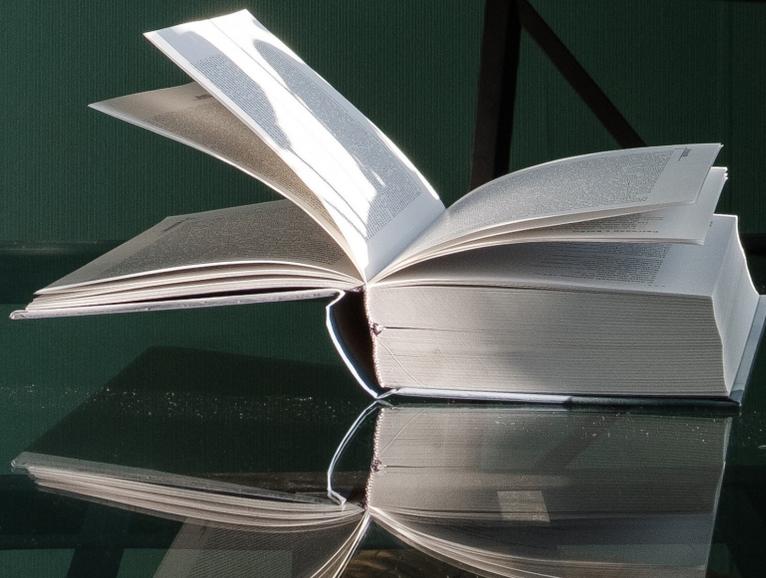


NOTEBOOK ON ETHICS, LEGAL ISSUES AND STANDARDS FOR COUNSELLORS & PSYCHOTHERAPISTS

TYOLOGY OF DISHONESTY BY HEALTH PRACTITIONERS

BY DR. GLENN SHEPPARD



Virtually all health professionals want to practice in ways that fulfill their commitment to ethical behaviour as expressed in their respective codes and standards of ethical conduct. They also share in a fundamental belief that honesty is essential to the maintenance of trust with clients and for the fulfillment of their fiduciary duty to them. However, ethical codes of conduct are aspirational in nature and, unfortunately, some practitioners, for a variety of reasons, fail in their promise to adhere to them and engage in unethical conduct including dishonest behaviour. My reflection on this aspirational perspective reminds me of Robert Browning's often-quoted expression that "a man's reach should exceed his grasp or what's a heaven for."

Despite Browning's apparent recognition that perfection will always remain outside our human reach, it is often a challenge to achieve an empathetic understanding of some acts of dishonesty by professionals and such conduct will continue to warrant professional and societal sanctions. I am reminded of one such example of professional dishonesty involving an individual who was providing counselling services with the unregulated title of counsellor. However, it became clear during the court proceedings related to some of his activities and with evidence from his clients, that he encouraged them to refer to him as a psychologist and did not correct others when they did so. He was legally sanctioned for this behaviour as a result of action taken by the provincial College of Psychologists. Of course, for a CCPA member, such conduct would also be in violation of the Article 5 of the **CCPA Code of Ethics**.

REPRESENTATION OF PROFESSIONAL QUALIFICATIONS

Counsellors do claim or imply only those professional qualifications which they possess, and are responsible for correcting any known misrepresentations of their qualifications by others.

I also became aware that a senior associate, a psychologist, working in the same counselling practice billed third party payers for this person's services using his own title and invoice. It was this case that prompted us to place the following prohibition in

the **CCPA Standards of Practice**:

Under no circumstances should counsellors submit their billing invoice as a surrogate for professional services provided by another service provider (p. 46).

We have no reliable means of knowing just how many members of the health professions deviate from ethical norms in their professional or public conduct. Of course, an analysis of the ethical complaints lodged with various ethical complaints committees can provide some insight into the types of ethical misconduct with which they deal. A recent study entitled **Typology of Dishonesty** commissioned by the UK Professional Standards Authority (PSA) did just that but with a particular focus on cases of misconduct that included the allegations of dishonesty.

THE PROFESSIONAL STANDARDS AUTHORITY (PSA)

The PSA is a British authority that oversees the activities of nine statutory bodies that regulate health professionals in the UK and social workers in England. It conducts reviews of these regulatory bodies, promotes improvements in professional standards, provides standards and accreditation for voluntary registration in unregulated health care organizations, and accepts assignments to conduct related work outside of the UK. One recent PSA study was an invited review of the complaints procedures and practices of the Saskatchewan Registered Nurses Association.

The study reviewed in this Notebook was commissioned by the PSA and conducted by two academic professionals—Ann Gallagher, Professor of Ethics and Care, University of Surrey, and Albert Jago, Senior Lecturer of Law, Royal Holloway University of London—who reviewed and analyzed 151 discipline cases that involved practitioner dishonesty. At the outset of their report, the authors observed that being honest may not always be straight forward. For example, a full disclosure of a grave diagnosis might be withheld based on the view that it is best to do so for the patient's own good. However, attitudes are now changing in favour of giving primacy to patient autonomy. Of course, the timing of disclosures, the language used, and the nature of the prognosis disclosed to clients remain important

considerations. At the beginning, they also provide the following definition of dishonesty:

To be honest is to be real, genuine, and bona fide. To be dishonest is to be partly feigned, forged, fake, or fictitious. Honesty expressed both self-respect and respect for others. Dishonesty fully respects neither oneself nor others. Honesty imbues lives with openness, reliability and candour; it expresses a disposition to live in the light. Dishonesty seeks shade, cover, or concealment. It is a disposition to live partly in the dark (Bennett 1993, p. 599).

Following their analysis, the authors identified the following six categories of dishonest conduct by health practitioners:

- ⇒ *"Dishonesty by omission—not disclosing—where the truth is withheld;*
- ⇒ *Dishonesty by commission—lying—where a registrant tells an untruth;*
- ⇒ *Impersonation—impersonating—assuming the identity of another person;*
- ⇒ *Theft—stealing;*
- ⇒ *Fraud—deceiving; and*
- ⇒ *Academic dishonestly—cheating."*

They highlight various examples from the disciplinary cases for each one of these from both the professional practices and private lives of health professionals. For example, the impersonation category, a nurse was found guilty of impersonating both a physician (who can use flashing green lights in the UK when attending to an emergency) and a police officer to facilitate speeding through traffic. The equipment was stolen from work. Another example of impersonation, in the private domain, was a practitioner who impersonated his brother in order to sit for examinations in his stead. This behaviour from the private lives of these individuals was sanctioned as professional misconduct and it brought their health professions into disrepute.

Examples of the most prevalent types of dishonesty found in the 151 cases were:

Of the 151 cases reviewed, the three most particular kinds of dishonest activities were, firstly, failure to disclose convictions/cautions to the regulator either upon registration or for the purposes of retention on the register (19 cases). Secondly, simple theft of identified monies, prescription pads and medication or drug paraphernalia (18 cases) and finally, receiving sick pay and salary from a 2nd employer simultaneously (13 cases).



"To be honest is to be real, genuine, and bona fide. To be dishonest is to be partly feigned, forged, fake, or fictitious. Honesty expressed both self-respect and respect for others."

Bennett 1993, p. 599

With respect to sanctions for dishonest conduct, the investigations found a variety of consequences were imposed, the most severe being revocation of a license to practice, which means a permanent suspension. However, most sanctions were moderate suspensions of a registration or license to practice.

The authors suggest that the results of their study might have some value if included in pre and in-service educational activities for health practitioners. For example, they might benefit from reflection on the following:

- ⇒ *The wide variety of forms in which dishonesty can arise,*
- ⇒ *The rationales given for acting in a way that is untruthful (e.g., “that rule is bureaucratic and unfair anyway”),*
- ⇒ *The challenges in being candid (e.g., forgetting to obtain a client’s signature for a document and having to choose between chasing down the client or forging the client’s signature), and*
- ⇒ *The consequences of dishonesty to one’s clients, one’s profession and oneself.*

They also offer regulators the following acronymic framework for use in their assessment of dishonest behaviours:

- ⇒ *Highlight the type of dishonesty and domain of offense*
- ⇒ *Organizational (environmental) issues that may have impacted on the offence?*
- ⇒ *Negative or aggravating individual factors that contributed to offence?*
- ⇒ *Explanations offered as possible mitigation?*
- ⇒ *Sanction applied—is it fair? Too lenient? Too severe? Is the sanction proportionate?*
- ⇒ *Training or professional education that may remedy?*

They conclude with this recommendation:

“We strongly recommend that educators and regulators capitalize on the rich resource of cases in their databases to illustrate the types of dishonesty and also to urge reflection on strategies that registrants may use to develop

their moral resilience.”

Although this study is a significant and welcome contribution to the ethics literature and resources for us as health professionals, much remains to be done. For example, a further examination of the organizational and collegial environments in which unethical behaviour might go unchallenged. Also, it would help to have a fuller understanding of the cognitive distortions and the fallacious logic in our ethical reasoning of which we are all capable when defending our inappropriate conduct. The power of these “ethics placebos” will be addressed in another notebook edition.

This study can be found at:

www.professionalstandards.org/uk/publications

The Notebook on Ethics, Legal Issues and Standards for Counsellors & Psychotherapists is published in each edition of COGNICA and is an additional ethical resource for CCPA Members.

Previous Notebooks include:

- ⇒ [Email Communication with Clients: A Brief Review and Some Recommendations](#)
- ⇒ [Scope of Practice for Counsellors](#)
- ⇒ [Counselling Records: Best Practices for Counsellors and Psychotherapists](#)
- ⇒ [A Supreme Court of Canada Decision, and the Goudge Report on Complaints & Discipline](#)

For a compilation of selected works, or to download the entire Notebook, [refer to our website](#).