
Disciplinary Action Against UK Health Professionals for Sexual Misconduct: A Matter of Reputational Damage or Public Safety?

Cathal T. Gallagher, LL.M, PhD; Jeta Thaci, MPharm; Georgina Saadalla, MPharm; Nasteha Mohamed, MPharm; Murwo M. Ismail, MPharm; Thelma Gossel, MPharm; Melissa Attopey, MPharm

ABSTRACT: The regulation of health care professionals in the United Kingdom (UK) falls under the authority of one of nine General Councils, each of which has a statutory duty to ensure the fitness to practice of a subdivision of these professionals. Among the matters that may call fitness to practice into question are deviations from published standards of behavior, which include the maintenance of appropriate sexual boundaries by practitioners. The aim of this article is to examine how the common fitness-to-practice process utilized by General Councils deals with registered health care professionals who have exceeded these boundaries.

Deductive thematic analysis was carried out on cases involving academic misconduct among registrants of the General Medical Council, General Dental Council, General Pharmaceutical Council, and Nursing and Midwifery Council, using themes derived from each council's standards for registrants and guidance for disciplinary panel members.

While each of these four cases involved some form of sexually motivated misconduct, the facts in each case were significantly different; however, not only was the outcome the same, but the rationale was similar in each instance. While the protection of the health, safety and well-being of the public may be considered in cases involving sexual misconduct, the need to maintain public and professional confidence in their respective professions is sufficient grounds alone to end the careers of health professionals who engage in sexual misconduct.

Introduction

Health Care Regulation

In the United Kingdom of Great Britain and Northern Ireland (UK), the professions of medicine, dentistry, pharmacy and nursing are regulated by the General Medical Council (GMC), the General Dental Council (GDC), the General Pharmaceutical Council (GPhC) and the Nursing and Midwifery Council (NMC), respectively.*

Each of these General Councils has a statutory duty to ensure the ongoing "fitness to practice" (FtP) of its registrants.¹⁻⁴ The overarching 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
3. Promotion and maintenance of professional standards and conduct for members of that profession

There is a degree of uniformity across the fitness-to-practice processes of the various General Councils, which are guided by the oversight body for health care regulators: the Professional Standards Authority for Health and Social Care (PSA). The PSA must review all fitness-to-practice cases by each regulator, and may appeal decisions through the courts.⁵ In addition, the PSA carries out annual performance reviews against its Standards of Good Regulation to assess how well the regulators are carrying out their fitness-to-practice functions.⁶

Fitness to Practice

If there are concerns that potentially call a practitioner's fitness to practice into question, the relevant General Council will start an investigation. Following the investigation, minor deviations from expected standards may be disposed of with a warning or

*The GMC, GDC, and NMC are the regulators for their respective profession for the UK; the GPhC regulates pharmacists in Great Britain (England, Scotland, and Wales) only. The Pharmaceutical Society of Northern Ireland (PSNI) is the regulatory and professional body for pharmacists in Northern Ireland.

lesser sanction. Cases may be referred for a substantive hearing only if a General Council is satisfied that there exists a real prospect that the registrant's fitness to practice is impaired and that removal from the practice register, known as "striking-off" in the UK, might be the appropriate sanction.^{7,8}

Substantive hearings follow an adversarial process. The format of hearings is constrained by the concept of impairment of fitness to practice. Hearings must follow a rigid structure comprising three stages, each of which is distinct and separate, 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 practice is impaired, based on the facts found.
3. *Imposing a sanction*, at which stage the panel issues an appropriate sanction.

At stage 2, the panel is required to decide on whether a registrant's fitness to practice is currently impaired; not whether it was impaired at the time at which the facts proven at stage 1 occurred. If the panel concludes that the registrant's fitness to practice is impaired, the hearing moves to stage 3, where a sanction may be applied in accordance with published guidance.^{9,12} The panel must show that it started by considering the least restrictive option, working upward to the most appropriate and proportionate sanction, which should be no more serious than needed to achieve the objectives outlined above.¹³ In ascending order of seriousness, the sanctions available to each General Council are:

- Take no further action
- Issue a warning
- Place conditions upon registration
- Suspend registration for up to one year
- Erase the practitioner's name from the relevant register (i.e., "striking-off")

When determining which is the appropriate sanction, each General Council must keep in mind its overarching objectives.^{8,9,10,12} This involves considering whether a given sanction is sufficient to protect the public, whether it is sufficient to maintain public confidence in the profession concerned and whether it is sufficient to maintain proper professional standards and conduct for members of that profession. The general nature of the misconduct, together with the specific facts of the case, may influence the

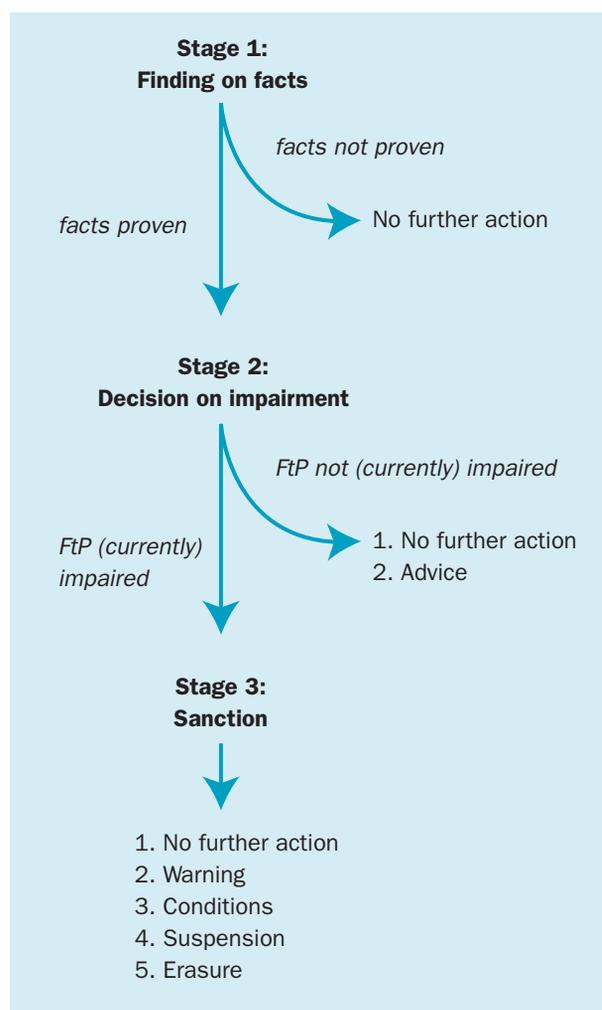
degree to which each of these factors are considered. For example, if a patient was harmed as a result of gaps in a practitioner's clinical knowledge that have been subsequently addressed through training, the risk of harm to further patients is minimal: However, the Council may wish to send the message to other practitioners that allowing such gaps to develop in the first instance is unacceptable and impose a sanction on that basis.

Standards for Health Care Practitioners

General Councils are required by their respective enabling legislation to publish guidance for registrants on standards of professional conduct.¹⁴ Each of the Medical, Dental, Pharmaceutical, and Nursing and Midwifery Councils produce a core guidance document for all registered practitioners,¹⁴⁻¹⁷ which

Figure 1
Three-Stage Fitness-To-Practice Hearing Process

Common to each of the General Medical, Dental, and Pharmaceutical Councils and the Nursing and Midwifery Council in the UK



is supplemented by additional ethical guidance building on the core principles.

As each Council sits under the umbrella of the PSA, there is much similarity between their respective guidance documents. Each provides guidance in areas such the provision of patient-centered care, the maintenance of professional knowledge and skills and the maintenance of patient confidentiality, expressed in a manner that is appropriate for each profession.

For example, each Council expects its registrants to put the interests of patients above their own. The importance of this is emphasized by its inclusion as the foremost standard in each of the Councils' respective guidance documents. Doctors are required to "make the care of their patients their first concern,"¹⁴ while dentists must "put patients' interests first."¹⁵ The expectation upon pharmacists to "provide person-centered care" and for nurses to "act in the best interests of people at all times" mirrors this.^{16,17}

Among the concerns that may call the fitness to practice of a member of any of these four professions into question are deviations from the published standards of behavior.

Aims and Objectives

The aim of this article 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 behavior built upon common principles. Rather, the goal is to examine how the common fitness-to-practice process utilized by UK regulators (Figure 1) deals with registered health care professionals who are alleged to have committed an act of sexual misconduct.

Among the objectives are to examine a range of sexual offenses committed by health care professionals, to determine the circumstances that aggravate and mitigate these offenses and to consider their effect on the severity of sanction.

Materials and Methods

Medicine, dentistry, pharmacy and nursing were chosen for study, as they are the four largest health care professions by membership — with 300,000, 119,000, 57,000 and 716,000 registrants, respectively. The General Optical Council, which regulates both ophthalmic and dispensing opticians, has relatively few registrants (30,000) and, consequently, fewer fitness-to-practice hearings. The Health and Care Professions Council is the regulator for 15

smaller allied health professions, ranging from 1,100 prosthetists to more than 50,000 physiotherapists, with a similar range in hearing numbers for each profession.

Professional regulators have a statutory duty to publish particulars of substantive orders and decisions made by any of their fitness-to-practice committees.^{2,3,4,18} The General Councils fulfill this duty by publishing determinations of fitness-to-practice hearings on their respective websites in accordance with their own publication and disclosure poli-

EACH COUNCIL EXPECTS ITS REGISTRANTS TO PUT THE INTERESTS OF PATIENTS ABOVE THEIR OWN. THE IMPORTANCE OF THIS IS EMPHASIZED BY ITS INCLUSION AS THE FOREMOST STANDARD IN EACH OF THE COUNCILS' RESPECTIVE GUIDANCE DOCUMENTS.

cies.^{19,20,21,22} 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 practice 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. In the case of the three former councils, decisions published between January 1, 2019, and September 30, 2020, which had been collected by the lead author, were collated. Only cases from July 1 to September 30, 2020, were included for the NMC, as this was the earliest date for which cases were still available when this project began.

A total of 344 determinations were published during the period of interest: 234 by the GMC; 44 by the GDC; 34 by the GPhC; and 32 by the NMC. The determinations were parsed on the basis of specific inclusion criteria. Only those cases in which the alleged misconduct was both sexually motivated and directed at either patients or colleagues were included. Other sexual misconduct, including criminal convictions for the possession of extreme pornography, engaging the services of a sex worker and other activities carried out outside the professional sphere were excluded. Only new hearings at which a registrant was appearing for the first time were included. Appeals, reviews and interim suspension hearings were excluded, as were those for which the determination was significantly redacted.

The GMC heard 14 cases that met the inclusion criteria; the GPhC heard only two such cases; and only a single case was heard by each of the GDC and NMC, respectively. One case was chosen from each of the GPhC and GMC with the aim of encompassing a broad range of sexual misconduct, effected against both patients and colleagues and occurring both inside and outside the clinical environment.

Deductive thematic analysis was carried out on each of these four cases, using themes derived from the General Councils' standards for registrants,¹⁴⁻¹⁷ and guidance for panelists.⁹⁻¹² Thematic analysis was chosen as an appropriate method for identifying, analyzing and reporting patterns within data. A deductive approach was employed, as the FtP process is so heavily influenced by guidance to which panelists must refer during their decision-making process. Failure to adhere to guidance increases the likelihood that a decision will be overturned on appeal and, as such, pre-existing themes derived from the guidance are expected to be found reflected in the written record. Themes included misconduct, insight, patient safety and public confidence.

Each of the research teams examined one each of the six combinations of the four regulators (i.e., GMC and GDC, GPhC and NMC, GMC and NMC, etc.), and verified the work of the colleague who had examined the combination with no common parties to their own. So, for example, the examination of the GDC and NMC was verified by the researcher who examined the GMC and GPhC, while the GMC and NMC comparison was verified by the researcher who looked at the GDC and GPhC.

As stated, regulators must publish the particulars of hearings. This includes details of the practitioners involved, including their names and registration numbers. Although these details are in the public domain, the authors believe that their inclusion here would detract from the discussion, so the practitioners have been anonymized.

Results and Discussion

Facts in Each Case

Doctor

It was alleged that, while registered as a consultant psychiatrist, Doctor A engaged in an inappropriate relationship with a vulnerable patient in his care.

Over the course of a 10-year period, during which he acted as the patient's treating psychiatrist, Doctor A extended their involvement beyond the acceptable boundaries of a therapeutic relationship.

It was alleged that, on one or more occasions, Doctor A held the patient's hand; hugged her; stroked her hair, face and ears; expressed his love for her; gave gifts to her; and, on one occasion, arrived unannounced at, and entered, her house. In finding each of these allegations proven, the tribunal noted that each took place in the context of therapeutic sessions while discussing traumatic and difficult life events. Consequently, the tribunal had insufficient evidence to safely conclude that this conduct was sexually motivated.

However, on separate occasions, Doctor A was alleged to have kissed the patient at least twice; placed her hand on his erect penis while kissing her; and to have masturbated her during consultations. In her witness statement, the patient described these events in a way that was "specific, graphic and mundane" and admitted that they were consensual acts. The nature and level of detail she shared was not found to be consistent with

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invention and the tribunal considered her to be a credible witness, and these allegations were also found proved. In addition, these allegations were found to be sexually motivated.

Doctor A admitted that he had failed to report or record any of the intimacy between himself and the patient, either in her medical records or to his employer and, consequently, to keep accurate and appropriate record details of these consultations. He also admitted that the patient was vulnerable at the material time as a result of her mental health.

Dentist

Dentist B was alleged to have engaged in sexually inappropriate behavior toward two female colleagues at several staff Christmas parties. The alleged behavior did not concern Dentist B acting in his capacity as a dentist.

The Professional Conduct Committee (PCC) of the GDC found that Dentist B attempted to place his hand down Witness 1's top and touch her breast, and on a second occasion — some seven years

later—he had touched Witness 1’s breasts. On a third occasion, he placed his hand on the thigh of Witness 2. In addition to statements by Witnesses 1 and 2, two further witnesses gave evidence, all of which was deemed credible by the committee. This was supported by a police report, which confirmed that a complaint was made immediately after the second incident involving Witness 1, and that they were called out to the scene.

The committee noted that Dentist B’s actions were non-consensual and involved him touching intimate areas on the bodies of Witnesses 1 and 2. It was satisfied that such behavior could not be considered as accidental, and that it was sexually motivated.

Pharmacist

The allegations against Pharmacist C were that while employed as a locum pharmacist he touched a patient’s breasts, requested that she remove her dress and put his hands up her dress. This alleged sequence of events occurred in a private consultation room during a visit from the patient to obtain Emergency Hormonal Contraception (EHC).

The panel relied primarily on oral evidence provided by the patient and Pharmacist C. The reliability of their respective accounts was assessed in order to deduce, based on the balance of probabilities, what version of events was more likely to have occurred.

The patient stated that a physical breast examination took place following discussion of her medical history. She was asked to remove her dress, which she declined to do. Pharmacist C decided to proceed anyway. She went on to describe how Pharmacist C subsequently put his hands on either side of her inner thigh until he reached her groin and continued to examine her for 5–10 seconds. Pharmacist C denied these allegations, stating the patient complained about swollen armpits and—at her request—he decided to complete a physical examination of her armpits only.

The panel considered the patient to be a reliable witness. She had revisited the pharmacy within 24 hours and relayed her complaint to the female pharmacist on duty that day. She further relayed the circumstances to the Clinical Governance Manager of the pharmacy business two days later. There was no evidence that these accounts were inconsistent. While there were some discrepancies between her accounts, these were deemed to be insignificant, as she reiterated the main events that took place in the consultation room to the committee consistently throughout, matching the initial complaint made over a year beforehand.

Pharmacist C’s assertion that the patient had presented with swollen armpits did not correspond with her various statements, in which she did not mention any such symptom. The committee considered whether there was a plausible reason why the patient would either invent or deny such a symptom but could see no reason why she would have withheld this detail. Pharmacist C stated that her symptoms were “unusual,” yet he did not record any details of his concerns in her patient medication record (PMR), although he asserted in his testimony that he had done so. The committee concluded that the patient

THREE FACTORS HELP DETERMINE THE FINDINGS OF IMPAIRMENT: WHETHER MISCONDUCT HAS OCCURRED, WHETHER A PRACTITIONER HAS INSIGHT AS TO THE INAPPROPRIATENESS OF HIS OR HER ACTIONS AND WHETHER PUBLIC PROTECTION HAS BEEN PUT AT RISK.

had not told Pharmacist C that she had swollen armpits, did not have swollen armpits, and had not asked him to examine her armpits. Because the committee considered that it could not rely upon Pharmacist C’s account on this salient point, its confidence in his account was undermined.

Pharmacist C was found both to have touched the patient’s breasts and groin. Due to confusion between the parties regarding the type of garment that the patient was wearing, it was determined unlikely he had asked her to remove her dress, and this allegation alone was found not proven.

The committee found the allegation that Pharmacist C’s actions in touching the patient were sexually motivated proven, utilizing PSA guidance on the maintenance of clear sexual boundaries between health care professionals and patients to support its decision.²³

Nurse

The extensive allegations against Nurse D were raised by five female colleagues from the hospital in which he worked. Nurse D sent inappropriate text-, photo- and video-messages, which were sexual in nature, to all five colleagues on several occasions. Two of his colleagues had been asked to perform sexual acts or be witness to sexual acts performed by him while at work. On one occasion, he blocked one colleague’s exit from a linen cupboard, masturbated, ejaculated into a towel, and then threw the towel at her. On a separate occasion, he masturbated in the presence of the

same colleague and requested her involvement with a recently deceased patient still in the room.

When interviewed by his employer and the police, Nurse D made full admission regarding the messages, stating that he did not believe that his messages were inappropriate, as he had a good working relationship with his colleagues, who “wanted and reciprocated” his advances. He did not address the allegations involving physical acts.

As Nurse D refused to engage with the NMC during its investigation, the committee relied mainly on the evidence provided by the witnesses, the police report and interviews conducted by his employer. After assessing the reliability of the witnesses’ accounts, all allegations against Nurse D were found proven.

Determining Impairment

After the facts of a case have been determined, panels consider whether the registrant’s fitness to practice is impaired, based on the facts found. Three factors help determine the findings of impairment: whether misconduct has occurred, whether a practitioner has insight as to the inappropriateness of his or her actions and whether public protection has been put at risk.

Misconduct

In determining current impairment fitness to practice, committees (or tribunals) are first required to satisfy themselves that the facts found proven at stage 1 amount to misconduct. It was found that Doctor A had significantly deviated from the standards of Good Medical Practice (GMP) in that he failed to “make the care of his patients his first concern,” “used his professional position to pursue a sexual or improper emotional relationship with a patient” and his conduct failed to justify his patients’ trust in him and the public’s trust in the profession.¹⁴

Dentist B’s conduct was in breach of the analogous standards for dentists, which require them to “ensure that their conduct, both at work and in their personal life, justifies patients trust in them and the public’s trust in the dental profession.”¹⁵ As his alleged misconduct involved colleagues, rather than patients, his patient care was not in question; however, he did fail to “act with integrity,” brought the profession into disrepute and failed to “treat colleagues fairly and with respect, in all situations and all forms of interaction and communication.”¹⁵

While determining if Pharmacist C’s actions amounted to misconduct, the GPhC concluded

that his touching of this patient was not clinically justified, and that consent was not given. By carrying out an unwarranted physical “examination,” he had “failed to make the care of the patient his first priority,” and he “abused the trust and confidence placed in a pharmacy professional by patients and the public.”¹⁶

Nurse D failed to uphold the dignity of his colleagues, to work cooperatively with colleagues, to uphold the reputation of the nursing profession, or to “act as a role model of professional behavior for ... newly qualified nurses, midwives and nursing associates to aspire to.”¹⁷

In each case, these cumulative deviations from expected standards were found to amount to misconduct.

Insight

Each General Council considers a lack of insight into the inappropriateness of the actions under consideration to be an aggravating factor, irrespective of the nature of the misconduct. The regulators adopt 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, recognize 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.”⁸ “When assessing insight panelists need to take into account factors such as whether the registrant has genuinely demonstrated insight—not only consistently throughout the hearing but also through their actions after the incident took place.”¹⁰ “This may include early admission of the facts, apologies to anyone affected, any efforts to prevent similar things happening again, or any efforts to put problems right.”⁹ “A registrant is likely to lack insight if they: refuse to apologize or accept their mistakes; promise to remediate, but fail to take appropriate steps, or only do so when prompted immediately before or during the hearing ... or fail to tell the truth during the hearing.”¹²

In determining Doctor A’s current state of impairment, the tribunal first considered the extent of insight into his actions, which they deemed insufficient. Although Doctor A had admitted to some of the findings, there was not enough evidence before them to suggest that he had learned how this type of behavior could be avoided in the future. The tribunal did acknowledge that Doctor A had attended courses on maintaining boundaries and

had recognized that he was “too available” to his patient; however, the serious nature of his actions could not be ignored. A finding of impairment had to be made in order not to greatly undermine public confidence in the medical profession.

The PCC heard evidence that, in an attempt to remedy his actions, Dentist B attended two courses on sexual boundaries; however, his lack of engagement through the proceedings exhibited to the committee that there was no real remorse or insight into the harm his actions had caused and that there was no evidence that he was aware of the seriousness of his conduct. In order to maintain the GDC’s professional standards and to restore the public’s trust in the profession, the committee determined that Dentist B’s fitness to practice was currently impaired.

Unlike Dentist B, Pharmacist C did engage fully with the GPhC’s proceedings; however, the committee was concerned that by continuing to dispute their findings, Pharmacist C exhibited his lack of insight. This lack of remorse increased the chance of repetition, and Pharmacist C’s fitness to practice was found to be impaired.

The NMC considered that Nurse D had shown no insight or remorse into his misconduct. It took into account the recording of Nurse D’s disciplinary interview provided by his employer, noting that he commented that his colleagues should have been strong enough to rebuff him if they did not like his behavior. He seemingly saw nothing wrong in how he had behaved, which he considered to be merely “flirting.” The panel noted that Nurse D would stop his behavior intermittently and then start it again, demonstrating that he had no respect for the wishes of his colleagues or insight into the impact that his behavior was having. The panel was of the view that there existed a serious risk of repetition based on his complete lack of insight, remorse or remediation, noting that that public confidence in the profession would be undermined if a finding of impairment were not made.

Patient Safety

Of these four practitioners, only Pharmacist C was found impaired on the basis of his potential risk of harm to patients or to the public. The committee was concerned that because there was no remediation, there was a risk that the behavior would be repeated, causing harm to patients and the public. It concluded, therefore, that a finding of impairment was required *on the grounds of public protection*.

The tribunal noted that Doctor A’s patient was vulnerable, and that his actions took the risk of inflicting further psychological harm upon her; however, it did not find his fitness to practice impaired on the basis of any further risk to patients or the public, but rather on the basis of the reputational risk to the profession.

There was also an aspect of public protection in Nurse D’s case: When his colleagues ignored or spurned his sexual advances, he would not hand over information about patients, nor would he provide assistance when requested by those colleagues. While this was a factor in the committee’s determination of misconduct,

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it was not considered when determining impairment. Rather, his impairment was necessary to “uphold public confidence in the profession.”

The GDC did not consider there to be any public protection issue in finding Dentist B’s fitness to practice impaired. Indeed, PCC considered that the lack of any patient involvement was a mitigating factor.

Imposing Sanctions

The tribunal considered that Doctor A’s behavior was an abuse of his professional position, that it was both repeated and progressive, and that it was performed upon a vulnerable patient with a history of mental health conditions, placing her at the risk of further psychological harm. Additionally, Doctor A failed to take action to distance himself from the patient’s care as soon as the doctor/patient relationship was compromised.

The tribunal had sight of Doctor A’s references and testimonial, which demonstrated his clinical ability is held in high regard by his colleagues and his other patients. Consideration was also given to mitigating factors, including the professional boundaries course undertaken by Doctor A and his previously unblemished career. However, the tribunal was mindful of guidance which states that it “is less able to take mitigating factors into account when the concern is ... of a more serious nature.”¹²

In coming to its decision as to the proper sanction, the tribunal first considered whether to conclude Doctor A’s case by taking no action but decided

that this would be wholly inappropriate. They subsequently decided that while conditions could be imposed to protect patients, no condition would sufficiently address the risk to public confidence and the upholding of standards.

In assessing the suitability of a period of suspension, the tribunal considered whether Doctor A's conduct was compatible with continued registration. Doctor A had accepted that he was aware of his patient's history of poor mental health and of her "particular vulnerabilities." Under these circumstances, it was to be expected that he would have exercised "especial care and caution in managing the clinical relationship." The tribunal was of the view that regardless of how the inappropriate relationship began, Doctor A clearly crossed doctor/patient boundaries on multiple occasions. It determined that this was an abuse of his patient's trust in him, and that it represented such a significant departure from GMP that it was incompatible with continued registration.

In ordering his erasure from the Medical Register, the tribunal "determined that sexual misconduct is a serious failing and the public would expect there to be an appropriately serious response," and "that members of the medical profession would find his conduct deplorable." These two objectives—upholding public confidence and maintaining proper standards—are cited in the tribunal's decision; unlike protection of the public, which is notably absent from its determination.

Similarly, the GDC found that Dentist B's erasure from the Dental Register was "necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standards of conduct required of a registered dental profession at all times." In doing so, it was mindful of guidance, which states that "erasure is the most severe sanction that can be applied by the PCC and should be used only where there is no other means of ... maintaining confidence in the profession."⁸

Pharmacist C did not demonstrate to the Disciplinary Committee of the GPhC that his understanding had real depth. It appeared to the committee to be "somewhat rehearsed and lacked any real understanding of the seriousness of the conduct found proved." The strategies described by Pharmacist C to avoid a repetition appeared to be devised primarily to avoid the risk of similar allegations in the future, rather than a real recognition of the inappropriateness of his behavior. Consequently, it was deemed

necessary in order to maintain both professional standards and public confidence in the profession to permanently exclude him from the profession.

As in the case of Doctor A, the sexual misconduct took place in a clinical setting. It involved the fabrication of a rationale for conducting an unnecessary clinical examination. This rationale was calculated to be alarming to the patient so that she would accede to being examined, and it had in fact alarmed her. Also, in common with Doctor A's case, the committee recognized that Pharmacist C had escalated his touching to include the patient's groin, having been "emboldened by the lack of challenge after the first touching." In contrast to Doctor A's case, the committee considered that this patient involvement and risk of recurrence were very relevant. While working upward to the most appropriate and proportionate sanction, the committee considered that "the public and other pharmacy and healthcare professionals, rightly, would be both shocked and appalled by [Pharmacist C's] behavior." It recognized that while the imposition of conditions restricting his practice could protect the public, this would not be "sufficient to mark the nature of the

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misconduct, nor would [it] maintain public confidence in the profession." This requirement to "mark the gravity of misconduct such as to protect the public interest by upholding standards in the profession and maintaining public confidence in the profession" was further emphasized with reference to specific guidance on cases of sexual misconduct provided in the GPhC's *Good Decision Making* guidance.¹⁰

The NMC was of the view that Nurse D felt safe in the knowledge that his behavior would not come to light because of his seniority. The panel noted that he felt able to continue this behavior over many years and saw nothing to suggest that he would stop if he were given the opportunity to continue in the profession. The panel was of the view that Nurse D's actions were serious and to allow him to continue practicing would undermine public confidence in the

profession and in the NMC as a regulatory body, and so determined that the appropriate and proportionate sanction was that of a striking-off order. Having regard to Nurse D's adversely affecting the public's view of how a registered nurse should conduct himself, the panel concluded that nothing short of this would be sufficient in this case.

Conclusions

While each of these four cases involved some form of sexually motivated misconduct, the facts in each case were significantly different. Two of the four hearings involved practitioners failing to maintain appropriate boundaries with vulnerable patients: In the matter of Doctor A, this involved a patient under his long-term care; while Pharmacist C opportunistically exploited a paternalistic interaction in order to engage in sexually motivated touching of a patient on a single occasion.

The other two cases had no direct patient involvement; rather, they involved the exploitation of a position of seniority to engage in the sexual objectification of colleagues. In the case of Dentist B, this occurred outside the workplace on two occasions separated by seven years, while Nurse D was engaged in a protracted campaign of sexually inappropriate behavior involving a large number of junior colleagues during working hours at the hospital in which he was employed.

It has been shown that a full range of sanctions are used in cases involving the falsification of qualifications.²⁴ In such cases, maintenance of public confidence and of proper standards are often satisfied with a sanction from the lower end of the spectrum of severity. Only where there is an ongoing risk to the safety of patients or the public is removal from the professional register usually necessary. Additionally, by examining a broad range of hearings from across the spectrum of misconduct, we have previously demonstrated that where practitioners show insight into their misconduct, or in cases where there is no

future risk to patients or the public, less restrictive sanctions may be appropriate.²⁵⁻²⁸ This includes cases involving serious dishonesty, which is deemed to be among the most severe aggravating factors by all four General Councils.⁹⁻¹²

This does not seem to apply where sexual misconduct is involved. In these four cases, covering a range of types of sexual offenses, not only was the outcome the same, but the rationale was similar in each instance. The various General Councils all determined that removal from the relevant register was the necessary sanction, based on the need to maintain public confidence in their respective professions. While Nurse D's withholding of patient information and assistance from colleagues when they did not go along with his advances was identified as an aggravating factor when selecting a sanction, it appears to have been given little weight by the

WHILE EACH OF THESE FOUR CASES INVOLVED SOME FORM OF SEXUALLY MOTIVATED MISCONDUCT, THE FACTS IN EACH CASE WERE SIGNIFICANTLY DIFFERENT.

NMC, which emphasized that the striking-off order imposed "was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behavior required of a registered nurse." Only the GPhC considered the risk to patients as an aggravating factor in its deliberations; however, when issuing a sanction, the committee noted that protection of the public could be achieved by the imposition of conditions, such as the requirement to see patients only in the presence of a chaperone. The decision to permanently exclude Pharmacist C from the profession was taken on the basis that "no sanction other than removal from the register was adequate in the public interest for the purpose of maintaining public

Table 1
Summary of Outcomes

Name	Regulator	Nature of violation	Outcome
Doctor A	GMC	Inappropriate relationship with a vulnerable patient	Erasure
Dentist B	GDC	Sexually inappropriate toward two female colleagues (non-clinical setting)	Erasure
Pharmacist C	GPhC	Inappropriate touching of a patient	Erasure
Nurse D	NMC	Sexually inappropriate toward multiple female colleagues (clinical setting)	Erasure

confidence in the profession and maintaining professional standards.”

In summary, while the protection of the health, safety and well-being of the public is always given due consideration, patient safety alone does not necessarily warrant suspension or removal of the practitioner in cases involving sexual misconduct; conversely, the need to maintain public and professional confidence is sufficient grounds alone for the career of a health care professional to be abruptly ended.

Limitations

Only four cases, selected to encompass a range of sexual offenses committed by health care professionals, were included in our analysis. It is difficult to determine a trend by analyzing such a small sample. Having acknowledged this, it must be noted that the number of cases involving sexual misconduct by health care practitioners in the UK is relatively small. Only one case that met the inclusion criteria was heard by each of the GDC and NMC during the data-collection period, and both cases have been discussed here. The GPhC heard only two such cases, while the GMC/MPTS heard 14, each of which included words to the effect that the sanction imposed was the only way to protect public confidence in the profession and to maintain proper standards of conduct. This was the case whether or not there was an ongoing public safety risk, which appeared to have little or no effect on the severity of sanction. On this basis, we believe that this trend would hold had all the sexual misconduct cases for these time periods been included. ■

About the Authors

Cathal T. Gallagher, LL.M, PhD, is Reader in Healthcare Ethics and Law at the University of Hertfordshire, UK.

Melissa Attoley, MPharm, Thelma Gossel, MPharm, Murwo Ismail, MPharm, Nasteha Mohamed, MPharm, Georgina Saadalla, MPharm, and Jeta Thaci, MPharm, were all master's candidates completing their dissertations under the supervision of Dr. Gallagher at the University of Hertfordshire during the drafting of this manuscript.

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