Hospital investigatory proceedings against doctors in England: A case for a change

Contents

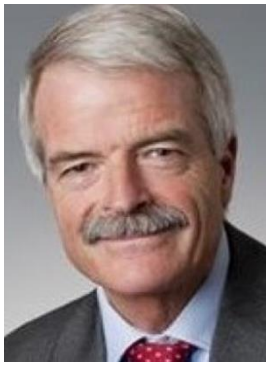
Foreword

I believe that this is an important paper. Nobody could read the case summaries in appendix two without a sense of shock at the time and expense that can be consumed when disciplinary proceedings are launched against clinical staff, let alone the delays, the secrecy, the uncertainty, and the unfairness that can ensue.

The proposals set out here may not be perfect, but they map out a practical approach to reforming the current procedures in order to minimise unfairness to individuals. Of course, fair disciplinary procedures are a necessary part of maintaining patient safety, and urgent action may sometimes be required. Whistle-blowing allegations need careful investigation, and truth can sometimes be elusive. But the impact that unfair disciplinary processings can have on the careers of innocent professionals is dramatic and punitive.

I commend these proposals as a powerful first step towards a fundamental review of the existing procedures and towards instilling best practice in their implementation.

Professor Sir Malcolm Grant CBE LLD, former chair of NHS England



Executive summary

Unfairness, bias, and discrimination are still highly prevalent in the disciplinary proceedings that NHS doctors are subject to, despite repeated improvement measures, recommendations, and reports. The personal and monetary costs of these disciplinary measures are costly but the true costs unknown and unaudited, as are the actions of those in trust management who lead these processes. We propose the establishment of an Independent and elected Scrutiny Panel with statutory powers to oversee and regulate disciplinary action against doctors in each NHS trust. This would establish a perception of balance and fairness that is long overdue and would also allow for transparency and proper audit.

This document addresses the situation as it affects doctors in hospitals in England, but it is envisaged that, should the proposals described in it be adopted, the system could be rolled out to primary care, the nursing profession, allied health professionals and other members of staff. It is also our expectation that these proposals would be adopted by all devolved nations.

Introduction

Maintaining High Professional Standards in the Modern NHS (MHPS) [1] is a framework for the handling of concerns about doctors and dentists in the NHS in England. Recognising that unfair proceedings have wide implications, MHPS was introduced in 2005 to tackle the blame and suspension culture. NHS Employers collaborating with the BMA wanted a framework that would guide disciplinary proceedings, minimising suspension, and the involvement of lawyers. Regrettably, these objectives have not materialised as intended. Sir Robert Francis in his 'Freedom to Speak Up' [2] review criticised the use of disciplinary procedures by NHS Trusts (Trust) saying, '*employers often felt challenged in how to separate safety concerns from disciplinary issues'*. Guidance on the appropriateness of disciplinary action in the form of 'A Just Culture Guide', has not improved practice [3]. An imbalance in the workforce in relation to bias in disciplinary action has long been recognised and ambitions to correct this set out [4]. Views by external observers suggest that there is a problem interpreting MHPS. Doctors challenge this conclusion and overwhelmingly believe that at the heart of the problem is the common practice and culture of misusing the MHPS disciplinary process.

Several professional organisations and affected doctors met under the auspices of *Our NHS Our Concern* to discuss the current situation [Appendix 1]. They universally expressed concerns about the continued unfair and discriminatory practices and agreed to petition calling for the establishment of an Independent Scrutiny Panel with statutory powers in each Trust.

This paper is written on behalf of all the above organisations. We are collectively calling for the urgent adoption of the proposals set out.

1. The case for change

1.1 Unfair and malicious proceedings continue, and a culture of secrecy, bias, and retribution prevails. The wide ranging and often permanent impact on health, mental wellbeing, livelihood, and loss of expertise resulting from these procedures afforded to the individuals affected have been widely acknowledged.

1.2 It should go without saying that all disciplinary action should follow the principles of natural justice; those are **'***Adequate notice, a fair hearing, and the absence of bias.'* Further, MHPS states that *'A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action.'*

These principles of natural justice and the requirement for audit are not observed by many, perhaps most Trusts.

1.3 Freedom of Information requests were sent to all English NHS Trusts in February 2021 with questions relating to their MHPS activity: number of concerns, full investigations, outcomes and ethnicity and gender of the doctors involved. None of the 140 Trusts approached submitted complete data. (See Table 1)

Table 1: Responses from trusts (n=140)

Responses	***Number***
No response to reminders over 9 months	10
Refusal on basis of cost	14
Refusal as low priority	1
Response promised but not received	12
Confidentiality compromised by low numbers: response refused	9
Confidentiality compromised by low numbers: data recorded as <5 or <10	21
Incomplete/limited data provided	73
Complete data submitted	0

Thirty Trusts declined to provide data on the grounds that low numbers would lead to identification of individuals. Confidentiality is important but we do not accept that this is a reasonable response and argue that this data should be available in the public domain.

The significant number of incomplete responses, refusals and non-responders suggest that most Trusts, despite the requirement in MHPS, keep no readily available records. It is manifestly clear therefore that Trusts have no mechanism to audit their MHPS activity, MHPS outcomes, and as such there is an absence of accountability and transparency in relation to disciplinary action against doctors and the recording of the decisions.

1.4 Financial costs of MHPS investigations and outcomes were also requested. Only one Trust provided financial data and stated that internal staffing costs related to MHPS activity ran into several hundred thousand pounds. Doctors who have been subjected to these processes report eye wateringly high costs accrued by individual Trusts. These sums range from tens of thousands to millions of pounds. The evidence quoted arises from personal communications between the parties and reports available from open data sources. These costs are borne by individual Trusts, but nonetheless paid from the NHS purse, therefore the taxpayer. MHPS rules require the cost of investigating doctors to be recorded and audited; this is clearly not happening.

2. Proposed solution

2.1. We propose that the government establish an Independent and elected Scrutiny Panel with full statutory powers in each Trust. Management would have to seek permission from this Panel before embarking on any formal investigatory process following informal enquiries in all cases.

2.2. The changes proposed are designed to identify and **stop unfair and malicious proceedings from the outset.** This process would result in an overall reduction of formal investigations, prevent the significant negative effects on doctors and their families and significantly reduce costs and wasted time. We believe that the introduction of the Independent Scrutiny Panel will improve trust in processes, remove bias and change culture in a positive way.

3. The Scrutiny Panel

3.1. Confidence in the panel would require it to be an independent body and be seen to be so. Appointed members would be at risk of being influenced by management and understandably, would not be perceived as being independent. A more acceptable form would be if the Panel consisted of elected senior doctors and senior nurses in the majority along with fewer non-executive members of the Trust Board.

3.2.a Elected members should be remunerated for the time that they spend on each case.

3.2.b The form of remuneration, whether as payment or time in lieu, would be left to local agreements between the Trust and the panel member.

3.3. Panel members would be required to undergo formal training. The panel should have access to independent legal and human resource advice.

4. Functions and responsibilities of the Panel

4.1. The Panel would need to consist of elected senior doctors, senior nurses, and non-executive members of the Board.

4.2. The Panel would elect a chair and a co-chair.

4.3. The Panel would receive and adjudicate applications, which would have to be received in writing. The applications to the panel would follow a protocol setting out the allegations, evidence and any mitigation stating what action had been taken, if any, to address the matter with the doctor concerned. The request should also clearly set out why such proceedings are appropriate and justified and include reference to all rules and governing principles.

4.4. The Panel may seek a written statement from the doctor involved.

4.5. The Panel considering an initial application would consist of at least two doctors, a senior nurse, and a non-executive member selected by the chair.

4.6 The Panel would ensure that any formal investigatory process or action was appropriate, justified, and free from bias.

4.7. The decision of the Panel would be given verbally and in writing within 48 hours.

4.8. There should be a right of appeal for both the doctor and the Trust (cf para5).

4.9. The Progress of formal investigations should be reported to this Panel at each stage, and at least monthly including costs incurred. The Panel would have the power to seek clarification or raise concerns at any stage if they felt actions were unjustified, flawed, or incorrect**.**

4.10.a The panel should be open to receipt of information given voluntarily by any member of staff, including information that they may wish to give in confidence.

4.10.b Should the panel decide to consider the contents of the information, it should divulge the information, maintaining the anonymity of the informant if applicable, to the Trust as well as to the doctor.

4.10.c Should the panel reject the information; it should direct the informant to an appropriate department or individual.

4.10.d Receipt of such information and details about what action was taken must be recorded in full.

4.11. On conclusion of formal proceedings, the decisions of the Trust management should also be submitted to the Panel. The Panel should scrutinise the management decisions and outcomes, to ensure natural justice had been applied and decisions and sanctions were appropriate, proportionate, and justified.

4.12. On completion of the process the Trust will submit audited costs for the investigation for review by the Panel.

4.13. The Panel will ensure that annual audits of MHPS activity, costs and outcome are carried out and reported publicly in an anonymised format.

4.14. At all times, the Panel should ensure they have followed MHPS guidance and the principles of natural justice.

4.15. The Panel would be required to provide quarterly reports to the Trust Board and annual reports to NHS England.

5. Appeal against the initial Scrutiny Panel judgement (cf para 4,8)

5.1. In case of a dispute between management and the panel relating to a decision to proceed or not with an investigation, management should submit a written appeal to the Chair, who would then form a larger panel consisting of at least three doctors, a senior nurse and two non-executive members. This appeal should be addressed within two weeks of receipt.

6. Panel and management etiquette

6.1. All verbal and written communications between the Trust, the Panel and external bodies should be recorded and be available for review at any time by authorised persons.

6.2. The Trust should ensure that all doctors are aware of the presence of the Scrutiny Panel and its members using an agreed communications strategy.

6.3. Management should not engage in any informal discussion with any member of the Panel.

7. Election to the Scrutiny Panel to be conducted by HR

7.1. Notice of an election and invitation for nomination of candidates to the Trust's Independent Scrutiny Panel should be properly advertised to all doctors and nurses.

7.2. Nominations should be submitted to HR within 14 days after the posting of the notice.

7.3. Each nomination should state the name of the candidate and be supported by two doctors or nurses as appropriate.

7.4. Election would be by secret ballot.

7.5. The electoral process for non-executive members would follow a similar process.

7.6. Panel members would be elected for a term not exceeding three years.

7.7. Number to be elected**:**
Senior doctors - 7
Senior nurses - 4
Non-executive members - 3

8. Eligibility of doctors and senior nurses to stand for election

8.1. To be eligible for election Panel members cannot hold or have held any Trust managerial responsibilities in the three years prior to the election.

8.2. Retired individuals would be eligible, subject to above constraint.

8.3. Panel members must agree to receive appropriate training.

8.4.a. Panel members must agree and sign a confidentiality agreement confirming that they will not discuss any case informally with members of management or other staff.

8.4.b. A breach of 8.4. will result in the immediate termination of the membership of the panel and may attract disciplinary proceedings.

8.5. Panel members would be entitled to stand for election for two further terms to encourage continuity.

8.6. Any Panel member who, during their term, accepts a Trust managerial responsibility would be required to stand down from the Panel. In these circumstances, and when a vacancy arises, instead of holding another election, the medical and nursing members of the Panel would invite a suitable candidate to substitute for the current term of that member

9. Eligibility of non-executive members

9.1. They must agree to receive appropriate training.

9.2. They would be entitled to serve for two more terms.

10. Supportive structure

10.1. The Panel would be supported by a nominated secretary who should also update the availability of members.

10.2. The Panel will be provided with a nominated room.

10.3. The Office should have access to telephone and IT facilities as routinely provided to doctors.

10.4. Contact details of the secretary and the chair should be easily accessible.

10.5. The process should be supported financially by NHS England, not by some other government fund. This is essentially NHS business

Conclusions

Changes made to the investigation and disciplinary process of doctors have failed to prevent increasing instances of unfair, biased, and malicious proceedings. Natural justice has not prevailed. The proposals made in this paper serve to rebalance the current situation by establishing an independent and elected statutory Scrutiny Panel in each Trust.

Currently there is absolutely no meaningful process in place to monitor and audit disciplinary proceedings and their outcomes. There is no record or audit of monetary costs.
While doctors have been penalised when found to be guilty Trusts have rarely been subjected to any form of scrutiny or disciplinary action when their actions may have been incorrect or misplaced. This issue requires further consideration.

This document addresses the situation as it affects doctors in NHS hospitals in England, but it is envisaged that, should the proposals described in it be adopted, the system could be rolled out to primary care, the nursing profession, allied health professionals and other members of staff. It is also our expectation that these proposals would be adopted by all devolved nations**.**

In the immediate future scrutiny panels could also be adopted as the local guardians for Freedom to Speak up.

In summarising our proposals, the first responsibility of every doctor is to do no harm. The overarching objective of the Independent Scrutiny Panel is to protect the public interest which includes ensuring that everyone involved in the trust act in and put the public interest first.

We welcome and support plans for the introduction of the Office of the Whistleblower currently going through Parliament [5].

References:
1. MHPS 205:
https://webarchive.nationalarchives.gov.uk/ukgwa/20130123204228/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

2. Freedom to speak up:
http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

3. A just culture guide – NHS England
NHS_0932_JC_Guide_A3 (england.nhs.uk)

4. Closing the ethnicity gap
https://www.england.nhs.uk/wp-content/uploads/2019/07/closing-the-ethnicity-gap.pdf

5. Bill for the Office of the Whistleblower 21 June 2021 - Baroness Kramer
https://lordslibrary.parliament.uk/office-of-the-whistleblower-bill-hl/

Written by Dr Arun Baksi, Dr Helen Fernandes, Dr Malila Noone, and Georgina Halford-Hall

Acknowledge of those who contributed to the further development of the paper in alphabetical order

Salam Al-Sam, Asher Ansari, David Church, Joydeep Grover, Rob Hendry, Chris Herkensee, Kamal Iskander, Omar Karim, Stuart Lythgoe, Don McCreadie, Christopher Moulton, Subramanian Narayanan, Christine Perry, Samrat Sengupta, Hina Shahid, Parag Singhal, Peter Yea

Appendix 1 names of supporting organisations in alphabetical order

Association of Pakistani Physicians and Surgeons of UK

Association of Physicians of Northern Europe

Bangladesh Medical Association

British Association of Physicians of Indian Origin

British International Doctors Association

British Islamic Medical Association

Doctors Association UK

Doctors for the NHS

Every Doctor

Hospital Consultants and Specialists Association

Justice for Doctors

Medical Association of Nigerians Across Great Britain

Medical Défense Shield

Medical Protection Society

Muslim Doctors Association

Nepalese Doctors Association

Our NHS Our Concern

United Iraqi Medical Association

WhistleblowersUK

Appendix 2 summary of cases –

Case 1. Dr A Story

I was a consultant of some 18 years when I was excluded pending the investigation of a single operative case where the patient had a poor outcome. The case was discussed in a Departmental meeting without my knowledge or input, by my Clinical Lead and immediately escalated to disciplinary investigation. My decision making around the case was criticised, including an allegation of gross negligence. I was immediately excluded but it was not until 6 months later during a MHPS interview that I was actually asked to give an account of myself. The MHPS investigation of the operative case accepted my version of events but concurrently I also faced MHPS investigations related to allegations of inappropriate sick leave, working in the private sector whilst on sick leave, breaching patient confidentiality at a national meeting and seeking to influence witnesses in the investigation. Again, none of these allegations were upheld yet I was not allowed to return to work. I later discovered a Serious Incident investigation also found in my favour, but its conclusions and the authors recommendations were deliberately concealed.

I then faced new allegations of dishonesty Instead of a further investigation into these a Capability Hearing was convened, where the allegations were upheld, and I was summarily dismissed.

I appealed this decision. At a MHPS appeal the Capability Chair did state that evidence that supported my account had been discounted at my hearing, to include evidence that a junior doctor had been asked to lie.

Prior to the Appeal Panel making a decision my Trust offered me a settlement agreement. They offered to reinstate me, although by secondment at a different Trust for a limited number of years. I had secured a secondment at different Unit. My Medical Director (also my Case Manager) was asked to support this. Following his involvement, with no explanation, the secondment offer was withdrawn.

To date, over one single operative case, despite what most would describe a successful career and illustrious CV, I would estimate my Trust has spent well in excess of a million pounds, pursuing disciplinary actions against me. I know of no other colleague in my Trust who has been subject to similar treatment. I am currently still without an opportunity to return to my career- 10 years of training, 18 years of practice as a consultant.

Case 2. **Experiences of Dr Usha Prasad version 1**

I completed my undergraduate and postgraduate training in UK, following which I obtained the CCT in cardiology and GIM in 2009. I then spent a period as a locum consultant in Yorkshire and obtained a substantive post in ESTH at which I was made the Lead Clinician in heart failure.

In 2011/12, I raised a number of safety issues (full list available on request), but none were addresses appropriately

In February 2013, an anonymous complaint against me was sent to the Trust. This led to an MHPS investigation that did not find any evidence and the matter was closed. In 2015, a second anonymous letter against me was filed, with copies sent to the Trust in addition to the GMC and CQC. This led to a lengthy MHPS investigation which again did not find any evidence but recommended that I should watch my communications. Subsequently, and without my knowledge, the author of the letters was asked to undertake an audit of my TOE activities. I sought an apology for subjecting me to baseless allegations against me, but this was not given. No attempt was made to investigate the author of the anonymous letter.

I November 2015, I sought an appointment to speak to the CQC at its routine visit to the Trust. Following an initial denial, I was then given an appointment to see Dr H. I explained my concerns about patient safety

to Dr H as I thought he was a COC member. It subsequently transpired that he did not belong to CQC but was an independent legal adviser to the Trust. I sought the minutes of the meeting, but this was denied.

In November 2015 I made a genuine error in reporting an angiography procedure. No harm was done to the patient. As a result, audits of my work were undertaken.

Dec 2015, I lodged a whistleblowing claim with the Trust and also a dignity at workplace complaint. I was subjected to continued harassment.

November 2016 - Dr Prasad lodged ET claim for whistleblowing detriments, victimisation, discrimination, and harassment. This was dismissed but an appeal was granted,

May 2017 - a list of 43 cases given to Dr B(external cardiologist) - without any discussion with me. I was not even shown the list of alleged 43 misconduct until 12 February 2018.

7 Feb 2018 - on the first day back to work from sick leave, halfway through a clinic, I was asked to leave; this was delivered by telephone by a BMA representative conveying instruction given by the MD (who was in the same building at the time). No reason for this action was given.

12 Feb 2018, I was sent an email with a list of 43 cases of alleged misconduct (on the list, patients were seen from 2013 to 2017) which were not investigated at the material time and at no stage during various meetings I was shown the list of 43 cases. Despite a tight timeline I gave my response.

August 2018 - Unavoidable death of a patient (P) whilst I was on clinical restrictions. I was asked to provide a Root Cause Analysis report on the patient's death. I suggested - system failure and also failures of some individuals. The RCA report also suggested referral to the coroner and sharing the report with CQC and the family. I was asked to remove these from the report; I refused to do so.

July 2019 - an invitation to attend disciplinary hearing (MHPS).

2 July 2019, 29 July 2019, and 14 October 2019 - Grievance submitted by me

Disciplinary hearing started in October 2019 and continued for several months.

17 January 2020 - CEO offers to discontinue the MHPS Hearing if I agreed to withdraw all claims against the trust (ET, grievance), agree to leave the trust after 6 - 12 months of paid return to clinical practice elsewhere. He was also going to help with revalidation if above was agreeable.

9th June 2020 - MHPS capability hearing: terminated contract on 9 June 2020 - based on SOSR (breakdown in relationship) and made clear that termination of contract was not due to capability.

On 22 June 2020 – I submitted an appeal of MHPS.

On 27 June 2020 - all matters referred to the GMC which included about 43 alleged clinical misconduct, the internal MHPS report about capability and conduct and lack of insight / reflection

From June 2020 until March 2021 - GMC investigated the case and closed the case with no case to answer.

Published references –

1. https://davidhencke.com/2021/03/10/exclusive-general-medical-council-investigation-exonerates-dr-usha-prasad-of-any-medical-failings/

2. https://davidhencke.com/2021/01/19/botched-internal-inquiry-hearing-into-dr-usha-prasad-at-st-helier-hospital-as-doctors-fight-death-from-covid-19/

Case 3. Dr Plum

Dr Plum is a 45-year-old renal physician who was appointed to her current consultant post five years ago. She trained in another part of the country and had been a consultant in a teaching hospital there but moved to the area she currently stays in for family reasons. She is aware that when she was appointed one of the local trainees had also applied for the post but was unsuccessful. It was clear her clinical and research experience made her the better candidate.

The unsuccessful candidate made Dr Plum's first few months uncomfortable as they often excluded her from conversations and made sarcastic comments in departmental meetings. All of this seemed to have blown over when this trainee left the area to take up a consultant post elsewhere.

Dr Plum was shocked and surprised to be summoned to the Medical Director's office on morning during a busy out-patient clinic. The Medical Director said they had no option but to suspend Dr Plum with immediate effect because serious allegations had been received about her care of patients and behaviour at work. Dr Plum asked what the allegations were and who had made them. She was told the 'concerns' would be sent to her in writing 'in due course,' but the Trust's policy for protecting whistle-blowers prevented them saying where the allegations had come from.

After ten days Dr Plum was contacted in writing to invite her to meet with an investor appointed by the Trust. No details were given about what was being investigated.

Dr Plum attended the meeting alone and was told that the concerns related to four areas:

- Not following guidelines for treating patients
- Inadequate hand washing on the renal unit
- Recruiting patients to studies without their proper consent
- Being rude at meetings and difficult to work with.

Dr Plum became very upset at the meeting and was told if she had mental health problems, she needed to seek the advice of Occupational Health.

Dr Plum decided to resign, and she was then referred to the GMC by the medical director who alleged she had refused to engage with the Trust's disciplinary process.

An IOT did not consider it necessary to impose any conditions on her registration and after eighteen months the MPTS did not find any of the allegations proven against her.

Sadly, she remains out of work.

Case 4

After 6 years of being driven out of my workplace for raising concerns about patient safety, I still cannot believe that something like this ever happened to me. I served our NHS for 38 years, 30 of them as a consultant. I have unblemished GMC record. My appraisals throughout the years have been full of documented evidence of my commitment and dedication to the job I do and the service I provide my patients and the community. In addition to providing clinical service, I am a teacher, a mentor, and a researcher.

I was under the illusion that NHS doctors were protected if they raised protected disclosure about protecting patient's lives and improving patient's experience. Instead of addressing the matters which were reported internally though the right chain of commands, starting with my line manager, the head of service, the freedom to speak up guardians and the responsible officer and his team, the tables were turned against me, and I found myself out in the cold with no one to care or listen. My hospital manufactured false allegations against me and started one MHPS investigation after another, amending the terms of reference as I managed to prove their claims to be untrue and baseless. They failed to appoint a clinical advisor to aid the process of

internal investigation. Instead, they appointed an HR person as a case investigator, paid her large sums of NHS funds to come up with a biased report against me. I continued to fight back the irregular and unfair methods followed by my hospital and as I did, the level of threat increased. Throughout the years of hardship, I discovered that the BMA was powerless, and my medical defence organisation had limited effect in challenging the aggressive and relentless twisted methods by my hospital. I contacted my respective Royal College asking for their help but found them irresponsive stating that they would interfere only if invited by my hospital to review the case. My hospital never referred me to the GMC for capability matters or conduct knowing that had they done so, their baseless allegations would have been discovered.

While severely injured and out in the cold for six years, I came across fellow consultants from other part of the UK who were treated in the same way. To my disbelief and horror, I discovered that their hospitals have used the same inadequate and disqualified investigator to issue biased MHPS outcomes against them.

At a time when the NHS was facing shortages and the GMC was calling retired consultants to come back to work following the Covid-19 Pandemic, those who were appointed in a position of trust and responsibility were using NHS funds to protect their reputation and drive hardworking and capable consultants out of the workplace.

Based on the GMC recommendations of good medical practice, caring doctors must raise concerns if they felt that patient's lives are in danger. Such doctors are supposed to be protected; I came to discover the bitter truth that this was not true. Whistle-blowers will remain targets for such abuse and irregularity until the current unfair practices are stopped. Since June 2015, I have been without a job, I remain defiant and waiting to be reinstated to help the NHS and save lives.

Appendix 3

1. Hospital Disciplinary Processes – The place of the MDOs

Dr Rob Hendry, Medical Director, Medical Protection Society

BACKGROUND

The reason MPS exists is to protect the careers, reputations and financial security of doctors, dentists, healthcare professionals and organisations around the world.

As an organisation wholly owned by its members, all of the money raised in subscriptions are used in the interests of members. There are no shareholders to pay dividends to. All decisions about how our resources are deployed are influenced by fellow doctors as the Council who act as the Board of Directors is chaired by a doctor and has a majority of doctors and dentists sitting on it as non-executive directors. Also, unlike many insurance companies, MPS employs a wide range of doctors skilled in medical law to support and advise members. This is especially important for members who find themselves the subject of disciplinary proceeding by their employers.

It is well recognised that not all NHS Trusts implement the procedures set out in Maintaining High Professional Standards (MHPS) in the same way and that doctors from different backgrounds are not always treated fairly in the same way. This is a matter of grave concern to MPS.

There is an urgent need to 'level up' the way in which medical staff are treated. Not only is it the morally right thing to do, but at a time where the NHS is chronically short of good doctors it is simply madness that able clinicians are taken out of the workforce for long periods and sometimes hounded out of medicine for ever. Junior staff in training become demoralised when seeing how their teachers and mentors are treated and overseas trained doctors considering a career in the UK will look to take their skills and experience to other, more welcoming, and supportive countries. Ultimately it is patients who suffer and all of us will be patients one day.

So where can we begin to make change?

It is possible to consider the issues in three main areas:

1. Before problems arise – what can be done to reduce the number of disciplinary cases and that those that do proceed are done so fairly?
2. When problems arise – ensuring fair treatment

When action needs to be taken – supporting doctors to get the right outcome and minimise the damage.

PREVENTION IS BETTER THAN CURE

The culture of the NHS needs to change. Despite claiming to have a 'no-blame' culture, many Trusts will often seek to ascribe blame to individual clinicians when things go wrong. Where there is dysfunction in a unit or department it is rarely due to a single individual's behaviour or performance. As the research by Atewologun, Kline and Ochieng showed, 'In groups' and 'Out groups' exist in medicine including relating to qualifications (including by country and within the UK by medical school) and ethnicity (including within ethnic minority populations). Members of ingroups can receive favourable treatment and those in out groups are at risk of bias and stereotyping.

The Scrutiny Panels as suggested in this paper, represent a practical proposal to redress this balance and their introduction would signal a desire to change and rebuild confidence in all staff the NHS comes to rely more and more on doctors and other healthcare workers who have trained outside the UK, the urgency of changing this culture is increasing. All incoming staff, and the teams they are joining, need far more comprehensive induction programmes to ensure alignment of expectations and discussions about how any

issues of conflict and disagreement will be handled. How performance is monitored and managed also needs to be transparent and explicit. All of this depends on strong and effective leadership.

FAIR AND BALANCED ASSESSMENT

There are few more distressing times in a doctor's life than when they are told they are to be the subject of a disciplinary enquiry. The rush of emotions that go through the professional's mind makes it difficult to cope and make balanced decisions. It is therefore vital that they have access to independent specialist advice. Sadly, a significant number of doctors in the NHS, particularly if they have trained outside the UK, are not aware of the importance of being a member of an MDO. They may assume that because medical negligence claims are covered by the NHS Clinical Negligence Scheme that membership of an MDO is only required for doctors doing private practice.

When a member is subject to any process that calls into question their competence as a doctor or queries their fitness to practise, they should contact their MDO as soon as possible. We have extensive experience in this area, unlike some Trust HR departments who may have rarely had to handle such cases. Early contact by either a medicolegal consultant or one of our lawyers with the employing Trust can go a long way in ensuring a fair process is followed. Possible routes for an informal approach can be discussed, in order to keep the doctor working if at all possible. In our experience the longer a doctor is out of practice, the more difficult it will be to return, even when they are fully exonerated by the disciplinary process. MHPS does have scope for creative solutions to be found if there is a willingness on all sides to avoid a 'win-lose' situation. The voice of the MDO is often louder than that of the isolated professional. Being able to point to successful examples in other Trusts can be helpful.

The MDOs also work closely with organisations such as the BMA and HCSA who are specialists in employment law issues. Again, it is important all doctors are advised to join a trade union as they may require specialist advice if the relationship with their employer breaks down. SUPPORTING YOU

As well as supporting doctors who are the subject of hospital disciplinary processes from the professional and legal points of view, looking after the mental wellbeing of members is seen as of paramount importance by MPS. From the support one of our medicolegal consultants can give as a fellow doctor, through to individual confidential counselling, we tailor the support to the member's needs.

In addition, as a members first organisation, we realise the importance of driving policy and culture change, which is why being able to work with groups such as the one set up by Dr Baksi and colleagues is of such importance. Drawing on the experience and insight of members allows us to develop and share policy ideas. We have regular contact with a range of stakeholders who we can seek to influence.

CONCLUSION

There are very few doctors who do not strive to practice the best standard of medicine they can. Where concerns arise, the reasons are usually complex and multifactorial. Having a fair, proportionate and just process for managing such concerns is challenging in today's overstretched and underfunded health service. The Scrutiny Panels as suggested in this paper are a practical way to redress the current imbalance and their introduction would signal a desire to change and rebuild confidence in all staff.

For any doctor who becomes entangled in such a situation it is important they have a strong ally to support and guide them through the process. They need someone in their corner to champion their cause and protect their career. This is what the MDOs were established to do over one hundred years ago and it is what they will continue to do while also working hard to help members reduce their risks and to change cultures.

2. Disciplinary Process for NHS Hospital Doctors – MDS's experience

Dr Joydeep Grover, Medical Director, Medical Defence Shield (MDS)

Medical Defence Shield was established in 2010 as a unique organisation providing practicing doctors in the UK with both Professional Defence and Employment Support in a comprehensive manner as opposed to the somewhat artificial division of conduct and clinical matters. We therefore support our members in employment processes as well as regulatory matters. MDS is founded on the principle of a 'not for profit' organisation and invests all its funds in furthering the cause of its members. While MDS has members from all backgrounds, the majority of its membership is comprised of doctors from ethnic minorities and international graduates.

MDS has extensive experience in dealing with doctors facing a variety of investigations under the MHPS which often lead to a double jeopardy of GMC referrals based on initial flawed and sometimes misunderstood or, sadly, motivated investigations.

In our experience we have noted that MHPS processes are not followed in the spirit they were designed for, making the process ambiguous, lengthy, and lacking direction. All NHS trusts do not consistently apply the framework, and more often than not the case managers are inclined to use the severest penalties (exclusion for example) which were only meant to be used as a last resort. We have also noted the separation between the case manager and investigator is lacking in practice, leading to inevitable bias in the process. The process rarely keeps to time causing severe morale damage to the doctors involved and leads to lack of motivation and disillusionment. Lastly there is no accountability or feedback for the managers who make incorrect decisions, or for colleagues who make vexatious/motivated complaints, thereby furthering and enabling a culture of bullying and harassment. The process thus rapidly progresses to 'blame culture' and 'punishment' rather than in the interest of safety, support, and improvement – what Maintaining High Professional Standards should be.

While it could well be argued that MHPS itself is not fit for purpose, this paper by Dr Baksi et al makes some very crucial points that could make this process fairer and align it closer to what it was initially intended to achieve.

The establishment of an independent and trained scrutiny panel which can objectively recommend the initiation or not of any actions under MHPS is a very positive suggestion that will reduce subjectiveness and arbitrariness of such important decisions. Such a panel in addition should be able to monitor the progress and timeliness of the investigation and remain responsive to the practitioner's concerns. The panel should also have scrutiny over outcomes or sanctions and any decisions that involve a referral to the regulator so as to ensure that this is not done frivolously or 'as a matter of routine,' or worse still as a threat. The panel should be assured that there were no conflicts of interest, and if these are identified there should be a clear process for the doctor to be able to address this.

Exclusion from work must remain an absolute last resort and must be justified with exceptional evidence to the scrutiny panel. If implemented it must be even more exceptional for it to be continued, not like currently when it is treated as a tick box exercise and 'automatic review.'

We also feel that the non-executive directors must be involved, engaged, and support the practitioners better with regular contact and mentorship. Further if independent experts are asked to comment, their appointment must follow a due process and the said expert must have access to all documentation in addition to the practitioner having an opportunity to meet them to highlight their side of the story. Similarly, the trust must share all correspondence on the matter, for example that with PPAS, with the practitioner in an open and honest manner.

There should be an automatic review after completion of each MHPS to provide feedback to the managers involved, and opportunities to share learning across trusts.

The setting up of an empowered, objective, and independent scrutiny panel, therefore, has the possibility of providing direction to MHPS processes to make them fairer, objective and fit for purpose thus bringing it closer to the spirit in which it was created by removing arbitrariness of individual actions. It also could ensure that involved staff do not feel devalued and depersonalised but are supported and empowered. Such an effort will be a positive step to redress the imbalance in the process to make it fairer for the doctors and will prove to be of immense benefit to the NHS by promoting just culture.

I would like to thank Ms Sarah Dodds, Head of Legal, Ms Nisha Kanungo and Ms Banita Sheemar, Solicitors at MDS for their inputs in this statement.