Making decisions on dishonesty charges and the professional duty of candour

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Why does dishonesty matter?

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We take concerns that a professional has been dishonest very seriously. This is because everybody should be able to trust the people providing them with care. Our over-arching objective to protect the public includes promoting and maintaining public confidence in the nursing and midwifery professions. If a professional is dishonest, it is likely to mean that the public cannot have confidence in them, which may affect their confidence in the profession as a whole.

What do we mean by dishonesty?

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Dishonesty is something that most people will recognise when they see it. To decide whether an action was dishonest, the Fitness to Practise Committee first needs to decide what the professional knew and believed about the facts at the time (the subjective part). Then, the Committee must decide whether the professional's actions, based on what they knew and believed at the time, were dishonest by the standards of ordinary people (the objective part). Whether the professional thought their actions were dishonest is not a relevant factor in deciding whether they were dishonest.[1] However, we may consider this and the context of the actions when deciding how serious the dishonesty was.

Is all dishonesty serious?

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As with any concern, a concern about the professional's dishonesty needs to show a risk to the protection of the public. Dishonesty that could risk the protection of the public is very serious, but not all allegations of dishonesty will present such a risk. The following non-exhaustive list gives examples of dishonesty which are unlikely to amount to misconduct as single incidents:

- A one-off example of dishonesty purely relating to a professional's private life, with no evidence of dishonesty related to their professional practice;
- An incident in professional practice that has no impact on public protection, for example relating to personal food in a communal fridge;
- An incident in professional practice where the professional recognises and remediates the dishonesty before there are any consequences. For example, this might include stating they have completed a clinical task when they have not, but acknowledging this was not correct, apologising and completing the task before there are any effects on clinical outcomes.

If such incidents became part of a pattern of dishonesty, this would be more likely to amount to misconduct.

If the Committee finds that a professional has been dishonest they are likely to receive a severe sanction. This can be true even if the dishonesty is not linked to professional practice.[2] Most findings of dishonesty result in a sanction of suspension or strike-off.[3]

However, not all dishonesty is equally serious.[4] In each case we will need to consider what happened and the impact it has on the protection of the public. It may also be appropriate to consider the context in which dishonesty happened

and the workplace culture; this means it will be helpful to hear from the professional about what happened from their perspective. The range of dishonesty is discussed more in our sanctions guidance.

When deciding on the seriousness of dishonesty, panels may find it helpful to consider the PSA's 2016 research into public and professional attitudes to dishonesty.

Dishonesty charges

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In all cases where we consider there is dishonesty, we should state clearly in the regulatory concerns and charges that we believe the professional's conduct was dishonest. This is because finding that a professional has been dishonest is very serious, and everyone involved should understand the importance of what is being alleged. If the charges do not explicitly include dishonesty, the Committee should not make a finding on dishonesty, and should not consider it at sanction stage.

The professional duty of candour

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The professional duty of candour is set out in section 14 of the Code. It requires professionals to be open and honest when something goes wrong when providing care. The duty was included by all health regulators in response to the findings of the Francis Inquiry, and applies when someone receiving care has been harmed or is put at risk of harm. We have published joint guidance with the GMC about the duty.

Breaches of the professional duty of candour are amongst the most serious category of concerns. Within our screening guidance, we list breaches of the professional duty of candour as a concern which will require further investigation and in our sanctions guidance as cases we regard as particularly serious. This is because concerns about the professional's candour may be more difficult for them to put right. This means that we will want a professional to tell us about their reflections and insight, because restrictive regulatory action is likely to be necessary if the concern hasn't been put right.

Breaches of the duty of candour will often also be dishonest, but this isn't always the case. However we always regard breaches of the duty of candour as very serious, whether or not they are also dishonest.

Example 1

A hospital patient is harmed as a result of medicine not being dispensed correctly. A junior nurse on the ward saw this and the resulting harm, but does not report this as he is afraid that he will get his colleagues into trouble. This is a breach of the duty of candour, but is not necessarily dishonest.

When we draft charges or regulatory concerns, we normally refer specifically to acts being a breach of the duty of candour. This is because it makes the charge more serious; the professional needs to understand this to defend themselves, and the panel need to consider it at sanction stage.

1. Ivey v Genting Casinos (UK) Ltd [2017] UKSC, para 74
2. Abiodun v Nursing and Midwifery Council [2015] EWHC 434 (Admin)
3. Hassan v General Optical Council [2013] EWHC 1887 (Admin)
4. Lusinga v Nursing and Midwifery Council [2017] EWHC 1458 (Admin)