Appeal No. UKEAT/0015/18/DA

EMPLOYMENT APPEAL TRIBUNAL

FLEETBANK HOUSE, 2-6 SALISBURY SQUARE, LONDON EC4Y 8AE

At the Tribunal
On 25 October 2018
Judgment Handed down
On 8 November 2018

Before

THE HONOURABLE MRS JUSTICE SIMLER DBE

PRESIDENT

SITTING ALONE

SHAREEN IDU — APPELLANT

EAST SUFFOLK & NORTH ESSEX NHS FOUNDATION TRUST — RESPONDENT

Transcript of Proceedings

JUDGMENT

APPEARANCES

For the Appellant	Mr Aidan O'Neill QC (One of Her Majesty's Counsel) Instructed by: Slater Gordon UK Ltd 50-52 Chancery Lane London WC2A 1HL
For the Respondent	Mr Simon Cheetham QC (One of Her Majesty's Counsel) Instructed by: Capsticks Solicitors LLP 1 St Georges Road Wimbledon London SW19 4DR

SUMMARY

Wrongful Dismissal

Unfair Dismissal

It was for the Employment Tribunal to decide as a matter of law, whether the misconduct allegations against the Claimant were properly to be characterised as 'professional misconduct' obliging the Trust to have an independent, medically qualified person on the disciplinary panel in accordance with the Department of Health's document, Maintaining High Professional Standards in the Modern NHS (MHPS) and the Trust's own internal policy. If the Tribunal erred in law in reaching its decision on that issue, the Employment Appeal Tribunal could interfere.

Considering the substance of each of the allegations against the Claimant, the Tribunal was as a matter of fact and law entitled and right to find that they had nothing to do with the exercise of the Claimant's "clinical or professional conduct or competence". The Tribunal did not err in law in reaching those conclusions.

Nor did the allegations raise issues of capability. It was no part of either sides' case that they did.

That being so, there was no breach of contract because the requirement to appoint an independent medical expert under MHPS was not engaged. Further, as no capability issue arose, there was no need to have an assessment of capability carried out by the National Clinical Assessment Service (NCAS).

THE HONOURABLE MRS JUSTICE SIMLER DBE

Introduction

1. This is an appeal from a judgment promulgated on 14 September 2017 of the Bury St Edmunds Employment Tribunal ("the Judgment"), comprised of Employment Judge Sigsworth and members, Ms Daniels and Ms Lee. The Tribunal dismissed all claims brought by Ms S R Idu (referred to as the Claimant as she was below, for ease of reference) against her former employer, the Ipswich Hospitals NHS Trust, now known as the East Suffolk and North Essex NHS Foundation Trust[1] ("the Trust"). The Tribunal had to deal with wide-ranging claims of whistleblowing detriment based on 32 asserted protected disclosures, unlawful sex and race discrimination, in addition to claims of ordinary and automatic unfair and wrongful dismissal.

2. This appeal concerns only the claims for ordinary unfair and wrongful dismissal and raises a narrow point of law. It concerns the meaning of the term "professional conduct" and how it was applied by the Employment Tribunal in determining whether disciplinary allegations against the Claimant included allegations of "professional misconduct" (or lack of capability) as used in the Department of Health's document, Maintaining High Professional Standards in the Modern NHS ("MHPS"), which sets out a framework covering disciplinary procedures for doctors and dentists; and consistently with that, as used in the Trust's own internal disciplinary policy.

3. The Employment Tribunal held that the disciplinary allegations all concerned the Claimant's personal (rather than professional) conduct and accordingly, under MHPS it was not necessary for the Trust to have an independent doctor on the disciplinary panel constituted to determine whether or not the allegations were proved and if so what sanction should be applied.

4. The single ground of appeal advanced on the Claimant's behalf by Mr Aidan O'Neill QC (who did not appear below) is that the Tribunal was in error of law in failing properly to characterise the conduct in issue (or some of it) as raising professional conduct and/or professional capability concerns, and not just personal conduct concerns. For the Trust, Mr Simon Cheetham QC (who did appear below) contends that the Tribunal made no error of law and properly characterised the conduct in issue in this case.

The contractual framework

5. The Trust's internal Additional Disciplinary and Capability Policy for Medical and Dental Staff (version 2.0, 2013) ("the ADC Policy") is required to be and is modelled on MHPS, which replaced earlier disciplinary procedures contained in circular HC(90)9.

6. HC(90)9 contained the following definitions:

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

[1] At the invitation of the Respondent Trust and in exercise of powers under s. 35 of the Employment Tribunals Act 1996 and by reference to Rule 29 of the ET (Rules of Procedure) I have amended the name of the Respondent to this appeal by substituting the East Suffolk and North Essex NHS Foundation Trust (as it is now known) as Respondent. The Claimant raised no objection to this course of action.

> Professional conduct. Performance or behaviour of practitioners arising from the exercise of medical or dental skills."

7. Page 3 of MHPS sets out the key changes from HC(90)9 including, relevantly:

> "The distinction between personal and professional misconduct is abolished. Doctors and Dentists employed in the NHS will be disciplined for misconduct under the same locally based procedures as any other staff member; …"

Notwithstanding that statement, the distinction appears to be maintained because, for example, Part III of MHPS headed "Guidance on Conduct Hearings and Disciplinary Procedures" provides:

> "1. 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 of doctors…should be dealt with under the employer's procedures covering other staff charged with similar matters. Employers are nevertheless strongly advised to seek advice from the NCAA (now NCAS) in conduct cases, particularly in cases of professional conduct.
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> 2. Where the alleged misconduct relates to matters of a professional nature, or where an investigation identifies issues of professional conduct, the case investigator must obtain appropriate independent professional advice. Similarly, where a case involving issues of professional conduct proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation."

8. The terms 'misconduct', 'personal conduct' and 'professional conduct' are not defined in MHPS.

9. Instead MHPS states that "*Misconduct can cover a very wide range of behaviour and can be classified in a number of ways*". At paragraph 4 under the heading "Codes of conduct" MHPs identifies four distinct categories into which misconduct will generally fall. These are in summary, (i) refusals to comply with reasonable requirements of the employer; (ii) infringements of disciplinary rules including contraventions of professional behaviour standards required by regulatory bodies; (iii) commission of criminal offences outside the place of work; and (iv) wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety or create serious dysfunction to the effective running of a service. Paragraph 5 recognises that examples of misconduct will vary greatly and provides that the internal codes of conduct should set out details of some of the acts that will result in a serious breach of contractual terms and will constitute gross misconduct, albeit recognising that a code cannot cover every eventuality.

10. Paragraph 7 provides:

> "Failure to fulfil contractual obligations may also constitute misconduct. For example, regular non-attendance at clinics or ward rounds, or not taking part in clinical governance activities may come into this category. Additionally, instances of failing to give proper support to other members of staff including doctors or dentists in training may be considered in this category."

11. MHPS makes clear that it is for the employer to decide on the most appropriate way forward but (at paragraph 9) *"if a practitioner considers that the case has been wrongly classified as misconduct, he or she… is entitled to use the employer's grievance procedure."*

12. Mr O'Neill QC submits that whilst not expressly delineating between professional and personal conduct, read in the context of the different procedural requirements set out at paragraph 2 of Part III MHPS (see above), the examples of categories of misconduct given in paragraph 4 (and 7) all concern professional misconduct save only category (iii). I reject this submission. It seems to me that the categorisation in paragraph 4 does not distinguish between personal and professional misconduct. The categories of misconduct identified can involve either personal or professional conduct (or perhaps both) depending upon the circumstances and facts of a particular case. Adopting an example suggested by Mr Cheetham QC in argument, refusal to comply with an employer's instruction not to smoke is likely to give rise to personal misconduct issues whereas refusing to perform a clinical procedure is likely to concern professional misconduct.

13. The Trust's own ADC Policy (which is contractual) reflects the national framework set out in MHPS and so far as relevant provides:

> "5.1 Misconduct matters for doctors and dentists, as for all other staff groups, will be dealt with under the Trust's Disciplinary Policy. The Trust will seek advice from the NCAS in conduct cases, particularly in cases of professional conduct. Where the alleged misconduct relates to matters of a professional nature, or where an investigation identifies issues of professional conduct, the case investigator must obtain appropriate independent professional advice. Similarly, where a case involving issues of professional conduct proceeds to a hearing under the Trust's disciplinary Policy the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation.
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> ……..
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> 5.4 It is for the Trust to decide upon the most appropriate way forward, having consulted the NCAS and their own employment law specialist. If a practitioner considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to use the Trust's Grievance Procedure. Alternatively, or in addition he or she may make representations to the designated board member".

14. Part IV of MHPS deals with "Procedures for Dealing with Issues of Capability" and provides as follows:

> "3. However, there will be occasions where an employer considers that there has been a clear failure by an individual to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability or consistently poor performance. These are described as capability issues. Matters that should be described and dealt with as misconduct issues are covered in part III of this framework.
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> 4. Concerns about the capability of a doctor or dentist may arise from a single incident or a serious of events, reports or poor clinical outcomes. Advice from the National Clinical Assessment Authority (NCAA) will help the Trust to come to a decision on whether the matter raises questions about the practitioner's capability as an individual

(health problems, behavioural difficulties or lack of clinical competence) or whether there are other matters that need to be addressed. If the concerns about capability cannot be resolved routinely by management, **the matter must be referred to the NCAA before the matter can be considered by a capability panel** (unless the practitioner refuses to have his or her case referred). Employers are also strongly advised to involve the NCAA in all other cases particularly those involving professional conduct.

5. Matters which may fall under the capability procedures include:

Some examples of concerns about capability

- Out of date clinical practice;
- Inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
- Incompetent clinical practice;
- Inability to communicate effectively;
- Inappropriate delegation of clinical responsibility;
- Inadequate supervision of delegated clinical tasks;
- Ineffective clinical team working skills. ……

8. It is inevitable that some cases will cover conduct and capability issues. It is recognised that these cases can be complex and difficult to manage. If a case covers more than one category of problem, they should usually be combined under a capability hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the employer to decide on the most appropriate way forward having consulted with an NCAA advisor and their own employment law specialist".

15. So far as concerns paragraph 5 (set out above), and matters identified which "may fall" under capability procedures, Mr O'Neill submitted that a purposive approach to this paragraph that has regard to the adverse consequences for a doctor dismissed on conduct grounds and the emphasis on informal measures including training, means that the list should be read as identifying matters that all fall under capability procedures, but there may be other matters not listed. In other words, "may" is to be read as "must" but not exclusively so. I do not accept this submission. Even allowing for a broader scope to be given to the concept of capability under MHPS, the examples given are not always and inevitably capability issues irrespective of the facts. To take the matter particularly relied on by Mr O'Neill, "inability to communicate effectively", concerns about a clinician who cannot communicate a procedure to his or her patient are likely to be dealt with under the capability procedures, whereas concerns about a clinician who is too drunk to communicate, or cannot communicate why he is in the car park without a permit are likely to raise conduct (and not capability) issues.

16. Part IV, paragraph 15 refers to the requirement in cases relating primarily to the capability (or lack of it) of a practitioner, to draw up an action plan with the assistance of NCAS, designed to enable the practitioner to remedy any lack of capability identified during assessments. Provision is also made for referral to NCAS before any consideration by a performance panel. As with professional conduct cases, capability cases must be heard by a panel that includes at least one medically qualified person independent of the employer.

17. The Trust's ADC Policy mirrors these requirements. It also makes clear that some cases will cover conduct and capability issues and can be complex and difficult to manage (see paragraph 6.4). It suggests that if a case covers more than one category of problem they will

usually be combined under a capability hearing though there may be occasions where it is necessary to pursue a conduct issue separately.

The facts

18. Given the narrow issue to which this appeal gives rise, it is unnecessary to set out the facts as found by the Employment Tribunal in any detail. It is sufficient for my purposes to deal with the procedure adopted by the Trust and the findings made by the Tribunal about the disciplinary allegations upheld against the Claimant which led to her summary dismissal.

19. The Claimant was a Consultant in Emergency Surgery, Major Trauma (with a specialism in upper gastro-intestinal surgery). She commenced permanent full-time employment in this role on 1 September 2014 and remained so employed until her summary dismissal on 10 May 2016.

20. There is no dispute that the disciplinary panel that dealt with her case did not comprise at least one independent medical practitioner. Nor was the capability procedure followed. Rather, the disciplinary allegations against the Claimant were treated by the Trust as raising matters only of personal rather than professional conduct, and were dealt with by a panel of Trust employees comprising Dr Simon Smith, a Consultant Radiologist and Associate Medical Director (who chaired the panel), Ms Karen Lough, Head of Operations, division 2 – surgery, and Ms Caroline Wiltshire, HR Business Partner.

21. The disciplinary case against the Claimant emerged as follows. As a result of a number of complaints and concerns (from various sources) raised about the Claimant, the Director of HR (Ms Clare Edmondson) decided to exclude her under section 4.7 MHPS, which allows for an immediate time-limited exclusion where there has been a breakdown in relationships between a colleague and the rest of the team. The Tribunal found that the Claimant's exclusion was reviewed as appropriate every two weeks and on 8 December 2015 it was decided that she could be permitted to return to work on restricted duties but kept out of the clinical environment in order to minimise any personal interactions. NCAS agreed this approach. The Claimant returned to work on restricted duties accordingly in late January 2016. In February 2016 Mr Alan Mack (an experienced HR professional who had undertaken complex investigations for the Trust previously) was appointed to undertake an investigation into a number of issues concerning the Claimant. There were 11 in total. Mr Mack met with the Claimant on 19 February 2016 and she responded to the issues raised (as the Tribunal described at paragraph 5.11).

22. On 28 March 2016 Dr Garfield as case manager considered the report produced by Mr Mack. He convened an ad hoc decision-making panel with himself, an HR representative and the Director of Emergency Medicine. Neither of the other two had been involved in any aspect of the case to that date. All three reviewed the report and Dr Garfield concluded that there was a case to answer, the concerns raised were ones of conduct and they were very serious (paragraph 5.14). He decided there should be a disciplinary hearing (which should also consider termination of employment on the basis of an irretrievable breakdown in normal working relationships) and the Claimant was informed of this decision on 8 April 2016. NCAS was updated on 19 April 2016.

23. The panel chaired by Dr Simon Smith was appointed. By letter dated 25 April 2016 Dr Smith invited the Claimant to attend a disciplinary hearing. The letter listed the allegations of

misconduct to be considered and these were essentially those considered by Mr Mack. In addition, the Claimant was told that the panel would consider whether there was a breakdown in trust and confidence between the Trust and the Claimant.

24. A disciplinary hearing took place on 10 May 2016. The Claimant attended in person and said she was happy to proceed without a representative or colleague. She did not call witnesses. The management case was presented by Dr Garfield who called witnesses and they were questioned by the Claimant. The hearing took the best part of the day. The panel deliberated thereafter but were unable to reach a conclusion, so returned the following Monday morning to deliberate further. Having made findings they reduced them and their conclusions to a 12 page letter. The Tribunal found at paragraph 5.16 that Dr Smith and his panel found seven allegations of misconduct to be proved. The Tribunal's findings in relation to the allegations proved are as follows:

(i) Allegation one: Clinical Lead issue (dealt with at paragraph 5.16 of the Judgment). The panel found that the Claimant continued to hold herself out as Clinical Lead, even after being told not to do so. The Employment Tribunal held "*Dr Smith and the panel made a finding that the Claimant had deliberately and consciously ignored reasonable instructions from senior managers on the issue*" of holding herself out as Clinical Lead.

(ii) Allegation two: job plan issue (paragraph 5.16). The Employment Tribunal referred to numerous attempts made by the Trust to work with the Claimant to agree a job plan (which was a requirement of the terms and conditions of NHS Consultants). However, *"(t)he Claimant had declined meetings on the basis that she was busy or had other commitments, although her timetable did not suggest that this was the case*." The Employment Tribunal referred to the panel's findings "*that the Claimant had refused to cooperate or engage with the Respondent in its attempts to create a job plan with her, and had done so without justification*."

(iii) Allegation three: refusing to provide cover for junior doctors during strike periods or explain her position (paragraph 5.16). The Tribunal referred to the panel's finding on questioning by it that "*the Claimant remained resolute in her position about her right not to undertake cover for strike periods and to refuse to explain her position*". Dr Smith's view from his own experience as a Consultant, was that all other Consultants had worked flexibly, prioritising the care and safety of patients and "*there was therefore a significant contrast with the Claimant who had flatly refused to do so*".

(iv) Allegation four: the 18 week target (or PTL) issue (dealt with at paragraph 5.17 of the Judgment). This involved a concern that the Claimant was listing patients for surgery who had been waiting less than 18 weeks rather than those who had breached or were about to breach the 18 week target, without any good medical reason for doing so. The Tribunal found that "*when challenged, the Claimant presented a number of reasons why she considered that her patient should be taken out of turn, but neither Mr Osman nor Mr Power were satisfied by these explanations*" (see findings at paragraph 5.8). At paragraph 5.17, dealing with this allegation, the Tribunal found that Mr Osman was "*unable to identify mitigation to justify them being taken out of turn*" given the waiting times of some of the patients. In response, the Claimant said "*the patients on her list on medical grounds were higher prioritised and urgent…*". When dealing with its

conclusions about the detriments the Claimant alleged she had suffered, at paragraph 13.2 the Tribunal summarised its findings in relation to the 18 week issue as follows: "*she would not explain why she was not following the Trust's policy on the PTL. We conclude that she had no good reason for not covering the strike, on the evidence we have read, and that she failed without good reason to explain to her managers why she could not stick to the 18 week waiting list rule*."

(v) Allegation five: tone and style of written and verbal communications with managers and colleagues (paragraph 5.18 of the Judgment). The Tribunal referred to a number of examples of this identified in the dismissal letter and in Mr Mack's report. For example, the Claimant called Mr Power a liar and when asked not to do so, repeated the comment. She referred to Dr Buckley as not to be trusted and unreliable. She ridiculed Mr Tuffaha in a handover meeting. The Employment Tribunal found that the disciplinary panel regarded such comments as inappropriate and derogatory.

(vi) Allegation six: refusal to leave 5 February 2016 surgical business meeting (paragraph 5.18). The Employment Tribunal held in relation to this meeting that "*the panel found that the Claimant's refusal to leave the meeting was unreasonable and her behaviour in response was wholly inappropriate*."

(vii) Allegation seven: the allegation that the Claimant was unmanageable (paragraph 5.19 of the Judgment). The example identified by the Employment Tribunal in this regard was the written response the Claimant provided to a GP's complaint which the panel found to be "*arrogant and expressly inappropriately critical of the GP*".

25. The Tribunal found that as far as sanction was concerned the panel regarded the conduct as so serious that it amounted to gross misconduct. "*The allegations taken together demonstrated a clear and sustained pattern of refusal to accept the authority of management, and a refusal to communicate with managers, peers and junior members of staff in a manner that was acceptable for. They felt that the Claimant's behaviour towards others frequently amounted to bullying. The Claimant consistently refused to accept any criticism of her behaviour, and reflect on the impact of her behaviour on colleagues and the service, demonstrating a significant lack of insight and a wilful refusal to comply with the standards and expectations reasonably set by the Trust*." The Claimant was accordingly dismissed.

26. She appealed the decision to dismiss her. An appeal panel was convened and there was a full rehearing (paragraph 5.22). The Tribunal found that the chair of the panel tried hard to keep the tone of the hearing courteous but struggled to do so in light of the Claimant's behaviour. The chair of the panel told the Employment Tribunal that she had "*never encountered anyone so combative, so dismissive and ultimately so rude as the Claimant was towards her colleagues*." The appeal was not upheld and the sanction of dismissal was maintained.

27. Critically, at paragraph 13.14 of the Judgment, the Tribunal referred to the allegations of unfair dismissal (both ordinary and automatic) and set out its conclusions. It held:

> "As far as procedure is concerned, then we note that this was not a case of professional misconduct. Therefore under the MHP's guidance, the Respondent did not need a panel with an external doctor on it. The disciplinary case was not about the Claimant's clinical or professional conduct or competence. There was no issue with this. Clinically

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> the Claimant was a good, or at least competent, surgeon. The concern was with her personal conduct."

28. At paragraph 13.15 the Tribunal referred back to the findings of fact made about the panel. It continued (with my emphasis added below):

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> "So far as the clinical lead issue is concerned… Dr Buckley herself told the Claimant not to hold herself out as clinical lead… Between December 2014 and July 2015 [the Claimant] was told on a number of occasions not to refer to herself as the clinical lead of the emergency service, *but she continued to do so, even when she could have been in no doubt that the Respondent (Dr Buckley and others) did not regard her as being appointed to that post*. With regard to the job plan, the Claimant's position was intractable and she stuck to the original job plan agreed, apparently, with Mr Omar, … *She refused to meet, discuss and agree with her current managers an up-to-date or contemporary job plan, despite the many attempts by the Respondent to do so*…. The Claimant also *failed to follow a reasonable management request to assist on the day of junior doctors' strike*…. We conclude she was not a team player and she later gave inadequate reasons for her non-support at that critical time for the Respondent. *There was no adequate explanation to her managers of why she could not cover the strike*. *If she had good reasons to prioritise certain of her patients over and above those on the 18 week waiting list, she did not share this and refused to share it with her line manager*…. Mr Osman, as the line manager, was the person who would make a proper assessment of the situation [in the context of managing the 18 week target or PTL] and make decisions about it. *He was not given the information by the Claimant on which he could do this.* Another reason why the Claimant was dismissed was because of her written and verbal communication with her colleagues, managers and admin staff. We set out in some detail in our findings of fact what that was. She should not have attended the business meeting that she attended on 5 February (even if the Respondent handled the situation badly) and *she disobeyed an express instruction from her line manager not to attend*. We entirely agree with the Respondent's assessment that *she had become unmanageable, in terms of refusing to explain or discuss her actions or do what was required*…. The Claimant *refused to follow the 18 week rule without adequate explanation and was un-cooperative over the junior doctors' strike*. *She was uncivil to the point of rudeness to colleagues and admin staff, and bullied Mr Tuffaha*. The Respondent was entitled to come to the view that all these matters, founded as they were on a substantial body of evidence, cumulatively amounted to misconduct on the part of the Claimant."

The appeal

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29. Before the Employment Tribunal the Claimant did not contend that her dismissal had anything whatever to do with her capability as a clinician. That was not her case and nor was it any part of the Trust's case that the allegations involved any issue about her clinical capability. The issue accordingly is whether the allegations against her were properly categorised as personal misconduct and not professional misconduct.

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30. So far as professional misconduct is concerned the only allegation she challenged as being professional misconduct rather than personal misconduct was allegation four. However it is common ground that a single allegation of professional misconduct would have required an

external medical member on the panel. In any event, I have considered all of the allegations for these purposes, by reference to both professional conduct and professional capability.

31. Mr O'Neill submits that the question for the Employment Tribunal in this case was whether the decision by the Trust that this was not a case of professional misconduct was objectively correct. Had the Employment Tribunal correctly directed itself in law it would have determined, on properly construing the relevant contractual documentation, that the Trust had wrongly categorised the case against the Claimant as one of personal misconduct rather than one concerning professional capability and that consequently the Trust's failure to follow the correct MHPS mandated procedure in this case amounted to a breach of contract.

32. He relies on Skidmore v Dartford and Gravesham NHS Trust [2003] UK HL 27 as the leading authority on the issue of the proper characterisation of conduct as professional or personal for the purposes of MHPS and submits that the starting point is the definition in the disciplinary code. He submits that Mattu v University Hospitals Coventry and Warwickshire NHS Trust [2012] EWCA Civ 641 does not alter this approach. It is an application of the approach to the particular facts. In any event Mattu was a significantly different case on its facts concerning as it did a doctor who had been suspended for five years and the issue was getting him back into clinical work without academic reskilling. Moreover, whereas in Mattu the appeal panel was entirely independent and included an experienced, eminent, medically qualified practitioner so that a degree of deference could properly be accorded to their decision on classification, the same is not true in this case where nearly all members of the appeal panel were employed by the Trust and the only outside member was not medically qualified.

33. Mr O'Neill submits that in light of Skidmore all allegations against the Claimant can properly be described as complaints about conduct arising from her professional duties as a Consultant Surgeon and/or as relating to her performance of a Consultant's normal responsibilities to patients. The complaints therefore arise from the exercise of her medical skills. In particular, he submits that as in Skidmore, the communication between her and the GP which formed the substance of the "un-manageability" complaint may be said to arise from the exercise of her duties as a Consultant. Similarly the complaints relating to her non-adherence to the 18 week period for people waiting for surgery was a clinical issue related to her professional conduct. He relies on the finding of the Tribunal at paragraph 5.17 that "patients on her list on medical grounds were higher prioritised and urgent", emphasising that she had professional medical reasons for what she did.

34. Consequently, he submits that at least some of the allegations against her should properly have been characterised as professional misconduct in the sense of allegations of "wilful, careless, inappropriate or unethical behaviour likely to… create serious dysfunction to the effective running of a service" and/or as "failure to fulfil contractual obligations by not taking part in clinical governance activities and by failing to give proper support to other members of staff". He contends that the issue in this case is centrally about how the Claimant could be required or expected to carry out her clinical duties as a member of the clinical team in the Trust's hospital. The Tribunal proceeded on the basis that in relation to the Claimant "professional misconduct" concerned only issues around her performance of and only of her surgical skills, rather than the manner in which she carried out all duties associated with her position as a Consultant Surgeon. Furthermore, there is nothing to indicate that the Tribunal was aware of the possibility of allegations constituting both professional misconduct and personal misconduct; or that some cases will cover conduct and capability issues and that in

such a case the proper approach is for all matters to be covered under the procedures provided for under a capability hearing.

35. At one point in his submissions Mr O'Neil went so far as to contend that if acting qua doctor, the conduct must be professional misconduct rather than personal misconduct. He recognised that this would mean the residual category of personal misconduct is vanishingly small and appeared to draw back from that position, submitting that he did not have to be that far because all of the allegations in this case relate to issues arising out of the exercise of medical skills and therefore fall squarely within the professional misconduct category.

36. I do not accept the submissions made by Mr O'Neill, and prefer the submissions of Mr Cheetham. My reasons are as follows.

37. I accept (as Mr O'Neill contends) that failure to constitute a disciplinary panel in accordance with the requirements of MHPS (and the Trust's own disciplinary procedure) would be a breach of contract and relevant to both the unfair and wrongful dismissal claims. Although it is for the Trust to decide on the appropriate way forward, it was for the Employment Tribunal to decide as a matter of law, whether the conduct was properly to be characterised as 'professional misconduct' obliging the Trust to have an independent, medically qualified person on the panel. If the Tribunal erred in law in reaching its decision on that issue, the EAT can interfere.

38. However, the mere fact that it is a doctor who is alleged to have committed misconduct is plainly insufficient by itself to lead to the conclusion that the conduct in question is professional (as Mr O'Neill appeared at times to suggest). If that were the case, all allegations of misconduct against a doctor would be of professional misconduct and no distinction could be made. Taking Mr Cheetham's extreme example, a doctor who, during a ward round, punches someone, is at the time working as a doctor and carrying out professional duties, but nobody would regard the act of misconduct as anything but personal as opposed to professional misconduct.

39. Following Skidmore (and recognising that it concerned circular HC (90)9 containing the definitions referred to, rather than MHPS which does not) and Mattu (which did concern MHPS), the proper approach requires an analysis of the conduct in question to determine whether, as a matter of substance, it has come about through factors associated with the exercise of professional medical (or dental) skills and/or responsibilities. Professional conduct in this context is to be construed broadly (having regard to serious consequences for a doctor of an adverse disciplinary decision) as covering not only clinical conduct, but the full range of a medical professional's responsibilities. However, the purpose of the distinction is to identify those cases in which an independent medical person is obliged to be on the disciplinary panel, and those where no such obligation arises. As Elias LJ explained in Mattu, the purpose in having a medically qualified person on the panel is to provide valuable professional insight (based on medical experience or expertise) into a relevant misconduct issue. Accordingly, in determining the correct characterisation of the conduct in question, it will be relevant to consider whether there is any utility in having a medically qualified person on the panel. That was the view of Keene LJ in Skidmore ([2002] ICR 403 at [34] CA), later approved by Lord Steyn at p.730 in the HL. It was also the view of the majority in Mattu.

40. It seems to me that when considering the substance of each of the allegations against the Claimant, the Tribunal was as a matter of fact and law entitled and right to find that they had

nothing to do with the exercise of the Claimant's "clinical or professional conduct or competence". The Tribunal did not adopt too narrow an approach by limiting itself to considerations of clinical conduct only, as it expressly made clear at paragraph 13.14 of the Judgment. Further, it clearly had in mind the distinction between personal and professional conduct and the procedural consequences flowing from that. I can see nothing in the Judgment to indicate that the Tribunal treated the concept of personal conduct as the general category, with professional conduct as a "carve-out". The Tribunal carefully and clearly distinguished between the two. The Tribunal was referred to Mattu, and it would have been open to it to find that one or more of the allegations amounted to both personal and professional misconduct, but it did not do so. Equally, it would have been open to the Tribunal to find that one or more of the allegations related to capability, but again it did not do so.

41. Although the Tribunal's conclusions on this issue are expressed very shortly and were criticised by Mr O'Neill, this is not a reasons challenge. The question is whether the Tribunal was right or wrong in the conclusion it reached. I am satisfied that as a matter of substance, the allegations against the Claimant did not involve allegations of professional misconduct understood in its broad sense. Taking each in turn:

(i) The complaint in allegation one was not that the Claimant held herself out as Clinical Lead and exercised that role, it was that she deliberately and consciously ignored the instruction not to do so. It is difficult to see what utility there could be in having a medically qualified expert on the panel to determine her culpability in this regard. No insight into the Clinical Lead role was required. The allegation revolved around a deliberate and conscious flouting of a reasonable instruction.

(ii) The same is true of the job plan issue (allegation two). It did not involve a dispute about what was in the job plan, or clinical/professional reasons why the Claimant could not or would not agree it. It was concerned, put simply, with a flat refusal to cooperate. Again, there could be no utility in having an independent medical expert on the panel to deal with that issue.

(iii) As a matter of substance, allegation three (the strike issue) concerned a flat refusal to provide cover coupled with a refusal to explain her position. That involved no professional medical skills or duties; nor the management of the doctor/patient relationship.

(iv) Allegation four (the 18 week target) is the only allegation that the Claimant herself described as relating to professional conduct. It is the only allegation that has caused me some difficulty because of the somewhat contradictory findings made by the Employment Tribunal. Ultimately however, I have concluded that the issue did not relate to the Claimant's clinical judgment about or professional responsibility for prioritising patients. Although there are some references in the findings to reasons given by the Claimant for prioritising patients as she did (which would suggest a professional conduct issue), the Tribunal came to clear findings that the Claimant "would not explain why she was not following the Trust's policy on the PTL. …. she failed without good reason to explain to her managers why she could not stick to the 18 week waiting list rule." It made a similar finding at paragraph 13.15 (that she refused to follow the 18 week rule without adequate explanation). In other words, the substance of the dispute was her refusal to provide an explanation for not complying with the Trust's administrative procedures requiring patients to be taken in turn. Additionally, it

is difficult to see what utility there could be in having a medical expert on the panel to deal with that issue. It was a personal conduct issue.

(v) Allegation five had nothing to do with professional conduct as a doctor, but concerned a simple allegation of rudeness. That was a personal conduct issue.

(vi) Allegation six had nothing to do with what the Claimant said at the meeting or why she attended in the first place. It raised no clinical or professional conduct issues but concerned simply a refusal to follow a reasonable instruction to leave. A doctor who disregards a reasonable, non-clinical, management instruction to leave a meeting, is in no different position to any other member of hospital staff who, given a management instruction to leave a meeting, disregards it. This was plainly a personal conduct issue.

(vii) The example given for the Claimant's unmanageability (allegation seven) concerned the manner in which she responded to the GP complaint. It was not the clinical content of the message or whether she had good clinical or professional reasons for doing what she did that led to the disciplinary allegation. It was the Claimant's personal conduct in being rude that was at issue. This too was a personal conduct issue.

42. Nor do these allegations raise issues of capability. It was no part of either sides' case that they did. Even taking a broader view of capability, and having regard to the Claimant's reliance on ineffective clinical team working, none of the allegations involve any issue about her clinical or professional capability. She did not assert this at any stage and nor did the Trust. Moreover, none of them raised "issues which, at least to a degree, needed medical experience or expertise for their determination" to echo Keene LJ in Skidmore in the Court of Appeal.

43. That being so, there was no breach of contract because the requirement to appoint an independent medical expert under MHPS was not engaged. Further, as no capability issue arose, there was no need to have an assessment of capability carried out by the National Clinical Assessment Service (NCAS).

Conclusion

44. In these circumstances, and in the absence of any error of law by the Tribunal, this appeal fails and is dismissed.