

Employers' Discipline of Doctors in the NHS

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John Hendy QC¹

As a consultant obstetrician and gynaecologist at the (then) London Hospital, Wendy Savage was suspended by, and her disciplinary hearing was conducted by, her employing health authority in accordance with the procedure set out in the NHS circular HM(61)112 to which (as I recall) her contract referred. The hearing was conducted with all the formality, intensity, length and expense of a civil trial. However, without such a rigorous quasi-judicial process, there can be little doubt that the spurious and unfounded nature of the bulk of the charges against her would not have been revealed and she would not have been reinstated.

This chapter offers some reflections on the disciplinary procedures of trusts employing hospital doctors in relation to allegations of misconduct. Space does not permit consideration of capability issues nor of the other means by which doctors' behaviour is regulated (such as the GMC).

As Professor Savage sets out in her introduction to this section of the book, the HM(61)112 procedure originated from ministerial guidance first given in 1951, three years after the founding of the NHS. It was superseded in 1990 by HC(90)9 which made relatively modest adjustments to the process. Now this important procedural framework providing vital protections for senior medical and dental staff against false allegations is in the course of being swept away and replaced by whatever disciplinary procedure for alleged misconduct the particular NHS trust adopts for the rest of its staff.² This chapter is intended to draw attention to the significance of the loss of some of the characteristics of the old regime under HC(90)9 and the protection it gave to senior medical staff and, thus indirectly, to patients.

The legal basis of HC(90)9

Whilst the NHS was a highly centralised organisation, circulars from the DoH were regarded as binding and there is little doubt that health authorities regarded themselves as bound by them. 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 reason of the application of trite employment contract law.³ This was fortified by a statutory instrument so that employing

1 Head of Old Square Chambers; Chair of the Institute of Employment Rights; Visiting Professor in the School of Law, King's College London; immediate past chair, Employment Law Bar Association; FRSM.

2 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 have changed and are beyond the scope of this chapter.

3 *National Coal Board v Galley* [1958] 1 All ER 91, CA; *Gascol Conversions Ltd v Mercer* [1974] ICR

authorities had no option but to be bound by HC(90)9.⁴

From the late 1990s and in keeping with devolution in the NHS, trusts were encouraged to adapt HC(90)9 and adopt the adapted version as their own procedure, rather than simply making a reference to HC(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, as the reported cases (below) show.

HC(90)9 procedures

The procedural characteristics of the HC(90)9 and paragraph 190 procedures are full and, in some respects, complex. The principal features were described 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:

2. This appeal raises important issues in respect of hospital disciplinary proceedings. The context is a contractual disciplinary code. Specifically, the issues arise because of the incorporation of Department of Health Circular HC(90)9 dated March 1990 in most hospital doctors' contracts. This Circular governed the hospital sector of the National Health Service before the creation of autonomous trusts under the National Health Service and Community Care Act 1990. It is still in use by autonomous NHS trusts. The disciplinary code provides for a difference in procedure depending on whether the case involves allegations of 'professional conduct' or 'personal conduct.' The former is governed by a judicialised procedure under Circular HC(90)9. The latter is governed by less formal disciplinary procedures without, amongst other things, the right of legal representation. Inevitably this relatively complex structure gives rise to issues of demarcation concerning the category in which a particular case falls...

12. The Circular is a lengthy document. For present purposes it is only necessary to set out a few extracts from it. The Circular draws a distinction between 'personal conduct', 'professional conduct' and 'professional competence'. Those categories of allegations of misconduct are defined in paragraph 3 of the Circular as follows:

'Personal conduct. Performance or behaviour of practitioners due to factors other than those associated with the exercise of medical or dental skills.

'Professional Conduct. Performance or behaviour of practitioners arising from the exercise of medical or dental skills.

'Professional Competence. Adequacy of performance of practitioners related to the exercise of their medical or dental skills and professional judgement.'

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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'.

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

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 paragraph 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 paragraph 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'.

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

13. ... While the distinction between professional and personal conduct goes back to 1956, the disciplinary arrangements presently reflected in HC(90)9 were the result of the deliberations of a Joint Working Party which published a report in August 1988 entitled 'Disciplinary Procedures for Hospital and Community Doctors and Dentists'. The Joint Working Party was made up of representatives of the Health Departments, the NHS and the professions. It was set up to 'review disciplinary procedures for hospital and community doctors and dentists' and specifically to 'consider the scope, operation and effectiveness of the disciplinary procedures' in Circular HM(61)112. Paragraph 3 of the report reads:

'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'.

The recommendations of the Working Party were accepted and gave rise to HC(90)9 which was published by the Department of Health in March 1990. The terms contained in HC(90)9 were imposed upon doctors by regulation 3 of the National Health Service (Remuneration and Conditions of Service) Regulations 1991 (SI 1991/481). It is now part of the employment contract of Mr Skidmore and of the employment contracts of almost all NHS hospital doctors.

19. ... The line drawn between professional conduct and personal conduct is conduct 'arising from the exercise of medical or dental skills' and 'other' conduct. ... The structure of the disciplinary code set out in HC(90)9 is a classic case requiring a broad and purposive interpretation enabling sensible procedural decisions to be taken.

HC(90)9, Annex B thus provides procedural steps protecting consultants faced with discipline by their employers over matters of professional conduct or professional competence. These steps are notably more extensive than those which applied to allegations of personal misconduct which were left to be dealt with by the employer's ordinary disciplinary procedure applicable to other categories of staff.⁵

The new disciplinary procedure

On 17 February 2005, the Secretary of State for Health⁶ issued *Directions on Disciplinary Procedures 2005* which required the Trust (and all other NHS bodies) by 1 June 2005 to implement the guidance contained in the document annexed to the said directions, entitled *Maintaining High Professional Standards in the Modern NHS 2005*.

5 In summary the HC(90)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 enquiries 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 enquiry is necessary.
- (v) If the chairman decides that a *prima facie* case exists, the NHS body should proceed to an enquiry.
- (vi) 'No member of the [enquiry] Panel should be associated with the [organisation(s)] in which [the practitioner] works.' The panel should be small, normally three 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 and 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 enquiry, 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 second part of the enquiry 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). Paragraph 190 appeals lay to the Secretary of State where a practitioner felt his or her dismissal was unfair – the reference was to paragraph 190 of the standard NHS Terms and Conditions of Service for Hospital Medical and Dental Staffs. Paragraph 190 provides a right to appeal where the doctor

This document should not be confused with a document of the same name issued⁷ in 2003 by the Secretary of State as an annex to HSC 2003/012 which was in itself an annex to the *Restriction of Practice and Exclusion from Work Directions 2003* which required Trusts by 1 April 2004 to implement the 2003 version of *Maintaining High Professional Standards in the Modern NHS*. The 2003 version contained only two parts, the second of which made some very helpful improvements to the regime for suspending doctors and so was to be welcomed. There is no doubt that some consultants have agreed to incorporation into their contracts of the 2005 version thinking that they were getting the benefit only of the new suspension provisions. If so, they have been misled. For the 2005 version, though reproducing the two parts of the 2003 version, contains further parts, amongst which is the new regime for discipline.

The 2005 version of *Maintaining High Professional Standards* (to which the rest of this chapter refers) covers both matters of conduct – both professional and non-professional – and competence (in the latter case involving the performance procedures of the National Clinical Assessment Service, formerly the NCAA, a body established by statutory instrument).

The essential features of the proposed disciplinary procedure were presaged in the Department of Health publication, *Assuring Quality of Medical Practice: Implementing 'Supporting Doctors, Protecting Patients'* (January 2001). Both that and *Maintaining High Professional Standards in the Modern NHS* are lengthy documents but the striking features of the new disciplinary procedure so far as allegations of professional misconduct are concerned are:

- HC(90)9 is abolished with the intention that the HC(90)9 type procedures protecting consultants and senior medical staff in relation to professional misconduct charges are swept away 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

considers his or her 'appointment is being unfairly terminated'. The right applies only to limited classes of doctor, in particular to consultants. The right is of diminishing significance since trusts and Hospital Authorities were told, and have heeded the advice, not to employ consultants after 1st April 1991 on terms which included paragraph 190. Trusts have excluded a paragraph 190 right of appeal in new contracts, leaving only those employed before 1991 with residual rights. Paragraph 190 cases will soon be of historic interest only. There was no right of appeal under paragraph 190 where the dismissal is on grounds of 'personal misconduct'. This has proved a fraught point in some cases. If a paragraph 190 appeal is lodged the dismissal may not be put into effect (save where the dismissal is summary). The appeal is to a panel which advises the Secretary of State and is chaired by the Chief Medical Officer or his or her deputy sitting with representatives of the profession. The doctor is usually legally represented and the proceedings are 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. Nowadays the degree of autonomy of trusts means that this option is very difficult and a recommendation of the third solution may be frustrated and end ultimately in unemployment if no employer will take the doctor.

6 Pursuant to powers conferred upon her by section 17 of, and paragraph 10(1) of Schedule 5 and paragraph 8(3) of Schedule 5A to, the National Health Service Act 1977 and paragraph 16(5) of Schedule 2 to the National Health Service and Community Care Act 1990.

7 Also pursuant to the same powers.

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, for example where exclusion is being considered.
- The 'Paragraph 190' right of appeal is said to be abolished.⁸
- The document contains new capability procedures always involving NCAS and new suspension ('exclusion') procedures.

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 give the opportunity of interview to the doctor under investigation who may be accompanied but, if the companion is legally qualified, 'he or she will not be acting in a legal capacity'. The case manager will decide if there is a case of misconduct which should be put to a 'conduct panel'. Regrettably the document is silent as to the composition of, the procedure before, and any appeal from a 'conduct panel'.⁹ These matters are left to the tender mercy of the NHS body's disciplinary procedure for other staff,¹⁰ save (see below) for the provision that the conduct panel must include a medically qualified member if the case involves professional conduct.¹¹ This contrasts with the 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.¹² In short, where misconduct – professional or otherwise – is alleged, the safeguards provided by the document are virtually non-existent.

The first (of only two) particular protections for the senior clinician under the new procedure is that where the allegation is in relation to professional conduct 'the case investigator must obtain appropriate independent advice' (paragraph 2). It is, of course, common for the trust to obtain an independent medical report or opinion from an expert selected by it, often without the practitioner's knowledge or agreement and with no consultation with him or her. Such reports are, in my experience, not written with the detachment required of medical reports written for the courts where there are explicit duties of independence and where the reporter knows that he or she may well be subjected to probing cross-examination. Under the conduct procedure adopted by trusts it may be unlikely that the reporting doctor will be called to give evidence and certain that he or she will not be subjected to the cross-examination of a professional advocate.

The second protection is that the panel hearing a case of alleged professional misconduct must include a member who is medically qualified and who is not currently employed by the NHS body. 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

8 Though whether a contractual right to a Paragraph 190 appeal can be abolished in so cavalier a manner may be doubted – see the *Gryf-Lowczowski* case considered below – though since the right of appeal is to a third party, the point is more complex.

9 I, para.17.

10 And the minimal statutory requirements in relation to discipline.

11 III, para.2.

12 IV, paras.13–51 together with Appendix A.

maintained by, for example, the appropriate Royal College).

Without doubt *Maintaining High Professional Standards in the Modern NHS*, in relation to allegations of professional misconduct, constitutes a downgrading of consultants' protection which appears to have met surprisingly little resistance and was agreed by the BMA (and the BDA). The most striking features are the abolition of the independent and legally chaired panel to hear serious disciplinary allegations,¹³ and the removal of the right of legal representation. The disciplinary procedures of most NHS bodies applicable to non-senior medical staff put the hearing of disciplinary allegations into the hands of a manager (after 2005 it will presumably be a 'panel' composed of a manager and one other).

Implementation of *Maintaining High Professional Standards in the Modern NHS 2005*

Though all NHS bodies were directed by *Maintaining High Professional Standards in the Modern NHS* 'to implement the framework within their local procedures by 1 June 2005', it was left to them as to how this was to be achieved.¹⁴ The ineptitude of many trusts meant that they failed, in accordance with the well-established principles of contract law, to effect variations to the contracts of employment of their consultants by the due date and consequently found that the HC(90)9 type disciplinary procedures in the existing contracts continue to bind them after June 2005.¹⁵ Thus in *Gryf-Lowczowski v Hinchingsbrooke Healthcare NHS Trust*,¹⁶ Gray J held:

12. [The Chief Executive] was asked by Mr Hendy for Mr Gryf-Lowczowski what steps, if any, had been taken by the trust to incorporate the NCAA procedures as part of its contractual relationship with Mr Gryf-Lowczowski. In answer Mr Pattison said that the framework document had been 'adopted at board level within the trust'. He suggested that that amounted to introducing the procedures laid down in the document as terms of Mr Gryf-Lowczowski's contract. Mr Pattison further told me that the framework had been discussed with the relevant professional bodies and that it was widely known. He did, however, concede that the trust had not written to every consultant to seek his or her agreement to the adoption of the new procedures in the contract of employment. No such letter had been written to Mr Gryf-Lowczowski.

...

56. The evidence is that the version of the contract of employment which is in the trial bundle was signed by Mr Gryf-Lowczowski on 2 October 2004... It is for the trust to satisfy me that the contract was thereafter varied so as to incorporate the procedure set out in Part IV of the framework document. As stated... above, the DoH directions

13 Or, as the press release of 17 February 2006, puts it: 'The employing trust is squarely responsible for the disciplining of its medical and dental staff not outsiders.'

14 Para.3 of *Directions on Disciplinary Procedures 2005* issued by the Secretary of State for Health under the National Health Service Act 1977 and the National Health Service and Community Care Act 1990.

15 In circumstances where a trust seeks to rely on contractual terms less favourable to the consultant than those found in *Maintaining High Professional Standards* (for example, those in Part II in relation to suspension), then there may be scope for arguing that the trust is bound by the implied duty to maintain trust and confidence to apply terms no less beneficial than those it was obliged to implement by the Secretary of State through his Directions: see *Mezey v South West London and St Georges NHS Trust*, 20 December 2006, transcript awaited.

16 [2006] IRLR 100.

required all NHS bodies to implement the framework by June 2005. In the ordinary way one would expect the trust as employer to draw up a revised contract for affected staff and to submit it to them for signature. That did not happen. [The Chief Executive]’s evidence as to the steps which were taken within the trust are set out at paragraph 12 above. In my judgement they fall well short of what would be required to establish that Mr Gryf-Lowczowski agreed to the variation of his contract for which the trust contends. I should add that I reject the submission of Mr Havers that the reference in clause 7 of the contract of employment (see paragraph 5 above) to ‘our disciplinary or capability procedures’ is to be construed as meaning ‘such disciplinary or capability procedures as the trust may from time to time adopt’. The reference used in my view meant and was understood to mean that the procedures set out in the Disciplinary policy and procedures, based on Health Circular (90)9, were to apply.

Removal of protection

A glance at the new disciplinary procedures in comparison to the old brings vividly to mind words written nearly 160 years ago describing the effect of modern changes to employment relations. They 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.¹⁷

Certainly, the protection of the professional reputation and career of the hospital consultant is now no greater than that of any other NHS employee. Whilst one might not argue that a labourer deserves less protection than a hospital consultant, the Working Party which drafted HC(90)9 was right to emphasise that dismissal from the NHS for a consultant on grounds of professional misconduct 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 by every employer in the fields in which he or she has chosen to work. Furthermore, notwithstanding the Government’s controversial impositions of fees on students, the cost to the public of 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 conduct represents unambiguously an assertion by the NHS towards their senior medical staff of the subservience inherent in the concept of the contract of employment.¹⁸ It is ironic that this development should have coincided temporally with

the court’s development of a doctrine of fundamental mutuality in the employment relationship both in relation to the essential qualities necessary to create a contract of employment¹⁹ and in the form of implied reciprocal duties to maintain trust and confidence – see below.

No-one can doubt that not only are there incompetent doctors, there are also some who behave so badly that they should be dismissed from employment.²⁰ 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 competent doctors falsely accused 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:

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.²¹

The NHS recognises 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.’²²

The fact is, however, that NHS disciplinary procedures are sometimes abused by those with ulterior motives. In his excellent report on the regulation of the medical profession, *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*,²³ Sir Liam Donaldson, Chief Medical Officer, Department of Health, found:

...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.²⁴

‘Today’ is the summer of 2006, one year after the 2005 procedures were to be implemented. He 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.²⁵

17 K. Marx and F. Engels, *Manifesto of the Communist Party*, 1st 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.

18 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*, 2nd edn, 1977, Chap. 1 at p.6) Also 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.

19 *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.

20 Sufficient to cite Harold Shipman the general practitioner who killed about 250 of his patients between 1972 and 1998, usually with narcotic drugs that he had stockpiled illicitly.

21 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.’

22 www.ncas.nhs.uk/toolkit/rebuilding.

23 14 July 2006 (part revised 31 August 2006).

24 Introduction at para.9.

25 Summary at para.28.

It follows that whatever modern techniques are used to avoid the blame culture and to enhance 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 their careers continue to warrant proper protection against the abuse of discipline.

The reasons for the particular protections intended by the working party which drew up HC(90)9 (cited by Lord Steyn – see above) thus remain unchanged today. *Maintaining High Professional Standards in the Modern NHS* offers no explanation for the need to sweep away the disciplinary protection of consultants. It simply states that ‘changes to NHS disciplinary procedures are necessary’.²⁶ A purported justification for the removal of these rights was asserted by a minister, John Hutton, in the accompanying press release:

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.

There is, as far as I am aware, no evidence that the HC(90)9 procedure was unfair to NHS staff – the usual complaint has been the fact of and the length of suspension prior to hearing. Exclusion and delay were not, however, inherent in the HC(90)9 process but more in the suspension process and the fact that suspension removed the imperative on management to act quickly. The suspension procedure is revised extensively by *Maintaining High Professional Standards in the Modern NHS* (though whether in reality it will improve matters for accused doctors remains to be seen). There can be little doubt that a procedure that gives the decision on whether to dismiss a consultant to management will certainly speed up the disciplinary process; but whether NHS staff would regard that as a price worth paying for avoiding the delays so common under HC(90)9 is dubious.

Mr. Hutton is obviously correct in pointing out that the exclusion of lawyers saves money. What is lost with the demise of HC(90)9 however, 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 (in relation to private practice), or intended to neutralise an outspoken defender of patient services from the economic imperatives of management. I regret to say that many (though, of course, not all) of the cases which come across my desk in chambers appear to me 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 in the NHS, and in particular the restrictions on funding and their clinical consequences,²⁷ was a

26 As a result, it states (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 that there were any reasons for the abolition of HC(90)9 type protections for senior medical staff.

27 For example: ‘NHS told: put money before medicine’, *Guardian*, 23 January 2006 – Health Secretary said to require trusts to put financial management ahead of clinical objectives; ‘Over 6000 jobs lost in the NHS in 2006’, *LRD Fact Service*, 13 April 2006, vol.68, issue 15; ‘Poor areas hardest hit by NHS cuts in London’, *Guardian*, 7 August 2006; ‘NHS becoming a brand like Nike, warns departing health director’, *Guardian*, 1 September 2006 – John Ashton resigned as Regional Director of Public Health for the North

factor tending towards measures that might assist in the neutering of opposition from within.²⁸ Some may consider it to be part of a longer term measure in the NHS whereby administration has been progressively removed 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 have sought to evade the procedural requirements of the disciplinary procedure of HC(90)9 – and before it HM(61)112. When the power of discipline is transferred from an independent panel chaired judicially to internal management and the consultant deprived of legal representation, it may be assumed that the attempts to evade due process will diminish in proportion to the ease of dismissing the ‘difficult’ consultant.

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 £58,400 for dismissals after 1 February 2006 and the latest statistics show that the median award actually awarded by tribunals was a mere £3,476 (average award: £7,303).²⁹ Though reinstatement is ostensibly the primary statutory remedy, in fact it was ordered in only 0.02 percent (14 out of 7,544) cases which went to a hearing.³⁰ In consequence, the remedy of unfair dismissal is of little value to consultants. If he or she can show that race, sex, religion, whistle-blowing or, now, age discrimination were reasons, 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.

The courts’ protection

I shall conclude this chapter by illustrating what a valuable protection senior NHS medical staff have lost with the demise of HC(90)9 type procedures.³¹ For the latter were enforceable as a matter of contract law and NHS employers could be enjoined from evading them.³²

West and said that there was a danger of two-tier health provision – he resigned because he could not face the fifth reorganisation of his department; ‘DHL signs £1.6bn health supply deal’, *Financial Times*, 5 September 2006 – this was the outsourcing contract of NHS Logistics, its purchasing arm. UNISON have called strike action (*Financial Times* 11 September 2006); ‘Nurses to leave NHS and sell services back through limited company’, *Financial Times*, 14 September 2006 – 700 nurses and therapists leave the NHS and set up private company to sell their services back to it; ‘Hewitt advisers deny political targeting of hospital closures’, *Guardian*, 16 September 2006 – Secretary of State confirms she has a ‘heat map’ showing where strong opposition is likely to be to government plans to close A&E departments but denies that map is to be used to avoid closures in sensitive marginal seats. See also *R (on appn of Rogers) v Swindon PCT and S of S for Health* [2006] EWHC 171 (QB) – a failed challenge to refusal to fund herceptin for breast cancer patient.

28 It is to be noted that the device of discretionary 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.

29 Employment Tribunal Service Annual Statistics 2004–2005.

30 Ibid.

31 Regrettably, space does not permit me consideration of the thorny issue of suspension – now given the dismissive and derogatory title of ‘exclusion’ – though the chapter by Michael Goodyear refers to much of

Before discussing the enforceability of HC(90)9 procedures it is as well to observe that there are a number of legal issues which are beyond the scope of this book but which must be considered when contemplating what appears to be a breach of a contractual procedure such as HC(90)9. One such is the coexistent implied (and often express) term requiring each party to maintain trust and confidence³³ and the unrelated, though similarly named, rule that injunctions will not be granted where the employer has no trust and confidence in the employee.³⁴ Likewise the possibility of judicial review³⁵ and the restricted scope of the Human Rights Act are factors to be considered.³⁶ Though the received wisdom in legal textbooks was for many years that injunctions could not be

the extensive literature on the subject. This too was the subject of further guidance in *Maintaining High Professional Standards in the Modern NHS*, superseding HSC 2003/112 which in its turn superseded HSG(94)49. 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 as the recent judgement in *Palmer* (see footnote below) shows. It is often thought that wrongful suspension is not challengeable but, though difficult, it is possible: see *Palmer; 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).

32 In some cases a declaration of right may be more easily available than an injunction and achieve the same result; see *Gunton v Richmond-upon-Thames London Borough Council* [1980] ICR 755, CA.

33 See *Malik v Bank of Credit and Commerce International SA* [1997] HL the implied term is 'a portmanteau term. Its specific operation in a particular case depends on the circumstances:' *R (Arthurworrey) v Haringey LBC* [2002] ICR 279 (at 286, para 44). The term does not operate 'on termination', the so-called Johnson exclusion zone (after *Johnson v Unisys Ltd* [2001] IRLR 279 HL), see *Eastwood v Magnox Electric Plc* [2002] IRLR 447 CA, though in *King v University Court of St. Andrews* [2002] IRLR 252 (OH) it was held that the implied duty of trust and confidence subsisted through a disciplinary process which led to the decision to dismiss. See also *McCabe v Cornwall CC* [2005] 1 AC 503 HL and the discussion in *Mattu* (see footnotes below) at para.89 ff.

34 The employer may not have lost confidence in the doctor's work, for example *Bliss v S.E. Thames RHA* [1987] ICR 700 (breach of contractual term by seeking to impose psychological examination in response to breakdown of personal relationship; no loss of confidence in the doctor's work – injunction granted). Or it may be that the immediate superior is supportive of the worker even if senior management doubts it: *Powell v LB Brent* (see footnotes below). The presence or absence of sufficient mutual trust and confidence is irrelevant if what is sought is preservation of the employment relationship (but not to compel resumption of duties) whilst a contractual disciplinary procedure is adhered to: *Robb v London Borough of Hammersmith and Fulham* [1991] ICR 514, QBD; followed in *Gryf-Lowczowski* and in *Kircher* (see footnotes below); see also *Peace v City and Edinburgh Council* [1999] IRLR 417, Ct of Sess (OH).

35 It is theoretically possible that the procedure was enforceable as a matter of public law. There is limited scope for an 'office holder' to utilise the mechanism of judicial review to restrain dismissal in breach of the rules of natural justice (*Ridge v Baldwin* [1964] AC 40, HL). Judicial review is available to compel the fulfilment of a public duty or to restrain an irrational decision by a public body. But an office holder's claim will not permit judicial review merely because 'his entitlement to a subsisting right in private law... incidentally [involved] the examination of a public law issue' per Lord Bridge in *Roy v Kensington and Chelsea and Westminster Family Practitioner Committee* [1992] IRLR 233, HL (see also McLaren v Home Office [1990] ICR 824, CA and see *R v Secretary of State for Foreign and Commonwealth Affairs, ex p. Council of Civil Service Unions* [1985] ICR 14, HL). But an 'ordinary' employee never could proceed by way of judicial review unless some 'public' element was involved in the decision being challenged, for example where an employer's right to dismiss was restricted or regulated by statute (*Malloch v Aberdeen Corpn* [1971] 1 WLR 158, HL; and *R v Civil Service Appeal Board, ex p Bruce* [1988] ICR 649, DC). In fact, judicial review has been unlikely to be of value to doctors after *R v East Berkshire Health Authority, ex p Walsh* [1984] ICR 743, CA made clear that (notwithstanding *R v British Broadcasting Corpn, ex p Lavelle* [1983] ICR 99, Woolf J), employees' terms of employment are purely matters of private law save to the extent that the employer has failed to incorporate statutory terms and conditions as opposed to failing to implement them properly where they have been incorporated (at p.752EF). See also *R (Arthurworrey) v Haringey LBC* [2002] ICR 279. For medical personnel this was confirmed in *R v Trent RHA ex p. Jones The Times*, 19 June 1986; and *R v South Glamorgan Health Authority ex p. Phillips* H Ct, 20 November 1986. Since the reported cases are concerned with a failure to follow HC(90)9 rather than a failure to incorporate it or any part of it, judicial review is an unlikely tool against a consultant's employer in this context. Though

granted to enforce a contract of employment,³⁷ in fact injunctions to restrain dismissals by employers in breach of the contractual disciplinary procedures have long-established antecedents going back nearly a century.³⁸ There have been many cases since, often involving doctors successfully enforcing NHS disciplinary procedures such as HC(90)9 including, most recently, a quartet of cases reported this year in which I had the honour to be instructed.³⁹

note the court's acceptance (without discussion of the aforementioned cases) that judicial review was available to a GP suspended by a PCT in breach of statutory regulations: *Malik v Waltham Forest PCT and S of S for Health* [2006] EWHC 487 (Admin), at para.23.

36 The Human Rights Act 1998 incorporating the European Convention, Art.6 of which requires a fair trial, seems to add little to the express provisions of HC(90)9. However reliance on it might be sought under the 2005 procedures. The obligation on public bodies under s.6 HRA means that employment matters in the public sector are not excluded from the Convention: for example, *Halford v UK* [1997] IRLR 471 (art.8); *Ahmed v UK* [1982] 4 EHRR 126 (art.11, art.14). Though private bodies have no direct obligation to apply the Convention under s.6(1) this does not exempt private bodies to which the state has delegated functions: *Castelloe-Roberts v UK* [1982] 4 EHRR 38. Art.6 lays down procedural principles which are an elaboration of the English common law principles of natural justice but go further including, for example, a right to a public hearing. However, 'disputes relating to the recruitment, employment and retirement of public servants are, as a general rule, outside the scope of art.6(1)': *Massa v Italy* (1993) 18 EHRR 266. This includes a claim for unfair dismissal: *Balfour v UK* (Comm. Decn. No. 30976/96) and a reprimand: *X v UK* (1984) 6 EHRR 583. But the category of 'public servants' is limited and may not extend beyond civil servants: *Neigel v France* [1997] EHRLR 424, so that in *Darnell v UK* (1991) 69 DR 306 a doctor employed by a regional health authority under a contract of employment was held not excluded from the protection of Art.6. However, whilst consultants employed by NHS bodies are not within the category of employee denied the protection of Art.6, the circumstances in which they can pray it in aid are limited because Art.6 will not bite unless the dispute involves the *determination of a civil right or obligation*. The general rule is that disciplinary proceedings do not ordinarily involve disputes over civil rights or obligations: *Albert and Le Compte v Belgium* (1983) 5 EHRR 533, para.25. On the other hand, the right to continue in professional practice is a civil right and Art.6 of the Convention will apply to a disciplinary body which is capable of deciding whether or not a consultant can continue in practice, notwithstanding that the body is, in form, private. Thus the GMC is bound: *Wickramsinghe v UK* [1998] EHRLR 338, and analogous medical regulatory bodies in Europe: *Gautrin v France* (1999) 28 EHRR 196; *Albert and Le Compte* (above). There must be doubt whether the consequence of dismissal by an NHS body of being unemployable within or without the NHS neo-monopoly is sufficient to engage Art.6. However, in *Malik v Waltham Forest PCT and S of S for Health* [2006] EWHC 487 (Admin) the English Administrative Court held that Art.6 would have been engaged in relation to a decision by a PCT to suspend a GP in breach of statutory regulations had the penalty been final rather than interim.

37 Relying particularly on *Hill v CA Parsons & Co* [1972] 1 Ch. D. 305.

38 *Crisp v Holden* (1910) Sol. J & Wkly. Rep. 784; *Smith v McNally* [1912] 1 Ch.D. 816.

39 See for example: *Barber v Manchester Regional Hospital Board* [1958] 1 WLR 181 (damages granted for a refusal to permit a paragraph 190 appeal); *Jones v Lee and Guilding* [1980] ICR 310 CA; *Irani v Southampton etc HA* [1985] ICR 590 (injunction to restrain implementation of proposed dismissal unless contractual disputes procedure exhausted – otherwise employer would be 'entitled to snap its fingers at the rights of its employees' at 604F); *Hughes v LB Southwark* [1988] IRLR 55; *Powell v Brent LBC* [1988] ICR 176 CA; *Wadcock v LB Brent* [1990] IRLR 223; *Robb v Hammersmith* [1991] ICR 514; *Jones v Gwent CC* [1992] IRLR 521 [tab 13] (final declaration that letter giving notice of dismissal was invalid together with final injunction to restrain dismissal); *Anderson v Pringle of Scotland Ltd* [1998] IRLR 64 Ct of Session (interim injunction to restrain dismissal in breach of a contractually incorporated redundancy procedure); *Peace v City and Edinburgh Council* [1999] IRLR 417, Ct of Sess (OH) (injunction granted to restrain employer from applying unagreed disciplinary procedure in place of contractual procedure; employee suspended; body of authorities recognised in which contractual procedures enforced by injunction: paras.11–12). In *Barros D'Sa v University Hospital Coventry and Warwickshire NHS Trust* [2001] IRLR 691 CA the employer sought to rely on a breakdown in trust and confidence to justify dismissal after HC(90)9 enquiry in which the panel had found minor misconduct which did not justify dismissal; it was held that the trust could not introduce matters of aggravation on which no charge had been put before or investigated by the panel. The quartet in which I was instructed included *Mattu v University Hospitals Coventry and Warwickshire NHS Trust* [2006] EWHC 1774 (QB) against the same

Conclusion

With the replacement of HC(90)9 procedures by ‘ordinary’ disciplinary procedures applicable to all trust employees, hospital consultants have lost valuable protections in relation to allegations of professional misconduct. The profession should consider carefully whether the restoration of some more formal procedure with an independent, legally chaired panel and a proper opportunity to challenge the charges through a professional advocate is not a necessary step towards the maintenance of the proper role of doctors in the NHS.

employer where a similar injunction would have been granted (but for an offered undertaking) to restrain the introduction of similarly aggravating material. The other three cases were: *Gryf-Lowczowski v Hinchbrook Healthcare NHS Trust* [2006] IRLR 100 (purported termination by frustration was held to be ineffective and an injunction would have been granted to continue the employment, but for undertaking in same terms); *Kircher v Hillingdon PCT* [2006] Lloyds Rep Med 215 (injunction granted to reinstate the employment after a purported dismissal had taken effect, the employer having failed to comply with HC(90)9 procedure); *Palmer v East & North Hertfordshire NHS Trust* [2006] EWHC 1997 (injunction granted to continue employment said to have been terminated by frustration).