If relevant, the opinion of the medical physics department should be sought, as their experience of the cost of reusables and service contracts is invaluable. Maintenance contracts can be punitive.

If no alternative finance is available, the statement has to take its chance with other bids. Sometimes it is preferable to ask the senior nursing staff to complete the process, as a well argued case by the "end user" will have great influence.

It is possible to persuade patients' relatives or charities to let you hold funds over, while saving for the remainder. A word with your finance director should ensure charitable status and avoidance of VAT. Remember that "one off" donations, no matter how generous, will not cover recurring revenue costs. The cost of equipment we use most frequently in A&E is usually within the grasp of a medium sized charitable event and as a result A&E has become a popular recipient of such benefactors. Across the board, about 30% of the costs of new equipment comes from charity monies.

The high profile that our specialty now enjoys makes the task of influencing outside charities and agencies more fruitful. An invitation to speak at a round table dinner or Rotary Club lunch may well bear fruit at a later date.

The trust will have a list of local charities which contribute towards equipment. The League of Friends and WRVS are usually very generous and should be approached. The equipment committee is usually well disposed to an offer of partial funding.

Patients like to support their local hospital, and sponsored events often bring forth sizeable funds. The local press is usually friendly and may help in advertising a fund raising exercise. This makes good copy and an approach to the editor is worthwhile.

If equipment is purchased through these routes, ensure that a small plaque is attached and the equipment is handed over at a suitably high profile ceremony. Invite the media and be prepared to speak.

Nurturing a charitable trust in this way may bring forth other gifts at a later date.

Return to the salesperson once the money is secured and negotiate hard. A sharp intake of breath and a sigh at the first price will usually bring about a reduction but don't forget about the extras. Remember *caveat emptor* and a consensus decision based upon hands on use. Good luck!

C D H OAKLAND
Bristol

Disciplinary procedures

It is a sad but inevitable fact of professional life that disciplinary procedures are necessary.

The medical profession works within clear margins of what is and is not acceptable, derived from a combination of professional standards and the General Medical Council (GMC). It has always had wide tolerance levels of behaviour, but public demands and expectations, as well as an increasingly litigious climate, mean that these levels are narrowing. Disciplinary procedures should serve as a warning, set out a system by which problems can be dealt with, and help to protect individuals by laying down specific regulations and guidelines.

General principles

It is important to distinguish between personal and professional misconduct. All of us who work in medicine are governed by the same moral and ethical principles as those affecting all citizens and we have no right to be treated differently. NHS trusts have a set of disciplinary procedures for all employees who behave badly or inappropriately. The medical profession is bound by such procedures.

Such procedures for personal misconduct range from a minor reprimand to immediate dismissal. For example, a doctor may steal or commit violence. The fact that such a misdemeanour occurred in a hospital is of no relevance. However, to prescribe illegally for example, necessitates the possession of a medical degree. If the difference between personal and professional misconduct is not straightforward, the question to ask is "does the possession of a medical degree make any difference to this misbehaviour?"

Professional misconduct

The formation of Trusts means that all nationally and previously agreed procedures are rewritten locally. Such rewriting follows discussions between the profession and local management (usually represented by the personnel department). To enable this process, local negotiating committees have been formed, elected by and representing all doctors.

For a single or repeated minor offence, for example constant late attendance or rudeness, it may be necessary to issue a written warning. This procedure is delegated to the medical director, or deputy, by the chief executive. The warning should indicate its duration and is included in the personal file of the doctor—rather like points on a driving licence. These remain confidential within the Trust. Oral warnings can be issued but they are kept off the personal record.

The medical director will be at the hub of any investigations concerning more serious allegations of professional misconduct or incompetence. Such allegations can come from any source and should be passed directly to the medical director.

Procedures will vary, but generally the medical director will consult the personnel director and the chairman of the hospital medical staff committee (CHMSC) who will investigate the allegations. Subsequent actions will depend on their findings.

(1) Nothing proven. No further action taken.
(2) Resolution of the problem on an informal basis. This often requires a meeting between the various parties with a check on the situation after three to six months.
(3) Personal misconduct or failure to complete job plans requires further action (that is, a written warning to change behaviour and further monitoring).
(4) If the allegation warrants further disciplinary action, an investigative hearing should be held between the medical director and personnel director with the doctor, who has the right to be represented by a friend, professional colleague, or representative. The next stage requires that the practitioner is notified of all charges and a disciplinary hearing is convened. Witnesses are called and the hearing is conducted along the lines of the Trust's policies. The practitioner

can seek advice from the BMA, the Medical Defence Union, or the Medical Protection Society.

(5) If the preliminary investigation decides that the allegation is serious, for example misuse of controlled drugs, the doctor is informed—verbally and then in writing—and a formal inquiry panel set up. A legally qualified chairman is nominated from the Lord Chancellor's department through the Department of Health. There should also be one professional member from outside the Trust and one nominated by the Trust, with maybe a third nominated by the joint consultants' committee (JCC). Both professional members are agreed by the Trust and the local negotiating committee.

Standard terms of reference will be clearly laid down by the chairman of the panel. Enough time is allocated to allow both sides to prepare their cases. The panel will be asked to produce a report which will be seen by the doctor to allow comment. Amendments are incorporated and again the doctor will see the report, which should define any guilt and make recommendations as to disciplinary action.

Special leave (suspension)

Occasionally events occur that require the doctor to be removed from the place of work (for example, because of accusation of incompetence or alcoholism). If a rapid resolution is not achievable, suspension may be the best solution. The doctor is told the reasons for this verbally and in writing. This allows a cooling off period and time for a full investigation.

It is most important that this action is not seen as proof of any accusation; the situation should not be prejudged before all the facts are available. This procedure can apply to all grades of medical practitioner, who are on full pay throughout. The procedure may ban the practitioner from the premises, but a friend or representative can act on behalf of the doctor.

Summary dismissal

For summary dismissal to occur a serious breach of discipline must have been committed and patients' welfare put at risk. The most often quoted examples are drug and alcohol abuse. Junior grades can be dismissed by their consultant, usually in the presence of a senior personnel officer. Appeals can be lodged within a specified time. Failure to do so is final. The appeals mechanisms should be clearly defined.

Often there has been a pattern of events leading to this and the fact that summary dismissal has occurred implies a failure of prevention.

Appeal procedure

Appeals are available to all career grade staff who consider their appointment has been unfairly terminated. Any such appeal is to an independent legally chaired panel, much as in the serious misconduct pathway. Termination of contract will not take effect during these hearings. The panel will confirm or reverse earlier decisions and action is taken accordingly. Non-career grade staff have a similar mechanism, often initiated through clinical tutors up to the postgraduate dean, before entering the standard specified procedure.

Following summary dismissal, a practitioner appointed before a Trust came into being can appeal to the Secretary of State for Health, under section 190 of the national terms and conditions of service. It is equally important that all practitioners appointed after Trust formation are given the opportunity of a fair hearing, by policies and procedures agreed with medical staff through the local negotiating committee and the Trust. The procedure must be completed within the negotiated time scale, normally a month.

Three wise men

This is laid down in HC (82) 13, and is employed when there is an alleged incapacity (mental or physical) of a practitioner. Usually this panel consists of the chairman of the hospital medical staff committee and two senior colleagues, who should be nominated on an annual basis by the medical staff. Frequently, though, it is the immediate past chairman and the present vice-chairman. The panel interviews the practitioner and initiates whatever action is required, including sending a report to the GMC if necessary.

The medical director

The chief executive will invest in the medical director a pivotal role in discipline. The clinical directors should deal with minor problems but the medical director is the link in any further procedures. It can be an unpleasant and demanding role. It is the medical director's responsibility to investigate all problems and proceed as required.

Conclusion

It is important for the medical profession to regulate itself as far as possible. We, the profession, are not perfect and must therefore be seen to be subject to rules and regulations, if for no other reason than to protect the patient.

I P STEWART
Plymouth