Employment tribunals and occupational health practitioners

Employment tribunals (ETs) (formerly named industrial tribunals) were first created in the 1960s under the Industrial Training Act. The current level of activity is >100,000 cases that are commenced each year, though less than a third of those come to trial. Principal complaints are of unfair dismissal and claims under the anti-discrimination laws, which now extend to discrimination on grounds of sex, race, disability, sexual orientation, religion and age. The tribunals consist of a legally qualified Chairman (either a barrister or solicitor) and two members who represent the interest of employers and employees, respectively. Each member of the tribunal has an equal vote, but in practice decisions are nearly always unanimous. Much of the legislation originates in European directives, and leading cases occasionally are taken as far as the European Court in Luxembourg, which has the final say on issues of European Community law.

Occupational health (OH) professionals are likely to become involved in a case which goes to a tribunal in potentially three areas. The first is a dismissal for incapability where the employee has been sacked for poor attendance caused by ill-health. The law requires that an employer considering dismissing for this reason should in most cases first seek medical evidence about the reason for the absence and the prognosis. The employer should also consider whether the employee could be redeployed in another available job, though there is no duty to invent a job. Medical advice about the functional abilities of the employee may be relevant here. The second is an employee or job applicant who claims that he or she is disabled within the definition in the Disability Discrimination Act 1995 and has been discriminated against because of the disability. The OH professional may be asked by the employer whether the employee is likely to be disabled and also to advise about possible adjustments to the physical environment or working practices which would assist the employee to do the job.

The third area is where the OH professional is an expert brought in from outside with no previous knowledge of the individual, essentially to assess the tribunal on matters which are outside their area of expertise. Such a witness has a primary duty to the tribunal and must not be partisan.

When chairing ETs, it is important to understand the role of OH professionals in contrast to clinicians. Lack of this understanding can lead to the tribunal rejecting the advice of the occupational physician in favour of the views of a clinician.

The Management of Health and Safety at Work Regulations 1999 require the employer to undertake a risk assessment of likely health and safety hazards created by its operations. In Jones v. Post Office ([2001] IRLR 384), a mail delivery driver contracted insulin-dependent diabetes. He was permitted on the recommendation of two senior OH physicians only to drive 2 h in every 24 h and complained to an ET that he had been unlawfully discriminated against on grounds of his disability. The employer’s defence was that the discrimination was justified as ‘for a material and substantial reason’. In the tribunal, the claimant called a consultant physician as an expert witness in his support. The employer called two senior occupational physicians on whose advice it had relied. The tribunal decided the medical issue by preferring the evidence of the clinician who advised that there was no reason why the employee could not continue to drive 8 h a day, but the Employment Appeal Tribunal and the Court of Appeal disagreed. A tribunal cannot go to the extent of disagreeing with a risk assessment which is properly conducted, based on the properly formed opinion of suitably qualified doctors, and which produces an answer which is not irrational. A tribunal is not permitted to make up its own mind on justification on the basis of its appraisal of the medical evidence and to conclude that the reason is not material or substantial because the medical opinion on the basis of which the employer’s decision was made is thought to be inferior to a different medical opinion expressed to the tribunal:

Where a properly conducted risk assessment provides a reason which is on its face both material and substantial, and is not irrational, the tribunal cannot substitute its own appraisal.

The issue was raised again in Surrey Police v. Marshall ([2002] IRLR 843) which concerned an applicant for a job as fingerprint recognition officer. She disclosed that she had bipolar affective disorder for which she had been hospitalized on three occasions. The force medical officer recommended that she was not suited for the position, having consulted her general practitioner (GP), and the offer of a job subject to medical clearance was withdrawn. She did not meet Marshall nor did she obtain a report from the job applicant’s consultant psychiatrist. Marshall had disclosed that she had previously been prescribed lithium but had stopped taking it because of side effects on her digestive system. She was now taking zopiclone and occasional amisulpride. At the tribunal hearing of Marshall’s complaint of disability discrimination, expert evidence was given by Lipsedge, consultant psychiatrist, in support of the occupational physician. He said in

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cross-examination that given the nature of her history, the
applicant was a highly vulnerable person to further psy-
chotic episodes. If she had been taking lithium, he would
have been more positive. Lipsedge’s opinion had not been
available to the occupational physician when she made
the decision to recommend rejection of the job applicant.
The tribunal held that the employer had not obtained
suitably qualified and expert medical opinion about the
particular circumstances of the job applicant’s case. It
was not a properly conducted risk assessment. The evi-
dence of Lipsedge could not be taken into account since it
came after the decision to reject the claimant’s job appli-
cation. The employer was liable.

This decision was held by the Employment Appeal
Tribunal to disclose an error of law. Following Jones v.
Post Office, the tribunal had to assess the competence of
the occupational physician and make a judgement as to
the adequacy of her risk assessment. Lipsedge’s evidence
that there was no need to ask for a psychiatrist’s report
was relevant to that issue and should have been consid-
ered. They also held that the tribunal had been unduly
critical of the OH physician’s qualifications. She was MD,
DObst, MRCP, MSc (OH) and AFOM. She had worked
as a specialist in occupational medicine for >10 years. In
her postgraduate training, she had spent 6 months at-
tached to a psychiatric unit.

‘. . . there is a real danger, if tribunals set too high a re-
quirement for medical advice as to justification, that
employers will be deterred from offering jobs because of
the expense, delay and difficulty of obtaining the correct
experts to report’. The ET’s decision was set aside.

Compare the decision of the Employment Appeal Tri-
190). Paul was a carpenter and plumber who had a
chronic depressive illness and had not been in paid
employment for 7 years, though he had worked as a vol-
unteer for Victim Support, which spoke highly of him. He
was under the care of a psychiatrist and on long-term
medication with Fluoxetine. He applied for two part-time
jobs with the Probation Service, one as a community ser-
vice supervisor and the other as a handyman. He was
offered the supervisor’s job subject to a satisfactory OH
report. This was a standard procedure; all positions with
the employer were offered on this basis. His completed
questionnaire, in which he revealed his health problems,
was sent to an experienced occupational health adviser
(OHA), a nurse. She asked for a report from his GP but
not from his consultant psychiatrist. The OHA knew that
the post of community service supervisor was particularly
stressful, especially as it involved coping with the chal-
 lenging behaviour of some offenders. She felt that the best
thing would be to put Paul into a stress-free job and re-
view his progress after 3 months. She reported to the
employer that Paul was fit for the handyman job but
not the supervisor job. The employer withdrew its offer,
but appointed Paul to the handyman post. Paul then con-
tacted the OHA and asked her to obtain a report from his
psychiatrist, who supported him. He said that the GP
hardly knew him. The OHA replied that it was a manage-
ment decision. Personnel told him that the decision was
based on OH advice.

The ET held that the OHA’s risk assessment was ade-
quate. The employer had not closed the door on the
possibility that Paul might eventually be appointed to
the supervisor’s post. The Employment Appeal Tribunal
disagreed. The risk assessment was inadequate because
not informed by competent and suitably qualified medi-
cal opinion. The GP had never treated Paul for his con-
dition, did not know him well and said nothing in his
report about his fitness for the post in question or his
ability to cope with stress. Further, the OHA had failed
to consider whether adjustments could be made to the
supervisor’s job, by, for example, gradually inducting him
into the role and providing a mentor. The case was sent
back to a different tribunal for a rehearing.

An important dictum was made by Justice Cox who
approved the practice of offering all prospective employ-
ees’ employment subject to OH clearance:

In many cases, having a disability does not adversely
affect an individual’s general health and the OH as-
essment will not lead to a refusal of employment un-
less the disability affects the applicant’s ability to do
the work and no reasonable adjustments can be made.
The existence of a disability does not of itself therefore
substantially disadvantage a disabled person who is
subject to this general requirement.

The Jones, Marshall and Paul cases concerned chal-
lenges to the advice of an OH professional after the em-
ployer has acted on it and a case has been taken to
a tribunal. The decision that the employer is normally
entitled to accept the advice of its own OHAs is a rational
one, since the employer cannot be expected to interpret
medical evidence. But what if the employer has conflict-
ing medical advice from an OH physician and the
employee’s GP or consultant before he makes the deci-
sion, for example, whether to dismiss. Which opinion
should he prefer? One recent case which highlighted this
dilemma was First Manchester Ltd v. Kennedy ([2005]
UKEAT/0818/04). Kennedy was a bus driver who had
been employed for 20 years. He first saw the company’s
occupational physician in 2001 when the doctor was dis-
mayed to discover that he had a heart condition which he
had not reported and had undergone a coronary angi-
oplasty. In 2003, Kennedy suffered chest pains at work and
an ambulance was called. He attended hospital but be-
fore being given a diagnosis he discharged himself against
medical advice. The OH physician was of the opinion
that he had suffered a minor heart attack. Kennedy saw
an independent specialist and was diagnosed as suffering
from hypertrophic cardiomyopathy. The consultant and
the GP supported Kennedy’s wish to continue driving,
but the OH physician was less sanguine. He performed a risk assessment and concluded that the employee had a heart condition that put him at risk of a sudden incapacitating event, that he was clinically obese, which increased the risk, and that in the past he had not fully disclosed his medical information in order to allow his medical attendants to make appropriate judgements. Driver and Vehicle Licensing Agency guidance is that someone with this condition can retain a Group 2 licence if he is asymptomatic, has no family history of sudden death, has no serious rhythm disturbances, hypotension does not occur during exercise and the condition is anatomically mild. Kennedy satisfied all but the last of those conditions. A 24-h electrocardiogram was normal. Nevertheless, the OH physician recommended that he was unfit to drive and the employer preferred his advice to that of the cardiologist and dismissed Kennedy, because there was no other job available that he was willing to do.

In an action for unfair dismissal in the ET, the tribunal, without hearing the OH physician in person, held that the dismissal was unfair. They said that the OH physician was not a cardiologist and was ‘biased’ against the employee because he had concealed information. On appeal to the Employment Appeal Tribunal, Justice Burton said this:

It is plainly important that a consultant occupational physician bears in mind different factors from the factors borne in mind by a specific medical specialist. It is also important that such a physician is entitled to be, and will be expected to be, robust in the interests of the protection of others, such as the consumer or the public. Robustness cannot be regarded as bias.

The case was sent back to a different tribunal to hear the evidence again. It was suggested that this time the OH physician should be called as a witness to allow him to answer the accusation of bias. The court held that an OH report can be relied on by the employer, even if it contradicts other medical reports, unless it is clearly unreliable (e.g. when it is not supported by evidence or has been made without a proper examination of the employee).

An example of the latter was Scott v. Secretary of State for Scotland ((1988) EAT 196/88) where an OH physician advised the employer that an employee with a neck injury was unlikely to be able to return to normal working simply on the basis of his absence record from his personnel file without examining or interviewing him.

A recent decision was Heathrow Express Operating Co Ltd v. Jenkins ([2007] UKEAT/0497/06). The claimant was a customer services representative which involved duties which were both safety related and safety critical. She was suffering from moderate depression after accidentally pricking herself with a used hypodermic needle left on a train, and while she was at work was disciplined twice for errors of judgement. She was seen by an independent consultant psychiatrist on the recommendation of the OH physician. He reported that she had made an excellent recovery and should be able to return to work and work until retirement age, though she would remain vulnerable to future similar episodes. The OH physician, however, recommended that she could not be allowed to return to safety critical activities because her judgement had been poor when she was depressed and this could recur. He thought that the psychiatrist was trespassing outside his area of expertise in advising that the employee was fit for work. As a result of the OH physician’s report, the manager was unwilling to allow the employee to return to her job and as no alternative was available she was dismissed. An ET held that the employee was disabled and her dismissal was not justified, but this was reversed by the Employment Appeal Tribunal who pointed to the Train Working Standards which provide that medical assessments shall be carried out by or under the supervision of a registered medical practitioner with experience of occupational medicine. The manager was entitled to rely on the advice of the OH physician who was better able to assess the risks of the job than the consultant psychiatrist.

Some employers have procedures which allow the employee to appeal to an independent physician if OH and clinicians disagree. This can be a lengthy and cumbersome process and is more commonly used where ill-health retirement is in issue in the public sector.

What conclusions can be drawn from these cases?

(i) It is important that representatives explain to tribunals the role of OH and emphasize that this is a specialty in its own right. It is also important to stress the qualifications and expertise of the OH physician and to point out that he or she has detailed knowledge of the job which is not available to the GP or specialist.

(ii) It is unnecessary for an OH physician in most cases to seek ‘independent’ specialist advice when making a decision on fitness for work. Whether to do so is a question of judgement. However, it is advisable to seek a report from the GP if there is doubt.

(iii) Failure to obtain a report from a ‘treating’ consultant is likely in practice to lead to the OH physician’s expertise being challenged. The OH physician’s advice may differ from that of the consultant, and the OH physician may be able successfully to defend it, but if the specialist’s opinion has not been sought the claimant will argue that the OH physician had insufficient evidence on which to base his or her advice. Again, this is a question of judgement.

(iv) The courts appear to accept that the occupational physician is in a different position from the clinician, whose primary duty is to the patient. The
occupational physician must also take into account the interests of the employer, the fellow employees and the general public. This is particularly relevant where there are safety issues. Nevertheless, advice must be based on evidence. Employers are inclined to be over-cautious and unhappy about employing anyone with a health condition. The advent of disability discrimination legislation has allowed prejudices to be confronted. There is a duty on employers to make reasonable adjustments to permit the disabled to work. Most health and safety laws impose only a duty of reasonable care, which allows the OH professional to balance the interests of the worker against those of third parties.

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