

**Attention is drawn to
the order prohibiting
publication of
certain information
in this determination**

**IN THE EMPLOYMENT RELATIONS AUTHORITY
AUCKLAND**

**I TE RATONGA AHUMANA TAIMAHI
TĀMAKI MAKĀURĀU ROHE**

[2019] NZERA 623
3067975

BETWEEN DKR
Applicant

AND WAIKATO DISTRICT HEALTH
BOARD
Respondent

Member of Authority: Rachel Larmer

Representatives: Blair Edwards and Kate Wilson, counsel for the
Applicant
Anthony Russell, counsel for the Respondent

Investigation Meeting: On the papers

Submissions and further 22 July 2019 from the Applicant
Information Received: 13 September 2019 from the Applicant
24 September 2019 from the Respondent
4 October 2019 from the Applicant
11 October 2019 from the Respondent
17 October 2019 from the Applicant
18 October 2019 from the Respondent

Date of Determination: 31 October 2019

DETERMINATION OF THE AUTHORITY

Non-publication order

[1] In a determination dated 2 October 2019 the Authority issued an interim non-publication order prohibiting publication, until further order of the Authority, of:¹

- (a) the applicant's name;
- (b) the applicant's area of practice;
- (c) the names and any information that may personally identify any of the patients who are referred to during these Authority proceedings.

[2] This non-publication order was made subject to the conditions that are set out in paragraph [47] of that determination.²

[3] The letters 'DKR' have been used in place of the applicant's name in order to comply with the interim non-publication order. These letters were chosen by an online random letter selection tool, so they bear no relation to the applicant's real name.

[4] The applicant may therefore be publicly referred to, for the purposes of these proceedings, until further order of the Authority, as "DKR".

Employment relationship problem

[5] DKR, seeks interim reinstatement to his position of Senior Medical Officer with Waikato District Health Board (WDHB).

Performance assessment requirement

[6] One of the main reasons DKR wants reinstatement is so he can take steps towards undergoing a Medical Council of New Zealand ("*the MCNZ*") performance assessment.

[7] The MCNZ resolved that DKR was to undergo a performance assessment, and would be subject to additional restrictions on his practice, in response to concerns the WDHB and the Health and Disability Commissioner ("*the HDC*") raised with the MCNZ.

[8] These concerns related to DKR's:

- (a) Clinical assessment;

¹ *DKR v Waikato District Health Board* [2019] NZERA 564.

² Above n1.

- (b) Technical performance;
- (c) Communication;
- (d) [Area of practice - subject to non-publication order] judgment; and
- (e) Informed consent processes.

[9] The Authority notes that DKR disputed all of the concerns that WDHB and HDC had raised with MCNZ, which he instead attributed to a “*dysfunctional employment relationship*”. The resolutions MCNZ made occurred after DKR had provided his views on the concerns that had been raised about his practice.

[10] In addition to resolving that DKR had to undergo a performance assessment, that was to include a review of his performance in carrying out [subject to non-publication order] procedures, MCNZ amended DKR’s voluntary undertaking regarding his performance of [subject to non-publication order] procedures.

[11] These restricted procedures could only be carried out by DKR with the prior approval of the Head of the Unit or designated Deputy under direct onsite supervision of DKR by a vocationally registered [area of practice - subject to non-publication order].

[12] WDHB says that it is unable, and/or it is unreasonable for it, to provide this prior approval and/or direct supervision of DKR, for the reasons set out in its affidavits. That evidence means that even if DKR was to be interim reinstated, WDHB claims he would still not be able to actually personally undertake the work he needed to do, for a performance assessment to be conducted.

[13] MCNZ will review the voluntary undertaking restrictions on DKR’s practice when the outcome of his performance assessment is considered. The MCNZ restrictions were put in place to protect public health and safety until the outcome of DKR’s performance assessment is considered by MCNZ.

[14] Although this determination does not refer to DKR’s speciality and areas of practice, in order to comply with the interim non-publication order, the Authority has carefully considered the specific evidence the parties have filed, as it relates to DKR’s area of practice.

Process required before performance assessment can be undertaken

[15] The process that is involved in the MCNZ lifting the current restrictions on DKR's practice is a potentially lengthy one.

[16] In order for a performance assessment of DKR to occur, certain preliminary steps ("*preliminary steps*") have to be taken, as set out by DKR in his first affidavit. This will involve the development, in association with DKR, of:

- (a) Terms of Reference; and
- (b) The selection of the Performance Assessment Committee ("*the PAC*"), again with DKR's input.

[17] DKR bears responsibility for initiating or following up these preliminary steps that are a precursor to him undergoing a performance assessment. No information has been provided to the Authority to show that any of these preliminary steps have yet been taken, leading to the reasonable assumption that they have not.

[18] There has consequently been a delay by DKR of over a year in putting these preliminary steps in place. That delay has not been explained. WDHB submits that delay is fatal to DKR's interim reinstatement application.

[19] Assuming the preliminary steps were resolved, DKR has not practised [subject to non-publication order] for over three years and [subject to non-publication order] for over a year. He is therefore no longer credentialed to work as a [subject to non-publication order] at WDHB.

[20] In order to be credentialed DKR would need to satisfy the Credentialling Committee ("*the Committee*"), comprised of a wide range of clinicians and lay representation, that should occur. The Committee operates under the Ministry of Health framework to ensure public safety, by the mechanism of credential verification against job description.

[21] WDHB anticipates there are significant impediments to the Committee credentialing DKR, for reasons discussed in more detail later in this determination.³

[22] Once the preliminary steps have been completed, and assuming DKR has been credentialed by the Committee, then administrative arrangements (“*administrative arrangements*”) are then made with the PAC for the date of the performance assessment.

[23] The performance assessment is contemplated to take place within two to four months of the discussion about administrative arrangements being resolved. In DKR’s case the requirement for him to be directly supervised by a vocationally registered [subject to non-publication] would impact on the date a performance assessment could occur.

[24] The performance assessment then occurs. After that has happened there are still a number of further steps consisting of:

- (a) The PAC prepares a draft report of the assessment;
- (b) DKR has an opportunity to comment on the draft;
- (c) A final report is prepared by the PAC for the MCNZ;
- (d) MCNZ then has to consider the final report and make a decision on the continued practice of DKR; and
- (e) MCNZ then considers what happens to the restrictions it has placed on DKR’s practice, including the amended voluntary undertaking that he signed in October 2018.

[25] Each step along the way can be subject to challenges and consequential delay. Therefore, the performance assessment and subsequent consideration by MCNZ of whether or not the current restrictions on DKR’s ability to practice should be lifted is a potentially long and convoluted process, depending on how many objections and challenges arise during that process.

[26] Even if DKR was to be reinstated on an interm basis pending the substantive determination of his dismissal grievance, it is uncertain whether or not he would be able to have completed his performance assessment before his current MCNZ practising certificate

³ See paragraphs [135]-[136].

expires in February 2020 or before the Authority conducts its substantive investigation in February 2020, or before the Authority issues its substantive determination.

WDHB's opposition to reinstatement

[27] WDHB opposes DKR's interim reinstatement on the basis that it is not safe for him to practice. It therefore says that the Authority should decline to exercise its discretion to interim reinstate DKR on the overarching grounds of protecting patient safety.

[28] WDHB says that DKR's delay of almost a year to facilitate a performance assessment by MCNZ fundamentally undermines his interim reinstatement application.

[29] WDHB further says that interim reinstatement is futile because it is highly improbable that DKR would have completed the preliminary and administrative arrangements, let alone had the performance assessment itself, before his substantive claim is heard by the Authority in February 2020.

Applicable law

[30] The Authority's jurisdiction to order interim reinstatement in personal grievance applications derives from s 127 of the Employment Relations Act 2000 (the Act). Section 127(4) requires the Authority, in making its determination, to "*apply the law relating to interim injunctions having regard to the object of this Act*". Section 3 sets out the object of the Act.

[31] An interim reinstatement order is discretionary. It is a temporary step to preserve the position pending resolution of the substantive claim(s).

[32] The law relating to how the Authority's interim reinstatement discretion is to be exercised is so well known that it does not require setting out again in full here. Suffice to say that the Authority must consider each of the following matters when weighing the exercise of its discretion:

- (a) Whether DKR has an arguable case that his dismissal was unjustified;
- (b) Whether DKR has an arguable case for the remedy of permanent reinstatement, if his dismissal is held to have been unjustified;

- (c) Where the balance of convenience lies between the parties pending the Authority's substantive determination; and
- (d) The overall justice of the case.

Material facts

[33] DKR had a series of short-term engagements with WDHB from late 2011 until 2015.

[34] In March 2016 WDHB offered DKR permanent employment as a Senior Medical Officer, which he commenced in May 2016.

[35] In July 2016 DKR was involved in a patient death. That resulted in a complaint from the patient's family and a coronial investigation was commenced. The complaint was referred to the HDC who commenced their own investigation. The HDC's and the Coroner's investigations are still ongoing.

[36] The HDC has issued a draft report to the parties for comment. DKR objected to WDHB providing the Authority with a copy of the HDC's draft report, so the Authority has not seen it.

[37] The 2016 patient death, along with other adverse patient outcomes in 2016, caused WDHB to raise concerns with DKR about his practice.

[38] In September 2016 the parties agreed that DKR's practice would be restricted while an investigation was conducted under clause 42 (*"the clause 42 investigation"*) of the Senior Medical and Dental Officers Collective Agreement (*"the MECA"*) The parties agreed that DKR would undertake alternative clinical services while that occurred.

[39] From September 2016 to May 2018 DKR provided these alternative (restricted) services for WDHB, in addition to some other referral and out-patient work within the region.

[40] By June 2018 a number of additional concerns had arisen for WDHB regarding DKR. At that point WDHB stood DKR down from all clinical duties, but he was still able to attend work.

[41] WDHB claims that despite its instruction to DKR that he not undertake any clinical duties, from August to October 2018 DKR engaged in clinical activities, involving creating new appointments for patients and rescheduling the dates of patients' follow up

appointments. WDHB viewed this as clinical activities and not simply administrative activities.

[42] DKR denied that he had engaged in clinical activities. He said these were simply administrative activities that had predominantly involved him taking steps to correct errors with patients' appointment bookings.

[43] In June/July 2018 WDHB engaged an Expert Clinical Reviewer (TS) to undertake a patient safety audit into some of the restricted clinical services that DKR had provided. This audit eventually encompassed all patients who had received [subject to non-publication order] clinical services from DKR over a defined period for patient risk management purposes.

[44] The report that resulted from TS's audit of DKR's clinical practice ("*the TS audit report*") was provided to the Authority. The initial random selection of 150 of DKR's patients for review was expanded to all patients as a result of issues the audit identified. This included:

- (a) Deficiencies in DKR's practice and proficiency;
- (b) Poor documentation;
- (c) Poor planning and follow up;
- (d) Poor communication;
- (e) Significant missed pathology and poor recognition of pathology by DKR.

[45] DKR disputes the findings in the TS audit report, and the conclusions that WDHB arrived at based on its Chief Medical Officer's ("*CMO's*") review of specific cases that had been identified in the TS audit report.

[46] DKR maintains that his clinical practice was appropriate, any errors that may have occurred were not his fault, and even if he was responsible for any errors then they all fell within normal and acceptable standards, so he has not underperformed in any way.

[47] DKR further says that even if there were performance issues (which he denies), then the WDHB (and not him) must bear the full responsibility for that. He blames WDHB for his lack of training and support of him and/or its failure to recognise DKR was possibly burnt out at the time the concerns arose.

[48] However DKR's expert's report (by Professor FF dated 23 May 2019) says that DKR appeared to have been "*appropriately trained and supervised*" regarding the restricted clinical duties he undertook.

[49] Professor FF also notes that DKR appeared to have a manner that was abrasive and unpleasant to patients and colleagues. Professor FF's view was that the complaints made about DKR were likely to have reflected that, and lack of collegial support, instead of problems with DKR's expertise.

[50] Professor FF said that the 'manner' concerns that had been reported about DKR was the sort of behaviour seen in doctors who are suffering burnout. Professor FF stated "*I am concerned about the comments made about DKR's manner and wonder if this reflects burnout.*"

[51] Professor FF, after reviewing DKR's restricted clinical practice only, concluded in his May 2018 report that "*His [DKR's] practice appears contemporary and he meets all the current KPIs that one would expect.*"

[52] Professor FF's report was couched in mostly generalised terms. He did not individually address each of the patients' situations that the TS audit report or WDHB's CMO had specifically identified as being of concern.

[53] Professor FF's report seems incomplete because it does not address the adverse outcomes that DKR's patients suffered in 2016. Therefore Professor FF does not provide any explanation about why WDHB's specific concerns about DKR's 2016 practice are without merit.

[54] Professor FF is silent on the fact that one of DKR's patients died, that WDHB and the HDC both raised concerns about DKR's role in that death, and that the MCNZ responded by placing additional restrictions on DKR's ability to practice.

[55] The fact that "*significant remedial action*" was required by WDHB to correct what it claims were deficiencies in DKR's patient care, that it had identified through the TS audit report, strongly indicates that there was likely some shortfall in the standard of clinical services provided to DKR's patients.

[56] Logically WDHB would not have had to intervene with “*significant remedial action*” if there had been no issues with any of DKR’s patients’ cases. Professor FF does not explain, with reference to specific patient cases, why WDHB cannot fairly or reasonably attribute the need for it to have to take “*significant remedial action*” to DKR’s poor practice.

[57] Professor FF was not instructed to comment on the 2016 concerns, that resulted in DKR agreeing to only undertake restricted clinical duties from September 2016 onwards. That omission is curious, because an assessment of the 2016 concerns appears to have been within Professor’s FF’s specific area of specialisation and expertise.

[58] If Professor FF’s report was intended to satisfy others that DKR was safe to practice and that there was no substance to any of the concerns about DKR that had led to WDHB’s dismissal of him, then Professor FF should have been instructed to address all of WDHB’s concerns with sufficient detail.

[59] Because Professor FF was put forward as DKR’s medical expert, it is reasonable to have expected him to provide his expert view on everything that had resulted in WDHB’s conclusion that DKR was “*grossly negligent*” and “*a danger to patient safety*”.

[60] Although DKR asked MCNZ to remove the restrictions on his practice in light of Professor FF’s report, it declined to do so. That suggests the MCNZ did not accept that Professor FF’s report had adequately addressed the public health and safety concerns that had caused the MCNZ to place additional practice restrictions on DKR.

[61] Nor does Professor FF address with specificity the adverse physical effects patients reported to nurses in the call centre about DKR’s treatment of them. Complaints about how DKR physically interacted with patients when performing the clinical services cannot be simply discounted as ‘poor manner’ concerns because they appear to have been broader than that.⁴

[62] The TS audit report warns WDHB that there was a “*significant risk*” of PTSD to the staff involved in the audit process, and in particular to the six nurses in the call centre who had listened to patients telling their stories of, and experiences with, DKR. This evidence tends to suggest that the feedback they received from patients was unusually distressing.

⁴ See appendixes of patient comments that are attached to the two nurses affidavits.

[63] The TS audit report recorded that the emotional toll on those who heard the patients' stories was so significant that it recommended WDHB should offer those individuals support and professional help. Two of these six nurses provided affidavits that confirmed the personal impact hearing from DKR's patients had on them.

[64] Professor FF's limited and generalised report is inadequate to establish that WDHB's patient safety concerns were entirely without merit or that the MCNZ restrictions on DKR's practice were unnecessary to protect public health and safety.

DKR's performance and practice

[65] In September 2018 WDHB set out in writing its specific concerns about DKR's performance and practice. These were grouped into four categories consisting of:

- (a) A draft report into three sentinel cases, including the patient death, that was prepared by WDHB's Chief Medical Officer (CMO);
- (b) A draft review by the CMO of specific cases that were identified during the general patient safety audit of the [subject to non-publication order] services that DKR had provided, (arising from the TS audit report);
- (c) Complaints from fellow staff members and from general practitioners (who had clients DKR had treated), about DKR's communication and competence;
- (d) DKR's 2018 annual performance review and the feedback from some of his peers relating to adverse comments they made about DKR's competency, integrity and communication.

[66] There have been extensive communications about these issues, between the parties and their legal counsel, that are too numerous to individually specify.

[67] DKR responded to the WDHB's concerns in November 2018, disputing that there were any deficiencies in his practice, communications or competence.

[68] WDHB replied to DKR in December 2018. Further responses were received from DKR in March 2019. WDHB says it considered the points DKR had made, but that his responses to its concerns were not satisfactory, and did not persuade WDHB that no further action was required.

[69] In April 2019 WDHB advised DKR of its preliminary disciplinary findings. That included WDHB's preliminary view that (among other preliminary findings) DKR had "*conducted a grossly negligent practice that is a danger to patients*" and/or "*was below the minimum standard required of a health practitioner.*" WDHB also put DKR on notice that his employment could be terminated.

[70] A disciplinary meeting occurred on 24 May 2019.

[71] DKR provided WDHB with a report from Professor FF that questioned whether DKR could have been suffering from undiagnosed "*burnout*", that possibly could have explained the concerns WDHB had about DKR's 'manner.'

[72] It is important to recognise that WDHB's concerns went beyond just DKR's manner.

[73] WDHB says that after considering all of the available information, including DKR's responses and information he had provided, it could fairly and reasonably have concluded that DKR had engaged in misconduct and serious misconduct. WDHB says that dismissal was the appropriate response to that, given the public safety risks that were involved in allowing DKR to continue practising.

[74] Because there were mixed findings of serious misconduct and misconduct, WDHB elected to terminate DKR's employment on three months' notice, by letter dated 31 May 2019.

[75] DKR's dismissal letter stated that:

- (a) Although DKR had sought to blame others for the 2016 patient death, DKR's poor decision making and judgment was fundamentally responsible for it;
- (b) Professor FF had only identified one patient from Appendix 2, (the CMO's review of the TS audit report) and regarding that patient Professor FF had acknowledged that DKR had missed the [patient's medical issue - subject to non-publication order] (seemingly implying an error);
- (c) While Professor FF considered that DKR's error rate was within acceptable range standards, WDHB's position was that DKR's errors were only one aspect of the wider concerns it had around his competency in [subject to non-publication order].

- (d) DKR's lack of note taking, reporting, poor communication with patients and GPs and complete lack of insight regarding such matters was of concern. An acknowledgement by him of these concerns was needed before there could be any practicable attempt to remediate these issues;
- (e) DKR's offer to attend a communication course and suggestion of "burnout" failed to acknowledge, let alone address, the wider issues relating to his competency in [subject to non-publication order], including his lack of note taking;
- (f) The significant and ongoing issues regarding his communication had resulted in local GPs and some WDHB specialists in his field of expertise losing confidence in him as a medical specialist. This loss of confidence was related to specific patient cases, in which his lack of professionalism and competency, and his failures in communication had been a significant factor in their stated loss of confidence in him;
- (g) DKR's breakdown in communication with administrative staff had impacted on the delivery of care to patients;
- (h) DKR's suggestion that he attend a communication course was undermined by his previous advice to WDHB that he had done so in the past but did not find them helpful, and that in his 2018 performance appraisal DKR had said that he did not consider that his communication was an issue. WDHB considered that DKR's lack of insight into his communication issues hampered any attempt at remediation;
- (i) The belated raising of burnout was not identified as a factor relating to the competency concerns, but was raised only in relation to communication issues, particularly regarding his abrasiveness;
- (j) DKR had engaged in clinical activities after being instructed to cease all clinical activities.

[76] WDHB concluded that DKR had "*conducted a grossly negligent practice that is a danger to patients and is below the minimum standard required of a health practitioner conducting* [his speciality – subject to non-publication order]."

[77] WDHB concluded that allowing DKR to continue practising would “*put patients at risk and bring WDHB into disrepute, particularly considering the extensive information gathered about his practice*”. DKR could therefore not realistically return to providing [subject to non-publication order] services for WDHB in a safe and appropriate manner, meaning he could not fulfil the key duties of his role.

[78] WDHB’s dismissal letter recorded that in addition to its concerns about DKR’s grossly negligent practice, it had:

[...] not observed any level of empathy or expressions of concern towards the patients (or their families) who have suffered as a result of his practice and conduct. Further, there has been no real self reflection by [DKR] about such. This is indicated by his denial of any fault and his attempt to cast blame on others for what occurred in relation to the patient death [...], which in itself represents a significant abrogation of his responsibilities as a senior medical professional.

[...]

These behaviours are so extensive and entrenched that they are not able to be remediated, contrary to your suggestions at the 24 May 2019 meeting.

[79] WDHB concluded that allowing DKR to resume providing services to patients would put those patients at risk. DKR was therefore dismissed on three months’ notice with his last day of employment being 30 August 2019.

[80] DKR’s application for reinstatement was filed with the Authority on 22 July 2019. The Duty Member declined urgency. This matter was allocated to a different Presiding Member who had offered the parties an early substantive investigation meeting in October this year. However that did not occur after DKR requested the first Presiding Member to recuse herself.

[81] The matter was subsequently transferred to this Member. The interim and substantive claims were then timetabled, in agreement with the parties.

Does DKR have an arguable case that his dismissal was unjustified?

[82] DKR bears the burden of establishing that he has an arguable case that he was unjustifiably dismissed. This is a relatively low bar for him to clear.

[83] Justification is to be assessed in accordance with the justification test in s 103A of the Act. This involves the Authority objectively assessing whether the process that WDHB used and the decisions that it reached about serious misconduct occurring and dismissal being the

appropriate sanction were what a fair and reasonable employer could have done in all the circumstances at the time DKR was dismissed.

[84] A fair and reasonable employer is expected to comply with its statutory and contractual obligations. That includes the good faith requirements in s 4 (1A) of the Act and each of the four procedural fairness tests in s 103A(3) of the Act.

[85] DKR raises issues about the process WDHB adopted, claiming it was fundamentally flawed, highly prejudicial to him and that the outcome was predetermined. DKR also challenges WDHB's substantive findings, because he disputes that any of his actions could have amounted to misconduct and/or serious misconduct.

[86] DKR's position is that he has not engaged in any blameworthy conduct. He believes that the WDHB has improperly targeted him for dismissal because of concerns it had about his manner. DKR says that WDHB should have given him training and support to address any performance issues including concerns it had about his communications, instead of dismissing him.

[87] Leaving aside the merits of DKR's arguments, these are the types of claims that applicants regularly make to the Authority when challenging a dismissal. They cannot therefore be said to be frivolous or vexatious.

[88] Like many applicants, DKR has also criticised the information that WDHB relied on when concluding that he had engaged in serious misconduct.

[89] DKR's claims that:

- (a) The decision maker was improperly influenced by a procedurally flawed and prejudicial report about him (the P & M report) that he claims was supposed to have been kept confidential;
- (b) WDHB failed to adequately consider Professor FF's findings that DKR's competency and practice was up to the required standard;
- (c) WDHB improperly relied on the subjective TS audit review report, because any errors that had identified would have been within the normal range of expected adverse patient outcomes;

- (d) DKR was deprived of the raw data that the adverse TS audit review report about him was based on;
- (e) WDHB failed to properly consider DKR's claims that he was possibly suffering from burnout over the period that the disciplinary concerns arose; and
- (f) WDHB improperly discounted DKR's offer to attend further communication courses, when it had an obligation to support him with that.

[90] WDHB disputes all of the points that DKR has raised, and has provided detailed affidavit evidence to support its position. These are matters that need to be properly tested during the substantive investigation meeting, when witnesses can be questioned and cross examined.

[91] It cannot be said that DKR does not have an arguable case regarding his dismissal grievance.

Does DKR have an arguable case for permanent reinstatement, if his dismissal grievance succeeds?

[92] Under s 125 of the Act, reinstatement is the primary remedy "*wherever practicable and reasonable*".

[93] Whether reinstatement is practicable and reasonable involves a balancing of the parties' competing interests.

[94] The full Employment Court in *Angus v Ports of Auckland (No 2)*⁵ observed that "*practicability is not the same as being "simply possible" irrespective of consequence*" and that "*practicality is capability of being carried out in action, feasibility or the potential for the reimposition of the employment*".

[95] DKR claims that he has an arguable case for permanent reinstatement because:

- (a) WDHB does not have any verified reasons for concluding that DKR's practice was negligent and/or unsafe, or that he was not competent. DKR relies on Professor FF's May 2018 report to establish that he was practicing at the standard expected of practitioners in his specialisation;

⁵ [2011] NZEmpC 160.

- (b) DKR is willing to complete communication courses and work on his communication and manner;
- (c) DKR's career will be at an end if he is not reinstated, because he is unlikely to find alternative employment as a medical practitioner while he is subject to the MCNZ voluntary undertaking that restricts his ability to practice.

[96] WDHB says that there are three fundamental issues that make permanent reinstatement unlikely:

- (a) The senior medical leadership at WDHB have no confidence in DKR's competence;
- (b) WDHB believes that DKR represents a very real risk to patient safety if he is allowed to practice; and
- (c) DKR is subject to ongoing investigations by third party organisations that could potentially adversely impact on him.

[97] The Head of Department for the speciality that DKR practices in and the WDHB's CMO have expressed a lack of confidence in DKR's competency. One of these witnesses had originally been supportive of DKR's employment.

[98] It is hard to see how DKR could practice at WDHB in light of these stated professional opinions about his practice, made by senior medical leadership. Specific patient cases and outcomes have been identified by WDHB to support those views. These specific concerns were not adequately addressed by DKR's expert, Professor FF.

[99] WDHB says that these known risks will compromise its integrity and reputation as a provider of medical services to the general public and would therefore represent a significant potential legal liability, should DKR be reinstated.

[100] WDHB submits that this reputational and legal liability is exacerbated by the ongoing professional, regulatory and public investigation into DKR's practice, including enquiries by HDC and the Coroner into a patient death.

[101] WDHB says that any or all of these external third party investigations could have a significant impact on DKR's ability to practise and provide services in any form. That creates significant ongoing uncertainty regarding the potential remedy of reinstatement.

[102] Based on the currently available evidence, there are significant barriers to the potential remedy of permanent reinstatement. Even at this early stage, where the evidence is disputed and as yet untested, there is compelling evidence that would make permanent reinstatement unreasonable and impracticable in this particular case. This includes:

- (a) The need for DKR to be credentialed (discussed later in this determination);
- (b) The difficulties DKR is likely to face in getting credentialed, given the evidence regarding his last three years of practice;
- (c) The current MCNZ restrictions on his practice;
- (d) The expiry of his current MCNZ practising certificate in February 2020;
- (e) The need for DKR to undergo a performance assessment;
- (f) The type of support WDHB would have to give DKR to enable him to undergo a performance assessment, which it says is unreasonable and impracticable for it to have to provide to him;
- (g) The level of direct and intensive supervision DKR would need from colleagues and WDHB if he was reinstated;
- (h) The amount of resources that would need to be expended by WDHB in supporting DKR if he was reinstated is unreasonable and impractical;
- (i) The practical barriers DKR is likely to face in obtaining a performance assessment because the Head of Unit has to approve the [work - subject to non-publication order] DKR undertakes. However that person deposed that he does not believe that DKR is able to perform clinical duties safely and that direct supervision of DKR while doing so would be impracticable. It would take other [staff speciality - subject to non-publication order] away from their own clinical duties, stretching an already strained system;
- (j) The negative effect DKR's behaviour has apparently had on others, such as patients, medical and non medical staff, as well as local GPs;
- (k) Loss of confidence in DKR by his senior medical colleagues;
- (l) Loss of confidence in DKR by local GPs, at least one of whom has refused to send any more patients to him;

- (m) Ongoing and unresolved professional, regulatory and public investigations into DKR's practice that have the potential to significantly impact his ability to provide any medical services in any form;
- (n) The CMO, who personally assessed the adequacy of DKR's patient care and adequacy of his practice and competency, says that DKR has demonstrated technical error, poor decision making and judgment, lack of insight, poor communication, a reluctance to take responsibility and muddled and confused thinking - even with the benefit of hindsight;
- (o) Significant remedial action was required by WDHB to correct deficiencies in DKR's patients' care;
- (p) WDHB had already restricted (by agreement) DKR's practice to more low risk clinical activities after adverse patient outcomes in 2016, but despite that further concerns arose;
- (q) DKR previously told WDHB that he had not benefited from any of the communications courses he had attended in the past;
- (r) An "*alarming number*" of DKR's patients reported significant or profound distress and discomfort and reported his communication to be unsatisfactory;
- (s) The CMO's evidence is that reinstating DKR would expose patients to unnecessary pain and distress as well as to the risk of unnecessary additional testing, in order for WDHB to avoid the risk of adverse outcomes occurring;
- (t) The CMO's professional view is that DKR cannot safely practice in his area of expertise "*in any fashion, supported or independent.*"

[103] For these reasons, DKR has been unable to meet the relatively low threshold of establishing that he has an arguable case that he would be permanently reinstated if his dismissal was held to have been unjustified.

[104] While leaving open the possibility that new evidence may be produced at the substantive investigation meeting that changes the Authority's assessment of the likelihood of reinstatement as a remedy, this interim reinstatement must be assessed based on the evidence that is currently before the Authority.

[105] The evidence produced to the Authority to date establishes that DKR is likely to be confined to an award of monetary remedies only, even if his dismissal grievance succeeds. He therefore falls short of establishing an arguable case for the potential remedy of permanent reinstatement.

[106] DKR's failure to establish that he has an arguable case for permanent reinstatement weighs against interim reinstatement.

Where does the balance of convenience lie between the parties?

[107] Assessing where the balance of convenience lies requires the Authority to weigh the competing considerations between the parties.

[108] DKR says that he must be employed in order to undertake the performance assessment required by the MCNZ. If he cannot complete a performance assessment then the voluntary undertaking, restricting his practice, will remain in place, making it difficult, if not impossible, for him to find alternative employment.

[109] DKR claims that his only opportunity to show that he is competent and fit to practice is if he is reinstated on an interim basis.

[110] However reinstatement is premature at this stage.

[111] The HDC's independent expert concluded that there had been "*significant departures from good practice*" by DKR regarding the patient death.

[112] Although DKR disputes that conclusion he is obviously still subject to serious unresolved concerns about his safety to continue practising medicine. It is therefore more appropriate that these concerns are resolved before he returns to practice.

[113] If there is no credible evidence that DKR's practice was grossly negligent, a danger to patients, or had fallen short of the required standards - as he believes is the case - then the Authority, the HDC and the Coroner will all be able, in accordance with their own unique jurisdictions, to confirm DKR's views about that in their respective decisions.

[114] Findings in DKR's favour (if that occurs) by these multiple external investigations is evidence that DKR could provide to the MCNZ in support of his request for a renewal of his practising certificate. He could also submit any findings that are positive to him to the

MCNZ, along with a request to remove the current restrictions that have been placed on his ability to practice.

[115] Conclusions reached by external investigations that are positive to DKR are relevant information that DKR could present to a potential new employer, to persuade it to support him through a performance assessment, should the MCNZ not rescind the current restrictions on his practice.

[116] However as it currently stands, DKR's claim that there is no evidence to support WDHB's concerns about his practice, and that there is no risk to patient safety if he is reinstated, is not credible, based on the evidence the Authority has seen.

[117] The MCNZ must have also considered that there were some issues that required further investigation because it imposed restrictions on DKR's practice, despite him denying any underperformance and attributing any problems that may have occurred to "*a dysfunctional employment relationship*".

[118] It does not make sense to return DKR to an employment relationship he told MCNZ was "*dysfunctional*".

[119] Likewise, DKR claims he has previously suffered from undiagnosed burnout which possibly adversely affected his 'manner'. However there is no independent evidence to show that any underlying burnout issues have been resolved, or that the effects of burnout would not be of concern if DKR was interim reinstated.

[120] The report DKR submitted from his Occupational Medicine Specialist dated 17 July 2019 described him (while employed) as having issues sleeping and with raised anxiety. It also notes that DKR's stress (while still working at WDHB) had increased due to the patient death, reviews of his clinical practice and criticisms from his colleagues.

[121] The Occupational Medicine Specialist recorded that DKR had felt much better mentally since finishing work and he "*no longer had the pressure of having his work held up for criticism or judgment.*" This suggests it is more appropriate not to interim reinstate DKR, due to his own wellbeing, particularly when there are ongoing investigations into his practice, that are likely to cause him to suffer increased stress and anxiety.

[122] There is also no credible evidence to suggest that the communication concerns that have been raised by WDHB would not recur if DKR was interim reinstated, or why these communication concerns would not create a risk to patients' care.

[123] DKR says that completion of his performance assessment is vital to him being able to obtain a certificate of good character and being able to renew his practising certificate when it expires in February 2020.

[124] DKR says that the value of reinstatement and ongoing employment by WDHB outweighs the value of any monetary compensation he might ultimately obtain, because if he doesn't complete a performance assessment to the MCNZ's satisfaction then the voluntary undertaking may never be lifted.

[125] DKR believes it is unlikely that a new employer will want to employ and/or support him through the completion of a performance assessment, meaning that his career would effectively be at an end if he is not reinstated to WDHB.

[126] DKR says he is close to retirement age so he will find it difficult if not impossible to find alternative employment at his age and no compensatory payment could replicate the value of the loss of his ongoing employment. DKR says that his right to work is a valuable one and that if it is not restored then his career may suffer lasting damage.

[127] The Authority acknowledges DKR's concern that he may not be able to continue practising medicine if he has not completed his performance assessment before his current medical certificate expires in February 2020. However his delay in taking preliminary steps to set up his performance assessment undercuts the concern he has expressed.

[128] DKR also has the option of applying to MCNZ to review his ability to practice again after the HDC, the Coroner and the Authority complete their respective investigations. More information from these independent investigators about the merits or otherwise of DKR's views regarding the safety of his practice is likely to be available at that time.

[129] That additional information is likely to result in the MCNZ being better placed to make a more fully informed decision about DKR's practice. So it is not a certainty that the Authority's failure to reinstate DKR to WDHB will result in the end of his career.

[130] While the potentially adverse impact that a failure to reinstate DKR may have on his future career is a factor in favour of interim reinstatement, it is not decisive of it. Other considerations must also be carefully weighed.

[131] WDHB points to the significant disruption that would be caused by an interim reinstatement. WDHB's decision maker provided an affidavit about the already considerable resources WDHB had expended in monitoring DKR's practice and performance over the past three years.

[132] She pointed out that a number of Senior Medical Officers had devoted significant amounts of time and resources to addressing, and seeking to remedy, failures in treatment by DKR. The Senior Medical Officers were assisted by various nurses and other administrative staff, which all came at the cost of the time and energy of those involved.

[133] Those individuals were also required to attend their own patients and patient needs, in addition to taking on the extra workload of assisting with issues involving DKR. It would unreasonably overburden them to have to also support DKR again, as well as carrying their own workloads, were he to be interim reinstated.

[134] WDHB said that the constant and intensive supervision that DKR would need if he returned to the workplace would require WDHB to expend resources it does not have. Doing so was therefore likely to have an adverse effect on other aspects of patient treatment.

[135] The CMO pointed out that because DKR was no longer credentialed to work in his areas of practice, he would have to be re-credentialed. That required DKR to satisfy the Credentialling Committee, with evidence, that he should be credentialled.

[136] The CMO believes that the Credentialling Committee would generally have difficulty credentialling a clinician who was subject to unresolved HDC complaints and disciplinary matters, who did not have unfettered registration from MCNZ, who could not necessarily provide evidence of competence (if challenged) and who could not provide evidence of recent clinical practice.

[137] WDHB removed DKR from all clinical duties in June 2018. Prior to that it had restricted his clinical duties, with his agreement, so that he was only undertaking lower risk

work. However, despite that restriction, subsequent concerns were raised regarding DKR's practice.

[138] The CMO's position is that WDHB has a duty of care to patients that cannot be discharged if it allows DKR to undertake procedures which he cannot adequately perform. The details of DKR's alleged inadequacy and performance and competency concerns identified by WDHB are set out in detail in the CMO's affidavit.

[139] I have not set out all of the evidence regarding the specific practice issues that have occurred, and that WDHB considers will arise if DKR returns, in order to comply with the non-publication order which prohibits publication of DKR's area of practice.

[140] The TC audit report of DKR's clinical practice identified deficiencies in his description and documentation of clinical findings. The CMO stated that maintenance of accurate records is a basic requirement of adequate medical practice and it is inconceivable for WDHB to facilitate clinical involvement of a practitioner who is unable to produce accurate documentation. DKR's expert Professor FF made no comment about that serious concern.

[141] The CMO further says that DKR's ability to complete procedures and to recognise whether they were complete was found to have been deficient. The CMO's evidence was that DKR's deficiencies in this regard sets the scene for patients having to undergo unnecessary testing or for patients having to face a risk of missed pathology.

[142] The CMO states that having knowledge of that risk, the WDHB cannot foster an environment where its patients are exposed unnecessarily to additional testing risks, or to the risk of disease being missed, which could potentially arise if DKR returned to practice.

[143] Two of the nurses who spoke to DKR's patients, who were audited, attached schedules to their affidavits of adverse comments 22 patients had made to them about the communication and treatment they had received from DKR. This made for harrowing reading. Professor FF did not adequately address these concerns.

[144] The CMO summarised the patient feedback as follows; "*an alarming high proportion of our patients reported significant or profound distress and discomfort and reported DKR's communication to be unsatisfactory*".

[145] The CMO maintains that the WDHB cannot in good faith expose their patients to unnecessary pain and distress and that adequate communication with patients is a minimum standard of competent practice.

[146] The Authority agrees that patient safety is of paramount concern.

[147] The potential loss of DKR's career, while admittedly extremely serious for him, should not take precedence over the risk of patients actually being harmed by him. Career loss is not as serious as a patient death.

[148] No patient would want to be treated by a practitioner that WDHB believes is "*grossly negligent*" to the extent that he "*is a danger to patients*", just because that practitioner has disputed their employer's assessment.

[149] It follows that if DKR was to be reinstated then the interim non-publication order would need to be lifted so that patients could be fully informed of the concerns that WDHB has about him. That would appear necessary so that patients were in a position to give informed consent before they agreed to be treated by DKR.

[150] The CMO was also concerned about DKR's failure to accept any of the feedback that had been provided during the various reviews that have been undertaken. WDHB further considers that DKR had refused to acknowledge the wisdom of his peers and had shown no meaningful insight into the practice and performance deficiencies that WDHB had identified. If that evidence is correct, then it increases the potential risk to patients.

[151] The CMO said that as a result of poor patient outcomes, DKR had elements of his practice reviewed by multiple peers. The reviewers included peers within his department, external reviewers contracted to complete a review under s 42 of the ASMS MECA, and two separate external reviewers contracted by the HDC's office.

[152] The CMO's evidence was that all of these reviewers have concluded that in respect of the patient death, DKR's practice was deficient. DKR did not accept those findings. He is described by WDHB as having adopted the position of challenging everything that has been raised with him.

[153] The Authority is not prepared at this interim stage to reject WDHB's assessment of patient safety, despite DKR strongly disagreeing with it.

[154] The CMO's evidence is that WDHB cannot discharge its obligation to maintain public safety if it allows DKR to return to work. That is serious evidence given by a very senior experienced practitioner who has personally reviewed all of the clinical and other concerns that WDHB relied on to dismiss DKR.

[155] WDHB says that the considerable support and assistance that would be required to facilitate DKR's return to work on an interim basis would come at considerable cost in terms of resources and time for WDHB, which could adversely impact on the ability to provide services to other patients.

[156] That means interim reinstatement has implications not just for DKR's patients but for the wider patient community, who could be required to wait longer for services, when there is already a backlog and delay in providing these services to them.

[157] WDHB also pointed out the additional disruption was likely to ensue because of the fraught relationships between many staff, GPs and DKR. It says that such disruption would not be justified for the limited time between now and the substantive investigation meeting in February 2020.

[158] WDHB says that the existence of restrictions on DKR's ability to actually perform duties militates against interim reinstatement.

[159] WDHB says that if DKR obtained interim reinstatement then he would be engaged in a supernumerary capacity only because another specialist would effectively have to be the individual that was actually providing the clinical services, because of the safety concerns WDHB has.

[160] That is not a good use of public funds. It also calls into question DKR's ability to actually undertake a performance assessment, even if he was to be interim reinstated.

[161] The affidavit evidence establishes that patients have suffered a range of adverse outcomes, including in one instance, death. Some patients have reported feeling traumatised months, if not years, after their interactions with DKR. While DKR says he is not responsible for any adverse patient outcomes, WDHB has concluded otherwise.

[162] The potential risk of patients being adversely affected or even possibly harmed if DKR returned to work is an unacceptable risk to take.

[163] After considering all of these factors, the balance of convenience clearly weighs against interim reinstatement.

Where does the overall justice of the case lie?

[164] Although DKR has been assessed as having an arguable case regarding his unjustified dismissal claim, the other factors (an arguable case regarding reinstatement and the balance of convenience) do not favour interim reinstatement.

[165] In terms of assessing the merits of DKR's substantive claims, while arguable, they are not strong.

[166] While DKR has rejected any responsibility for adverse patient outcomes or patient safety issues, other medical reviewers have had a different view.

[167] There is evidence that WDHB considered all of the points DKR raised, but did not accept them, for reasons it set out in their communications with him. There is also evidence of relevant information being shared with DKR and of him being given an opportunity to comment on that information before he was dismissed.

[168] The importance of public safety issues involving patients cannot be understated. It is of paramount concern.

[169] Patients who receive medical services from DKR are at their most vulnerable. They have a fundamental right to not be exposed to unnecessary risks of potential harm.

[170] The public need to be able to trust that WDHB takes patient safety seriously. That includes not exposing patients to medical practitioners that WDHB has assessed are "*grossly negligent and a danger to patient safety*".

[171] The safety of patients and the integrity of the public health system must take precedence over DKR's desire to return to work. Patient safety considerations must be the overriding criteria in a situation like this, where serious misconduct, involving adverse patient outcomes, is disputed by the clinician.

[172] WDHB's finding that DKR's practice was grossly negligent and that he poses a danger to patients goes to the very heart of his professional responsibilities and performance

of his duties for WDHB, rather than being an issue of behaviour that is incidental to the core provision of such services.

[173] WDHB is also publicly funded and it is important to ensure that public funds are spent prudently. Reinstating DKR to a supernumerary position is contrary to the financial prudence the public expects from its DHBs. Public funds are better spent on delivering health services.

[174] If DKR was returned to work he would drain time, energy and the resources of others who would be required to supervise, manage and support him. That would also take those resources away from their own patient loads, which are already under considerable pressure.

[175] DKR's patients could potentially be exposed to the risk of harm and other patients would be likely to have their treatment or services delayed, as a result of WDHB resources being diverted to support DKR's practice.

[176] The disruption that the interim reinstatement of DKR would cause is not practicable or reasonable given the considerable disruption that has already occurred due to the various issues involving DKR.

[177] The overall justice of the case weighs strongly against DKR's interim reinstatement.

The outcome

[178] DKR's application for interim reinstatement does not succeed.

[179] WDHB as the successful party is entitled to a contribution towards its actual costs. However, costs will be assessed once the substantive matter has been resolved.

Rachel Larmer
Member of the Employment Relations Authority