their website (PSA, April 2020).

Further knowledge generation flowed directly from this project, including both new Professional Standards Authority Fitness to Practise studies, but also further research into this area commissioned by other regulators (e.g., Christmas & Fylan, 2018; Gallagher & Jago, 2016; Griffin et al., 2019) and outside the health context (Searle & Rice, 2018). These projects are distinct, but linked, by drawing on and developing the authors' expertise in understanding and analysing counterproductive work behaviour across different contexts. Through the three parallel streams of impact, new relationships were developed which helped to shape novel and distinct questions about counterproductive work behaviour and its detection, antecedents, progressions, and deterrence. These add to, but also provide some challenge of, current understandings of counterproductive work behaviour, for example in the omission of significant but rare behaviours such as patient death, which is not included in the current taxonomies (e.g., Robinson & Bennett, 1995; Gruys & Sackett, 2003). Relationships are a critical feature for such knowledge generation (Rynes et al., 2001). Thus, alongside practitioner-focused reports, activities focused on the production of academic papers for conferences, which in turn facilitate knowledge exchange within academic communities.

Dissemination

Written and oral presentations of Professional Standards Authority's report were nonetheless foundational to the final 'dissemination' activity stream; this is central to delivering evidence-based insight (Briner & Rousseau, 2011) that can advance the detection and prevention of counterproductive work behaviour within health organisations. Through presentations based on the report at annual Professional Standards Authority conferences (2017, 2018, 2019, 2020), it was disseminated to other regulators, such as the Financial Conduct Authority, and international health regulator networks, including those in Canada and Australia. This is beneficial to the development of the authors' networks, but it also consolidates Professional Standards Authority's position as a regulator at the forefront of Fitness to Practise understanding and upstream regulation. The report was also disseminated to employers through its uptake by two distinct parties (Rynes et al., 2001). First, it was

adopted by counterfraud health professionals (NHS Scotland Counter Fraud unit) who used its evidence in their awareness-raising events, and in their further synthesising of its key learning for National Health Service (Scotland) leadership training. Second, a government department with interest in organisational threats disseminated its insights about counterproductive work behaviour beyond health organisations through including the work in various security and training events specifically for the energy, telecoms, engineering, defence, and securities sectors. As a result of this, and through Searle and Rice's winning of a 2018 UK Economic and Social Research Council (ESRC)-funded project on counterproductive work behaviour and subsequent successful ESRC Festival of Social Science grant broader employer attention was gained; this synthesised practical elements from the Professional Standards Authority and subsequent projects to produce a practitioner toolkit regarding counterproductive work behaviours (https://crestresearch.ac.uk/cwb/).

Uncaptured Misconduct and avenues for further research

While these third-party endorsements and uptake of materials are important in dissemination and awareness-raising, it is nonetheless challenging to adequately capture the individual and organisational adoption of this work and the resultant changes that have occurred (Rynes et al., 2001). Analysis of impact is also constrained by the paucity of metrics that have been identified and collected regarding change at either individual professional, or organisational level for both Professional Standards Authority and third parties. The protracted timeframes to organisational and academic impact from these complex events chains, and journal publications' long lead times are likely to suppress insight into the project's true impacts. Additionally, in this study, we were limited to the data available on Fitness to Practise in Professional Standards Authority's database and in the determination documents passed to Professional Standards Authority by the individual regulators. As a result, we could only analyse what was captured by Professional Standards Authority's own Fitness to Practise categories and in these Fitness to Practise determination documents. The documentation produced is designed to fulfil a legal process and summarises information from across a whole case file of documents and hearings - it is not designed for wider systematic analysis. For instance, the

Fitness to Practise determination documents do not routinely record the geographical location(s) of misconduct, which would be of great value for Professional Standards Authority and individual regulators' upstream efforts, to better identify 'hotspot' locations with elevated levels of risk and harm for patients. Instead, ascertaining such information required detailed qualitative coding of the Fitness to Practise determination documents by using the UK's Department of Health's existing numeration for hospitals. While we did identify important associations between these cases and the results of their wider staff surveys, our limited funding constrained this recoding to focus on only a subset of cases, and only those locations where survey results were available. It may therefore provide only a partial identification of these 'hot' locations.

The Professional Standards Authority system uniquely numbers case, which has the unintentional impact of obscuring repeat counterproductive work behaviour offenders. Through this emphasis on cases, rather than on individuals, opportunities to examine repeat perpetrators were missed. Recent study from the Australian health regulatory context has revealed important insights, notably by differentiating the various types of misconducts for the same professions as here, and revealing areas where recidivism is more likely (Bismark et al., 2013; Spittal et al., 2015; 2019). Interestingly their work identified both theft/fraud and sexual misconduct as recidivist categories, with important implications for regulators regarding the application of Fitness to Practise sanctions and potential for remediation. Our analysis did, however, raise awareness within Professional Standards Authority of how they could re-categorise these misconducts, collapsing their current 40 elements into more manageable and meaningful units through applying established counterproductive work behaviour taxonomies (e.g., Robinson & Bennett, 1996; Gruys & Sackett, 2003). Further, our own recoding of categories and close reading of these Fitness to Practise determination documents helped identify additional forms of misconduct which they do not currently record, but which psychologists suggest are important in this domain, such as withdrawal behaviours or poor attendance (Berry et al, 2007).

Our project was constrained in the volume of cases that comprised our subsequent qualitative analysis. It was guided by systematic random sampling, but only a partial view of these different

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professions and their deceptive activities has been obtained. Although thematic saturation was indicated, there may be further value in selecting a larger sample of similar types of cases – for instance, in providing comparison between the organisational and interpersonal targeted activities. Further, the determination documents include little systematic collection of situational variables, since their purpose is solely to record a legal hearing process in summary form. As a result, situational variables that are recognised by psychologists as significant to counterproductive work behaviour are not included; critically these aspects are likely to be more pronounced in a health context (Johns, 2018), which involves delivery of 24-hour and potentially emotionally exhausting services. These omissions include consideration of prior sleep quality (Barnes et al., 2011; Gold et al., 1992), personality details such as low trait self-control (Spector et al., 2006), experience of negative emotions (Kiefer & Barclay, 2012), or care requirements that are likely to produce depersonalisation and disidentification (Bolton et al., 2012).

In addition, an important limitation of the project was its sole focus on these legal documents, rather than including in-depth interviews with perpetrators, health professionals, Fitness to Practise determination panel members, or other stakeholders, which would be invaluable in improving insight into the mindsets and behaviours of the individuals involved. A further funded Professional Standards Authority study has shown how these Fitness to Practise cases can be used to analyse the moral mindsets for those undertaking another critical counterproductive work behaviour, sexual abuse (e.g., Searle, 2019). An unexpected finding in this initial study was evidence from the determination documents, of differences in the level of sanctions that are applied at hearings for these different professions. If this were the case without reasonable justification for the disparity, it could be the cause of significant erosion of public trust. However, justifiable disparity could arise for many reasons that are not included in determination documents. Thus, a limitation of our study is that we only had access to determination documents (summary documents produced from misconduct cases that result in a legal hearing) which do not enable a reliable assessment of these further factors. Professional Standards Authority already scrutinise serious cases as a means of ensuring the public are being protected. However, this type of research is important in providing insight into comparative processes

and outcomes with subsequent studies (e.g., Griffin et al, 2019) considering sanctions more

systematically.

Conclusion

Work psychology is in a unique position at the nexus of academic study and organisational practice.

This paper draws on psychological frameworks and utilises sequential multi-method analysis of

individual incidents of professional misconduct to offer important insights into professionals'

misconduct. Through this paper, we differentiate three important and dynamic strands of ongoing

impact: dialogue, knowledge generation, and dissemination, that may be instructive regarding impact

gathering for other projects that cross the academic and professional spheres. Collectively, these

accumulative strands show the significance of practitioner and academic exchanges as critical to

provoking the formation of new research questions that matter for theory and practice.

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