Hospital disciplinary procedures

This article welcomes the end of suspensions for hospital doctors under the old disciplinary procedures and examines the new disciplinary framework.

Between April 2001 and July 2002, over 200 doctors were suspended by NHS hospital and ambulance trusts in England at an average cost of £188 000 per doctor. Reasons for exclusions included concerns over a doctor's clinical performance, his/her professional relations with patients or his/her personal conduct (National Audit Office (NAO), 2003). These exclusions took place under the old disciplinary procedures which were criticized as 'unfair, expensive and time-consuming' and have now been replaced by a new disciplinary framework.

As will be illustrated in this editorial, this change is long overdue and welcome. However, the final sections of the framework have only just been published and it is as yet unclear what impact the changes will have.

FAILURES OF THE OLD DISCIPLINARY PROCEDURE

Failings in the previous disciplinary procedures were highlighted in a NAO report, 'The Management of Suspensions of Clinical Staff in NHS Hospital and Ambulance Trusts in England', which was published in November 2003. The report was critical of the way suspensions were being managed by trusts, commenting; 'basic management principles are not being followed in a number of cases'.

Of the 46 cases surveyed by the NAO in June 2003 (NAO, 2003), only 18 trusts highlighted the role of the National Clinical Assessment Service (NCAS) in their disciplinary procedures, despite evidence that it could help managers find alternative measures to suspension.

In the Medical Defence Union's (MDU) experience, a number of members were being subjected to prolonged investigations, many of which found no cause for concern and eventually reinstated the doctor. With limited experience of carrying out disciplinary procedures, trusts often applied the old voluntary guidelines on suspensions differently, leading to significant inconsistencies. Even where there were no issues of patient safety, suspension was often one of the first steps taken and, in some cases, doctors were not even given the reasons for the suspension.

As well as costing the NHS vast sums of money – £40 million annually, according to the NAO – suspensions brought additional repercussions for the doctor, which included stigma, media intrusion and loss of clinical skills.

Stigma

Suspension was supposed to be a neutral act, but was rarely perceived as such by the doctor, the public or other employers. This could damage a doctor's reputation, for example, by raising undue concerns among his patients at a time when the allegations against him were not proven. In many cases suspended doctors were later reinstated with no further disciplinary action taken against them.

Media intrusion

The distress felt by the doctor was often compounded by the fact that information about the suspension found its way into the media. Doctors were prevented from even discussing the case against them because of their duty of confidentiality and were unable to respond to 'trial by media'.

Loss of clinical skills

Doctors who were suspended for longer than a few months began to lose their clinical skills while they waited for their case to be heard.

THE NEW DISCIPLINARY FRAMEWORK

In December 2003, the NHS announced a new disciplinary framework for hospital doctors (and dentists) working in the NHS called *Maintaining High Professional Standards in the Modern NHS* (Department of Health (DH), 2003). The framework was divided into five sections, although initially only the first two – 'Part I: Handling initial concerns' and 'Part II: Restriction of practice and exclusion from work'– were published and implemented.

NHS trusts and primary care trusts were required by the 'Restriction of practice and exclusion from work directions' (DH, 2003) to notify their strategic health authorities (SHAs) of the action they took to comply with the first two sections of the framework by 1 April 2004. The SHAs were then required to report on their implementation to the Secretary of State by 30 September 2004.

The remaining three parts of the framework were agreed and published in February 2005. These will come into force on 1 June 2005. They consist of: 'Part III: Conduct hearings and disciplinary matters', 'Part IV: Procedures for dealing with issues of capability', and 'Part V: Handling concerns about a practitioner's health'.

The new procedures were agreed by the Department of Health, the British Medical Association and the British Dental Association. The MDU has contributed to the process by providing a medico-legal perspective. It is

too early to tell how the new disciplinary framework will operate in practice but some of the key changes are as follows.

An end to suspensions

Above all, the new procedures are designed to end lengthy suspensions, formal or informal. Informal suspensions were often referred to as 'gardening leave'. Instead, if, after careful investigation, there are reasonable concerns about a clinician, the framework sets out a variety of options that the employer must actively consider, seeking advice from the NCAS. These include supervision of duties by the medical or clinical director, restriction of practice so that clinicians can still work in areas that are not under investigation.

Exclusion, as suspension is now called, should be reserved 'for only the most exceptional circumstances' (DH, 2005). It is meant to be used only as a temporary expedient, a precautionary measure and not as a disciplinary sanction. Whether it will be perceived this way remains to be seen.

The involvement of the NCAS

The MDU welcomes the fact that managers are now encouraged to seek advice and assistance from the NCAS in the first instance, so that it can help them to investigate the problem and suggest alternative means of resolving it.

The organization has been able to build up expertise in dealing with such matters and can offer assistance to individual managers who may have little experience.

Capability hearings

The final framework distinguishes between allegations that relate to a doctor's capability (professional competence) and conduct (personal behaviour). The procedure acknowledges the need for medical experts to opine on matters of clinical expertise and judgment. This is an important distinction because cases involving allegations about a doctor's professional competence can become highly technical and complex, and many of the issues to be considered may not be readily understood by non-clinicians.

To ensure that the rights of the doctor under investigation are protected, such cases inevitably need the involvement of clinical experts. The consequences for doctors who lose their NHS post as a result of a disciplinary investigation into their capability are severe. It is unlikely that such a doctor would find a position elsewhere in the NHS or the independent sector.

It is vital, therefore, that there are safeguards built into the disciplinary procedure to ensure that doctors have a fair hearing, and that any decisions about competence are properly and fully informed. The framework states that wherever possible, employers should aim to resolve issues of capability through ongoing assessment and support.

Concerns about a doctor's capability must be referred to the NCAS before they can be considered by a capability panel. Chaired by an executive director of the trust, and including at least one medical practitioner not employed by the trust, capability panels will hear cases where the trust believes it has grounds to pursue the matter or where the doctor has refused to cooperate with referral to the NCAS.

Panels must call on the advice of an independent medical expert. Witnesses will not be compelled to attend a hearing to give evidence and to be cross-examined, but if they do not their written evidence will be given less weight. Doctors will not be allowed legal representation during the hearing, although they are allowed a representative who can be a medico-legal adviser or lawyer as long as the lawyer does not act 'in a formal legal capacity' (DH, 2005).

The MDU has some concerns about these aspects of the procedure because, as stated earlier in this article, the consequences for doctors who lose their jobs can be so severe. It is the MDU's view that when doctors' careers are at stake, they should have legal protections such as the presence of a lawyer who is able to cross-examine witnesses and to test their evidence. However, the new procedure does not contain these safeguards.

The capability panel will have the power to make a range of decisions. This includes:

- An oral agreement that there must be an improvement in clinical performance within a specified timescale, including a written statement of what is required and how it might be achieved (stays on the employee's record for 6 months)
- A written warning that there must be an improvement in clinical performance within a specified timescale, including a written statement of what is required (stays on the record for 1 year)
- Final written warning that there must be an improvement in clinical performance within a specified timescale, including a written statement of what is required (stays on the record for 1 year)
- Termination of contract.

The framework makes it clear that there should be a 'robust appeal procedure' and sets out the procedure to be followed. The appeals panel, which must not have had previous direct involvement with the case, can hear new evidence and call on others to provide specialist advice. The MDU's concerns that the doctor may not be assisted by a lawyer acting in a legal capacity apply equally here.

If the doctor leaves the trust before disciplinary proceedings have been completed, the framework states that the investigation should be completed where possible and every effort must be made to ensure the employee remains involved in the process.

Conduct hearings

All NHS employers need to have their own code of conduct which sets out details of acts that could lead to summary dismissal. The framework states that:

> **'each case must be investigated, but as a general rule no employee should be dismissed for a first offence, unless it is one of gross misconduct.' (DH, 2005)**

It is for the employer to decide the most appropriate way forward, having consulted the NCAS and their own employment law specialist.

Where a doctor is accused of a criminal act, the document makes clear that there should not be concurrent investigations into the same evidence. However, where the criminal offence would, if proven, mean that the doctor posed a risk to patients, it suggests that:

> **'... the employer would have to give serious consideration to whether the employee can continue in their job once criminal charges have been made'**

or whether they should be moved to other duties or excluded (DH, 2005).

Confidentiality

The MDU welcomes the direction that NHS employers must maintain confidentiality at all times and that there should be no press notice issued when a doctor is subject to disciplinary procedures.

Many of members of the MDU who have been disciplined by hospital and trust employers have found that some details of the case have found their way into the media, locally and nationally. This invariably causes the practitioner and their families considerable distress during what is already a time of great stress. Disciplinary proceedings are a private matter between an employer and employee and should remain private and the MDU are pleased that the framework acknowledges this.

Clear role for occupational health services

The MDU were pleased to note that the new disciplinary procedures recognize the role of the occupational health services to help doctors in cases where their impairment of performance is solely because of ill health.

Part V of the procedure makes clear that the trust should attempt to continue to employ the doctor provided this does not place patients or colleagues at risk.

CONCLUSION

The first two parts of the framework are already seeing some positive results with more referrals to the NCAS and an apparent reduction in suspensions. It remains to be seen how the new disciplinary procedures will operate in practice, but we hope that they will be fairer and more consistent than the previous system. As always members who have any concerns about disciplinary investigations are advised to contact the MDU. HM

Dr Hugh Stewart

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Department of Health (2003) *Maintaining High Professional Standards in the Modern NHS: A Framework for the Initial Handling of Concerns About Doctors and Dentists in the NHS*. HSC, 2003/012. DH, London

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KEY POINTS

- A new disciplinary framework has been published for hospital doctors working in the NHS
- The new procedures are designed to end lengthy suspensions
- Concerns about a doctor's capability must be referred to the NCAS before consideration by a capability panel
- All NHS employers should have their own code of conduct
- NHS employers must maintain confidentiality at all times

Editorials

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