Attention is drawn to paragraph [12] of this determination prohibiting publication of certain information

Determination Number: AA 128/07
File Number: AEA 1289/05

Under the Employment Relations Act 2000

BEFORE THE EMPLOYMENT RELATIONS AUTHORITY AUCKLAND OFFICE

BETWEEN	Dr Y (Applicant)
AND	Bay of Plenty District Health Board (Respondent)
REPRESENTATIVES	Bruce Corkill for Applicant Mark Beech and Karen Jones for Respondent
MEMBER OF AUTHORITY	Robin Arthur
INVESTIGATION MEETING	14, 15 and 16 November 2006 in Tauranga
SUBMISSIONS	23 November 2007 (Applicant); 30 November 2007 (Respondent); 6 December 2007 (Applicant in reply); 13 March 2007 (Applicant on non-publication issues); 20 March 2007 (Respondent on non-publication issues)
DATE OF DETERMINATION	27 April 2007

DETERMINATION OF THE AUTHORITY

Employment relationship problem

[1] The applicant ("Dr Y") is a doctor dismissed by the respondent in June 2004 after 11 years service to the Board and its statutory predecessors. His dismissal followed an investigation by the respondent of a complaint about the doctor's management of a patient ("Patient A") who later died. He seeks a declaration that he was unjustifiably disadvantaged by the employer's conduct of the investigation and then unjustifiably dismissed. He applies for orders for reinstatement, lost income, compensation and costs.

[2] The Board says its investigation and decision to dismiss for serious misconduct were properly conducted and justified with the applicant given all appropriate opportunities to explain and respond before the decision to dismiss him was made.

Non-publication orders

[3] Interim non-publication orders were in place to the date of the investigation meeting for reasons given in Determination AA 132/06 (20 April 2006). These orders referred to the name of the applicant, his former position and other details which might identify the part of the Board's services for which he worked and any information that would identify Patient A or her family. The anonymising letters Y and A have no relationship to the actual names of the doctor or patient.

[4] At the investigation meeting those interim non-publication orders were extended until the date of determination. A preliminary view of the Authority was advised to parties that any further non-publication orders should cover the names of Dr Y and Patient A and her family but

not the area of practice or specialty of the doctor. The parties supported the Authority's view regarding the names of Dr Y and Patient A and her family but were to have the opportunity to make submissions on the question of publication of the doctor's area of practice or specialty.

[5] By minute of 5 March 2007 the parties were invited to make submissions on the appropriate scope of the non-publication orders – and particularly the area of specialty reference.

[6] The applicant submitted that suppression of the area of specialty was necessary to protect the integrity of any interim or ongoing order for the non-publication of the doctor's name. As the name of the respondent was known, disclosure of the applicant's specialty, would make him readily identifiable.

[7] The respondent seeks indefinite continuation of non-publication orders relating to the names of all patients – not just Patient A – referred to in the evidence and the names of the families of those patients. I have no hesitation in agreeing on that point.

[8] The respondent also seeks non-publication orders relating to the applicant's identity, the respondent's identity together with the staff members who gave evidence and the area of specialty. However, referring to the approach taken by the Employment Court's in *X v ADHB* (unreported, AC 10/07, 23 February 2007), it suggests that any non-publication order regarding the applicant's name should expire after the 28-day period allowed for challenge of whatever may be the Authority's determination of the substantive issues between the parties.

[9] I decline the respondent's application for non-publication of its name. It has already been published in relation to an earlier stage of this matter in the mainstream media and in legal publishers' head notes on Authority determination AA 132/06. The respondent provides public health services. The adequacy or otherwise of its dealings in employment disciplinary matters with its medical staff is, in the public interest and in the absence of any special reasons to the contrary, properly open to scrutiny through public access to the determinations of the Authority and the courts above.

[10] Similarly there is no reason for non-publication of the names of staff members and others who gave evidence. They did so either as former managers or, in the case of two specialists who gave evidence, as medical professionals with recognised knowledge and expertise. Knowledge of their names and roles does not risk compromising the integrity of the orders for non-publication of the names of Dr Y, former patients and families.

[11] Weighing various factors I have found the following to be decisive in resolving to make no ongoing non-publication order regarding the area of practice or specialty:

(i) As in the ADHB case, all other clinicians working for the respondent now or at the earlier material time might otherwise be the subject of suspicion; and

(ii) The nature of the evidence – and the need to refer in some detail to the particular requirements of practice in this area of specialty – would otherwise require a bowdlerising of the determination which is corrosive of the wider public interests: *GWD Russells (Gore) Ltd v Muir* [1993] 2 ERNZ 332, 340-1; and

(iii) The orders regarding the names of Dr Y and former patients and their families is most likely enough to protect their identities and differing interests, and any restriction on publication should, as a matter of principle, be the least amount necessary. While some family, friends and health professionals who have been involved in some way may, by linking what they already know with the area of specialty, be able to identify the applicant, it is likely that they already know this. As a matter of practicality, an order for non-publication of that particular piece of information would not give any additional protection to any real sensitivity or interest of those provided with anonymity by orders covering names only.

[12] **Accordingly I make the following orders under Schedule 2 clause 10 of the Employment Relations Act 2000 ("the Act"). The following evidence or information in this matter is not to be published:**

(i) The name and any other identifying details, apart from gender and occupation, of the applicant (who is to be referred to only as Dr Y);

(ii) The names and any other identifying details, apart from gender, of Patient A and any other former patients of Dr Y, and of those patients' family members.

(iii) Any personal details of patients and their treatment referred to in the pleadings, witness statements, oral evidence, and the documents provided by the parties for the purposes of the Authority's investigation, except to the extent that these are discussed and described in this determination.

[13] I decline the respondent's proposal that any non-publication order regarding Dr Y's name 'expire' after the 28-day period allowed for challenge of the Authority's determination. That approach is not appropriate here. Apart from the prospect of challenge of this determination to the Employment Court, there may be matters still to be dealt with by the relevant health disciplinary body or, in respect of registration, the Medical Council and specialist college. I do not know if this is so or likely, but if it were, such matters would likely fall outside such a limited time frame. The present orders are in place indefinitely but, should there be any application to the Authority or Court to vary or remove them, the process for considering such an application should ensure the relevant parties have adequate notice and opportunity to comment before a further decision is made on the basis of factors as they stand at that time.

The Authority's investigation

[14] The applicant's statement of problem was lodged on 19 December 2005 and the respondent's reply lodged on 25 January 2006. An application in February 2006 for removal of the matter to the Employment Court was refused in April 2006. The parties arranged and attended mediation in May 2006 but the applicant advised in August 2006 that the matter had not been resolved and sought continuation of investigation by the Authority.

[15] Witness statements were provided by the applicant; his industrial advocate, Henry Stubbs of the Association of Salaried Medical Specialists ("ASMS"); consultant psychiatrist and chair of the New Zealand committee of the Royal Australian and New Zealand College of Psychiatrists, Allen Fraser, appearing as an expert witness for the applicant; the respondent's former Clinical Director of Mental Health Services, Mark Fisher; consultant psychiatrist Tom Flewett who was commissioned by the respondent in December 2002 to review and report on the applicant's care of Patient A; the respondent's chief operating officer Graham Dyer; and the respondent's former Chief Executive Officer Ron Dunham who made the decision to dismiss the applicant. Each man attended the investigation meeting to answer questions from the Authority and additional questions from counsel. Dr Fisher's attendance was by telephone as he was, at that time, completing a two year posting to a role in mental health services in south-west England. At the conclusion of the investigation meeting I asked counsel for both parties whether there was anyone else I needed to talk to and was told there was not.

[16] All the evidence given – in writing and orally, and including detailed medical information – along with the many background documents, has been fully considered in preparing this determination, however the determination records only facts and findings necessary to resolve the employment relationship problem within the Authority's jurisdiction and not for any other purpose.

The background

[17] Dr Y was employed by the respondent in January 1993 as a psychiatrist. He was appointed as a Medical Officer Special Scale ("MOSS"), a role indicating that he did not have specialist registration. He had completed medical training abroad, came to New Zealand in 1986 and worked as a psychiatric registrar before being employed by the respondent.

[18] He initially had temporary registration and was granted general registration by the Medical Council in 1997. He has not attempted the New Zealand Registration Examination which tests knowledge and skills across all the major clinical disciplines. His registration imposed conditions that he practise medicine only in the field of psychiatry and under the general oversight of two vocationally registered practicising psychiatrists who worked in the same location. The applicant had not passed vocational registration exams required by the relevant professional college for full registration as a specialist, sometimes called a consultant.

[19] Oversight Agreements sent to the Medical Council referred to oversight comprising weekly clinical discussions and attendance at quality assurance meetings.

[20] While Dr Y remained designated as a MOSS psychiatrist, he negotiated with the respondent for a salary and benefits at similar levels as those available to specialists. His evidence was that, at the material times, he functioned and exercised authority as if he were a consultant.

Patient A

[21] In July 1999 Dr Y made his first assessment of Patient A, a woman referred to Tauranga Hospital by her local GP.

[22] Hospital records show Patient A saw Dr Y nine times between July 1999 and September 2001 – three times in 1999, three times in 2000 and three times in 2001. Correspondence from Dr Y says that on the last occasion he saw Patient A – at her request in September 2001 – she declared that she had "*some feelings for*" him and he discharged her "*finally*" back to her GP's care.

[23] Throughout this period Patient A sent some 27 handwritten personal letters to Dr Y. On three occasions Dr Y replied to these letters.

[24] In November 2001 Patient A's GP wrote asking Dr Y to see Patient A again to discuss adjusting her medication and what she had described to her GP as "*some personal problems*". Dr Y wrote to the GP on 26 November 2001 with some advice regarding the appropriate medication until Patient A could see one of his colleagues – to whom this determination need only refer to as Dr Z - at an appointment on 5 February 2002. He said that colleague looked after the area in which Patient A lived. From the documents available, it appears that the GP's letter had been referred to Dr Z but that Dr Z had arranged for Dr Y to reply to the GP.

[25] Patient A learnt through her GP in late November or early December 2001 that she would see Dr Z at an appointment in February 2002 rather than see Dr Y as she had requested.

[26] According to hospital records, Patient A next contacted the respondent's Mental Health Services by a telephone call to its crisis team on 28 December 2001. After speaking with her, a nurse talked to Dr Y about Patient A's medication and he advised on a change to it. When the nurse rang again to pass on that advice, Patient A spoke of fears that Dr Y was trying to hurt her because she had declared her affection for him. She rang again the next day to apologise for comments about Dr Y.

[27] In early January 2002 Patient A's new GP wrote to the respondent's Mental Health Services asking for Patient A to be seen. The letter referred to Patient A having stopped seeing Dr Y because "*she had developed feelings of love for him*". It also advised that the GP

was concerned about Patient A saying she felt suicidal and had made some plans for suicide. The GP asked for a case worker to visit Patient A at her home and she was visited on 10 January 2001.

[28] Patient A died by suicide on 24 January 2002.

Patient A's family complains

[29] A week later Patient A's daughter and sister arranged to come to the hospital and meet with Dr Y. According to a file note he made later on the day of the meeting, Patient A's sister was critical of the care provided by Dr Y and the respondent's Mental Health Services. She indicated that the family would take the matter further.

[30] Patient A's sister made a complaint to the respondent alleging that Dr Y had continued to treat Patient A knowing she was developing strong emotional feelings towards him and that he saw her after an organisational change at the hospital meant that Dr Y was no longer supposed to see patients from the area where Patient A lived.

Dr Fisher investigates

[31] Dr Fisher, who was Dr Y's clinical director, provided a copy of the complaint to Dr Y and asked for his comments. Dr Y's reply – among other things – said that when he was told that Patient A did not live in the geographical area covered by his medical team that he "*arranged an appointment for her through the secretaries with the responsible Doctor for the area of her domicile*".

[32] Following Dr Y's reply Dr Fisher prepared a draft "Serious Incident Review Report". Such a report was standard procedure in relation to an incident of this type.

[33] Dr Fisher's draft report noted that Dr Y acknowledged he was aware that Patient A might have some feelings for him as early as April 2001. This was due to the content of some of the letters she sent him. While he had discharged her back to the care of her GP at that point, he later arranged further appointments with Patient A at her request. Dr Fisher is critical that Dr Y's letter to Patient A's GP in September 2001 did not indicate that the September appointment had dealt with the issue of Patient A's feelings towards him, or indicated that he would not see her again. Dr Fisher also expressed concern at several aspects of Dr Y's management of Patient A's case, including whether his diagnosis of her condition warranted the drug regime prescribed for her. He concluded that:

> *Dr [Y] either failed to recognise ample signs that [Patient A] was forming an excessive emotional attachment towards him early in 2001, or that he failed to manage those feelings both with [Patient A] and through the development of an appropriate management plan. In view of [Patient A's] personality traits and social situations, she was a high risk to have developed these sorts of feelings towards a sympathetic doctor. However, I acknowledge that the whole clinical area of patients becoming overly attracted towards their clinician is a complex one, and an area in which I have limited expertise.*

[34] Dr Fisher recommended an external review from an independent psychiatrist, expert in the issue of transference in doctor-patient relationships, and who could give a second opinion on concerns about risk assessment, diagnosis, medical investigation and record keeping.

[35] Transference is a term used in psychology and psychiatry to explain the nature of a relationship which may develop between patient and doctor. Some patients may develop strong feelings of affection – described as attachment and idealisation – towards their doctors. Practitioners in the area are concerned to ensure that such feelings are properly managed, including any risk of dependency and feelings of abandonment by patients where changes are made in their care.

[36] In July 2002 Dr Fisher advised Dr Y that he had reviewed Patient A's file and considered there were questions regarding Dr Y's management of her care. He also advised that he

considered external review by a psychiatrist was appropriate and that Dr Y would be shown the letter commissioning that review before it was sent.

[37] A letter in October 2002 from the Mental Health Services General Manager Chris Nolan to Dr Y's counsel on medico-legal matters, Jenny Gibson, advised that the respondent was still investigating Patient A's case. However Dr Y was told that any investigation of a complaint could result in recommendations for disciplinary action. At a subsequent meeting between Dr Y, his counsel, Dr Fisher and Mr Nolan, it was agreed that Dr Y's counsel would be provided with a copy of the letter of request for external review. This was done in early November 2002. Ms Gibson responded criticising the draft letter commissioning a review as identifying concerns already held by Dr Fisher. She asked that formal terms of reference and a draft process be prepared for comment. The respondent's lawyers replied rejecting that request and describing the draft review letter as fair and balanced in setting out the general background, the respondent's concerns and the family's complaint.

External review

[38] Dr Tom Flewett was identified by the respondent as a suitable expert to conduct an external review of Dr Y's management of Patient A's case. He is a consultant psychiatrist with the Capital Coast District Health Board.

[39] By letter dated 19 December 2002 Dr Fisher asked Dr Flewett to investigate and review Dr Y's management of Patient A and answer these questions:

1. *Were there significant warning signs of the nature of the relationship that should have been attended to earlier by [Dr Y]?*
2. *Should he have taken action earlier? Was his management of the situation, once her feelings were declared, adequate or appropriate?*
3. *Is there any evidence that her transfer of care to another psychiatrist was not managed adequately?*
4. *Was there any evidence that [Dr Y] kept her on as a "special patient" as the complaint alleges?*
5. *Is there any suggestion that [Patient A's] suicide was contributed to by [Dr Y's] handling of her care?*

[40] Material available to Dr Flewett included the clinical file and Dr Fisher's own report. Dr Flewett also spoke to Dr Fisher and a social worker who had been involved with Patient A's file. He also met separately with Dr Y and with Patient A's sister and daughter.

[41] On 7 May 2003 he provided a draft of his report for comment from Dr Y and his representatives of the respondent. Dr Y's counsel asked for copies of handwritten notes made by Dr Flewett during his meetings, which were provided.

[42] In August 2003 Dr Flewett received a letter from Dr Y's counsel requesting amendments to the draft report. He subsequently included a number of the requested amendments to the draft. He left a number out. In his evidence he explained that this was either because they dealt with material he did not consider within the scope of the review he was asked to conduct or had no overall bearing on his recommendations. He also assumed that the respondent would take into account the comments of Dr Y's counsel in considering his own report.

[43] The final version of Dr Flewett's report, dated 6 October 2003 and just over seven pages long, provided specific responses to the questions asked and set out nine recommendations. It expressed concern about the diagnosis made and the medication prescribed to Patient A. It described Dr Y's management of Patient A's correspondence as "poor". It stated:

> *He did not respond to clear evidence of idealisation and emotional feelings expressed towards him and he did not consider the potential fallout on the discontinuation of treatment in terms of rejection and abandonment and the potential for this to reach psychotic intensity, given her past history.*

> *[Dr Y's] transfer of her care was poorly co-ordinated and not documented. Given the risks of suicide, which had been identified at the time of initial assessment and further communicated by her General Practitioner and commented on by the Crisis Team, the absence of a clear line of medical responsibility is of further concern.*
>
> *Given the above points, I have concerns about the management of other patients on his caseload.*

[44] Dr Flewett also criticised inadequacies of the respondent's systems at the time – that is up to late 2001. These included poor multidisciplinary processes, a lack of formal reviews of patients and no minute taking during meetings.

[45] He concluded that Dr Y should have acted earlier and immediately transferred Patient A to another psychiatrist once she declared her feelings. Such a transfer would also have had to consider risks of rejection and abandonment leading to a suicidal intent. However he concluded there was no evidence Patient A had been treated as a "special patient" or that Dr Y's handling of her care was a specific contributor to Patient A's suicide.

[46] Specific recommendations made included close supervision of Dr Y and a formal audit of all his patient case load, his assessments of those patients and documentation completed. Dr Flewett also recommended urgent attention to various systems and processes in mental health services if that had not already been done.

[47] Dr Flewett provided his final report to the respondent's solicitors on 14 October 2003 but copies were not provided to Dr Y, his ASMS advisor or his counsel Ms Gibson until early December 2003.

Stand down of Dr Y

[48] From March 2003 Dr Y had not attended work. He had been away from work on extended leave to take an overseas trip and was due to return to work on 17 June 2003.

[49] The previous day Dr Fisher telephoned him and said that the Flewett report (still at that stage a draft) would be available to collect at the hospital the following morning. On the account given by Dr Fisher, Dr Y was also asked to attend a meeting to discuss the draft report and a proposal that he not return to his clinical work until he had responded to the review. On the account given by Dr Y, this telephone conversation involved the unilateral suspension of Dr Y from his duties.

[50] By letter on 17 June Dr Fisher and Mr Nolan told Dr Y that, because Dr Flewett's draft report identified some serious concerns, "*some interim measure*" to ensure patient safety and to protect both the respondent and Dr Y was needed while clinical and employment issues were addressed. The letter advised that the respondent considered Dr Y ought to "*refrain from carrying out clinical duties pending the outcome of the clinical review and any disciplinary process that may flow from that*". He was told he would be paid his base salary but not be required to attend work. He was asked to accept that proposal and to meet to discuss the issue.

[51] Following discussion between the parties representatives, Mr Stubbs advised the respondent's solicitors that Dr Y "*reluctantly agree[d] to refrain from clinical duties*" pending the completion of Dr Flewett's review. Mr Stubbs's evidence refers to that acceptance being on the basis of an expectation – communicated to the board's solicitors – that the need for the stand-down would be reviewed within two months, by which time the final Flewett report should be completed. There is no evidence that the board agreed to such a time limit. Dr Y remained on his average salary from the time of his stand down until his dismissal but was not required to attend work.

Subsequent action by the Board

[52] In January 2004, after Dr Y and his advisors had received the final Flewett report, the

respondent advised that it wished "*to recommence its review of [Dr Y's] performance in relation to the [Patient A] matter pursuant to its rights under clause 29.7 of the applicable collective agreements*". That clause allowed the respondent at any time and where circumstances were sufficiently serious to "*review the performance of an employee in respect of any particular matter*".

[53] At the same time Dr Y, through Mr Stubbs, sought agreement that he return to work on the basis that Dr Flewett's report identified "*no clinical issues that would preclude [Dr Y] from resuming normal duties as soon as possible*".

[54] Other commitments of the parties' representatives resulted in no meeting being held to discuss their respective issues until 16 April 2004.

[55] Meanwhile on 7 April Dr Fisher and the acting General Manager of Mental Health Services wrote to the respondent's CEO Mr Dunham regarding Dr Y's care of Patient A and the reports of Dr Fisher and Dr Flewett on it. The letter summarised what it called "deficits in a number of areas". It concluded:

> *In spite of some difficulties in the systems in place in Community Mental Health Services at Tauranga Hospital, it is clear that [Dr Y] did not provide clinical care for [Patient A] to a level which would be expected from a MOSS Psychiatrist of his experience.*
>
> *In addition deficiencies in his standard of practice are sufficient to justify a finding of serious misconduct against [Dr Y].*
>
> *In the context of [Dr Y's] previous complaints and his previously demonstrated lack of attention to concerns regarding his clinical abilities, it is recommended that employment should be terminated by the Bay of Plenty District Health Board.*

[56] On 16 April 2004 the respondent's CEO Ron Dunham and a board solicitor met with Dr Y, Mr Stubbs and Ms Gibson to discuss Dr Y's performance, in light of the content of the reports on Dr Flewett and Dr Fisher. During the meeting, according to Mr Stubbs' evidence which I accept, Mr Dunham confirmed that he had to consider and decide whether on the basis of what was now known about Dr Y's handling of Patient A's case alone there were grounds for Dr Y's dismissal.

[57] In writing six days later Mr Dunham advised Dr Y that he had concluded that Dr Y's handling of Patient A's case did constitute serious misconduct. Mr Dunham referred to having been advised by Dr Fisher that Dr Fisher considered Dr Y's professional behaviour "*wanting and that it comprises serious misconduct*". Dr Y was invited to a meeting to discuss the consequences of that finding as to his clinical conduct and advised that the meeting could result in the termination of his employment.

[58] At that meeting, held on 20 May 2004, the parties agreed, and Mr Dunham confirmed shortly after in writing, that Mr Dunham's finding of serious misconduct to that date was in relation to Dr Y's clinical handling of Patient A's case. Whether there was serious misconduct in relation to what was referred to as "the employment side" was still to be decided through a process of meetings and submissions. Arrangements were made for a detailed response from Dr Y and his advisors before a further meeting was held. Mr Dunham also provided a copy of Dr Fisher's 7 April letter.

[59] In early June Mr Stubbs, as previously arranged, provided a detailed response from Dr Y to the specific concerns of the respondent. Under five headings the six-page document analysed the information and comments made in Dr Fisher's and Dr Flewett's reports and provided Dr Y's detailed responses. The concerns addressed were those set out in Dr Fisher's letter to Mr Dunham of 7 April and were identified as:

1. [Dr Y] did not properly address issues around [Patient A's] diagnosis.
2. Proper investigations were not completed during the course of her treatment.
3. Risk assessment and discharge planning were poor.

4. [Dr Y] did not provide good communication to or leadership for the other members of the multi-disciplinary team.
5. [Dr Y] did not adequately identify [Patient A's] excessive attachment to him nor respond to this in any clinically appropriate manner.

[60] This submission was discussed in detail at a further meeting of Dr Y and Mr Stubbs with Mr Dunham and other representatives of the respondent on 1 June 2004.

[61] Following that meeting Mr Dunham took further advice from Dr Fisher about the responses given by Dr Y. He had Dr Fisher's comments recorded in a table alongside the responses given in Dr Y's submission.

[62] Mr Dunham also discussed Dr Y's case with his Chief Medical Officer Dr Paul Malpass. Mr Dunham's evidence was that while he discussed the issue with Dr Malpass as a "wise head" and with Dr Fisher, the decision he ultimately took to dismiss was his decision alone in his role as CEO.

[63] By letter of 15 June 2004 Mr Dunham told Dr Y that he had finally concluded Dr Y's clinical handling of Patient A's care constituted serious misconduct "*and the consequence of that is summary dismissal*". Dr Y was paid three months notice.

The applicant's case

[64] The respondent's decision and process of deciding to dismiss the applicant was subject to an exhaustive and sophisticated critique by his counsel.

[65] Dr Y's case is that the respondent's investigation was not full and fair because Mr Dunham's decision was based on flawed reports from Dr Fisher and Dr Flewett.

[66] Dr Fisher is said to have not been sufficiently independent to provide an initial report as he was aware of other complaints against Dr Y, had some issues himself with Dr Y and had been involved in the care of another member of Patient A's family. Dr Fisher and Dr Flewett are also criticised for failing to fully interview Dr Y about several factual issues.

[67] The Flewett report is criticised as not independent because the questions to which it responded were set by Dr Fisher who had already formed his own strong view. That strong view was conveyed to Dr Flewett so that, it is said, his report was clearly influenced. The Flewett report is also said to be inadequate because Dr Flewett did not interview Patient A's GPs or Dr Z. Submissions by Dr Y's counsel Ms Gibson are said not to have been taken seriously.

[68] The fact that Patient A died is also said to have influenced the respondent's approach to the disciplinary process resulting in a decision to dismiss.

[69] Involvement of Dr Fisher, Mr Nolan and Dr Malpass in discussions with Mr Dunham, and reliance by Mr Dunham on advice from them, is said to have compromised Mr Dunham's investigation, as evidenced by failing to follow recommendations made by Dr Flewett to manage Dr Y's future practice.

[70] The respondent is criticised for a delay of more than two years in resolving this matter – Dr Y was advised in May 2002 of the complaint regarding Patient A's care and dismissed in June 2004.

[71] Other "contextual matters" are also said to have been ignored, including Dr Y's heavy workload, inadequate professional oversight of Dr Y's work, lack of support for Dr Y from colleagues and a lack of regular performance reviews.

[72] The respondent is also said to have reneged on an arrangement agreed between Dr Y and his managers in January 2003 to deal with a clutch of complaints in relation to other

patients and his relationships with colleagues. During the Authority's investigation meeting this was referred to as a "clear the decks" exercise which had expressed a commitment from both parties to put aside past problems. Dr Fisher, who was involved in that exercise, is said to have broken that agreement by referring in his 7 April letter to "previous complaints" in support of his recommendation to dismiss Dr Y.

[73] The arrangement made in June 2003 for Dr Y to "refrain from duties" is said to have been an unjustified suspension which he was forced into accepting and which continued too long.

[74] The respondent is also said to have failed to identify and justify the threshold it applied to determine serious misconduct. The applicant argues that what would be required would be conduct of a level equivalent to "gross negligence" and whatever the shortcomings there may have been in his care of Patient A, they did not amount to a level of failure, if all contextual factors had properly been taken into consideration, amounting to gross negligence. What may amount to 'serious misconduct' is said to be defined in Dr Y's 1993 individual contract with the respondent which includes a reference to "*any gross negligence by the Employee in the performance of duties*".

The respondent's case

[75] The respondent says that the reports of Dr Fisher and Dr Flewett, and the evidence of Dr Fraser, clearly identify serious clinical issues which the employer was entitled to investigate. The reasons for the subsequent decision to dismiss were, firstly, a failure to provide clinical care to the level expected from a MOSS psychiatrist and, secondly, inadequate file management. These failures were a series of incidents rather than a single event that cumulatively amounted to negligence warranting summary dismissal.

[76] The respondent relies on its disciplinary policy issued in January 2002 to define serious misconduct as behaviour which "*undermines the contractual relationship between employee and company, and/or seriously threatens the well-being of the organisation, the staff or clients and may warrant dismissal without notice*".

[77] The respondent says its investigation was fair with the applicant fully represented and able to respond to and comment on all relevant information throughout.

The law

[78] The dismissal occurred before the present s103A statutory test of justification came into force. The parties agreed that the applicable legal test for justification of the dismissal is that stated in *W & H Newspapers v Oram* [2000] 2 ERNZ 448, 457:

> *… in a personal grievance, once the employee has established a prima facie case of unjustifiable dismissal, the onus is on the employer to justify the dismissal. The Court has to be satisfied that the decision to dismiss was one which a reasonable and fair employer could have taken. Bearing in mind that there may be more than one correct response open to a fair and reasonable employer, we prefer to express this in terms of "could" rather than "would", used in the formulation expressed in the second BP Oil case ([1992] 3 ERNZ 483 (CA) at p 487).*
>
> *The burden on the employer is not that of proving to the Court the employee's serious misconduct, but of showing that a full and fair investigation disclosed conduct capable of being regarded as serious misconduct. …*

[79] Considering the question of conduct capable of being regarded as serious misconduct, the Court in *Oram* made this statement of the law (as it was then):

> *If, in a particular case of summary dismissal, the employer shows that the conduct was such that a fair and reasonable employer could see it as deeply impairing of the basic confidence and trust essential to the employment relationship, it would hardly be necessary to consider, as a separate step, whether in all the circumstances the employee*

ought to have been dismissed. This assumes, of course, that the fair and reasonable employer did take into account all the relevant circumstances of the conduct and the particular employment relationship in determining that the necessary confidence and trust had been deeply impaired.

The issues

[80] The issues to be resolved in this determination include:

(i) Whether there was a full and fair investigation?

(ii) Whether the employer's investigation disclosed conduct capable of being found to be serious misconduct?

(iii) If the applicant's dismissal was unjustified, what remedies are appropriate, and particularly, is reinstatement practicable?

Discussion

(i) a full and fair investigation

[81] The justifiability of the respondent's decision to dismiss Dr Y for serious misconduct rests on the fullness and fairness of the process carried out by Mr Dunham in making the decision.

[82] The question here is the extent to which Mr Dunham relied on the reports of Drs Fisher and Flewett for an analysis of the factual background and professional responsbilities or went further, where necessary, to find additional information and analyse the conclusions already drawn. During the course of the Authority's investigation, the question arose of whether Mr Dunham should have done more to examine the exchange of information about Patient A's care between her GPs (there were three involved over the relevant period) and Dr Y, and between Dr Y and Dr Z in late 2001 after Dr Y had arranged for Patient A to be seen by that psychiatrist rather than himself in future. Dr Y's evidence was that although he had not documented a handover, he had made it verbally to Dr Z. I accept Dr Fisher's evidence that the expected professional practice would have been for Dr Y to have prepared a written summary or review of Patient A's case to be put on her file. That was not done.

[83] Dr Flewett accepted during questioning that it was "remiss" of him not to have inquired of the Tauranga GPs about their communication with Dr Y about Patient A but that he had not talked to Dr Z because that was outside the terms of reference of his review.

[84] However I do not accept that not making inquiries of the GPs and Dr Z was a serious flaw in the respondent's investigation, or the reports on which Mr Dunham later relied. I prefer and accept Mr Dunham's evidence that the issue highlighted here was a failure of Dr Y to properly document Patient A's case. If there were more extensive and relevant discussions with her GPs, he had not documented them on her file. Similarly it was not a satisfactory standard of practice to effect a handover of a patient from one psychiatrist to another by what Mr Dunham called "corridor talk", particularly in the circumstances of identified transference or attachment issues which put Patient A at risk. Even if Mr Dunham had got confirmation from Dr Z of the oral handover, that would not have resolved the failure of Dr Y to prepare and place on Patient A's file a proper written review of her case and treatment.

[85] Dr Flewett had recommended an immediate formal audit of the assessments and diagnoses of all Dr Y's other patients. The respondent had not implemented that recommendation – made in October 2003 – at the time that it was considering disciplinary action on Patient A's case in April 2004. However I do not consider this to be a failure to fully investigate. At worst such a review may have revealed other cases of unsatisfactory practice. At best it would have shown that any inadequacies in care were isolated to Patient A alone and did not include other patients of Dr Y. However I again accept Mr Dunham's evidence that he was considering disciplinary action solely on the circumstances and merits of Dr Y's handling of Patient A's case and not other patients, so an audit relating to other patients was not necessary to reach conclusions in relation to Patient A's care.

[86] Dr Y's strongest argument on justifiability is that the respondent's investigation was flawed from the 'get go' because of the strong position taken by Dr Fisher in preparing the draft Serious Incident Report and in his letter commissioning Dr Flewett as an external reviewer.

[87] Against that concern I weigh various factors. These include the fact that Dr Y had the opportunity for imput and comment before Dr Fisher drew his initial conclusions in his draft Serious Incident Report. I also accept Dr Flewett's evidence that he was not overawed by Dr Fisher's opinion and formed his own views from an independent review of the file and interviews with key people, including an interview with Dr Y. Both Dr Fisher and Dr Flewett were specialists operating in a professional environment where second opinions are frequently sought and contrary views are expected and accepted if well-founded. I observed this, for example, in the evidence given at the investigation meeting by Dr Flewett and Dr Fraser who both properly conceded fair points where that was appropriate to do so. In that light I do not accept that Dr Flewett's report was 'skewed' by Dr Fisher's instructions or that Mr Dunham was wrong to rely on it as an independent assessment of the clinial standard of care provided to Patient A. Another pointer to its independence was Dr Flewett's readiness to criticise some of the respondent's contemporary "systemic processes" for patient care – a criticism which would not have been made if it were merely a hollow exercise to please Dr Fisher or the respondent's senior managers.

[88] I also do not find the weight of evidence favours the applicant's argument that Dr Fisher's views were firmly set against him. Dr Fisher had certain responsibilities as Clinical Director – which included preparing the draft Serious Incident Review Report. That this report came to a firm conclusion cannot of itself be taken to show a bias against Dr Y. There is also evidence that Dr Fisher remained open to arguments put forward by Dr Y which he considered to be valid. In a record of his responses to the applicant's final submissions – the table prepared by Mr Stubbs – Dr Fisher accepts a number of points. Dr Fisher accepted that he understated how many times Dr Y had recorded his risk assessments about suicide or other risk of harm by Patient A. He also accepted Dr Y's arguments that he had a high case load and had faced hostility in his practice from some registrars and consultant colleagues.

[89] On balance I prefer the evidence of Dr Fisher that his review was conducted properly as part of his line management responsiblities, however unsavoury his conclusions may have been to Dr Y, and were not, as implied by the applicant, part of a campaign to undermine him.

[90] I do accept there was a potentially important initial flaw in Mr Dunham's investigation. When he met the applicant and his representatives on 16 April Mr Dunham did not, it appears, reveal that he already had a recommendation from Dr Y's manager, Dr Fisher, that Dr Y be dismissed for serious misconduct, made in Dr Fisher's letter of 7 April. However that recommendation came to light shortly after that meeting, as a result of a letter from Mr Dunham to the applicant's representative. This resulted in an agreement between the parties that the conclusion reached to date regarding serious misconduct was in relation to clinical issues rather than a conclusion on employment issues. A subsequent process of submissions and meetings remedied, I find, any procedural error relating to the earlier oversight: *Rankin v A-G* [2001] ERNZ 476, 527 applied. Those additional submissions also provided an adequate forum for any issues that had been earlier raised by Ms Gibson, but not accepted by Dr Flewett for amendment to his draft report, to be raised independently by Dr Y's representatives.

[91] Mr Dunham also remedied, I find, the prospect that circumstances relating to other patient complaints and strained relations with some colleagues were factors in determining what disciplinary action, if any, was required regarding the clinical findings about Patient A's case. At the time Mr Dunham was adamant that the situation would be assessed on Patient A's case alone and he reasserted that view in his evidence to the Authority investigation. I was not persuaded by any of the evidence for the applicant that Mr Dunham strayed from that commitment. That he was aware of a background of some other friction and concerns does not, of itself, undermine the integrity of the decision made in relation to Patient A's case. In making that assessment I also take account of Mr Dunham's evidence that he was an experienced manager with a nursing background, including in mental health services. I accept

that he was not unduly swayed by what he called the "noise" – which I take to mean peripheral concerns and heightened emotions – around cases of these type but was able to, and experienced enough to, put irrelevant considerations aside. I accept his evidence that he was not unduly influenced by the fact that the matter under review included the death of a patient by suicide. While that was a sad aspect of the situation it was not treated more severely than any other circumstance that resulted in a serious incident review report, such as a 'near miss' suicide attempt, unexpected harm to a patient, or harassment of staff.

[92] I also find that there was no unfairness in Mr Dunham discussing the case with Dr Malpass. Mr Dunham says, and I accept, that it was he and he alone who made the decision to dismiss. He was entitled as that decision maker to have the assistance of another senior clinician as a 'sounding board' to assist with the process of assessing the weight to give to the reports of the two clinicians – Dr Fisher and Dr Flewett – on whether Dr Y's clinical management of Patient A's case was adequate. There is nothing to seriously suggest that Dr Malpass's role as a 'sounding board' elevated his role to a decision maker by whom Dr Y would then have been entitled to be heard.

[93] I also find against the applicant in respect of the claim that the request that he refrain from duties, made in June 2003, was an unjustified suspension. The respondent has a technical point on whether this was raised within the required statutory period as a personal grievance for unjustified disadvantage, although I note that the applicant, through his representatives did purport to 'reserve his rights' at the time. However, regardless of that technical point, the applicant did agree to go on 'garden leave' albeit reluctantly. In light of the content of the Flewett report, on which that request was based, the respondent had to take some precautionary measures. It was a move which also protected the applicant and he did not suffer financially from it.

[94] There is some force to the argument that the matter then took too long to resolve. The responsibility for that, however, does not lie solely at the respondent's door. The documentary evidence shows that availability of representatives for both parties, and an extended period of leave by the applicant at one point, added many months to the process of dealing both with the clinical assessment of the handling of Patient A's case and then any disciplinary consequences.

(ii) serious misconduct

[95] While I have not found that the respondent's investigation may be impugned as not sufficiently full or fair, there remains the central issue of whether the investigation disclosed conduct capable of being found to be serious misconduct.

[96] This involves considering what the employer found out about what happened in Dr Y's clinical management of Patient A's care and what account is to be taken of factors that the employer and Dr Y say impacted on that care.

[97] I emphasise that – as well understood and accepted by the parties and all the witnesses – there is no suggestion of any kind that Dr Y was involved in any inappropriate physical or otherwise personal relationship with Patient A. The issue was entirely about his clinical management of Patient A's case and concerns as to whether he had appropriately handled the treatment of Patient A in terms of her diagnosis, her medication, his recording of her treatment and how he dealt with her letters expressing affection for him.

[98] At the heart of the respondent's concerns was the response of Dr Y to the content of the many letters sent to him by Patient A. Dr Y accepted that from at least April 2001 the expressions of affection and attachment to him made it appropriate for another practitioner to deal with Patient A in future. However he did not make arrangements for that handover until November 2001 and he did not provide the new psychiatrist with a written review of Patient A's case.

[99] Dr Y's initial comment to Dr Fisher, repeated in his interview with Dr Flewett, was that he had recognised by April 2001 that Patient A may have developed what he called "*some feelings for me*". Despite being aware of this issue, he agreed to see Patient A again in September.

[100]One example from Patient A's letters to Dr Y during 2000 and 2001 is sufficient for the purposes of this determination:

> *"I feel really happy I have found someone that really understands me. I always care about the ones that are there for me. I feel I want to be there for you anytime. … Your caring friend [Patient A]. PS Thanks again for your kindness. Your (sic) so beautiful"*
> (April 2001)

[101]Dr Fisher's assessment was that Dr Y had failed to recognise ample signs of Patient A forming an excessive emotional attachment and failed to develop an appropriate management plan. Dr Flewett took a similar view of this and the arrangements made by Dr Y to transfer the care of Patient A to Dr Z, saying in his review, that he was "*left with great misgivings about the transfer process and the management of risk*". By this both had in effect identified that Dr Y's practice in relation to Patient A seriously threatened her well-being and I accept this comes within the scope of what an employer could regard as serious misconduct in the circumstances of this case.

[102]Similarly the opinions of both clinicians, on whom Mr Dunham relied for his own assessment, expressed grave concerns about the diagnosis reached and medication prescribed by Dr Y for Patient A. Dr Flewett noted a lack of clarity in Dr Y's diagnosis and medication regime for Patient A. Dr Fisher was concerned that Dr Y was uncertain about diagnosing Patient A as schizophrenic but continued to treat her with high doses of anti-psychotic medication.

[103]While Dr Fraser, giving evidence to the Authority's investigation, did not accept the extent of the criticisms made by Dr Fisher and Dr Flewett, he accepted that Dr Y's incomplete diagnosis of Patient A was not good practice. He described Patient A's case as one of a very sick person who was under recognised and under treated.

[104]However there are matters of context said to be relevant to whether the applicant's actions amounted to serious misconduct in all the circumstances – that is whether Dr Y's workload was too great, whether he was not provided with the required professional oversight of his work, and whether hostility from some colleagues prevented him from being able to talk with them and get any necessary support in treating Patient A.

[105]I do not accept that workload was a relevant contextual factor ignored by the employer in making its assessment of whether serious misconduct occurred in the circumstances of this particular case. The issue is not whether Dr Y was too busy to be able to properly attend to Patient A's case. He did in fact see her. It is about what he did with the time available.

[106]Similarly the alleged hostility of some colleagues was not an overlooked relevant contextual factor. The evidence showed that it was an issue raised with and considered by the employer – it was included in Mr Stubbs' submission table and Dr Fisher's response to that. Dr Y says that he did seek assistance from his colleagues by raising the case, and particulary the content of Patient A's letters, in a regular psychiatrists' review meeting. Dr Fisher, who would have been at such a meeting, does not recall it being discussed. Dr Y says it was but his colleagues did not have any useful suggestions. However there is no record on Patient A's file that Dr Y had actually raised the issue, or any suggestion that he considered seeking assistance from colleagues or his overseers in dealing with management of her case, or that he had tried and failed to get assistance before November 2001.

[107]The provision of regular oversight – which the Medical Council required as a term of registration for Dr Y – is a relevant factor. It appears that oversight was not provided as regularly or thoroughly as might have been expected. However I do not accept this is a factor which counts against the employer in this case. The evidence is clear that the Medical Council

requirement is for the doctor who is subject to oversight to make the necessary administrative arrangements for it to occur. There is nothing to suggest that Dr Y attempted to do so but was thwarted and thus left without proper professional guidance. Rather the evidence supports, I find, the view that Dr Y was resistant to oversight as really being unnecessary for someone of his experience and who was effectively acting as a consultant. That evidence includes the observation of independent investigators of a matter involving another patient's care in which Dr Y played a part. That inquiry's report noted that "*Dr [Y] was not amenable to supervision and feedback which made Dr Fisher's task difficult*".

[108]The supposed difficulty with oversight also appears to be a belated argument given that Dr Y told Dr Flewett when they met in March 2003 that he had plenty of oversight.

[109]Dr Y's evidence was that he was aware of the phenomenon of transference and its associated risks. He was aware of the content of Patient A's letters, her fragile state and a history of suicide in her family. He was aware in November 2001 that she would not be seen by his colleague Dr Z until February 2002. Despite knowledge of this risk and this gap in psychiatric medical care, he arranged for the news of her change of clinician to be conveyed through her GP. I am satisfied from the evidence of Drs Fisher, Flewett and Fraser that all psychiatrists would be aware that this was a period of significant risk and that Dr Y did not adequately manage that risk. It is not clear that he had anything more than a brief discussion with Dr Z about taking over the care of Patient A. However the events of arranging for a change in clinician was not an isolated event in relation to Patient A's file. Its overall content was both lacking in proper diagnosis and documentation and what was there was sufficient to raise significant concerns for the two clincians who reviewed it.

[110]Standing back and looking at the case as a whole, I accept that Mr Dunham, considering the opinions of two clinicians who had closely reviewed the case, and analysing those opinions with the assistance of another senior clinician, could have reasonably come to the conclusion that inadequacies of diagnosis and treatment amounted to serious misconduct by the applicant.

[111]I do not accept that the standard was necessarily that of the bald term of 'gross negligence' referred to in the applicant' earlier employment contract. That clause referred to serious misconduct including gross negligence but does not state it is confined to that and other types of conduct referred to in that clause. The real issue is not the label on the conduct but its content. The events of Patient A's care could reasonably, I find, be found to have reached the high threshold of being misconduct of sufficient gravity to warrant dismissal (*BP Oil Ltd v Northern Distribution Workers Union* [1992] 3 ERNZ 483, 514) and deeply impairing of the basic confidence and trust that a district health board must be able to have in a psychiatrist if the employment relationship is to remain on foot (*Oram*).

[112]Having made that finding of serious misconduct, which I have accepted could reasonably be made on the information before it, the respondent then made the decision to dismiss. It was, having made such a finding, a decision that was within the range of measures that the respondent could make in such a situation. In this case, the respondent's decision had a harsh consequence on the clinical career of a highly trained medical professional. However, under the *Oram* test, even if the Authority considered the decision was harsh, the decision was one for the respondent to make and the Authority is not entitled to substitute its own assessment for that of the employer.

[113]Dr Flewett had made recommendations on how to manage Dr Y's practice but these were made on the assumption that the respondent would intend to continue Dr Y's employment. It was not bound to follow Dr Flewett's recommendations made on clincal matters in respect of its decision on disciplinary matters.

[114]Dr Fraser's evidence was to the effect that if he were the employer in such a situation, he would have found Dr Flewett's recommendations largely satisfactory as a basis on which to continue Dr Y's employment and manage his practice. Dr Fraser says he would not have made the same decision as the respondent. As an expert witness, with considerable experience at a

senior level, I considered Dr Fraser's evidence very closely but came to the conclusion that neither he nor I could substitute our view on the appropriate outcome for that of the respondent. If I were applying the present s103A test, in which Dr Fraser's evidence would have been of assistance in considering objectively what a fair and reasonable employer would have done, the outcome may have been different. However that is not the relevant test here and I must apply the *Oram* standard as I understand it to apply to the circumstances of this case.

Determination

[115]For the reasons given above, I find that the decision of the respondent to dismiss the applicant for serious misconduct was one it was entitled to make in the circumstances. Specifically I find that the respondent could reasonably come to the conclusion that the inadequacies in Dr Y's clinical management of Patient A's care amounted to misconduct of sufficient gravity to deeply impair the respondent's basic trust and confidence in him and to warrant summary dismissal for serious misconduct.

[116]Accordingly I dismiss Dr Y's personal grievance application.

[117]Because of the conclusions reached regarding these issues I have not had to address the issue of any remedies.

Costs

[118]Costs are reserved. Counsel will be aware of the relevant principles on costs awards in the Authority: *PBO Ltd v Da Cruz* [2005] 1 ERNZ 808. The parties are encouraged to resolve any costs issue between themselves. If they are unable to do so, the respondent may lodge and serve an application within 28 days of the date of this determination for the Authority to determine the matter of costs. The applicant will have 14 days from that latter date to reply before costs are set by the Authority. No application will be considered outside these dates.

Robin Arthur
Member of Employment Relations Authority