Fitness to practise determinations for academic dishonesty among UK health professionals

Abstract

Context

In the UK, the regulation of health and social care professions falls under the remit of one of ten General Councils, each of which have a statutory duty to ensure the continuing fitness to practise of its registrants. Among the matters that may call fitness to practise into question are deviations from published standards of behaviour, which include requirements for honesty and academic integrity from practitioners.

Aims

To examine, through a series of related case studies, how the common fitness to practise process utilised by UK regulators deals with registered healthcare professionals attempting to gain an advantage by falsifying academic qualifications.

Methods

One fitness to practise case involving academic dishonesty from each of the the General Medical Council, General Dental Council, General Pharmaceutical Council, and Nursing and Midwifery Council were compared using themes derived from each council's standards for registrants, and guidance for disciplinary panel members.

Results

A range of sanctions were imposed based on the severity of the academic dishonesty, its potential reputational damage to the profession, and the ongoing risk to the health and welfare of patients and the public.

Conclusions

There was a significant degree of consistency between the processes used by each General Council. During each case, the same aggravating and mitigating circumstances were considered when determining both fitness to practise and sanction. Maintenance of "proper standards" and of public confidence in the professions in response to an act of academic dishonesty can be dealt with a sanction from the lower end of the spectrum of severity. A lack of insight invites a period of suspension from practice in which to reflect. Where there is an ongoing risk

to the safety of patients the public, or where a practitioner does not engage, a striking-off order may be appropriate.

Keywords

Academic misconduct; postgraduate education; fitness to practise; disciplinary action.

Introduction

Healthcare regulation

In the UK, the regulation of health and social care professions falls under the remit of one of ten General Councils. Among these are: the General Medical Council (GMC), which is the regulator for doctors; the General Dental Council (GDC), which oversees dentists and dental care professionals; the General Pharmaceutical Council (GPhC), which regulates pharmacists and pharmacy technicians; and the Nursing and Midwifery Council (NMC), which – as its name suggests – has nurses and midwives under its purview.

Each General Council has a statutory responsibility to ensure the continuing fitness to practise (FtP) of its registrants (Dentists Act 1984; Medical Act 1983; Nursing and Midwifery Order 2002; Pharmacy Order 2010). The over-arching aim of each General Council in exercising this function is the protection of the public, which involves the pursuit of the following objectives:

1. protection, promotion and maintenance of the health, safety and well-being of the public;
2. promotion and maintenance of public confidence in their respective professions; and
3. promotion and maintenance of professional standards and conduct for members of that profession.

There is a degree of uniformity across the fitness to practise processes of the various General Councils, which are guided by the oversight body for healthcare regulators: the Professional Standards Authority for Health and Social Care (PSA). The PSA must review all fitness to practise cases by the ten regulators and may appeal decisions to the High Court (National Health Service Reform and Health Care Professions Act 2002, s. 29). In addition, the PSA carry out annual performance reviews against its Standards of Good Regulation to assess how well the regulators are carrying out their fitness to practise functions (The Performance Review Standards, 2016).

Fitness to practise

Concerns raised by General Councils are assessed at in terms of whether the practitioner's fitness to practise is impaired. Fitness to practise was introduced as a term to bring all forms of allegations together under a unifying concept and thereby reduce procedural complexity (Case, 2011).

Although the concept of impairment is not defined in the statutory provisions, it involves some deterioration of the practitioner's ability to practise in their specific profession. The decision in CHRE v NMC & Grant (2011), determined that when resolving the matter of impairment, hearing panels should consider if the practitioner:

> "has in the past acted and/or is liable in the future to … put a patient or patients at unwarranted risk of harm; and/or
>
> has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
>
> has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the … profession."

If there are concerns that potentially raise questions about a practitioner's fitness to practise, the relevant General Council will start an investigation. Following the investigation, minor deviations from expected standards may be disposed of with a warning or lesser sanction. Cases may be referred for a substantive hearing only if a General Council is satisfied that there is such a serious failure to meet standards that there exists a real prospect the registrant's fitness to practise is impaired and that removal from the professional register (i.e. license revocation) might be the appropriate sanction (Good Decision-Making, 2017, para. 3.1; Guidance for the Practice Committees, 2016, para. 56).

Substantive hearings follow an adversarial process**.** The format of hearings is constrained by the concept of impairment of fitness to practise. Hearings must follow a rigid structure comprising three stages, namely:

1. *finding on the facts*, during which the panel decides on disputed facts before moving on to stage 2;
2. *deciding on impairment*, during which the panel considers whether the registrant's fitness to practise is impaired based on the facts found; and

3. *imposing a sanction*, at which stage the panel may issue an appropriate sanction.

At stage 2, the panel are required to decide on whether a registrant's fitness to practise *is* currently impaired; not whether it *was* impaired at the time at which the proven facts occurred.

The step of assessing whether the registrant's fitness to practise is currently impaired as a result of their misconduct focuses panellists on their public safety remit, away from any punitive mindset that could be fostered.

If the panel concludes that the registrant's fitness to practise is impaired, the hearing moves to stage 3, where a sanction may be applied in accordance with published guidance (Fitness to Practise Library, 2018; Good Decision-Making, 2017; Guidance for the Practice Committees, 2016; MPTS Sanctions Guidance, 2020). The panel must show that it started by considering the least restrictive option, working upwards to the most appropriate and proportionate sanction, which should be no more serious than needed to achieve the objectives outlined above (Giele v GMC, 2005). In ascending order of seriousness, the sanctions available to each General Council are:

- no further action;
- warning;
- conditions upon registration;
- suspension of registration (for up to one year); or
- striking-off (i.e. erasure from the professional register).

Standards for healthcare practitioners

General Councils have a duty under their respective enabling legislation to publish guidance for registrants on standards of professional conduct. Each of the Medical, Dental, Pharmaceutical, and Nursing & Midwifery Councils produce core guidance document for all registered practitioners (Good Medical Practice, 2013; Standards for Pharmacy Professionals, 2017; Standards for the Dental Team, 2014.; The Code, 2018).

As each Council's fitness to practise activity is overseen by the PSA, there is a great deal of similarity between their respective guidance documents. Each provides guidance in areas such the provision of patient-centred care, the maintenance of professional knowledge and skills, and the maintenance of patient confidentiality, in a manner that is appropriate to the role of each profession within the healthcare team. For example, each Council expects their registrants to behave honestly with respect to their qualifications, experience and skills. Doctors are explicitly required to "always be honest about [their] experience, qualifications and current role" (Good Medical Practice, 2013, para. 66), while dentists must "only carry out a task or a type of treatment if [they] are appropriately trained [and] competent" (Standards for the Dental Team, 2014, para. 7.2.1). Likewise, pharmacists are required to "recognise and work within the limits of their knowledge and skills" (Standards for Pharmacy Professionals, 2017, p. 11), while acting "with honesty and integrity" in their interactions with patients, employers and the public (ibid, p.13).

The NMC is perhaps the most explicit in laying down its expectation with regard to academic dishonesty, requiring nurses and midwives to "[m]ake sure that any advertisements, publications or published material [they] produce or have produced for [their] professional services … accurately reflect [their] relevant skills, experience and qualifications (The Code, 2018, para. 21.4).

Among the concerns that may call fitness to practise of a member of any of these four professions into question are deviations from these published standards of behaviour. Actions intended to fake competence, inflate previous salaries, and conceal restrictive practices have previously been referred to as "academic dishonesty": analysis of 11 cases of fraud among doctors and nurses covering a period from 1 January 2014 to 31 December 2016 revealed that 72% of such cases included motives pertaining to individuals' own personal or professional gain (Searle, Rice, McConnell, & Dawson, 2017).

Guidance for fitness to practise panels

In addition to setting standards for the practitioners on their registers, each General Council also provides guidance for the members of their respective fitness to practice panels (MPTS Sanctions Guidance 2020; Guidance for practice committees, 2016). Risk of harm to patients and the public and dishonesty are amongst the most

severe aggravating circumstances described in each regulator's fitness to practise guidance. The NMC, for example, identifies "conduct which puts patients at risk of suffering harm" among the list of features that may invite a more severe sanction (NMC Sanctions Guidance, 2018), while the GPhC recognises that "there are some acts [including dishonesty] which, while not presenting a direct risk to the public, are so serious they undermine confidence in the profession as a whole (Good Decision-Making, 2017, para. 6.8).

Additionally, regardless of its nature, each regulator considers a lack of insight into the inappropriateness of the misconduct under consideration to be an aggravating factor when determining a sanction. The respective Councils have a consistent approach to the definition and interpretation of insight.

> "Insight might be defined as an expectation that [a practitioner] will be able to: review their own performance or conduct; recognise that they should have behaved differently in the circumstances being considered; and identify and put in place measures that will prevent a recurrence of such circumstances (Guidance for the Practice Committees, 2016, para. 5.22)."

Following the ruling in the appeal case of Cohen v GMC (2008), panels are required to consider all aggravating and mitigating circumstances at Stage 2 (deciding on impairment) *before* further considering them (if necessary) at Stage 3 (imposing a sanction).

Aims & objectives

This article presents four case studies of academic dishonesty: one from each regulator for nurses, doctors, dentists and pharmacists in the UK. The aim is not to compare professional guidance published by the respective regulators, nor to compare interpretation or outcomes between regulators, as each follows an essentially identical process based on standards of behaviour built upon common principles. Rather, the goal is to examine how the common fitness to practise process utilised by the regulators deals with registered healthcare professionals attempting to gain an advantage by either claiming to have postgraduate qualifications that they have not obtained, or by cheating in assessments for such qualifications.

Among the objectives are: to examine a range of academic offences committed healthcare professionals; to determine those circumstances that aggravate and mitigate these offences; and to consider their effect on the severity of sanction.

Materials and Methods

The NMC, GMC, GDC, and GPhC, and were chosen as they are largest General Councils overseeing discrete professional disciplines, with 716,000, 300,000, 119,000, and 57,000 and registrants, respectively.

Professional regulators have a statutory duty to publish particulars of substantive orders and decisions made by any of their fitness to practise panels (Medical Act 1983, s. 35B(4); General Dental Council Fitness to Practise Rules 2006, rule 32; Pharmacy Order 2010, art. 50; Nursing and Midwifery Order 2002, art. 22(9)). The General Councils fulfil this duty by publishing determinations of fitness to practise hearings on their respective websites in according with their own publication and disclosure policies (NMC Guidance on Publication, 2018; GMC Publication and Disclosure Policy, 2020; GDC Publication and Disclosure Policy, 2018, para. 14; GPhC Publication and Disclosure Policy, 2020, Appendix A2, para. 4). The GMC, GDC, and GPhC maintain the information on their respective websites for a minimum of 12 months from the date of publication in any case where a registrant's fitness to practise is impaired. Determinations remain listed on the NMC website for either four months, for the duration of any order imposed, or for five years in the case of a striking-off order. For the three other General Councils, decisions published between 1 January and 31 December 2019, which had been collated by the lead author, were parsed. NMC cases from 1 July to 31 October 2020 were included as this was the earliest date on which cases were still listed when this project began. Cases were selected based on specific inclusion criteria. Only new cases at which a registrant was appearing for the first time with respect to a given allegation were included. Appeals and interim suspension hearings, which follow different procedural rules, were excluded, as were those that were significantly redacted. Of 33 qualifying cases heard by the NMC; 138 by the Medical Practitioners Tribunal Service (MPTS; the disciplinary panel of the GMC), 58 by the GDC, and 21 by the GPhC, only one from each involved academic dishonesty.

As stated, regulators must publish the particulars of hearings. This includes details of the practitioners involved, including their name and registration number. While these details are in the public domain, the authors feel that their inclusion here would detract from the discussion, so the decision to anonymise the practitioners has been taken.

Results and Discussion

Stage 1: Facts in each case

Doctor

Dr A, a medical practitioner registered with the GMC, was advised by her educational supervisor to sit an exam set by Royal College of General Practitioners (RCGP), which is a legal requirement of working in a General Practitioner (GP) training post. She agreed and was granted study leave to prepare for the exam: however, when the results were released, the necessary certification did not appear her e-portfolio.

Dr A informed her supervisor that there was an error with the IT system, and that she had in fact passed the exam. She subsequently forwarded an e-mail to her supervisor, which she said had come from the RCGP, indicating that she had passed. Concerned that the absence of the certificate on her e-portfolio would become an issue in her training, her supervisor contacted the exams department at the RCGP expressing his concerns.

The college was immediately concerned about the authenticity of the email, as it did not notify candidates of their results in that way. Following a short internal investigation, the RCGP was unable to verify that Dr A had had taken the exam or – indeed – that she had ever applied to sit it. It did, however, discover an e-mail from Dr A explaining that she had forgotten about the application deadline and asking for guidance on how to make an application to sit the exam at a later date.

Dr A was invited to a meeting by her supervisor, during which she admitted that she had not taken the exam and had subsequently fabricated an email containing her results. It was agreed at this meeting was that Dr A would complete a self-referral to the GMC, explaining that she had lied to her educational supervisor about applying

to sit the exam. Dr A also informed the GMC that she had “constructed” an email from the RCGP.

A few months later, a record was noted in Dr A’s e-portfolio that she said she had undertaken eight hours of additional clinical training: however, no evidence had been supplied. Following a request by her supervisor, Dr A submitted two completed worksheets bearing comments and signatures purportedly from her clinical supervisors. It later transpired that Dr A did not complete any additional clinical training and that the worksheets had been falsified from blank worksheets obtained by her.

In addition, Dr A had – on more than one occasion – told her educational supervisor that she had completed all the legal requirements to begin GP training, though she was aware that she had not.

In front of the MPTS, Dr A admitted to all these allegations and thus the tribunal found them proven.

Dentist

Dr B was alleged to have forged several references and a certificate of completion for a three-year postgraduate programme in endodontics at the University of California, and to have submitted these to the National Health Service (NHS) in support of his application for inclusion on the Dental Performers List (DPL).

Evidence in the form of a witness statement indicated that Dr B was not known to the person from whom he claimed to have received a reference. After reviewing the reference in question, the panel concluded that it was highly unlikely to have come from the person to whom it was attributed due to “sporadic and inappropriate use of capital letters and poor grammar.” A signed letter from a second purported referee also confirmed that Dr B was not known to him “in a personal or professional capacity.”

The Chair of the Division of Endodontics at the University of California provided written evidence to the panel stating that Dr B had never attended the university.

The panel was satisfied that Dr B had forged these documents with the intention to mislead the staff at the NHS, and that this conduct was dishonest.

Finally, it was alleged that, when notified of the GDC's investigation, Dr B forwarded an email purporting to be from one of his referees. The GDC contacted this person to authenticate the email. In a written statement, he confirmed that the e-mail was not from him; nor did he recognise the sender's email address as his own.

Pharmacist

In September 2016, Ms C submitted a cardiovascular disease paper to the University of Keele as part of a postgraduate diploma in clinical pharmacy. Plagiarism-detection software at use within the university identified high levels of similarity between Ms C's paper and one submitted paper by another student in 2015.

When challenged by the university, Ms C made a written statement in which she stated:

> "I can confirm I did not use, copy or obtain [another student's] work to complete my assessment … the first time I saw [his] work was when it was sent to me from the academic misconduct team … I can assure you I have not taken, copied or plagiarised his work."

Ms C was referred to the student fitness to practise committee of the university when the other student sent an email to the academic misconduct team confessing that he had sent Ms C a copy of his assignment, but that he had not anticipated she would plagiarise his work. At the university committee, Ms C was directed to make a self-referral to the GPhC.

At the onset of the proceedings, Ms C's representative indicated that all the factual allegations made against her were admitted, and the GPhC's fitness to practice panel found them proven on the basis of this admission.

Nurse

It was alleged that Ms D provided a falsified copy of a certificate for a Master's degree in Advanced Nursing at the University of Wolverhampton – which was a requisite qualification for her role – to her employer. In addition, she also provided a certificate of completion for two continuing professional development (CPD) courses in "sepsis recognition and management" and "safeguarding children".

Concerns were raised when the employer noticed that the degree certificate looked different from those presented by other nurses who attended the same university,

and that Ms D's CV did not include the Master's degree. When asked to produce original certificates, she claimed that she "had been burgled and had lost the documentation in a fire." At a subsequent meeting, she claimed to have "completed the course but had lost the certificate and had made a new one." She was referred to the NMC by her employer.

During the NMC's investigation, the university confirmed that that the certificate was not authentic and that it had no recording of Ms D completing a Master's: rather, she had undertaken a single module in prescribing.

The panel was satisfied on the balance of probabilities that she had forged the certificate, that she deliberately sought to mislead others to believe that she had that qualification, and that this was dishonest. They made similar findings regarding the CPD certificates.

Stage 2: Impairment of fitness to practise

Doctor

Referencing those paragraphs of the GMC's Good Medical Practice (GMP) guidance that deal with honesty regarding experience and qualifications, trustworthiness in communications with patients and colleagues, and truthfulness when signing documents, the MPTS found that Dr A's repeated lying to her educational supervisor about her progress and attempting to cover up her deception amounted to serious professional misconduct (Good Medical Practice, 2013, paras. 65, 66, 68 and 71).

Additionally, the tribunal expressed that "Dr A's actions amounted to a deliberate forgery" and such acts of dishonesty were clear breaches of GMP and amounted to serious misconduct.

The tribunal considered that lying with regard to meeting the legal requirements for GP training also amounted to serious misconduct, and that Dr A's actions of continuing to practise meant she was breaching an important part of the regulatory framework she was subject to, which may have put colleagues in a difficult position and may have impacted upon her indemnity insurance.

The MPTS was of the view that Dr A had demonstrated insufficient insight and had not produced adequate evidence of remediation for her dishonest conduct. It bore in mind that Dr A's dishonesty spanned a long period and that it persisted after her self-

referral to the GMC, noting that she "undertook the forgeries [of the timesheets] at the time her previous dishonesty [regarding the exam] had already become apparent."

Her later dishonest acts, committed whilst already under investigation by the GMC helped the tribunal determine that Dr A had not demonstrated a wider appreciation for the consequences of her actions.

While Dr A's misconduct could have had very serious consequences for her own practice, her actions were not determined to pose a risk to the health of patients or the public.

Dentist

In reaching the decision that Dr B's fitness to practise was impaired, the GDC used the standards set out in their Standards for the Dental Team. Dr B's actions were also found to be dishonest and intended to mislead the parties he submitted the documents to. His actions failed in the requirement to "justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them … [including] … education activities in which you are involved" (Standards for the Dental Team, 2014, para. 1.3.1).

Dr B's dishonesty also persisted over a protracted period of time, and he had not exhibited any understanding into the issues that had brought him before the GDC. The panel considered Dr B's dishonesty on multiple occasions and lack of insight or remorse to be aggravating factors.

The GDC did not consider risk to health of patients to be an aggravating factor in Dr B's case.

Pharmacist

The GPhC considered that Ms C's had its professional standards in that she did not act with honesty and integrity to maintain public trust and confidence in the profession, nor did she meet accepted standards of personal and professional behaviour or respond honesty and openly to the complaint made against her (Standards for pharmacy professionals, 2017; Standard 6). They identified two distinct acts of dishonesty: submitting the paper; and lying about the other student's involvement.

The GPhC identified Ms C's insight as a major mitigating factor. Ms C had been open and honest since the event and had used her experience to educate colleagues as to the importance of abiding by professional standards. Her remorse and contrition were considered genuine, and she had a good understanding of the impact of her actions on public confidence in the profession.

The GPhC determined that should Ms C's actions not have been detected, she would have achieved the qualification, and then have gone on to practise in that area, without having the necessary skills and knowledge. However, as she was noticed and had subsequently shown genuine insight, the actual risk to the public was very small.

Nurse

The NMC found that Ms D's failed to "act with honesty and integrity" in her "calculated deception". Specifically, her actions amounted to a breach of standards in that she failed to "act with honesty and integrity" (The Code, 2018, para. 20.2) or to "act as a role model of professional behaviour for students and newly qualified nurses" (ibid, para. 20.8).

They considered her dishonesty to be sophisticated and deep-rooted. Additionally, the panel highlighted the implications of forging qualifications and the risks that followed to patients in her care, and to colleagues under her management.

The panel considered Ms D's lack of accountability and limited insight when deciding upon impairment. Consequently, it decided that Ms D's repeated dishonesty and failure to recognise the seriousness of her actions amounted to misconduct and that her FtP was currently impaired.

A reflective statement submitted to the NMC by Ms D was deemed to show only limited insight. Ms D demonstrated her understanding of the significance of honesty and integrity in the profession. The panel found her actions did not reflect the thoughts presented in the statement, illustrating that her insight was superficial.

Additionally, it was clear to the NMC that Ms D did not have the necessary qualifications to practise in her role since she fraudulently acquired her certification, in breach of its standards:

> "[Registrants must] practise in line with the best available evidence … [by maintaining] the knowledge and skills [needed] for safe and effective practice" (The Code, 2018, para. 6).

The panel believed that this could not be ignored, especially concerning Ms D's false claim that she had attained a CPD certificate in the management of sepsis "placed patients at an unwarranted risk of harm."

Stage 3: Sanction

Previous studies by this group have demonstrated that the aggravating circumstances discussed above are associated with more severe outcomes (Gallagher & De Souza, 2015; Gallagher & Foster, 2015; Gallagher, Greenland, & Hickman, 2015). Where dishonesty was identified as an aspect of either a doctor or a dentist's misconduct, it was twice as likely that erasure from the relevant register would be the eventual outcome than in cases where it was absent. For the profession of pharmacy, removal was over eight times as likely to result where dishonesty was involved. Where risk of harm was an issue, it was almost three times more likely that erasure from the medical register would be the eventual outcome than where no further risk was present. This compares to one-and-a-half times in dentists and two times in pharmacists. Risk of harm may include consideration of insight on the part of the practitioner. Unless some insight into the inappropriateness of their actions can be demonstrated, a panel will be unable to satisfy itself that there is no risk of a recurrence of those actions. Where insight is not evident, it is likely that conditions on registration or suspension may be neither appropriate nor sufficient.

Doctor

The MPTS had regard to paragraph 128 of the Sanctions Guidance, which states: "Dishonesty, if persistent and/or covered up, is likely to result in erasure" (Sanctions guidance for members of Medical Practitioners Tribunals, 2020). However, it bore in mind that Dr A was at an early stage in her medical career, she had co-operated fully with the proceedings and was capable of developing fuller insight and remediating her behaviour.

The tribunal determined that a period of 12 months suspension would be an appropriate and proportionate sanction which would protect public confidence in the profession and promote and maintain proper standards of conduct and behaviour.

Dentist

The PPC decided that to take no action against Dr B would be insufficient due to the seriousness of his misconduct and the risk of repetition. A period of conditions was then considered: however, due to Dr B's lack of remorse and insight, the panel believed that there were no workable conditions that would be appropriate and restore public confidence in the profession.

Given the significant risk of a repetition of his actions, suspending Dr B's registration would also be insufficient to maintain public confidence in the profession and uphold professional standards. The panel concluded that Dr B's conduct was "fundamentally incompatible with him remaining on the Register", and that the only appropriate sanction would be erasure.

Pharmacist

The GPhC found that Ms C's significant efforts to remediate her misconduct did not detract from its seriousness, so a sanction was necessary. They did accept Ms C's difficult personal circumstances at the time, and the impact this had on her judgement. Balancing those various factors, the panel concluded that Ms C had "brought the pharmacy profession into disrepute by her plagiarism and subsequent attempts to cover up her actions." This could cause members of the public to question the authenticity of pharmacists' professional qualifications thus undermining confidence in the profession.

Its conclusion was that a warning would be sufficient to address its concerns regarding the need to maintain public confidence and to declare and uphold proper professional standards.

Nurse

The NMC considered whether placing conditions on Ms D's registration would be appropriate: however, it questioned whether she could be trusted to comply with such conditions. It also considered that the imposition of conditions may not be effective, as her misconduct is "not something that can be addressed through retraining." The sanctions guidance suggests that a suspension order can be imposed if "the [panel] is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour" (Fitness to Practise Library, 2018).

Given Ms D's lack of insight, it was decided that imposing a suspension order would not be appropriate.

Ms D was removed from the Register.

Table 1: *Summary of common factors cited by each panel as relevant to the outcome in the cases of Dr A, Dr B, Ms C, and Ms D.*

Name	A	B	C	D
Profession	Medicine	Dentistry	Pharmacy	Nursing
Nature of allegations	Lying about (postgraduate) qualification; falsifying certification; repeated behaviour	Lying about (postgraduate) qualification; falsifying certification; falsifying references	Plagiarism (postgraduate qualification);	Lying about (postgraduate) qualification; lying about CPD; falsifying certification
Allegations proven	All admitted	All proven	All admitted	All proven
Level of insight	Incomplete	None	Complete; genuine	Limited
(Further) risk to public ?	No	No	No	Yes
Damaging to reputation of profession?	Yes	Yes	Yes	Yes
Sanction	Suspension (12 months)	Erasure	Warning	Erasure

Conclusions

The facts in each case were broadly similar: each involved a practitioner claiming to have a postgraduate qualification that they have not have (or cheating in an assessment for the award of such a qualification) to gain personal advantage. The basis of the findings of misconduct and subsequent impairment were based primarily on dishonesty and the requirement to maintain public confidence in the professions: however, the outcomes were markedly different. Ms C was issued with a warning, while Dr A was suspended from practising 12 months pending a review, and both Dr B and Ms D were removed from their respective registers.

Although similar in their facts, each case has a specific set of mitigating and aggravating circumstances that affected the outcome.

Ms C was found by the panel to have been open and honest with the GPhC from the outset, referring herself for investigation and admitting to all allegations at stage 1 of her hearing. Her contrition was genuine, her insight was complete, and her engagement with colleagues as to the folly of acting as she had satisfied the panel that the risk of repetition was negligible. She had only recently qualified as a pharmacist at the time the misconduct occurred. In the meantime, she had gone on to legitimately obtain the diploma and the panel did not consider her a risk to patients of the public looking forward. As such, they determined that a warning was appropriate and proportionate, and sent the correct message to the profession and the public.

Dr A, like Ms C, was an “adolescent professional” lacking in experience at the time of her misconduct. She was not deemed to be serious risk to the public: while it was noted that she may have affected her own indemnity insurance, she had not claimed to have any clinical expertise that she did not possess. Unlike Ms C, however, she had not demonstrated an appreciation for the consequences of her actions, her insight was incomplete and there was a risk of recurrence. By subjecting her to a suspension, she would have time to further develop her insight and understanding around the impact of the issues of dishonesty on patients and the reputation of the profession, allowing her to present evidence of remediation at a review tribunal.

Ms D was an experienced practitioner at the time her misconduct occurred. She also showed only limited insight. In this case, however, the panel considered there was a risk of the repetition of behaviour that placed patients at risk of harm, namely: claiming to have clinical expertise that she did not, in fact, possess. It was therefore necessary for the protection of the public to restrict her practice. Having shown little remorse or contrition, the panel reached the decision that this restriction should be permanent.

Similarly, Dr B’s lack of insight and remorse and his outright denial of any wrong-doing was indicative of a real risk of repetition of the dishonest conduct, which included claiming to have expertise and experience in endodontics. Dr B did not engage with the GDC in their adjudication of his misconduct, save to (erroneously)

explain that he was not registered with the GDC and had never practised dentistry in the UK, and to express his contempt for the entire process. This disdain for, and lack of engagement with, the fitness to practise process has been shown to be associated with more severe sanctions, on the basis that no remediation of any sort can be presented by the registrant (Caballero & Brown, 2019; Gallagher, 2021).

In summary, maintenance of public confidence and of proper standards in response to an act of academic dishonesty can be dealt with a sanction from the lower end of the spectrum of severity. A lack of insight invites a period of suspension from practice in which to reflect. Where there is an ongoing risk to the safety of patients the public, or where a practitioner does not engage, removal from the professional register may be necessary. This is consistent with guidance provided to panellists by their respective General Councils. The GMC, for example, cites “inaccurate or misleading information on a CV” as a form of dishonesty (MPTS Sanctions Guidance, 2020, para. 125(d)), which would be aggravated by a “lack of evidence that the doctor understands the problem and has insight” (ibid., para. 25). Erasure may be mandated “where there is a continuing risk to patients” (ibid., (para. (109(c)). The NMC, GDC and GPhC provide similar direction in their respective guidance (NMC Sanctions Guidance, 2018; Good Decision-Making, 2017; Guidance for the Practice Committees, 2016).

Consistency within guidance – whether for practitioners or panellists – inevitably leads to consistency within outcomes. The US, unlike the UK, has over two hundred professional licensing boards made up of rotating panels mostly comprising individuals from the profession being regulated, operating with little or no guidance (Allensworth, 2019). Where consistency of outcomes cannot be demonstrated, a process review is warranted. Further research comparing disciplinary processes and outcomes within these jurisdictions and others would significantly add to the limited existing literature.

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