

**Royal College of Physicians  
and  
Faculty of Forensic and Legal Medicine  
Joint Conference**

**MULTIPLE MEDICO-LEGAL JEOPARDY**

**Thursday 27 November 2008**

*at the Royal College of Physicians,  
11 St Andrews Place, Regent's Park, London NW1*

**HC(90)9 v MHPS: managers win after doctors' own goal!**

**By**

**John Hendy QC<sup>1</sup>**

**Introduction**

Every NHS doctor has at the back of his/her mind the knowledge that an error may result in a claim for damages by a patient. Every NHS doctor is conscious of the powers of the GMC to erase his/her registration if things go wrong. But few think much about the possibility of being disciplined or even sacked by their employing NHS Trust.

The doctor facing patient claims or GMC charges has the protection of legal representation, an independent tribunal and formal procedural safeguards. Yet such protections have recently been swept away for the doctor whose professional reputation, career, vocation and livelihood is at stake in disciplinary proceedings brought by his/her NHS employer.

**History**

The procedure for NHS employers investigating and pursuing serious disciplinary cases of professional misconduct or incompetence against senior medical staff was, until June 2005, a procedure called HC(90)9 (Annex B for serious allegations). This was set out in a Health Circular in 1990. It was a slightly more refined version of its

---

<sup>1</sup> LIB, LIM, FRSM, FRSA, Head of Old Square Chambers, Visiting Professor in the School of Law, King's College, London; Chair of the Institute of Employment Rights, former Chair, Employment Law Bar Association.

1961 predecessor, HM 61(112), which in turn originated from Ministerial guidance first given in 1951.

The detailed disciplinary procedure set out in these documents was fortified by paragraph 190 of the standard NHS Terms and Conditions of Service for Medical and Dental Staff which gave the staff to whom it applied the right, if dismissed, to appeal to the Secretary of State and claim the dismissal was unfair. If upheld such an appeal would result in reinstatement or redeployment to another NHS Trust (the “third solution”).<sup>2</sup>

Whilst the NHS was a highly centralised organisation, circulars from the DoH were regarded as binding. The NHS standard terms and conditions of employment for consultants of the 1960s, 70s and 80s specifically referred to HM 61(112) as the disciplinary procedure and hence it was incorporated into the contract of employment between the doctor and the employing authority by application of trite employment contract law.<sup>3</sup> This was fortified by a statutory instrument so that employing authorities had no option but to be bound by HC90(9).<sup>4</sup>

---

<sup>2</sup> Paragraph 190 appeals lay to the Secretary of State where the doctor considers his or her “appointment is being unfairly terminated.” The right applies only to limited classes of doctor, in particular to consultants. The right was of diminishing significance since Trusts and Hospital Authorities were told, and heeded the advice, not to employ consultants after 1<sup>st</sup> April 1991 on terms which included paragraph 190. Trusts excluded a paragraph 190 right of appeal in new contracts, leaving only those employed before 1991 with residual rights. There was no right of appeal under paragraph 190 where the dismissal is on grounds of “personal misconduct.” This proved a fraught point in some cases. Once a paragraph 190 appeal was lodged the dismissal could not be put into effect (save where the dismissal is summary). The appeal was to a panel which advised the Secretary of State and was chaired by the Chief Medical Officer or his or her deputy sitting with representatives of the profession. The doctor was usually legally represented and the proceedings were formal. The Secretary of State could, on the recommendation of the panel, confirm the dismissal, or direct it to continue, or (the “third solution”) “arrange some other solution agreeable to the practitioner and the employer.” Before the break up of the NHS into trusts, the third solution was relatively easy to operate by the expedient of moving the doctor to another hospital, near or far. In the latter years of paragraph 190’s existence, the degree of autonomy of Trusts meant that this option became very difficult so that a third solution could be frustrated and end ultimately in unemployment if no Trust would take the doctor.

<sup>3</sup> *National Coal Board v Galley* [1958] 1 All ER 91, CA; *Gascol Conversions Ltd v Mercer* [1974] ICR 420, CA; *Keir and Williams v County Council of Hereford and Worcester* [1985] IRLR 505, CA; *Marley v Forward Trust Group Ltd* [1986] ICR 891, CA; *Morris v C H Bailey Ltd* [1969] 2 Lloyd’s Rep 215, CA; *Petrie v Mac Fisheries Ltd* [1940] 1 KB 258. Whilst in the past mere “policies” have not been regarded as incorporated into the contract (*Dryden v Greater Glasgow Health Board* [1992] IRLR 469, EAT; *Wandsworth London Borough Council v D’Silva* [1998] IRLR 193, CA; *Grant v South-West Trains Ltd* [1998] IRLR 188, QBD), with the advent of the implied term of trust and confidence employees are now likely to be able to rely on the latter in order to enforce compliance with a disciplinary ‘policy’: Moore-Bick L.J in *Deadman Bristol City Council* [2007] IRLR 888 at paras.17-18.

<sup>4</sup> Reg. 3 of the National Health Service (Remuneration and Conditions of Service) Regulations 1991 (SI 1991/481).

From the late 1990s and in keeping with devolution in the NHS, Trusts were encouraged to adapt HM 90(9) and adopt the adapted version as their own procedure rather than simply making a reference to HM 90(9) in the paragraph dealing with disciplinary matters in the terms and conditions statement they issued to their consultants. Typically the Trust's adapted version was referred to in the contractual document so that it was thereby incorporated into the contract of employment. In my experience the Trust variations from the original were not great.

On 17<sup>th</sup> February 2005 the DoH issued a statutory instrument, "Directions on Disciplinary Procedures 2005", effective from 1<sup>st</sup> June 2005, annexed to which was *Maintaining High Professional Standards in the Modern NHS*.<sup>5</sup> The Directions withdrew HC(90)9 and *MHPS* instructed NHS Trusts (and advised Foundation Trusts) to replace HC(90)9 type procedures with whatever disciplinary procedure for alleged misconduct the particular Trust had for the rest of its staff.<sup>6</sup> For alleged incapability *MHPS* established a new procedure.

### **HC(90)9 procedures**

The procedural characteristics of the HC(90)9 Annex B were full. The principal features were described as a "judicialised procedure" by Lord Steyn in the leading decision of the Judicial Committee of the House of Lords in *Skidmore v Dartford & Gravesham NHS Trust* [2003] ICR 721 HL. He found that:

12. ... In cases involving personal conduct Annex B provides that "the position of a doctor or dentist is no different from that of other health service staff". With regard to cases involving professional misconduct and professional incompetence, Annex B of the Circular provides in para 8 that the panel (consisting usually of three members) should have a legally qualified chairman. Moreover in such cases Annex B of the Circular provides, inter alia, in para 12 for the following further procedural rights:

"The practitioner should have the right to appear personally before the investigating panel and to be represented (either by a lawyer . . . or otherwise), and to hear all the evidence presented to the panel. He should have the right to cross-examine all witnesses and to produce his own witnesses, and they and he may also be subjected to cross-examination".

---

<sup>5</sup> The DoH published an earlier version of *MHPS* in 2003 as an annex to the Restriction of Practice and Exclusion from Work Directions 2003. This contained the first two parts of what became the 2005 document dealing with, in particular, exclusion. The essential features of the proposed disciplinary procedure in Part III of *MHPS* 2005 were presaged in the Department of Health publication, *Assuring Quality of Medical Practice: Implementing 'Supporting Doctors, Protecting Patients'* (January 2001).

<sup>6</sup> Since 1996, GPs (not being employees) who breach their service conditions have been dealt with by NHS disciplinary committees and the NHS Tribunal, pursuant to the National Health Service (Service Committees and Tribunal) Amendment Regulations 1996 (SI 703/1996). These procedures too have changed and are beyond the scope of this paper.

By contrast the internal procedure applicable to cases of personal conduct contains no such safeguards and is generally more informal.

Lord Steyn cited from the report which led to HC(90)9:

"The Working Party recognised the professions' concerns that disciplinary procedures for senior doctors and dentists must ensure that the grounds for dismissal have been fully justified, since a specialist who has been dismissed from an NHS post on professional grounds would be unlikely to find alternative employment elsewhere. The professions felt that the procedures used should be sufficiently weighty to reflect both the long periods of training and competitive selection processes which doctors have undergone before appointment to senior posts, and also the potential gravity of the outcome of such procedures".

HC(90)9, Annex B thus provided procedural steps protecting consultants faced with discipline by their employers over matters of *professional conduct* or *professional competence* which were notably more extensive than those which applied to allegations of *personal* misconduct (dealt with by the employer's ordinary disciplinary procedure applicable to other categories of staff).<sup>7</sup>

- 
- <sup>7</sup> In summary, the HC90(9) Annex B procedure required the following steps to be taken:
- (i) Following an incident or complaint being made involving the professional conduct or competence of a medical or dental practitioner, the Chairman of the NHS body must determine whether there is a *prima facie* case which, if well founded, could result in serious disciplinary action (such as dismissal).
  - (ii) The prior inquiries to establish whether or not a *prima facie* case exists is undertaken by the Director of Public Health.
  - (iii) The '*doctor should be warned in writing immediately of the nature of the incident which has been alleged, or of the complaint which has been made, and that the question of an inquiry, which might lead to serious disciplinary action, is under consideration*'. Copies of '*all relevant correspondence*' should be sent to the practitioner who is entitled to make comments in response.
  - (iv) The practitioner should be given '*reasonable time*' to make representations and to seek advice before any final decision is taken (by the Chairman) as to whether an Inquiry is necessary.
  - (v) If the Chairman decides that a *prima facie* case exists, the NHS body should proceed to an Inquiry.
  - (vi) '*No member of the [Inquiry] Panel should be associated with the [organisation(s)] in which [the practitioner] works.*' The Panel should be small, normally 3 persons and chaired by an independent legally qualified Chairman nominated by the Secretary of State from a panel appointed by the Lord Chancellor (in practice this is usually a QC). At least one member should be professionally qualified in competence cases all should be so qualified and at least one of the same specialty as the practitioner in the same grade. Before the professional members are chosen there should be consultation with the Joint Consultants Committee (usually interpreted as a veto exercised by the JCC).
  - (vii) Terms of reference of the panel should be drafted and given to the practitioner. The practitioner should be provided '*as soon as possible*' with copies of correspondence and witness statements.
  - (viii) The hearing is held in private (unless the parties agree otherwise). The practitioner has the right to be represented (including legal representation), to be present throughout and to cross-examine witnesses and produce his own. The rules of procedure are determined by the chairman who usually applies, so far as he or she can, the rules of procedure of the civil courts (including as to the standard of proof – often the subject of submissions).
  - (ix) At the conclusion of the Inquiry, the Panel is required to prepare a report consisting of two parts. The first part contains the Panel's findings. The second part should contain a conclusion as to whether the practitioner is at fault, and may also contain a recommendation as to disciplinary action.
  - (x) The Panel has no power to impose disciplinary sanctions of itself and the penalty is determined by the NHS body (usually the Chief Executive) in a further hearing at which legal representation is not permitted. The Chief Executive is not bound by the recommendation of the Panel but must not seek to take into account any aggravating factor and must take into account any mitigation from the practitioner (see *Barros D'Sa v University Hospital Coventry and Warwickshire NHS Trust* [2001] IRLR 691 CA; *Mattu v University Hospitals Coventry and Warwickshire NHS Trusts* [2006] EWHC Civ 1774).
  - (xi) The practitioner should be given a copy of the first part of the Panel Report and afforded time to respond with any corrections of fact and other observations. The practitioner should be furnished with a copy of

## The new disciplinary procedure

The new 2005 disciplinary procedure for the NHS in *Maintaining High Professional Standards in the Modern NHS* covers both matters of conduct – both professional and non-professional – and competence.

Features of the new procedure are:

- HC90(9) itself is abolished. HC 90(9) type procedures in Trust policies and contracts were to be removed and replaced by the same disciplinary procedures as for all other staff employed by the employer:

Misconduct matters for doctors and dentists, as for all other staff groups, are matters for local employers and must be resolved locally. All issues regarding the misconduct of doctors and dentists should be dealt with under the employers' procedures covering other staff charged with similar matters.

- The NCAS is to be involved in all serious cases, e.g. where exclusion is being considered.
- The 'Paragraph 190' right of appeal is abolished.
- The document contains new capability procedures, always involving NCAS and new suspension ("exclusion") procedures.

## The conduct procedure under MHPS

In the usual conduct case the investigation is to be carried out by a "case investigator" under the oversight of the Medical Director as "case manager". The case investigator "must obtain appropriate independent advice" (Part III, para.2) and must give the opportunity of interview to the doctor under investigation. At all stages the doctor may be accompanied but, if the companion is legally qualified, "he or she will not be acting in a legal capacity" (Part I, para.14; Part IV, para.22).<sup>8</sup>

---

the second part of the Inquiry Panel's Report in good time before any disciplinary hearing called by the NHS body.

- (xii) Time limits are set out for each stage and the total up to the disciplinary hearing 'should not exceed 32 weeks.' In reality, the time limits have been more honoured in the breach than in the observance.
- (xiii) There is no provision for appeal save by the Paragraph 190 route, though since NHS bodies have been adapting HC 90(9) to make it their own, they have often included an appeal machinery to members of their Board (this is in keeping with section 40 of the General Whitley Council Terms and Conditions of Service which provided such an internal appeal where Paragraph 190 did not apply).

<sup>8</sup> How it is possible for a lawyer representative to act otherwise than in a legal capacity is opaque. This provision and the extent of the Trust's discretion to allow legal representation in an appropriate case was discussed in *Kulkarni v Milton Keynes NHS Trust* [2008] EWHC 1861 (QB), where a challenge to the exclusion of legal representation failed, though the judgment is under appeal

The case manager will decide if there is a case of misconduct which should be put to a “conduct panel.”<sup>9</sup> The document is silent as to the composition of, the procedure before, and any appeal from a “conduct panel”, save for the provision that the conduct panel must include a medically qualified member (not currently employed by the NHS body) if the case involves professional conduct (Part III, para.2).<sup>10</sup> This contrasts with detailed provisions for capability cases which go to a “capability panel”, the composition of which, the procedure for which, and the appeal mechanism from which are all set out in Part IV.

There is no requirement for the membership of either Panel to be agreed by the clinician to the Panel - even under the capability procedure “it is for the employer to decide on the membership of the Panel” (Part IV, para.20).

There is no requirement that witnesses giving evidence against the clinician (even expert evidence) must attend the hearing to be cross examined - even under the capability procedure” witnesses... will not necessarily be required to attend...” (Part IV, para.17).

### **Removal of protection**

The striking differences between HC(90)9 and *MHPS* are immediately apparent:

- No independent Panel with a legally qualified Chair; instead a Panel presided over by the local HR Manager will hear the case;<sup>11</sup>
- No right to be legally represented;<sup>12</sup>
- No right to hear and cross-examine all witnesses providing evidence against the doctor;
- No procedure by which to apply to the independent Chair in advance for directions such as disclosure of witness statements or documents.

---

<sup>9</sup> I, para.17.

<sup>10</sup> There is no requirement of agreement by, or even consultation with, the accused doctor in the selection of this panel member, no requirement that he or she is of the same specialty, and no requirement of non-association with the NHS employer (nor any requirement that he or she be on an approved list maintained by, for example, the appropriate Royal College).

<sup>11</sup> As the press release of 17<sup>th</sup> February 2006, puts it: “The employing Trust is squarely responsible for the disciplining of its medical and dental staff not outsiders.”

<sup>12</sup> See footnote 8 above.

There can be no doubt that, in relation both to allegations of professional misconduct, and lack of competence, *MHPS* constitutes a fundamental degradation of the procedural protections which senior medical staff formerly enjoyed for over fifty years.

One curiosity is why the medical profession acceded to this. *MHPS* is an agreed settlement, not an imposed diktat. Nye Bevan claimed to have stuffed consultants' mouths with gold to buy their acceptance of the NHS. Surely no-one is so cynical as to think that they were bought off again by the salary increases in the near contemporaneous New Consultant Contract? Were it so, it was a cheap price for the surrender of legal protections guaranteed by the European Convention on Human Rights and Fundamental Freedoms in relation to equivalent allegations brought by the GMC or by a patient with a damages claim. Perhaps the lack of opposition to the removal of their rights has a less sinister explanation – maybe no-one appreciated the significance of what they were about to lose.

The absence of these protections against unfair disciplinary proceedings brings vividly to mind words written nearly 160 years ago describing the effect of modern changes to employment relations. The authors wrote that:

[capitalism] stripped of its halo every occupation hitherto honoured and looked up to with reverent awe. It has converted the physician, ...the man of science, into its paid wage-labourers.<sup>13</sup>

Certainly, the protection of the professional reputation and career of the senior medical practitioner is now no greater than that of any other NHS employee. Whilst it can be argued that a labourer deserves no less protection against unfair discipline than a hospital consultant, the Working Party which drafted HC 90(9) was right to emphasise that dismissal from the NHS for a senior medical practitioner on grounds of professional misconduct or incompetence almost inevitably means the end of his or her career and vocation. In contrast dismissal of an unskilled worker may be a bitter blow but does not generally mean that he or she is blacklisted nationally (and usually internationally) by every employer in the trade. Furthermore, (notwithstanding the Government's controversial impositions of fees on students) the cost to the public of

---

<sup>13</sup> K. Marx and F. Engels, *Manifesto of the Communist Party*, 1<sup>st</sup> ed., 1848. For a modern and brilliant analysis of the historical development of the employment relationship see S. Deakin and F. Wilkinson, *The Law of the Labour Market*, OUP, 2005, esp. chap.2.

training the consultant runs into hundreds of thousands of pounds, the benefits to the public of which are wholly lost if the consultant is dismissed and rendered unemployable as a doctor.

The removal of protections against disciplining of hospital consultants in relation to professional matters is an assertion by the NHS towards their senior medical staff of the subservience inherent in the employment relationship in fact and in law.<sup>14</sup> It is ironic that this development should have coincided temporally with the courts development of a doctrine of fundamental mutuality in the employment relationship both in relation to the essential qualities necessary to create a contract of employment<sup>15</sup> and in the form of implied reciprocal duties to maintain trust and confidence.<sup>16</sup>

No-one doubts that there are there incompetent doctors, and some who behave so badly that they should be dismissed from employment. The imperative to protect the public is recognised by all. Patient safety must have a higher priority than justice for doctors. But the two are not incompatible. And dismissal of falsely accused competent doctors does nothing to protect patients.

It is a principle of disciplinary practice that the aim should not be to punish but to improve. The ACAS Code of Practice on Disciplinary and Grievance Procedures states:

---

<sup>14</sup> As the founder of academic employment law, Professor Sir Otto Kahn-Freund wrote: “the main object of labour law has always been, and I venture to say will always be, to be a countervailing force to counteract the inequality of bargaining power which is inherent and must be inherent in the employment relationship.” (*Labour and the Law*, 2<sup>nd</sup> edn., 1977, Chap. 1 at p.6 and see K. Klare, “Countervailing Workers’ Power as a Regulatory Strategy”, and R. Welch, “Into the Twenty First Century – the continuing Indispensability of Collective Bargaining as a Regulator of the Employment Relation”, both in H. Collins, P. Davies, R. Rideout, *Legal Regulation of the Employment Relation*, 2000.

<sup>15</sup> *Dacas v Brook Street Bureau* [2004] IRLR 358 CA, para.49; *Cable & Wireless v Muscat* [2006] EWCA Civ 220 CA, para.35, both relying on *Carmichael v National Power* [2000] IRLR 43 HL, para.20 (Lord Irvine) and para.36 (Lord Hoffman) and *Montgomery v Johnson Underwood Ltd* [2001] IRLR 269 CA, paras. 21, 23, 46, and 47.

<sup>16</sup> In *Malik v Bank of Credit and Commerce International SA* [1997] IRLR 462 Lord Steyn formulated the term as follows [at paragraph 54]: The employer shall not, without reasonable and proper cause, conduct itself in a manner calculated or likely to destroy or seriously damage the relationship of confidence and trust between employer and employee’. In *Johnson v Unisys Ltd* [2001] IRLR 279 HL (Tab 28), Lord Hoffman observed that the implied term, as formulated above, ‘is concerned with preserving the continuing relationship which should subsist between employer and employee.’ See also: *R (Arthurworrey) v Haringey LBC* [2002] ICR 279; *Gogay v Hertfordshire CC* [2000] IRLR 703 CA; *Home Office v Evans and Laidlaw* UKEAT /0285/06/DM, LTL 22/1/2006. Lightman J in *Kramer v South Bedfordshire Community NHS Trust* [1995] ICR 1066, 1071 held that reasonableness was an implied contractual term in the categorisation of disciplinary charge.

Disciplinary procedures should not be seen primarily as a means of imposing sanctions but rather as a way of encouraging improvement amongst employees whose conduct or performance is unsatisfactory.<sup>17</sup>

The NHS itself has stated that “People with skills are expensive to replace. It makes sense to try to rebuild a career rather than scrapping probably still useful experience, skills and knowledge.”<sup>18</sup>

The fact is that NHS disciplinary procedures are sometimes abused by those with ulterior motives. The ability of management (in particular) to do so is now markedly enhanced. Furthermore, Sir Liam Donaldson, Chief Medical Officer, found in *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*:<sup>19</sup>

that there was something of a climate of fear and retribution, so that any lapse in performance or simple human error was seen as punishable by suspension, disciplinary action and referral to the General Medical Council. This remains the case today.<sup>20</sup>

“Today” was the summer of 2006, one year after the 2005 procedures were to be implemented. Sir Liam pointed out that:

A culture of blame and retribution has dominated the approach to this whole field so that it has been difficult to draw a distinction between genuine misconduct, individual failure, human error provoked by weak systems, and untoward outcomes which were not the result of any specific failure. An ‘off with their heads’ approach to every problem will ultimately make healthcare and medical practice more dangerous, since no one will admit their own mistakes, nor will they want to condemn a colleague’s career to ruin.<sup>21</sup>

It follows that whatever modern techniques are used to avoid the “blame culture” and to improve performance, senior medical staff who have committed so much of their own lives to their careers and who represent such a high investment by the nation in those careers continue to warrant proper protection against the abuse of discipline.

The justifications for the particular protections intended by the working party which drew up HC 90(9) (cited by Lord Steyn, above) thus remain valid today.

---

<sup>17</sup> Published under statutory powers, September 2004. The first “core principle of reasonable behaviour” set out in the ACAS Handbook states: “Use procedures primarily to help and encourage employees to improve rather than just as a way of imposing a punishment.”

<sup>18</sup> [www.ncas.nhs.uk/toolkit/rebuilding](http://www.ncas.nhs.uk/toolkit/rebuilding).

<sup>19</sup> 14<sup>th</sup> July 2006, partly revised 31<sup>st</sup> August 2006.

<sup>20</sup> Introduction at para.9.

<sup>21</sup> Summary at para.28.

## Justification for change

Various reasons have been put forward as the rationale for the changes in disciplinary procedure for senior medical staff.

*MHPS* itself offers no explicit explanation. It simply states that “changes to NHS disciplinary procedures are necessary.”<sup>22</sup>

The Minister, John Hutton, in the press release accompanying *MHPS* claimed that:<sup>23</sup>

We must do all we can to avoid doctors and dentists being suspended for long periods on full pay. The existing procedures are unjustifiably prolonged and are not fair to NHS staff, taxpayers or patients. The new process ensures resources are not diverted away from patient care into the pockets of lawyers.

True, a common complaint had been the length of suspension/exclusion prior to HC(90)9 hearing. Such delays were, without doubt, often excessive.<sup>24</sup> This unfairness is advanced implicitly as a rationale for *MHPS* – see p.1 of *MHPS*.<sup>25</sup> But apart from prolonged exclusion, there is, as far as I am aware, no evidence that the HC 90(9) procedure was unfair to NHS staff.

Exclusion was not inherent in the HC 90(9) process (which in fact says nothing about exclusion). Neither was extensive delay inherent (save for that inevitable in the convening of an independent Panel of three plus lawyers and witnesses for both sides, the prior exchange of statements and documents and the subsequent writing of the Panel report). The potent cause of delay was the fact that exclusion of the doctor removed the imperative on management to proceed with any haste.

The pre-existing exclusion procedure, HSG (94)49, was revised by *MHPS* Part II, though the actual changes by the latter provide little greater protection than the

---

<sup>22</sup> A result, it claims (para.1, explanatory note), of the introduction of *Shifting the Balance of Power*, the Employment Act 2002 and the Follett report (*A Review of Appraisal, Disciplinary and Reporting arrangements for Senior NHS and University Staff with Academic and Clinical Duties*). I could find nothing in those documents which purported to suggest any reason for the abolition of HC 90(9) type protections for senior medical staff.

<sup>23</sup> DoH, 17<sup>th</sup> February 2005, ref 2005/0062.

<sup>24</sup> Measured in years. In the case of Dr. Pauline Bousquet well over a decade. But delay in doctors' cases was not confined to HC(90)9 cases: 9 years for an unfair dismissal claim in *Darnell v UK* (1993) 18 EHRR 205, ECtHR.

<sup>25</sup> Exclusion is the subject of Part II of *MHPS* and is a central focus of Part I. These parts were published in 2003, which no doubt reassured many members of the profession as to what was to come.

former.<sup>26</sup> Whether in reality *MHPS* will improve decisions on exclusion remains in doubt.

One objective will be achieved: long exclusions pending a hearing will become a rarity with the advent of a procedure that fundamentally downgrades protection against dismissal itself. Doctors are simply being sacked. Whether senior doctors would regard that as a price worth paying to avoid lengthy suspension pending a fairer hearing is dubious.

Mr. Hutton is obviously correct in pointing out that the exclusion of lawyers saves money. But distasteful as it may be to non-lawyers, representation by a skilled and legally qualified advocate remains a central pillar of every system of justice. The denial of the right to such representation to doctors whose vocation and career is in jeopardy requires persuasive justification. Little is evident.

Furthermore, what is lost with the demise of HC 90(9), is the independence and impartiality of the process - independence which is essential to prevent senior medical staff being dismissed on trumped up charges generated by personal malice or professional jealousy, or intended to neutralise an outspoken defender of patient services from the economic imperatives of management. I regret to say that some of the cases which come across my desk in Chambers appear to be darkened by the malevolent shadows cast by such (almost inevitably unprovable) factors.

The real reason for the deprivation of the special employment protections of hospital consultants is not obvious. It might well be thought that the current turmoil and debate in the NHS about its future was a factor tending towards measures that might assist in the neutering of opposition from within.<sup>27</sup> Some may consider it to be part of a longer term measure in the NHS whereby administration has been progressively removed

---

<sup>26</sup> It is said that these developments have diminished the number of doctors on long term suspension and it may be so. But the suspension procedural requirements are still breached: e.g. *Mezey v SW London & St George's Mental Health NHS Trust* [2007] IRLR 237, QB, CA. It is often thought that wrongful suspension is not challengeable but, though difficult, it is possible: see *Mezey*; *Gogay v Hertfordshire CC* [2000] IRLR 703 CA (damages granted for stress brought on by unjustified suspension); and *Malik v Waltham Forest PCT and S of S for Health* [2006] EWHC 487 (Admin).

<sup>27</sup> It is to be noted that the device of discretionary Clinical Excellence Awards – which are very valuable, measured in tens of thousands of pounds a year – appears sometimes to be the carrot against which the stick of disciplinary charges is juxtaposed to obtain the acquiescence of consultants.

from clinicians and placed in the hands of managers in a fast growing culture which gives primacy not so much to patient care but to the economic performance of the organisation. Perhaps there are other imperatives.

Whether these explanations have any credibility or not, the cases speak for themselves. In case after case heard by the High Court, NHS employers were enjoined from evading the procedural requirements of HC 90(9). Now the power of discipline has been transferred from an independent panel chaired judicially to internal management, and, in the absence of legal representation for the doctor, it may be assumed that evasions of due process will diminish (in proportion to the ease of dismissing the 'difficult' doctor).

By the same token, because of the formal nature of HC 90(9) type procedures, it was possible to obtain effective enforcement of the procedure in the courts.<sup>28</sup> By contrast the great discretion vested in managers in consequence of *MHPS* means that there now is little scope for recourse to the courts for doctors undergoing discipline.<sup>29</sup>

### **Unfair dismissal**

It is, of course true that a dismissed consultant, like other employees, has a right to make a claim to an employment tribunal for unfair dismissal under the Employment Rights Act 1996. However, the maximum compensation is limited to £63,000 for dismissals after the 1<sup>st</sup> February 2008 and the latest statistics show that the median award actually awarded by tribunals was a mere £3,000 (average award: £7,974).<sup>30</sup> Though reinstatement/re-engagement is ostensibly the primary statutory remedy, in fact it was ordered in only 0.3 percent (23 out of 8,415) cases which went to a hearing, 0.06% of cases disposed of by the tribunals.<sup>31</sup> And reinstatement/re-engagement orders are not binding: an employer prepared to pay additional compensation may disregard any such order made. In consequence, the remedy of unfair dismissal is of little value to consultants. If he or she can show race, sex,

---

<sup>28</sup> E.g. *Barber v Manchester Regional Hospital Board* [1958] 1 WLR 181; *Barros D'Sa v University Hospital Coventry and Warwickshire NHS Trust* [2001] IRLR 691 CA; *Mattu v University Hospitals Coventry and Warwickshire NHS Trust* [2006] EWHC 1774 (QB); *Gryf-Lowczowski v Hinchbrook Healthcare NHS Trust* [2006] IRLR 100; *Kircher v Hillingdon PCT* [2006] Lloyds Rep Med 215; *Palmer v East & North Hertfordshire NHS Trust* [2006] EWHC 1997; *Mezey v S.W.London & St. George's etc Trust* [2007] IRLR 237 (QB).

<sup>29</sup> E.g. *Kulkarni v Milton Keynes NHS Trust* [2008] EWHC 1861 (QB)

<sup>30</sup> Employment Tribunal Service, *Annual Statistics 2006-2007*, 2008.

<sup>31</sup> Ditto.

religious, whistle-blowing or, now, age discrimination, awards can be significantly higher. But proving an illegitimate reason for dismissal is much harder than proving, in front of an independent specialist panel, that allegations of professional misconduct or incompetence are not justified.

## **Conclusion**

With the replacement of HC 90(9) procedures by “ordinary” disciplinary procedures applicable to all Trust employees, senior medical staff have lost valuable protections in relations to allegations of professional misconduct and capability.

In my view, the profession should consider carefully whether the restoration of some more formal procedure in relation to allegations of professional misconduct or incompetence is not a necessary step towards the maintenance of the proper status of doctors in the NHS.

The fundamental requirements in relation to charges of professional misconduct or lack of capability are:

- (i) that the chair of conduct and capability panels is an independent lawyer experienced in the field drawn from a list maintained by the Ministry of Justice (preferably from an agreed list between the BMA and the MoJ), and
- (ii) that the senior medical practitioner should be entitled to be legally represented.

The structure can then be elaborated from those two fundamentals. Of course, there would need to be elementary procedural rules dealing with the obvious matters: clarity of allegation, disclosure of documents, witness statements, directions, procedure at the hearing, binding nature of the decision.

It might be thought that this is just the special pleading of a lawyer. If so, disregard the motivation and consider only whether, if you were faced with an allegation of professional misconduct or incompetence which could end your career, you would be happy knowing that you would *not* be permitted to have the services of an experienced advocate to defend you.

JH

24<sup>th</sup> October 2008