

## COMMENTARY

# The suspensions scandal\*

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### Summary

The process by which senior hospital doctors are disciplined within the National Health Service is analysed. The mechanisms used are discussed and a number of faults are identified. Many of these faults give an unfair advantage to management and are contrary to the rules of 'Natural Justice'. These faults lead to an excessive number of doctors being wrongfully suspended for an unnecessarily long period. The process is oppressive to doctors as well as being contrary to the Human Rights Act. A number of risk factors are identified; race, sex, speciality and obstetricians appear to be particularly vulnerable. The process causes significant morbidity as well as having a 2% mortality. The process is also remarkably inefficient with management, despite all the inbuilt advantages, unable to prove that the suspended doctor is at fault in the majority of cases. It is also very wasteful of the NHS's financial resources.

Imagine an industry has a process which is not used very much but, when used, makes about half of the workers involved in that process quite ill, some very seriously, and causes a 2% mortality. Imagine further that the management know all about it, have known for years and do nothing about it. Imagine further that the government know all about it, have known about it for years and does nothing very effective about it. You would imagine there would be a public health outcry! You would expect the worker's Trade Union leaders would be knocking on the door of 10 Downing Street demanding protection for their members, but no, this industry is the National Health Service the workers involved are us, the doctors, and the very special process is the suspension process. What is even more surprising is that the employers claim that theirs is the best and more caring industry in the world! They claim that suspension is a neutral act. It is not. It is a deeply hostile act which damages the doctor, his reputation and standing among his colleagues, his friends, his family and his place in society. It can induce life-threatening disease such as myocardial infarction. The philosophy seems to be 'keep saying it often enough and the public will believe it'.

The Secretary of State for Health knows it is untrue. He admitted it in the House of Commons (Milburn, 1995). He quoted a regional medical officer who also said so in an article written in the *British Medical Journal* (Donaldson, 1994). He said those things when he was just a back-bench Member of Parliament sitting on the Public Accounts Committee looking into the waste of money that resulted from one prolonged suspension that lasted 11 years. Now he is the Secretary of State for Health, and that regional medical officer is now

the Chief Medical Officer. Yet there has been no public retraction of the untruth that suspension is a neutral process. To tacitly support a known untruth is unethical.

To give an example: a gynaecologist was off sick with a temporary illness and was recovering well. He received an call from a past patient of his who clearly required an emergency but relatively minor operation. The patient begged him to do it as she had great trust in him; so he did. A couple of day later he returned to full working for the NHS and was promptly suspended, accused of fraud for working in the private sector while claiming to be off sick. Explanations that one had an ethical duty to attend to one's own patients if possible and if the patient asks for it, and that he was recuperating and able to do minor surgery but not work a full day, made no impression on a hostile management. The gynaecologist took an overdose of a hepatotoxic agent, developed severe liver failure then acute pancreatitis, and died.

The question of problem doctors has not been quantified officially. The Department of Health keeps no reliable statistics. There was one set, kept by a regional medical officer. He recorded (Donaldson, 1994) an account of hospital doctors referred to him for possible suspension and dismissal. These figures for the North East of England extrapolated across the country mean that during the professional lifetime of the average hospital consultant one doctor in three is or will become a 'problem doctor', one whom managers consider as a possible case for dismissal. As the NHS is effectively a monopoly employer of hospital doctors, managers are suggesting that these doctors should be considered for hounding out of the country and driven into exile. The offences documented varied but were mainly trivial—for example, the doctor who insisted on taking some of his annual leave when the hospital was at its busiest. Presumably he liked to going ski-ing with his family. This case illustrates the total lack of perception and understanding of what constitutes a serious offence which justifies major disciplinary action. There is also a presumption that the doctor is a loyal slave of the employer and must follow the employer's whims irrespective of his own or his family's wishes, but there is no reciprocal loyalty. That regional medical officer is now the Chief Medical Officer for the whole country. There is no sign that he has changed his views of what constitutes a 'problem doctor'. This is a fundamental point. Managers seem to have no idea of what

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constitutes a serious offence which justifies draconian action. Many of them have been cocooned within the NHS and have no experience in the real world of managing large organisations employing a wide variety of people, or what constitutes normal industrial relations. There is supposed to be a system of staged warnings, oral warning, written warning, suspension and dismissal, agreed as a National Code for all employers. The code was drawn up by ACAS, the Arbitration, Conciliation and Advisory Service. When this was raised at a disciplinary tribunal the Queen's Counsel chairing the tribunal wrote in his report that the ACAS Code did not apply to doctors 'as they were educated'. There is apparently one law for the poorly educated and a different law for the well educated. There has been no public declaration as to what education level one passes from being protected to being discriminated against. Is it O level, A levels, first university degree or specialist diploma?

Some 15 years ago the Society of Clinical Psychiatrists became aware that there seemed to be a growing psychiatric problem over suspended doctors. A study group was set up to investigate the whole problem. The study group is now called 'Suspended Doctors Group'.

The first step was to define the problem and to determine what were the rules for suspension. The first proposal about suspending and disciplining a doctor was made 13 years after the National Health Service was established. Before this there apparently had been no problem. Following this the number of suspended doctors was about one to two a month. Clearly, there was no great medical problem. The rules are contained in the document HM 61/112 (NHS, 1961) These classify offences into one of three categories: professional incompetence, professional misconduct and personal misconduct. These categories are crucial and have not changed significantly. In 1990 (NHS, 1990) the system was amended in a health circular (HC 90/9) following much political lobbying by the Society of Clinical Psychiatrists. This circular introduced into the system the class of 'intermediate offences'. The system was changed further in 1994 (NHS, 1994). Of significance is the fact that the title changed. Instead of instructions to hospital managers they have become "Guide Lines". The Department of Health has lost control. Individual trusts can do what they like and in law the government cannot interfere unless it takes over the whole trust. Rogue trusts now abound where managers throw their weight around determined to keep doctors 'in their place'. Finally, the whole thing was consolidated in 1997 (CCSC/NHS Confederation, 1997). Because these are guidelines and the disciplinary tribunals are not established by law, but only are administrative suggestions, they contradict Article 6 of the Human Rights Act. The Act says that no one should be deprived of his/her civil rights (to practice as a doctor) without a hearing before an impartial tribunal established by law. Because the NHS is a monopoly employer of doctors, and has already been recognised as such by European Court of Human Rights in Strasburg, and because it maintains a network of communication between hospital trusts so preventing employment elsewhere, Article 6 applies.

The three categories, professional incompetence, professional or personal misconduct, are of vital importance as they determine how the doctor shall be judged. The allocation of category is made by the Trust that has

initiated the suspension. That is also written into the rules. Legally, it cannot normally be challenged. When one doctor did go to court seeking this on grounds of fairness the judge looked at the letter of the law, or rather at the instructions written into HC90/9, and said that trusts can call anything. This judgment was made notwithstanding the other ruling (CCSC/NHS Confederation, 1997) that where misconduct is alleged, the professional misconduct rules should be applied unless *all* the alleged offences were unrelated to professional matters. Nowadays trusts may call anything personal misconduct because that gives them better control, a factor striking at the heart of the Human Rights Article 6 requiring an independent impartial tribunal.

Rules are clearly meant to be broken and in over 300 suspensions the study group is aware of only two in which the hospital trust followed the rules. Two of 300 is poor compliance. It is not all doom and gloom, as some hospital trusts in their terms and conditions of service do have a mechanism of appeal against wrong classification and this has, on occasion, proved very useful. Anyone seeking new employment should negotiate on employment that there is such an appeal mechanism in the unlikely event of him or her being suspended.

*Professional incompetence* is judged by a panel of doctors, with a legally qualified chairman, usually a barrister who agreed to take such cases. The chairman is then selected from a panel maintained by the Lord Chancellor's Office. This seems eminently reasonable, until one learns that Trusts pick and chose whom they consider the most suitable—for their cause. There is no 'taxi-rank' turn of who is next on the list, as exists in the courts. Hospital Trusts can also comment adversely to the Lord Chancellor's Office if they are dissatisfied with the nominated chairman's performance, thus undermining the principle of judicial independence. Half the doctors chosen to sit on the panel are hand-picked by the hospital trust. The other half are nominees from the local consultants' committee. Unlike the trusts, neither the suspended doctor nor his union have any say, although they do have powers to object but only if they have demonstrable reason to anticipate bias. The panel are wined and dined by the trust who also pay them, while the suspended doctor has little chance to approach them informally. The analogy is drug-company-sponsored research: it could be all above board but... All this is in flagrant contradiction of Article 6, which requires an impartial tribunal.

The second category is *professional misconduct*. There is still the hand-picked chairman and half the panel and hand-picked local lay people, usually either local lawyers or retired personnel officers, in essence pro-establishment people. The other half are doctors also from the local consultants' committee.

The third category is *personal misconduct*, which is judged entirely by lay people nominated by the Chief Executive Officer, often from within his own staff. Because it is the chief executive officer who is nominally producing the charge and is responsible for it this exerts under pressure on a junior official should he or she make a judgment against the chief executive officer.

When suspended, the doctor is supposed to be told within a reasonable time why he is being suspended. One doctor had to go to court a year after being suspended to find out why, only for the court to be told that they were

still looking for a reason and had several hundred more dossiers to examine. Note the change in language; case files became dossiers.

The outline of the case is supposed to be presented to the doctor who is asked for his comments. That is, the doctor is usually not asked to give his side of the argument or case until after he has been suspended. This, of course, opens the whole situation to knee-jerk suspensions. The chief executive then decides whether there is a *prima facie* case requiring a formal disciplinary hearing. The Medical Director may only at this stage start seeking reasons.

Although there are laid-down time limits for the various stages, Trusts ignore the rules. Only two in 300+ have observed the rules, the most common breach being that of time. The reason is usually that the doctor is able to make an effective reply to the allegations and then the trust must go digging, trawling, desperately trying to find something, anything to justify the suspension lest they should be sued. One surgeon did successfully sue and was awarded a very large sum. There was an appeal and he won again in the appeal court (Law Reports, 1985).

For defence there are the defence bodies such as the Medical Defence Union and the Medical Protection Society, as well as the Medical and Dental Defence Union of Scotland (MDDUS). Unlike an insurance company, none will guarantee to defend you, so despite their very high fees you may be left high and dry. One doctor had to pay £10 000 in legal costs from his own pocket to successfully defend his suspension because the MDU was not minded to defend him. The BMA will normally try to negotiate a settlement rather than fight and they do face an internal conflict of interest if the opposition are also BMA members (approximately one-third of all suspensions arise from allegations by other doctors). The Hospital Consultants and Specialists Association (HCSA) provide a straight insurance service but you have to find the legal team, brief the lawyers and find your own expert witnesses. You do, however, have much greater control over the dispute and possible mechanisms of resolution. Many household domestic insurance policies provide cover for employment disputes but they vary considerably and may have capped sums; but they do enable a decent second legal opinion.

The Society of Clinical Psychiatrists has published two reports, the last 3 years ago, identifying some of the problems (Tomlin and Jacobs, 1989, 1999). Over the last 15 years we have records of 325 suspensions. The records vary in quality and there may be a settlement accompanied by a gagging clause so we do not get to hear the final outcome. If the doctor returns to his native country or otherwise emigrates, contact is lost and so again the final outcome is unknown. Twelve of the 325 suspensions belong to this category. According to the Suspended Doctors Group figures, there are about 80 cases still outstanding. In the past the figures have been compared with those of the defence bodies. The most recent figures are that the Medical Protection Society thinks it has about 30 suspended doctors currently on its books while the Medical Defence Union claim 40–60, but it is a shifting field. It seems the Group still has records of about 90% overall.

Suspensions are supposed to be a matter of last resort when all other means of resolving the problem have been

exhausted. That is the instruction and this rule is broken repeatedly. Before the Bristol debacle the study group had referred about one suspension a month and sometimes less. After Bristol it became one a week or more. There is a mixture of a knee-jerk reaction and plain ignorance. One consequence of Bristol was the GMC's action against the medical administrator. Since then all medical directors are concerned that if they do not do something the moment there is a complaint they are at risk of being struck off the medical register themselves. Similarly, Chief Executive officers are concerned that they might be pilloried in the press if they do not take action following a complaint. Both may be pitifully ignorant of the relevant medical facts, although administrators seem to think that possession of a medical degree and perhaps a higher diploma in a speciality makes a doctor an expert in all branches of medicine. Intellectual arrogance by some medical directors also contributes. It is extraordinarily easy for someone in a particular speciality to make comments about a colleague for the colleague to be suspended, because the medical director does not have the knowledge to understand either the significance of the complaint or its statistical background. One example is that of a colleague who had a high incidence of postoperative complications following gynaecological surgery. The administrators did not know the normal rate for postoperative complications, or what adjustments should be made for case-mix, but he had had a run of such complications which contrasted sharply with his subnormal complication rate over the previous 6 years. He was suspended, and then investigated. It emerged that none of those investigating him were fluent in statistical variation or understanding that occasionally runs of unusual events can occur by chance. The General Medical Council were consulted and they recommended additional training, which the suspending health authority blocked or attempted to block for a number of years, panicking the personnel department of the prospective trainers over projected risk or other distortions, and effectively deskilled the gynaecologist. In another case a senior professor of neurosurgery complained about a more junior consultant, but when the mortality figures were analysed the professor had a higher mortality rate than the suspended neurosurgeon. Now it is open season for anyone with a grudge to make a malicious complaint causing the doctor to be suspended.

There is one key factor that runs through the entire medical disciplinary system, both NHS and GMC. This is the lack of quality statistical data on average outcomes following various treatments for different diseases, allowing for case-mix, as well as some understanding of how to interpret such data. All we usually get is some pompous pontification from a so-called expert who is relying on a rose-tinted clinical impression of his own work. There is a need for the Royal College of Obstetrics and Gynaecology to set up objective standards at least of the more common or more serious problems, after due allowance for case-mix, that could stand up to scientific scrutiny. What is the mortality following the various types of hysterectomy? What is the rate of unintentional cutting of the ureter during abdominal hysterectomy (and what steps therefore could be taken to minimise further this risks). What is

the rate of wound dehiscence? Such an approach could be a lead to all other Royal Colleges.

This numerical ignorance is widespread. One very eminent QC presiding over a disciplinary hearing said, in effect, that there was no place in the NHS for doctors whose performance was below average. It took a long time to persuade her that this meant, by definition, dismissing half of all the doctors. There was no apparent understanding of what is a normal distribution. Such an approach seems to be permeating the General Medical Council through its use of lay members in its disciplinary hearings.

There was a recent development involving calling in a 'flying squad', the rapid response team, from the Royal Colleges. This has proved to be a disaster. The team fly in. They are presented with a mass of carefully selected data and then carefully selected witnesses by the hospital trust. Statements are made to the team in secret, and there is no cross-examination to establish their veracity. Witness statements which are in the doctor's favour are suppressed. The accused doctor does not know what is being said about him or by whom. He has no chance to examine the evidence and give his side of the various cases. One example involved an orthopaedic surgeon accused of poor hip surgery. One hundred casenotes were given to the rapid response team. These were notes of patients who had complained of pain in the hip at the postoperative follow-up; often it was pain in the other hip. The team skimmed through the notes and said that the surgeon needed further training and that some of the surgery was poor. It was only after the team had left that the accused surgeon was able to examine the casenotes and found that a very substantial number had been operated upon by her locum while she was off on maternity leave. When those were subtracted her post-operative problems rate was exactly the same as her colleagues; but the trust and the Royal College still refuse to acknowledge this. The absence of comparators is also very common in such cases. That is scandalous. It would not be tolerated in any scientific body asked to assess evidence, nor in any reputable journal.

Another recent development is the NCAA, the National Clinical Assessment Authority. This assesses the suspended doctor and includes psychometric analysis, which can last 6 hours, to judge whether the person is in the right speciality or has personality problems. Unfortunately, there is no independent study which establishes the scientific accuracy or clinical value of such a refined analysis. More important is the attitude that it is problem doctors who are referred to the NCAA. This means that any assessment is based on bias, that it is the doctor who is the problem, not anyone else. This generates among suspended doctors a deep disbelief that they will be treated fairly, as they have already been labeled as a problem doctor. The worst problem is that the NCAA has no teeth. It cannot make a trust reinstate a suspended doctor. For example, a gynaecologist was suspended and said to be in need of further training in ultrasound scanning. He obtained that training. He reported himself to the General Medical Council who found no problem. He reported himself to the Royal College, again they found no fault. He reported himself to the NCAA and they found no problem and told the trust to reinstate him. The Trust refused. He has since negotiated a significant financial

settlement, otherwise the trust would have had to face an embarrassing constructive dismissal case heard in public.

Following the Bristol enquiry the suspension rate rocketed. Last winter it dropped, following the introduction of the NCAA. That lasted 4 months, with suspensions falling from one a week to one in 6 weeks, after which the rate picked up again. The National Audit Office then announced an investigation into the financial implications of suspensions and are asking every trust to justify the money spent on current suspensions, including gardening leave, special leave and other names designed to conceal what was really going on. That, too, has had a dramatic impact and again the suspension rate has fallen to about one in 6 weeks. Very recently the NCAA announced that it had prevented five of six suspensions of doctors referred to it. What is not known is whether the cases referred to them were trivia, such as was described in the Donaldson report (Donaldson, 1994), such as the doctor taking his annual leave to suit his family circumstances, or were more serious. This figure, however, is generally comparable to the overall finding of the study group that more than five of six suspensions could not be justified, despite the most strenuous efforts of the hospital trust, and either the doctor was reinstated or paid to go away in an expensive financial settlement.

So who is at risk? Figure 1 shows the rate of suspensions per 1000 consultants in a speciality relative to the rate in general medicine. Thus an anaesthetist is twice as likely to be suspended than a physician, a surgeon more than four times likely to be suspended, but the surprise figure was the obstetricians: more than seven times more vulnerable than physicians. They are the most vulnerable of all the specialities within the National Health Service. One has to ask why, and there appear to be three factors: antipathy within the delivery suite, quarrels and jealousies over private practice and professional boredom with a lust for power.

Another way of interpreting the data is to ask whether there are special risk factors apart from the specialty? Figure 2 shows obvious sex discrimination. There were 47 female doctors suspended out of nearly 330 suspen-

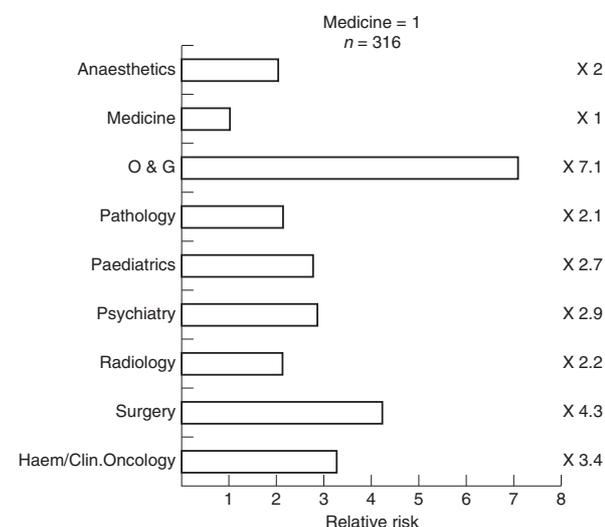


Figure 1. Risk of suspension by speciality.

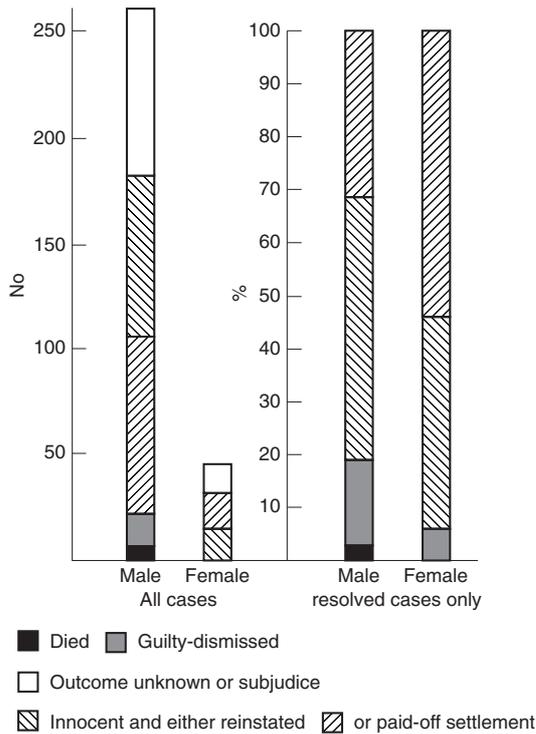


Figure 2. Sex difference.

sions. Female doctors accounted for 15% of all suspensions. Where the cases have been resolved the suspension was only found justified in only 6%. That is, 94% these female doctors were suspended unjustly. In contrast, males, who make up 85% of suspensions, the case was found against them in 16%. Female doctors are more law-abiding than male doctors, so that there are proportionately more female doctors wrongly suspended than male doctors. What is worse, the figure shows that fewer of the wrongly suspended women doctors are reinstated compared with the men. Male hospital managers or male medical directors find it very difficult to admit that they have falsely accused a woman doctor and then have to face her in the daily running of a hospital.

There is a similar picture among doctors from ethnic minorities (Figure 3). There is endemic racism institutionalized throughout the hospital service (Coker *et al.*, 2001). Doctors from overseas make up 40% of all subconsultant posts and 40% of medical students, but only 20% of consultants (DoH, 2000) Such doctors are twice as likely to be suspended compared with Anglo-Saxon doctors. They are also more likely to be found guilty and dismissed. There also appears to be an anti-Semitic bias, in that the proportion of Semites among the suspended doctors is 10 times that of Jews in the population at large, as recorded by the Board of Deputies. However, there are grounds for believing that the estimate of Jews in the population at large is a significant underestimate because of the matriarchal nature of their data collection.

Who is doing the accusing? It has been possible to identify who was behind the suspension in 287 cases. If we subtract those cases which are alleged to have a criminal or partially criminal basis (which can vary from fraudulent expense claims to allegations of

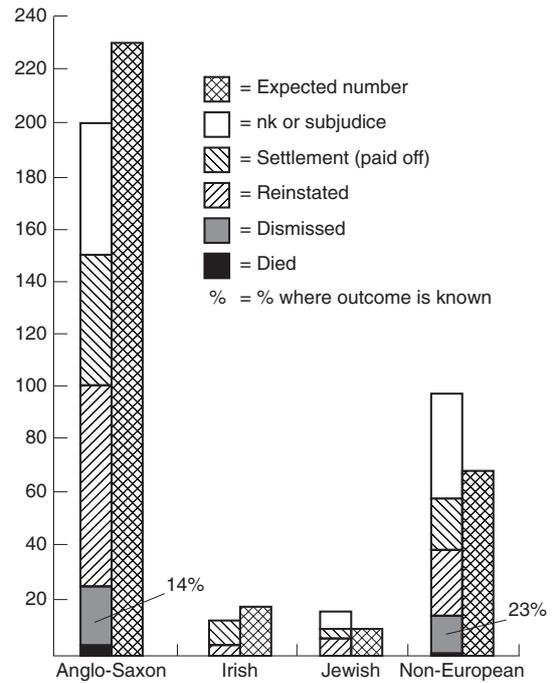


Figure 3. Racism.

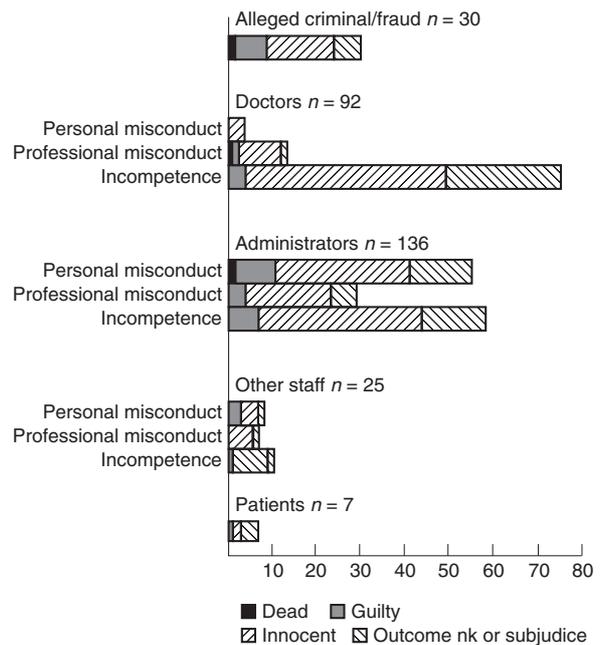


Figure 4. The accusers in 287 suspensions.

manslaughter) there are just over 250 identifiable accusers (Figure 4). The most striking thing is how few are from patients only about 6%. The second is that doctors account for over a third of suspensions, usually allegations of incompetence. One would expect the accuracy of a doctor making allegations about incompetence to be substantial, but in fact it is no different from that of administrators also accusing the doctor of incompetence. Examining the motives of these cases, regrettably this showed interdepartmental quarrels and jealousies, related to private practice or power-seeking to remove a head of department, simple personality clashes, and so on.

Among those accused by administrators are whistle-blowers who have a genuine case. The study group has records of more than 15 doctors who were suspended after whistle-blowing on a colleague who was genuinely at fault. To give an example, a young radiologist in charge of breast cancer screening was alerted by the National Cancer Registry that his area had a serious excess of interval, that is missed, breast cancers. He conducted an audit and identified that a very senior colleague appeared to be at fault. He was unable to arrange an appropriate discussion with that colleague. He went to the management with his fears and was promptly suspended, accused of conducting an unauthorized audit. A subsequent committee of radiologists said that missing 50% of breast cancers was acceptable. Curiously, about this time two radiologists from another area were charged with professional incompetence by the General Medical Council for missing 21% of cancers in a breast cancer screening program, where in fact the GMC's own experts missed only a very few less. There was no evidence presented of the normal distribution of this error rate. Whistle-blowers who appeal to the National Health Service Executive under the Public Disclosure Act will not be protected, as the NHSE does not have the authority to intervene. The hospital trusts are out of central control. The only protection whistle-blowers have is to resort to litigation.

This presentation has concentrated on the various scandals associated with the suspension of hospital doctors. The whole process is scandalous. It is also illegal under the Human Rights Act, as is the GMC's system of control. Neither the NHS nor the GMC appear to be concerned about this illegality, but two doctors are taking their cases to the Human Rights Court at Strasbourg. The Study Group has previously helped one such doctor and won, but this contempt for the law is serious.

It is unacceptable that suspended doctors have to be advised what action they must take to save their own lives from the hostile actions of their employers. That is, for example, to seek medical advice over depression before the depression reaches suicidal levels, or to take low-dose aspirin to save themselves from dying from a stress-induced heart attack. There have been two such myocardial deaths in a little over 300 previously healthy doctors and their families, as well as a number of non-fatal heart attacks—virtually all due to the employer's deliberate hostile actions. No other employer is allowed to cause the death of its staff with such reckless impunity.

There is also the waste of money. It is estimated that suspensions cost the NHS between 25 and 50 million pounds per annum. This expenditure is used by the NHS to find, on average, seven bad doctors a year and among those, one in four will be genuinely professionally incompetent and pose a risk to patients. The finding of only two dangerously bad doctors a year out of a workforce of over 20 000, despite the most strenuous efforts by the administrators, suggests that there is not a serious nationwide problem of professional incompetence among senior hospital doctors, all of which makes the need for revalidation, etc. An expensive waste of time. No one has conducted a cost-benefit analysis of revalidation; but if your revalidation is not satisfactory you could be suspended, despite the lack of evidence of the population at large suffering because of professional



Figure 5. Report from the *Daily Mail*, 22 July 1998, p. 26. (Reprinted with permission from the Daily Mail.)

incompetence. Hospital doctors are remarkable good at keeping themselves up to date.

The final scandal may be seen in this headline from a national newspaper (Currie, 1998) (Figure 5). It is scandalous that patients were deprived of their food in order to save money because the administrators persisted in persuing an unjustified suspension, and spending money on lawyers or possibly paying over the odds for locums. That Scottish trust is still in dispute with that doctor, and that dispute has cost an estimated 1 million pounds and is now entering its seventh year.

*Postscript:* Since the preparation of this article it has been reported that the NCAA have had, in a little over a year, more than 500 calls from administrators from Hospital Trusts throughout the country concerning possibly suspending this or that doctor (Andrews, 2003). Over the 30-year career span of a consultant this amounts to 15,000 doctors being considered by administrators as problem doctors, each of whom might deserve, in the opinion of the administrators, to be suspended and dismissed. Although some of these calls

related to General Practitioners or established non-consultants yet this figure must be matched against the approximately 21,000 consultants employed in the NHS. These figures confirm the impression generated earlier (Donaldson, 1994), that administrators think that a very large proportion, a third to a half, of all senior doctors will become problem doctors at some time during their careers. Such widespread suspicion clearly points to a breakdown of confidence and trust between administrators and doctors.

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