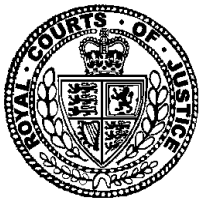

Neutral Citation Number: [2019] EWCA Civ 1649

Case No: A2/2018/2862

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE EMPLOYMENT APPEAL TRIBUNAL
The Honourable Mrs Justice Simler DBE

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 08/10/2019

Before :

LORD JUSTICE UNDERHILL
(Vice-President of the Court of Appeal (Civil Division))
LORD JUSTICE LINDBLOM
and
LORD JUSTICE IRWIN

- -

Between :

SHAREEN IDU	**Appellant**
- and -	
THE EAST SUFFOLK & NORTH ESSEX NHS FOUNDATION TRUST	**Respondent**

- -
- -

Aidan O'Neill QC (instructed by **Slater & Gordon UK Ltd**) for the **Appellant**
Simon Cheetham QC (instructed by **Capsticks Solicitors LLP**) for the **Respondent**

Hearing date: 17 July 2019

- -

Approved Judgment

Lord Justice Underhill :

INTRODUCTION

1. The Appellant is a surgeon. In January 2014 she was employed by what is now the East Suffolk and North Essex NHS Foundation Trust as a Consultant in Emergency Surgery at Ipswich Hospital. Following a disciplinary investigation she was in April 2016 charged with gross misconduct. A disciplinary hearing took place on 6 May, and on 10 May she was informed that she had been found guilty of the misconduct alleged and was summarily dismissed. A subsequent internal appeal was unsuccessful.

2. The Appellant brought proceedings in the Employment Tribunal for unfair dismissal (both "ordinary" and "automatic", in the latter case by reference to the whistleblower provisions), "whistleblower detriment", sex discrimination, race discrimination, wrongful dismissal and unlawful deductions from wages. Her claims were heard over a number of days in May 2017 in Bury St. Edmund's before a tribunal chaired by Employment Judge Sigsworth. By a judgment and written reasons sent to the parties on 14 September 2017 her claims were dismissed in their entirety.

3. The Appellant was permitted to pursue an appeal to the Employment Appeal Tribunal on a single point, which I can summarise as follows. The Trust's disciplinary procedure provided that "cases involving issues of professional conduct" must be heard by a three-person panel, which must include a medically-qualified person who is not an employee of the Trust (for short, "an independent doctor"). There is a similar requirement in "capability cases"; and in such cases there is also a requirement on the Trust, prior to the initiation of disciplinary proceedings, to seek advice from the National Clinical Assessment Service ("the NCAS") – formerly the National Clinical Assessment Authority ("the NCAA"). In this case the Trust proceeded on the basis that the allegations against the Appellant related to her conduct and not her capability and that the conduct in question was not "professional". Accordingly there was no prior referral to the NCAS and the allegations were considered by a panel which did not include an independent doctor: in fact it consisted of a chair who was a consultant radiologist and Associate Medical Director of the Trust, the Trust's Head of Operations (Surgery) and an HR Manager. The issue in the EAT was whether the charges against the Appellant did in fact involve issues of capability or professional conduct, in which case the wrong procedure was followed.

4. The Appellant's appeal to the EAT was dismissed by a judgment of the then President, Simler J, handed down on 8 November 2018. This is an appeal against that decision. The Appellant has been represented by Mr Aidan O'Neill QC, who appeared in the EAT but not the ET, where the Appellant was unrepresented. The Trust is represented by Mr Simon Cheetham QC, who appeared in both the ET and the EAT.

THE CONTRACTUAL PROVISIONS

5. Para. 17 of the Appellant's contract of employment, which follows a template for consultant surgeons negotiated nationally, reads:

> "*Disciplinary Matters*
>
> Wherever possible, any issues relating to conduct, competence and behaviour should be identified and resolved without recourse to formal procedures. However, should we consider that your conduct or behaviour may be in breach of our code of conduct, or that your professional competence has been called into question, the matter will be resolved through our disciplinary or capability procedures (which will be consistent with the 'Maintaining High Professional Standards in the Modern NHS' framework), subject to the appeal arrangements set out in those procedures."

6. The "'Maintaining High Professional Standards in the Modern NHS' framework" referred to in that passage is set out in a document issued by the Department of Health in 2005 entitled *Maintaining High Professional Standards in the Modern NHS* ("the MHPS"). The background to the introduction of the MHPS is explained in the judgment of Lord Hodge in *Chhabra v West London Mental Health NHS Trust* [2013] UKSC 80, [2014] ICR 194, at paras. 3-8 (pp. 196-8), and I need not give details here. The MHPS has five parts. The parts relevant for our purposes are Part III ("Conduct Hearings and Disciplinary Matters") and Part IV ("Proceedings for Dealing with Issues of Capability"). The effect of the provision in para. 17 of the standard consultant contract that the Trust's disciplinary and capability procedures will be "consistent with" the MHPS framework is that its provisions can for practical purposes be treated as incorporated into each such contract; and in fact the contractual provisions with which we are concerned in this appeal track the requirements of the MHPS virtually word-for-word.

7. The Introduction to Part III of the MHPS begins:

> "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 and dentists 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 in conduct cases, particularly in cases of professional conduct.
>
> 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.*"

The passage which I have italicised is the source of the requirement on which the Appellant primarily relies in this appeal, and the issue in that regard turns on the words which I have underlined. The MHPS contains no definition of "professional conduct".

8. The Trust has two sets of disciplinary/capability procedures. The first appears at Appendix 1 to a document applicable to all staff entitled *Disciplinary Policy and Procedure and General Rules of Conduct for Trust Staff*: I will refer to it as "the DP Procedure". The second is to be found in Appendix 1 to a document entitled *Maintaining High Professional Standards – Additional Disciplinary & Capability Policy for Medical & Dental Staff*, which, as the title shows, is applicable only to medical and dental staff: I will refer to it as "the ADCP Procedure". Para. 5.1.3 of the DP Procedure provides for a disciplinary hearing to be conducted before a two-person panel to comprise a manager and an HR representative, with the option to add "a third person … e.g. if appropriate to advise the manager on issues around professional conduct". Para. 5.1 of the ADCP reads:

> "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* [emphasis supplied]."

It will be seen that the final sentence is in substantially identical terms to the final sentence of para. 2 of Part III of the MHPS; its effect is to supplement para. 5.1.3 of the DP by providing (ignoring the reference to dentists, which is irrelevant for our purposes) that in the case of an allegation of professional misconduct against a doctor the option of appointing a third person becomes mandatory and that that person must be an independent doctor.

9. As to capability, para. 4 of Part IV of the MHPS provides that where concerns about the capability of a doctor cannot be resolved routinely by management "the matter must be referred to the NCAA before the matter can be considered by a capability panel". Para. 18 provides that a "capability hearing" should be heard by a panel of three, at least one of whom "should be a medical or dental practitioner who is not employed by the Trust". Those provisions are reproduced in paras. 6.1 and 7.6 of the ADCP.

10. Neither the MHPS nor the ADCP contains a formal definition of "capability", but para. 3 of Part IV (reproduced at para. 6.1 of the ADCP) refers to failures occurring

"through lack of knowledge, ability or consistently poor performance". Para. 5 (para. 6.2) says:

> "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."

11. Prior to the introduction of the MHPS the procedures to be followed in disciplinary proceedings against doctors in the NHS were prescribed in Department of Health Circular HC (90)9. This required different procedures depending on whether the allegations in question related to "professional conduct", "personal conduct" or "professional competence". These were defined as follows:

> "*Personal Conduct* – Performance or behaviour of practitioners due to factors other than those associated with the exercise of medical or dental skills.
>
> *Professional Conduct* – Performance or behaviour of practitioners arising from the exercise of medical or dental skills.
>
> *Professional Competence* – Adequacy of performance of practitioners related to the exercise of their medical or dental skills and professional judgment."

Cases involving matters of professional conduct or competence had to be dealt with by an independent panel with a legally qualified chairman and at least an equal proportion of medical and lay members (a procedure sometimes characterised as "quasi-judicial"); while cases involving personal conduct fell to be dealt with internally by the management of the trust in question, with an appeal to a panel of its board.

12. Although under the MHPS "professional conduct" and "capability" cases are heard by a panel with a majority of trust employees, the requirement for an independent doctor clearly reflects the same underlying policy as the provision under HC 90(9) for a quasi-judicial panel, namely that in such cases an additional element of independence and medical expertise is necessary; and it was common ground before us that the

approach to the categorisation of such cases should be the same under the new regime as it was under the old.

13. I should mention at this point a couple of points about terminology. First, although the MHPS does not, like HC 90(9), specifically refer to "personal conduct" to denote cases not involving professional conduct, that remains a useful label for such cases. Secondly, although the provisions with which we are concerned use the phrase "professional conduct", in the context of disciplinary proceedings we are concerned with allegations of *mis*conduct, and I will accordingly sometimes refer to "professional misconduct".

THE ALLEGATIONS

14. The allegations against the Appellant are set out in the dismissal letter as follows:

> "1. You have and continue to refuse to accept that you are not the Clinical Lead for Emergency Surgery
>
> 2. You failed to accept a reasonable management instruction to stop referring to yourself or holding yourself out as the Clinical Lead for Emergency Surgery
>
> 3. You have refused to engage appropriately with management in relation to fulfilling your job plan commitments or to negotiate a revised job plan
>
> 4. You have refused to follow a reasonable management instruction to provide cover for Lavenham ward for the day of the junior doctors' strike on 1 December 2015 or to provide an appropriate explanation for this refusal
>
> 5. You have refused to provide an explanation for listing patients for surgery who have been waiting less than 18 weeks rather than those which have breached (or may be about to breach) the 18 week target
>
> 6. The tone and style of your written communication with colleagues and managers are inappropriate and were, in the main, rude and uncivil and on occasions, aggressive, amounting to bullying and harassment, despite being required to desist from communicating in such a way
>
> 7. The tone and style of your verbal communication with colleagues and managers are inappropriate and were, in the main, rude and uncivil and on occasions, aggressive, amounting to bullying and harassment, despite being required to desist from communicating in such a way
>
> 8. Your have become unmanageable as a consequence of your behaviour and refusal to address this despite being requested to

> 9. You refused to follow a reasonable management request to leave the surgical business meeting on 5 February 2016 and your attitude and behaviour towards colleagues was unacceptable."

15. In the course of the hearing in the ET those allegations were re-analysed under seven headings, though broadly following the same sequence; but in principle we should proceed by reference to how they were formulated for the purpose of the initial disciplinary proceedings.

THE AUTHORITIES

16. The issue whether a particular disciplinary allegation or allegations involved professional misconduct for the purpose of HC 90(9) or the MHPS has been considered in two authorities which it is necessary to examine in some detail – *Skidmore v Dartford & Gravesham NHS Trust* [2003] UKHL 27, [2003] ICR 721, (affirming the decision of this Court [2002] EWCA Civ 18, [2002] ICR 403); and *Mattu v University Hospitals Coventry & Warwickshire NHS Trust* [2012] EWCA Civ 641, [2013] ICR 270. I should also mention that the issue had already come up in *Saeed v Royal Wolverhampton Hospitals NHS Trust* [2001] ICR 903, but the reasoning in that case has been qualified by the later authorities, and I need say no more about it.

17. In *Skidmore* a surgeon was charged with lying to the family of a patient about how she had come to suffer serious harm during an operation which he had conducted. The applicable disciplinary procedure was that under HC (90)9. The Trust had brought disciplinary proceedings against the surgeon on the basis that the allegation was one involving personal conduct. The House of Lords, affirming the decision of this Court ([2002] EWCA Civ 18, [2002] ICR 403), held (a) that the correct characterisation of the conduct charged was a matter for the Court and not for the trust (see the speech of Lord Steyn, with whom the other members of the House agreed, at paras. 15-17 (pp. 728-9)); and (b) that its characterisation by the trust had been wrong and that the conduct in question fell to be characterised as professional and not personal.

18. The first point is not in issue before us. As regards the second, Lord Steyn said, at paras. 18-22 (pp. 729-731):

> "18. It is now necessary to consider how the case against Mr Skidmore should be categorised. The starting point must be the proper interpretation of the definitions contained in the disciplinary code. It seems right to treat the definitions of professional conduct ('behaviour of practitioners arising from the exercise of medical or dental skills') and professional competence ('adequacy of performance of practitioners related to the exercise of their medical or dental skills and professional judgment') as the primary categories. Personal conduct is the residual category consisting of 'behaviour … due to factors *other* than those associated with the exercise of medical or dental skills' (emphasis added). If a case is properly to be categorised as involving professional conduct or competence, the judicialised disciplinary route under HC(90)9 is obligatory. That is so even if the case could also be said to amount to personal misconduct.

19. For present purposes it is unnecessary to examine the distinction between professional conduct and professional competence. It is common ground that professional competence is not a relevant category. The line drawn between professional conduct and personal conduct is conduct 'arising from the exercise of medical or dental skills' and 'other' conduct. How this distinction should in practice be applied must now be considered. The structure of the disciplinary code set out in HC (90)9 is a classic case requiring a broad and purposive interpretation enabling sensible procedural decisions to be taken. It would, for example, be surprising if a case where a doctor embarked on an intimate medical examination of a woman, which he knew to be wholly unnecessary, necessarily fell outside the scope of what may constitute professional misconduct. After all, in such a case, the doctor is using his position as a hospital doctor to perpetrate an act of serious professional misconduct. I cannot, therefore, agree with the ruling in *Saeed* (para 24, at p 910D) that an indecent assault committed by a doctor during a medical examination cannot constitute professional misconduct within the code. It is a case of a doctor misusing his ostensible medical skills for improper purposes. In my view it falls within the scope of professional misconduct within the definition. Relying on the text of HC (90)9 I take the view that a purposive construction, and common sense considerations, point towards a broad interpretation of professional conduct.

20. Since the decision in *Saeed* and the hearing in the Court of Appeal there has become available the Joint Working Party Report setting out the reasons for the line drawn between professional and personal misconduct. The emphasis is on the serious consequences for a doctor of an adverse decision, making a doctor dismissed on professional grounds virtually unemployable. In my view this background material reinforces a broad interpretation of HC (90)9 notably in respect of what may amount to professional misconduct. It supports the interpretation that when in a doctor/patient relationship a doctor commits deliberate misconduct it may come within the category of professional conduct.

21. Keene LJ concluded that the allegations against Mr Skidmore fell within the category of professional conduct and that was the appropriate machinery to be used. He explained, at pp 410-411:

> '32. First, the appellant was lying about the performance by him of an operation. The operation did not merely provide the occasion or opportunity for his misconduct, as happens in some cases where a medical examination of a patient provides an opportunity for an indecent assault, to take a familiar example. The operation here was the subject matter of the lie, and the conduct on the part of the appellant would not have taken place but for the exercise of his medical skills in the course of the operation. It comes into a different category from lies told about a matter not involving his

> medical skills, such as, for example, whether he had been having an affair with a member of the nursing staff.
>
> 33. Secondly, the history of this matter shows that it was seen as part of the applicant's professional duty to respond to the complaint by Mr A and to communicate with the patient and his general practitioner, and in due course with the Chief Executive. He was patently expected to respond to the letter from the patient relations manager and the enclosed complaint. Indeed, any surgeon would be expected to explain to a patient what had happened during the course of an operation if something untoward or unexpected had taken place, as the GMC booklet "Good Medical Practice" indicates. Such an explanation surely is to be regarded as conduct arising from the exercise of his medical skills. The doctor in such a situation is acting in the course of fulfilling a professional responsibility. In the same way, it is part of a consultant's normal responsibility to keep a patient's general practitioner informed of the success or failure of an operation which he has conducted. So the letter of 21 April to the general practitioner is to be seen as arising from the exercise of the applicant's medical skills during the operation.
>
> 34. Thirdly, it is to my mind relevant that the allegations against the applicant raised issues which, at least to a degree, needed medical experience or expertise for their determination. I have in mind in particular the applicant's attempted explanation of how he confused the number of units of blood transfused. Despite [counsel's] attempts to persuade us to the contrary, it seems to me that some medical experience was required to give proper consideration to that proffered explanation. The internal disciplinary procedure does not necessarily involve anyone with medical experience determining such an issue. The independent procedure under the Circular does. That too points towards the proper categorisation of the allegations here.'

This reasoning is irresistible.

> 22. Given the interpretation, which I have adopted, it is in truth self evident that lies told by a doctor to a patient about important details of an operation can amount to professional conduct. After all in such a case the medical practitioner is professing to speak as a doctor about a matter covered by his medical skills. The argument to the contrary on behalf of the Authority must be rejected."

19. Lord Clyde gave a speech concurring in Lord Steyn's conclusion and reasoning. At para. 27 (p. 732 C-D) he identified the starting-point in the analysis as being "whether the conduct complained of is due to factors associated with the exercise of medical or dental skills".

20. In *Mattu* a consultant who was returning to work after an extended absence was charged with misconduct comprising three allegations, in short: (1) that he had refused to comply with the trust's reasonable requirements by refusing to sign an action plan and co-operate with the re-skilling process, and "acting in such a way as to render yourself unmanageable"; (2) leaking confidential information about the trust and making false allegations about it; (3) exaggerating the extent of his ill-health. The contractual disciplinary procedure was modelled on the MHPS and included a provision in substantially identical terms to that with which we are concerned in this case, i.e. requiring that the panel include an independent doctor where the case involved issues of professional conduct. It was common ground in this Court, though not at first instance, that allegations (2) and (3) did not involve issues of professional conduct. But there was an issue about the proper classification of allegation (1). Stanley Burnton and Elias LJJ held that it did not issues of professional conduct but Sir Stephen Sedley held that it did. Although Stanley Burnton and Elias LJJ thus constituted the majority as regards the outcome of the appeal, there are some points on which Elias LJ and Sir Stephen agreed and where Stanley Burnton LJ at least arguably took a different view. I take the judgments in turn.

21. The relevant part of the judgment of Stanley Burnton LJ is at paras. 27-34 (pp. 280-2). At para. 27 he summarised the reasons given by the trial judge for finding that allegation (1) did not involve issues of professional conduct. He quoted (at p. 289 E-F) his observation that:

> "[the allegation] on its face is nothing to do with the exercise of professional skills by Dr Mattu. It is a refusal to comply with reasonable requirements, a failure to comply with reasonable instructions and acting in an unmanageable way."

At paras. 28-31 he said this:

> "28. In my judgment, it is inappropriate, if at all possible, to construe paragraph 3.2 of the Disciplinary Procedure as if it were a statute. It is written in discursive terms. A practical, purposive interpretation is appropriate, from which a sensible and hopefully clear criterion for determining in advance of a disciplinary hearing whether an outside medically qualified panel member is required. In this connection, I understand it to be common ground that not every allegation of misconduct against a doctor is to be regarded as one of professional misconduct.
>
> 29. The fact that it is a doctor who is alleged to have committed the misconduct is insufficient. If it were otherwise, all misconduct allegations against a doctor would be of professional misconduct. Secondly, the allegation must concern his employment by his employer. Misconduct outside the scope of his employment, for example shoplifting, may give rise to disciplinary proceedings before the General Medical Council, but in the absence of an applicable express or implied term of the contract of employment will not of itself be a breach of that contract.

> 30. In my judgment, the basis of the distinction between professional misconduct and non-professional misconduct under MHPS and the Disciplinary Procedure is the requirement for an independent medically qualified panel member. If there is no utility in having a medically qualified person on the panel, it is difficult to see that the allegation is of professional misconduct so as to require his or her *ex hypothesi* unnecessary participation.
>
> 31. It is, therefore, necessary to analyse and to classify the allegations in question. As mentioned above, I am clear that neither allegation (2) nor allegation (3) was of professional misconduct. Allegation (1) concerned, in essence, a refusal by Dr Mattu to return to clinical work unless and until the Trust agreed to his academic re-skilling. There was no issue as to his clinical re-skilling: that was about 80 per cent complete by November 2010. Once completed, there would be no question as to his clinical competence, to enable him to work as a consultant cardiologist. Thus, the primary issue was whether the requirement that he return to work without academic re-skilling was one the Trust was reasonably entitled to make under its contract with Dr Mattu. This issue did not involve any medical skill or expertise for its resolution: it was an employment, a managerial, issue. There was also an issue as to whether Dr Mattu's conduct in relation to this issue showed him to be unmanageable. That too was not an issue in relation to which a medical qualification was relevant."

I need not refer to para. 32. At para. 33 (pp. 281-2) Stanley Burnton LJ distinguished *Skidmore*. He said that in that case:

> "… the allegation against the doctor was that he had deliberately misled a patient and her family about what had happened in an operation he had carried out. That allegation related to his clinical conduct towards the patient and her family, which is not limited to the carrying out of the operation, but included explaining to the patient what had occurred. Hence the allegation was of professional misconduct. In the present case, there was no allegation as to Dr Mattu's clinical conduct."

(It is fair to say that he also noted that *Skidmore* was concerned with HC 90(9) rather than the MHPS, but that does not appear to be central to his reasoning.) Finally, at para. 34 (p. 282 A-B), he said this:

> "I would add that I should be slow to interfere with the decision of the Appeal Panel on the classification issue. Its members were all independent of the Trust, and highly qualified. They concluded that the allegations against Dr Mattu raised no clinical, i.e., medical issue. I do not think that this was not a sensible way to approach the question. ..."

22. Elias LJ dealt with the classification issue at paras. 81-89 of his judgment (pp. 294-6). At para. 81 he rejected a submission made on behalf of the trust that its decision about

the correct characterisation of the allegations was reviewable only on the basis of bad faith or irrationality. He continued, at paras. 82-83:

> "82. Both Sir Stephen Sedley and Stanley Burnton LJ start from the premise that the definition of professional conduct is inextricably linked with the procedure for determining conduct issues: if there is some purpose in having a medically qualified person on the disciplinary panel because that person can provide a valuable professional insight into a relevant issue before the disciplinary body, the proceedings should be interpreted as involving an issue of professional conduct. As Keene LJ put it in the case of *Skidmore v Dartford and Gravesham NHS Trust* [2002] ICR 403, para 21, in language subsequently approved by Lord Steyn in the House of Lords ([2003] ICR 721) a relevant factor will be whether the allegations raise issues 'which, at least to a degree, needed medical experience or expertise for their determination'. That observation was made in the context of the old rules contained in Circular HC (90)9, but in my judgment, it is equally applicable to these procedures. Accordingly, for reasons given by Sir Stephen, I would reject the submission of … counsel for the Trust … that professional misconduct should always and necessarily be equated with clinical misconduct, although no doubt in the vast majority of cases it will be.
>
> 83. So the issue is whether the expertise and experience of a qualified medical member were required to deal with the issue in dispute. Stanley Burnton LJ concludes that they were not. I agree with his conclusion on allegations 2 and 3. He identifies the issue in allegation 1 as being whether the Trust was entitled to require Dr Mattu to return to clinical work without first undergoing academic re-skilling. This was not a question for a medical expert since its resolution involved no medical insight. Stanley Burnton LJ concludes that this is an employment or managerial issue which involves no question of professional conduct; nor does the related allegation, that he was unmanageable."

At paras. 84-87 he explained why he differed from Sir Stephen Sedley about the characterisation of Dr Mattu's refusal to return to work without completing a period of academic re-skilling. I need not set his reasoning out in full. Essentially, his reason was that the issue whether Dr Mattu was obliged to return to work in advance of any academic re-skilling "involves no issue of professional conduct and a qualified doctor would have no experience or expertise relevant to assessing the reasonableness either of the order or of Dr Mattu's response to it" (para. 87). At paras. 88-89 Elias LJ makes two further supporting points. First, at para. 88, he says that he is (like Stanley Burnton LJ) reinforced in his conclusion by the fact that none of the members of the disciplinary panel saw the case as involving professional conduct. He observes (p. 296 B-C):

> "I too would not readily interfere with the conclusion of an experienced and independent panel on an issue of classification."

Second, at para. 89 he notes that Dr Mattu himself had not raised any point about the classification of the issue at the time.

23. I turn to the judgment of Sir Stephen Sedley. His reason for reaching a different conclusion about allegation (3) from that of Stanley Burnton and Elias LJJ appears at para. 152 of his judgment (pp. 309-310), which reads:

> "It is incontestable that Dr Mattu's professional work for the Trust included research. If so, a dispute about his need for re-skilling in research after a long period of illness was as much a dispute about professional conduct as a dispute about the usefulness of his research in earlier years would have been. In fact the more problematical word in the latter context might be 'conduct'; but since the allegation was of refusal to comply with a reasonable managerial requirement to sign an action plan which made no provision for reskilling in research, it seems plain enough that what was at issue was Dr Mattu's professional conduct. It was conduct because the charge concerned a refusal to cooperate; and it was professional because the refusal concerned an aspect of his job, research. It was – reverting to the *Skidmore* test – precisely the kind of issue on which an administrator needs a doctor's input if he is to reach an informed and just conclusion."

Two other aspects of his judgment are, however, relevant. First, at para. 145 p. 308 G-H) he says:

> "I respectfully differ from the approach of Lord Justice Stanley Burnton to this question in paragraph 30. His proposition that the requirement for an independent doctor is 'the basis of the distinction between professional misconduct and non-professional misconduct' seems to me to invert cause and effect. It is surely the distinction between these two forms of misconduct which is the basis of the requirement for an independent doctor."

Secondly, at para. 148 (p. 309C), he says that "professional conduct" cannot be treated as equivalent to "clinical conduct".

24. Para. 30 of Stanley Burnton LJ's judgment appears to make the question whether the panel would be assisted by the opinion of an independent doctor the definitive touchstone of whether the conduct in issue was "professional". As to that, Mr O'Neill adopted the observations of Sir Stephen Sedley at para. 145 of the judgment about inverting cause and effect and submitted that on this point the majority comprised Sir Stephen and Elias LJ, who at para. 82 referred to the need for (independent) medical expertise only as "a relevant factor": that was, he said, how the question had been treated in *Skidmore*. I think that Mr O'Neill has a point here, but its significance should not be over-stated. I see the logical force of the observation by Sir Stephen Sedley on which he relies; but neither Sir Stephen nor Elias LJ suggests that in considering the correct characterisation of conduct which is the subject of a disciplinary charge it is irrelevant or unhelpful to ask whether independent medical expertise or experience is likely to be of assistance in resolving the issues raised by the charge. On the contrary, asking that question is precisely the kind of purposive

approach advocated by Lord Steyn in *Skidmore*, because it engages with the reason which underlies the requirement for the panel to include an independent doctor; and I see no reason why in most cases it may not provide a helpful and reliable route to the answer. As Elias LJ points out, Keene LJ at para. 34 of his judgment in that case (approved by Lord Steyn) expressly treated the question whether the issues required medical expertise or experience for their determination as a relevant consideration in reaching his decision; and Elias LJ likewise went on to use it as the main prism through which he considered the correct characterisation of allegation (3) – see paras. 83-85 of his judgment. It seems to me clear, as a matter both of common sense and of authority, that there will normally be no error of law in approaching the issue of whether a charge involves "professional conduct" by asking whether its resolution requires the experience and expertise of an independent doctor.

25. Both counsel before us proceeded on the basis that notwithstanding the replacement of HC 90(9) by the MHPS, and the difference in the details of the relevant wording, the essence of the distinction between professional and non-professional/personal conduct was unchanged and that *Skidmore* accordingly remained authoritative on that issue. That appears to have been the view also at least of Elias LJ and Sir Stephen Sedley in *Mattu*, both of whom relied on *Skidmore* in their respective reasoning. In any event it seems to me plainly correct: the term "professional" is common to both HC 90(9) and the MHPS, and the disappearance of the explicit definition seems to reflect the preference for a more discursive and less legalistic style[1] rather than any intention to change its meaning. We were referred to a statement in the introduction to the MHPS, which identifies the key changes[2] introduced by it, that "the distinction between personal and professional misconduct is abolished". Taken out of context that is misleading: as we have seen, special procedures are expressly required in cases involving professional conduct. But it is clear from the rest of the passage that what is meant is that there will no longer be a quasi-judicial external panel to hear cases of professional misconduct, as there was under HC 90(9).

26. In my view the guidance relevant to this case that can be taken from the decisions and reasoning in *Skidmore* and *Mattu* can be summarised as follows:

    (1) The starting-point is that the defining characteristic of professional conduct is that it arises from the exercise of medical skills. That was the definition in HC 90(9), treated by Lord Steyn in *Skidmore* as the governing provision (see para. 19 of his speech); and, as I have said, there is no reason to suppose that any different meaning was intended in the MHPS. It clearly does <u>not</u> connote anything done by a doctor in the course of his or her work: that point is trenchantly made by Stanley Burnton LJ at para. 29 of his judgment in *Mattu*.

    (2) The paradigm of professional conduct is conduct by doctors in the course of their treatment of patients, i.e. clinical conduct, so that professional misconduct will normally equate to clinical misconduct: see the end of para. 82 of the judgment of Elias LJ in *Mattu*. But, as he also says, agreeing with Sir Stephen

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1 I am bound to say that I doubt how wise that preference was, in a context which is bound to give rise to legal issues; but that is another matter.

2 I cannot give a more precise reference because, unhelpfully, the MHPS has neither page numbers nor continuous paragraphing.

Sedley at para. 148, that will not always be the case. (Arguably Stanley Burnton LJ regarded the two as synonymous – see the end of para. 34 of his judgment; but if so he was in a minority.)

(3) The question whether conduct "arises from" the exercise of medical skills (or, in Lord Clyde's words, "is due to factors associated with" it) is imprecise and there will sometimes be borderline cases. Lord Steyn advocates a "broad" approach, but that term is in itself imprecise and it is necessary to understand the context in which he used it. The approach taken in *Skidmore* was broad inasmuch as the conduct in question did not occur in the course of the surgeon's actual treatment of the patient but in the course of his explaining it to her family; but the connection with the exercise of medical skills was clearly very close, since not only was the surgeon explaining what he had done clinically but such an explanation was itself part of a doctor's professional obligation (see paras. 32 and 33 of the judgment of Keene LJ approved by Lord Steyn). It does not follow from *Skidmore* that anything done by a doctor which in some way relates to the exercise of his or her medical skills involves their professional conduct. That is established by the conclusion of the majority in *Mattu* as regards allegation (1). Notwithstanding that part of the allegation in that case concerned the claimant's unwillingness to co-operate in a re-skilling plan, which evidently related to his professional skills, it was held not to involve professional conduct: it was described, rather, by Stanley Burnton LJ at para. 31 of his judgment as "an employment, a managerial, issue", and Elias LJ at para. 83 expressly adopted that description.

(4) In deciding on what side of the line a particular case falls, it will typically be relevant and helpful to ask whether the resolution of the issue raised by the charge requires the experience and expertise of an independent doctor: see para. 24 above.

(5) It is also legitimate to attach weight to the fact, if it be the case, that a doctor has not in the disciplinary proceedings themselves challenged the trust's characterisation of the allegations in question: see para. 88 of the judgment of Elias LJ in *Mattu*. No doubt how much weight can be given to that fact will depend on the particular circumstances.

27. I would add, because it is relevant to part of Mr O'Neill's submissions, that it is clear from *Mattu* (applying *Skidmore* in the context of the MHPS) that the question whether the conduct charged should be characterised as professional has to be determined by the Court and not by the trust.

THE DECISIONS BELOW

28. I should start by noting that no point about whether her case should have been treated as one involving professional misconduct was explicitly made in the Appellant's very full and articulate Details of Complaint or in the agreed list of issues, derived from the pleading, on the basis of which the case proceeded. The pleading did include an unparticularised allegation that "the Respondent did not follow its own procedure (MHPS)", but it is far from clear that the point which the Appellant had in mind was that the allegations should have been treated as involving professional conduct or

capability. It does not appear either that the Appellant challenged the composition of the original disciplinary panel either before it or as part of her internal appeal.

29. However, Mr Cheetham told us that the Appellant did in her closing submissions take that point as regards allegation 5 (allegation (iv) in the ET's analysis); and that in that connection he referred the Tribunal to *Mattu*. It was not part of the Trust's case before us that the issue was not open to her.

30. No doubt because of the way in which it arose, the Tribunal only dealt with the issue very briefly. At para. 13 (14) of the Reasons it said:

> "As far as procedure is concerned, then we note that this was not a case of professional misconduct. Therefore, under the MHPS 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, the Claimant was a good, or at least competent, surgeon. The concern was with her personal conduct."

31. Turning to the decision of the EAT, Simler P summarised the issue at para. 4 of her judgment:

> "The single ground of appeal … 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."

32. After dealing with certain subsidiary issues. Simler P said, at para. 41:

> " … 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."

(Simler P's numbering of the allegations reflects the analysis of the ET rather than how they appear in the decision letter – see para. 15 above – and it will be seen that she refers to one or two points of detail taken from the ET's Reasons which do not appear in that letter. But it is sufficiently clear how her reasoning applies.)

33. As regards capability, Simler P said at para. 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."

THE APPEAL

34. Despite Mr O'Neill opening his oral submissions by saying, correctly, that the appeal concerned "a narrow and focused point", the "Appeal Notice for the Appellant" which is apparently intended to stand as the Grounds of Appeal runs to no fewer than fourteen pages. It is diffusely expressed and reads more like a skeleton argument than a pleading – though there is a separate skeleton argument which itself runs, if one includes the appended chronology, to 29 pages. This Court has sought repeatedly to explain that it is assisted by having concise – and I would say numbered – grounds of appeal which do no more than identify the specific errors of law alleged, with the development of submissions about those errors being left to the skeleton argument (see, e.g., *Rasheed v Secretary of State for the Home Department* [2014] EWCA Civ 1493, *per* Moore-Bick LJ at para. 12, and *Harverye v Secretary of State for the Home Department* [2018] EWCA Civ 2848, *per* Hickinbottom LJ at paras. 56-57): well-pleaded grounds of this kind need rarely exceed more than a page or two.

35. It accordingly requires a little work to identify the actual grounds of appeal. However, the section in the Notice headed "Error of Law on the part of the Employment Tribunal" (paras. 18-23) appears on analysis to identify three. None of them was in fact developed by Mr O'Neill in his oral submissions, and I can accordingly take them quite briefly.

36. The first (at paras. 18-21) is that the Tribunal equated professional misconduct with clinical misconduct. I can see no basis for that submission. It is true that in the passage from its Reasons which I have quoted the Tribunal says that the disciplinary case was not about the Claimant's "clinical or professional conduct"; but that language was perfectly apt, since, as I have said at para. 26 (2) above, clinical conduct is the paradigm of professional conduct. I note, however, that at para. 21 Mr O'Neill does say that "the proper *Skidmore* test is … to the effect that 'professional conduct' is to be construed broadly as including not only clinical matters but as covering the full range of a consultant's professional responsibilities": I shall return to that submission presently.

37. The second ground, at para. 22, is that the Tribunal proceeded on the misapprehension that the correct categorisation of allegations for the purpose of the MHPS was a matter for the Trust and not the Court and that its decision on that question could accordingly only be challenged on rationality grounds. I can only say that I can see nothing whatever in the Tribunal's language to suggest that it fell into that error, and I am at a loss to see on what basis it was pleaded.

38. The third ground, at para. 23, is that the Tribunal gave inadequate reasons for its characterisation. I do not agree. Its reasoning was understandably succinct, but in my view it was sufficient given the way in which the point had been raised. In any event, since the issue is one of law the point goes nowhere: the ultimate question is simply whether the Tribunal's classification was right.

39. Paras. 24-34 of the Grounds are headed "Errors in Law on the part of the Employment Appeal Tribunal". The principal point made, at paras. 24-32, is that it was wrong of the EAT to seek to substitute its own reasons for those given by the ET. I am not sure that that is the correct way of describing what Simler P did in this case, but it does not matter. As the Appellant herself insists, whether the allegations in this case involved professional conduct (or capability) within the meaning of the MHPS is a matter of law, on which the EAT was not only entitled but obliged to reach its own view. Apart from that point, two challenges are made to Simler P's judgment, which I take in turn.

40. First, it is said that Simler P decided the "professional conduct" issue simply by asking "whether *as a matter of fact* there would have been any '*utility'* in having a medically qualified person on the panel [emphases in original]". It is correct that under some, not all, of the sub-paragraphs in para. 41 Simler P referred to this factor. That is itself perfectly legitimate: see para. 26 (4) above. I do not, however, read her as treating it as the only relevant question. Nor do I agree with Mr O'Neill's description of her conclusion on that point as one of "fact": what she was doing was assessing the nature of the allegation to decide whether it was of a character that required medical experience or expertise for its determination. There is nothing in the reasoning of this Court in *Skidmore* or *Mattu*, or of the House of Lords in *Skidmore*, to suggest that that is an exercise that can only be performed by the first-instance tribunal.

41. Secondly, there is a challenge to Simler P's statement at para. 42 of her judgment that it "was no part of either side's case" that the allegations raised issues of capability. Reference is made in particular to the Claimant's closing submissions in the ET. As already noted, Mr Cheetham accepts that the Claimant did at that very late stage contend that her case should have been treated as raising capability issues (and/or, as I understand it, as a professional misconduct case). To that extent, Simler P's statement is not strictly accurate; but it is clear that what she had in mind was that the point had not been taken at any earlier stage in the proceedings. In any event, she rejected the Appellant's submission on the merits.

42. I have felt obliged to deal with the formal grounds of appeal, but I have to say that the challenges which they advance to particular aspects of the reasoning of the ET and the EAT mask the real issue, which is – straightforwardly – whether the Trust's allegations against the Appellant did, contrary to what they held, involve professional misconduct and/or issues about her capability. To be fair to Mr O'Neill, he did tackle

that question directly in his oral submissions. I take in turn the conduct and capability issues.

43. As regards misconduct, Mr O'Neill proceeded by going through each of the allegations in turn with a view to showing that they involved issues of professional conduct. That was an appropriate course in principle, but it soon became clear that the same underlying issue arose as to each. He was constrained to accept – with one possible exception, to which I will return – that none of the allegations concerned the way in which the Appellant had exercised her medical skills. But he submitted that that was not determinative because the question was whether the conduct in issue "arose from" the exercise of those skills, and that that was a question which was to be approached broadly, so as to "cover the full range of a consultant's professional responsibilities" (see para. 36 above). For example, allegation (3) – that she refused to co-operate in agreeing a job plan – involved her professional conduct because it concerned her work "*qua* consultant". Likewise, allegation (4) – that she refused to provide during the junior doctors' strike – involved the care of patients and thus her work as a doctor.

44. I do not accept that submission. It follows from my analysis of the authorities, and in particular from para. 26 (1)-(3) above, that I do not believe that the fact that impugned conduct may be associated with a doctor's work necessarily means that it arises from his or her exercise of their medical skills. In my view in the case of each of the allegations the fact that the Appellant is a doctor was no more than the context in which the allegations arose: the gist of all those allegations concerned her relationship with the Trust's management and with colleagues and staff with whom she had to deal. They did not arise out of the exercise of her medical skills. That is obvious as regards allegations (1) and (2), which concern her job title and leadership role, and also allegations (6), (7) and (9), which mostly concern her rudeness (though (9) also covers an act of insubordination). But it is also true of allegations (3) and (4). Allegation (3) is not about the substance of what medical skills she should be exercising but about an alleged refusal to co-operate in agreeing a plan.[3] Allegation (4) is simply that she refused to work at all (coupled with a failure to give any explanation). In truth, the entirety of the allegations could be covered by the phrase used in allegation (8), namely that she had "become unmanageable": that was a phrase also used about Dr Mattu, and Stanley Burnton LJ's conclusion that allegation (1) in his case raised "an employment, a managerial, issue", with no element of professional misconduct, seems to me equally applicable here.

45. I should say a little more about allegation (5), which is that the Appellant had refused to provide an explanation for listing patients for surgery who had been waiting for less than the target maximum of eighteen weeks in priority to those who had already reached the maximum. Mr O'Neill pointed to evidence from a Trust witness, referred to by the ET, to the effect that the Appellant had advanced medical reasons for the cases in question which the Trust had rejected. He submitted that that showed that the allegation was indeed that the misconduct related to the way in which she had exercised her medical skills. But Simler P addresses that very point at para. 41 (iv) in her judgment and gives cogent reasons for concluding that that did not represent the

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3 It might be possible to envisage a case where that was a spurious distinction; but we were shown nothing to suggest that Simler P was wrong to conclude that that was not the case here (see para. 41 (ii) of her judgment).

gist of the complaint against her, which was – as the allegation is indeed formulated – that she refused to provide an explanation. Neither in his skeleton argument nor in his oral submissions did Mr O'Neill demonstrate that her analysis was wrong. Mr Cheetham took us to the passages in the ET's Reasons to which Simler P refers, and they support her conclusion.

46. The foregoing reasoning seems to me to be essentially the same as that of Simler P at para. 41 of her judgment, and, like her, I would hold that the allegations against the Appellant did not involve her professional conduct.

47. Mr O'Neill's submissions as regards the capability aspect were much less sustained. He candidly accepted that the allegations did not at first sight look as though they raised issues of capability. But he referred to the examples of "concerns about capability" given in the MHPS which I have set out at para. 10 above, and he submitted that some at least of the allegations could properly be regarded as evincing an "inability to communicate effectively" and/or "ineffective clinical team working skills". This point is not in fact raised in the grounds of appeal, but in any event I can see nothing in it. The MHPS (and ADCP) says no more than that the examples given "*may* fall under capability procedures": as Simler P observes at para. 15 of her judgment, the examples given "are not always and inevitably capability issues irrespective of the facts". Where the conduct in question takes the form, as alleged here, of rudeness, bullying and intransigence in dealings with management (without any suggestion of any underlying medical condition) it would not make sense to characterise it as raising capability issues: they are certainly not the result of lack of knowledge or ability (see para. 3 of Part IV of the MHPS).

DISPOSAL

48. I would dismiss this appeal.

Lord Justice Lindblom:

49. I agree.

Lord Justice Irwin:

50. I also agree.