POSITION STATEMENT

Getting it right

The principles that should underpin disciplinary proceedings against doctors

Opening remarks

Doctors face considerable pressures throughout their career. One of the most professionally challenging things doctors can experience is having disciplinary proceedings brought against them by their employer.

Our in-house experts assist with the wide range of legal and ethical problems that arise from a doctor's professional practice. This includes continually supporting members going through disciplinary proceedings.

These proceedings can have career altering implications, so it is essential that they are conducted properly and with respect for due process. Unfortunately, we often witness first-hand the anxiety and concern these processes cause doctors, particularly when they are handled badly. This happens too often.

Through this paper, we aim to start a debate which is urgently needed – to make sure employers are getting disciplinary proceedings right, and what should happen when they fall short.

We want to work with employers, NCAS and others to make real improvements in this area. We set out what a good process should look like, the core principles involved and what actions we think a range of stakeholders should take. We do not have all the answers. We want to work together with stakeholders to identify a clear range of actions that can be implemented for the benefit of all concerned. This paper is the first step.

The importance of getting it right

Disciplinary action and restrictions on a doctor's practice must only be taken in the most serious of cases. Doctors who fall short of the high standards expected of the profession should have appropriate action taken against them – but good doctors who find themselves the subject of a disciplinary, and who are found to have no case to answer, need to be supported back into practice as soon as possible.

Bad disciplinary procedures do not just impact on the doctor(s) directly involved. They affect the whole culture of the organisation. Where due process and fairness are lacking, a culture of fear amongst doctors in our NHS cannot be completely addressed.

Government and NHS led initiatives to improve openness and learning in the NHS relies on doctors having confidence in senior management and its commitment to due process. This is just one of the reasons why it is so important to get this right.

Current framework

In England, doctors employed by the NHS and who are the subjects of a disciplinary are taken through the *Maintaining High Professional Standards* (MHPS) framework. MHPS came into effect in 2005, replacing the previous framework *HC(90)*.

Twelve years on, we believe MHPS represents how good practice in disciplinary proceedings should look.

There is, however, a large variation in how it is implemented. The *Directions on Disciplinary Procedures 2005* required NHS England bodies to implement the framework within their own local procedures. Consequently, every NHS Foundation Trust, under MHPS, has discretion as to the precise protocols and procedures' it has in place to conduct a doctor's disciplinary. In many ways this is the route of MPS's concerns about the handling of disciplinary proceedings. Each Trust has individual policies with their own nuances. Each has its own redeeming features, and many have shortcomings.

In supporting our members, we have seen disciplinary proceedings on a broad spectrum – ranging from the effective, to the frustrating, to the deeply flawed.

Principles for a good disciplinary process

We support members through disciplinary processes in all four countries of the UK, and also provide tailored support to our members around the world.

We are therefore well placed to comment on what needs to be in place in a 'good' disciplinary procedure to allay shortcomings.

In this brief paper, we identify four core principles that should underpin a 'good' disciplinary process:

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Timeliness
Proportionality
Fairness to all parties
Accountability of Employers
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While this paper is focused on the experience of *MHPS* and its application by NHS England Trusts, these principles are largely applicable to other employers, and other healthcare providers in other countries.

What are we calling for; how can employers *get it right?*

Call to action for all employers

Disciplinary action should only be contemplated in the most serious of cases when other approaches have been exhausted. When a doctor is put through a disciplinary process, it

should begin and conclude in a timely manner. Where restrictions and exclusions are placed upon a doctor in the meantime – these should be proportionate to the nature of the allegation and the terms of reference of the investigation. The doctor and their representatives should receive fair treatment during proceedings, with due process followed and all necessary disclosures made.

To ensure this happens in every case, we want to start a debate about:

How best practice can be achieved, and achieved with consistency. Crucially, where a Trust or another employer is found to have behaved in a seriously wrong way during proceedings, a clear method needs to be established to hold them to account.

Principles

Timeliness

'Disciplinary proceedings should move forward and conclude in a timely manner, with delays kept to a minimum'

Being the subject of a disciplinary process is an incredibly anxious time for the doctor involved. It can also be a difficult time for their family and colleagues. Amongst this, we must not lose sight of the impact that disciplinary action against a doctor can have on their patients – particularly where the doctor is excluded from some or all forms of clinical practice.

Patient care is best served when a doctor is in the consultation room; on the ward; in theatre. Where a doctor is excluded from their duties while subject to a disciplinary investigation, it is in everyone's interest for the matter to be settled in a timely manner. Too often, disciplinary proceedings are unnecessarily prolonged, and marked by repeated delays. When a case is not managed properly, slow case management engrains the issue and solidifies the problem it was ultimately trying to address.

Case Study

A consultant surgeon (Dr P) is recruited by a Trust. Dr P is an otorhinolaryngologist (ENT) and is a sub speciality expert. Upon assuming the post, a few years pass where she works without incident in her new hospital Trust. However, there are distinct personality differences between her and the main group of consultant surgeons. Before too long a cohort of that group initiate concern's about Dr P's performance, citing poor outcomes and potential patient harm – without providing specific examples.

The Trust begin proceedings, and takes the initial decision to exclude Dr P. After representations are made on Dr P's behalf, the exclusion is lifted, and replaced with restrictions on her practice so the complex surgery is no longer performed. As the process moves forward, details are slow to be shared with the Dr and her representatives and the investigation lacks any momentum. An investigation that should have taken months turns into years. Almost two years on, the case has not moved forward significantly.

Dr P is now a deskilled surgeon. When the investigation finally provides its determination, it finds Dr P has no fundamental issue with competence, but certain procedures she carries out result in poor outcomes irrespective of the surgeon leading it.

Owing to a breakdown in relations between Dr P and her colleagues, as well as the Trust, a negotiated exit is agreed for Dr P and a new consultant surgeon is recruited; 30 months on from the initial complaints being lodged.

Away from the disciplinary and regulatory plane, in summary criminal proceedings, there is well established case law which emphasises the importance of adjunction and decision making occurring swiftly:

Crown Prosecution Service v Picton ***[2006] EWHC 1108 (Admin)***

The High Court judgement in the case of Alan *Picton* is regularly cited in proceedings brought in the magistrates' court.

The *Picton* judgement relates to delays and adjournments in criminal proceedings brought against defendants on summary charges. In the judgement, the Court held, amongst other standards, that:

- Magistrates should pay great attention to **the need for expedition** in the prosecution of criminal proceedings; **delays are a scandal**; they bring the law into **disrepute**; summary justice should be **speedy justice**; an application for an adjournment should be rigorously scrutinised.

- Where an adjournment is sought by the prosecution, magistrates must consider both **the interest of the defendant in getting the matter dealt with, and the interest of the public that criminal charges should be adjudicated upon**, **with the guilty convicted as well as *the innocent acquitted.***

While their origin is from a distinctly different legal jurisdiction, these standards would seem to be of equal relevance to disciplinary proceedings. Case Investigators and Case Managers should be fully alert to the need for expedition in moving disciplinary proceedings forward, and that constant delays are unacceptable as they bring the whole process into disrepute.

The disciplinary panel must consider the interests of patients, the doctor and their colleagues in getting the matter dealt with in a timely fashion. It is in everyone's interest that doctors found to have fallen short of the high professional standards expected of them, begin remedying that as soon as possible. Where that is not possible, given the nature and/or extent of the breach, the need to move the process swiftly forward to regulatory action *(The General Medical Council, GMC)* is also vital.

Most importantly however – where a doctor is found to have no case to answer – it is firmly in their best interests, as well as their patients, for them to return to work and continue proving patient care as soon as possible.

Disciplinary proceedings should move forward and conclude in a timely manner, with delays kept to a minimum.

Proportionality

'Any move to exclude the doctor from their duties must be proportionate to the nature of the investigation'

Where there are clear patient safety concerns attached to a doctor's continued practice – either in whole or in part – then exclusion or appropriate restrictions on their practice may well be required.

We are concerned about the considerable lack of consistency between Trusts in respect of the way they deal with concerns about doctors. This is particularly true on the matter of their exclusion and restriction policies. Some Trusts appear to regularly move towards exclusions in the first instance, which after the promptest of representations on behalf of the doctor – are often reduced to restrictions on the doctor's practice, as that is more than sufficient to satisfy all parties that patient safety is being maintained.

Case Study

At the age of 55, Dr J (a consultant anaesthetist) is motivated to come out of early-retirement. Despite being offered his old post back at his Trust, he decides to take up a locum position at a neighbouring Trust instead.

Dr J decided not to take up the offer to return to his old Trust, as the neighbouring Trust was experiencing particular staffing problems and was in greater need. Dr J goes on to locum at that Trust for a number of years, and so acquires employment rights. As such, despite a successful consultant recruitment campaign, the Trust cannot dismiss Dr J. Following a conversation with HR, he agrees to stop performing his full breadth of anaesthetic practice and reduces the number of hours he works – but declines persistent advances to stop altogether.

A few months later, a consultant surgeon raises a concern about the quality of Dr J's blocks, and cites two patient complaints from the previous week where it is alleged that Dr J poorly explained the procedure to the patients. The Trust immediately moves to exclude Dr J on this basis. After representations are made, that exclusion is lifted, and Dr J is instead restricted to only carrying out non-clinical work.

After a lengthy investigation process, Dr J is found to have no case to answer – but decides to leave the Trust nevertheless.

Ensuring patient safety is the first duty of any doctor – a duty made clear in the first paragraph of the GMC's *Good Medical Practice* guidance. At the start of that particular guidance paragraph, it states: *"Patients need good doctors".* Too often we see 'good doctors' excluded from practice when, for the purposes of a disciplinary investigation, all conceivable patient safety concerns could be addressed through appropriate restrictions being placed on the doctor's practice. The result; a demotivated and deskilled doctor who faces an uncertain future professionally, regardless of the outcome of the investigation.

Any move to exclude or restrict the doctor from their duties must proportionate to the nature of the investigation. It should not be an indefinite move whereby the length of the exclusion or restrictions determines the ultimate outcome – irrespective of the findings of the investigation and the disciplinary process.

Fairness to all parties

'For a process to have credibility, and to support a culture of openness and learning, proceedings should be conducted in a fair and transparent way'

A doctor's right to a fair hearing during disciplinary proceedings is deeply enshrined in law. Yet we are regularly involved in disciplinary proceedings – supporting members – where that fairness, and equal treatment for the doctor, is not present and they are not given a fair chance to present their case.

For instance, when disciplinary proceedings reach the stage of the case manager formally notifying the doctor of the terms of investigation (and the details of who has been appointed as the case investigator and which non-executive director is to sit on the panel), the doctor and their representative will be invited to an initial meeting to discuss the allegations.

Under *MHPS,* individual Trusts are not under an obligation to disclose in advance the full list and nature of the allegations they will put to the doctor at that meeting. They *should* be under such an obligation.

Under current rules, in many cases, the doctor may not be given information about the nature of the allegations, how they were raised or by whom, nor the information gathered so far to support or discredit them. It is well established that the issues under dispute in a case should be known to both parties before one is asked to provide testimony. Appropriate disclosure allows the doctor and their representative to consider their response, and present their side of the story. Where this happens in Trusts', MPS believes it is an example of good practice.

For a process to have credibility, and to support a culture of openness and learning, proceedings should be conducted in a fair and transparent way – if after all they are truly intended to find answers to the concerns raised, and see that they are properly addressed as well as the doctor appropriately dealt with.

Doctors also have an implied contractual right to a fair process, and as employers, Trust's need to ensure that they abide by the letter and spirt of their own disciplinary policies.

West London Mental Health NHS Trust (Respondent) V Chhabra (Appellant) [2013] UKSC 80

The case of Dr Chhabra concerned the role of the case investigator and case manager, under the MHPS disciplinary framework.

In this case, the terms of reference of the case investigator had been set by the case manager (the Trust's Medical Director), and in response to a concern raised by Dr Chhabra and her representatives, the Trust had undertaken that a Mr Witshart – the Trust's Associate Human Resources Director – could take no part in the investigation.

When both the terms of reference were subsequently expanded, and Mr Witshart not only brought into the process – but his advice directly heeded, and the level of criticism against Dr Chhabra increased on his request – Dr Chhabra began legal action and appealed to the Supreme Court.

The Supreme Court unanimously allowed Dr Chhabra's appeal. The Court found there were a number of **irregularities in the disciplinary proceedings** brought against Dr Chhabra, that collectively rendered the convening of the conduct panel unlawful as a material breach of her contract of employment. Furthermore, the **disregard for the undertaking** that had been given not to include Mr Witshart in proceedings **breached the obligation of good faith** in the contract of employment. Dr Chhabra had an implied contractual **right to a fair process**, and *managers under MHPS are expected to act in a way that an objective observer would consider reasonable.*

Moving forward – the next steps

As we said at the outset of this paper, we do not claim to have all the answers to how shortcomings in doctors' disciplinary proceedings can be improved.

We want to work with employers, NCAS and others so we can share perspectives, and agree on the best way forward. This is essential if real and tangible improvements are to be made. MPS and other medical defence organisations (MDOs) have a role to play as well, in ensuring that disciplinary proceedings are dealt with in an effective manner.

Prior to setting out our recommendations for others to adopt moving forward, MPS makes a commitment that:

- *We will always act diligently and with respect for process in supporting a member going through a disciplinary process*
- *We will support the doctor to engage in the process in a timely and appropriate matter*, to ensure quality standards are maintained, and patient care protected
- *We will always stand up for our member when they are subjected to unfair treatment in disciplinary proceedings.*

MPS makes these commitments because we all have a role to play in getting disciplinary proceedings right.

We invite others to consider their role:

NHS employers

- Trusts should ensure that the terms of reference of investigations are specific and go to the central issues of concerns rather than broad, unspecified headings which can lead to protracted and unfocused investigations
- Case Managers and Case Investigators should undergo NCAS approved training before beginning their roles in disciplinary proceedings – to ensure that they are aware of the nature of their role, as well as their responsibilities. There should also be compulsory 'refresher' courses
- Non-Executive Directors should be made fully aware of their roles and responsibilities in holding the Trust officers to account

- There must be a demonstrable commitment to ensure that HR advisers in Trusts are knowledgeable and have an in-depth understanding of the principles and processes of MHPS

- Foundation Trusts should have their disciplinary proceedings independently audited to ensure the letter and spirit of MHPS is being complied with.

NCAS

- *Assisted Action Plans* – which NCAS used to provide to employers and individual doctors during disciplinary proceedings – should be reinstated as a matter of routine. The emphasis of these documents was rightly on trying to keep doctors at work wherever possible, and they had tangible benefits

- When Medical Directors receive expert advice during proceedings, NCAS should ensure that they have been given as detailed and balanced information as possible. Too often, the information provided is vague and can be selective, and broader advice should be sought.

GMC

- In the next revision of *Good Medical Practice* and/or *Leadership and Management for all doctors,* serious consideration should be given to making explicit reference to a Medical Director's (and others) responsibility to ensuring disciplinary proceedings are conducted appropriately and compliant with the letter and spirit of the governing framework

- The GMC should hold Medical Directors and those involved in conducting disciplinary proceedings accountable in the same way they would any other registrant for their conduct

- The GMC should commit resources to work with Responsible Officers to promote best practice for those conducting disciplinary proceedings.

Department of Health & Social Care

- When presented with evidence, the Department must commit to publicly name Trusts who are found to consistently depart from the agreed MHPS standards and principles for disciplinary proceedings

- The General Practice first tier tribunal should also be reviewed, to see if any aspects could be transferred to secondary care

- Consideration urgently needs to be given to how a doctor can seek to rectify failings of a disciplinary proceeding while it is still ongoing. Far too often recourse can only be sought through the courts, either when proceedings have concluded or a nearing a close

- Consideration should also be given to amending the Responsible Officer regulations to require Responsible Officers to ensure fair and efficient disciplinary processes are in place, both in terms of implementing MHPS and the principles set out in this paper.

As we initiate this conversation, MPS stands ready to work with these organisations and others, to ensure we have disciplinary procedures in place that are fair, proportionate and timely. All this is to the benefit of the NHS, patients' and doctors; *getting it right* is essential.