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Maher v Counties Manukau District Health Board (Auckland) [2007] NZERA 15 (22 January 2007)

Determination Number: AA 15/07 File Number: AEA 80/06

Under the [Employment Relations Act 2000](#)

BEFORE THE EMPLOYMENT RELATIONS AUTHORITY AUCKLAND OFFICE

BETWEEN Dr Nazir Maher (Applicant)
AND Counties Manukau District Health Board (Respondent)
REPRESENTATIVES Philip Bartlett for Applicant

Anthony Russell for Respondent

MEMBER OF AUTHORITY Marija Urlich

INVESTIGATION MEETING 1, 2 and 3 August 2006

SUBMISSIONS RECIEVED 10, 15 and 18 August 2006

DATE OF DETERMINATION 22 January 2007

DETERMINATION OF THE AUTHORITY Employment relationship problem

[1] Dr Nazir Maher was employed by Counties Manukau District Health Board ("CMDHB") as a medical officer special scale ("MOSS"), in the specialty of psychiatry, from 1 November 2005 until his dismissal on 24 June 2005. The events which occasioned his dismissal were:

(i) the degree of restrictions placed on Dr Maher's practising certificate by the

Medical Council of New Zealand ("MCNZ"); (ii) performance concerns; and (iii) a finding of serious misconduct in regard to prescribing.

[2] Dr Maher says his dismissal was unjustified because:

(i) CMDHB should have waited for the outcome of MCNZ's competency assessment; (ii) he did not have a reasonable opportunity to address CMDHB's performance

concerns; and (iii) there was no reasonable basis upon which to conclude the prescribing incident amounted to serious misconduct.

[3] By way of remedies Dr Maher seeks permanent reinstatement to the position from which he was dismissed, compensation for distress consequent to his dismissal, reimbursement of lost wages from date of dismissal until reinstatement or final determination of this application and three months notice pursuant to clause 45 of the relevant collective employment agreement.

[4] CMDHB says Dr Maher's dismissal was justified in the circumstances:

(i) the MCNZ restrictions placed on his medical certificate meant he could not perform his duties as a MOSS;

(ii) the performance concerns were serious and ongoing; and (iii) the finding of serious misconduct was well founded.

[5] The parties have attended mediation.

[6] To determine this employment relationship problem the Authority must decide:

(i) whether CMDHB's investigation was fair and reasonable;

(ii) whether CMDHB was justified in concluding that Dr Maher' conduct amounted to

serious misconduct; and (iii) whether dismissal was the appropriate outcome.

[7] A permanent non-publication order is made in respect of any user of mental health services referred to in this determination. This order extends to their identity or any matters which lead to them being identified.

Background

(i) supervision

[8] Dr Maher has practised medicine, in the specialty of psychiatry, in New Zealand for seven years. During this time has worked for district health boards in Tauranga, Wanganui and immediately before his appointment to CMDHB, for approximately one month, in Invercargill.

[9] CMDHB offered Dr Maher a MOSS position at its Community Mental Health Centre in Otahuhu. His terms and conditions of employment were set out in a written agreement dated 29 October 2004. This agreement incorporated the New Zealand District Health Boards Senior Medical and Dental Officers Collective Agreement (effective 1 July 2003 until 30 June 2006) ("the MECA").

[10] Soon after entering this employment agreement Dr Maher learnt of restrictions placed on his medical practice by MCNZ. He drew these restrictions to CMDHB's attention which then entered discussions with MCNZ as to how its supervision and monitoring requirements could be met. Dr Maher was involved in these discussions. Compliance with the MCNZ's restrictions was necessary to enable Dr Maher to begin to see patients.

[11] The supervision and monitoring arrangements agreed between MCNZ, CMDHB and Dr Maher were:

- • a consultant psychiatrist, to be agreed between the parties, would supervise Dr Maher's practice and write a report containing observations of Dr Maher's practise and a summary of findings; and
- • Dr Maher would meet the cost of that supervision.

[12] Ian McKenzie, General Manager Mental Health Services CMDHB wrote to Dr Maher on 16 November that the MCNZ restrictions:

"...create[s] quite an onerous burden upon our organisation that may be unsustainable.

Considering these aspects of your contract we will endeavour to provide adequate supervision and support to enable you to receive interim registration and work clinically until the December meeting of the MCONZ."

[13] Dr Roger Elliott, a consultant psychiatrist, external to CMDHB, agreed to carry out Dr Maher's supervision. He observed Dr Maher's practice for about ten hours in December 2004 and wrote a report addressed to Dr Margaret Aimer, CMDHB's Clinical Director of Mental Health, dated 22 January 2005. During these ten hours Dr Elliott observed Dr Maher interviewing five patients, gave him feedback of his observations of his practice during those interviews and reviewed clinical files with Dr Maher. Dr Elliott's report raised a number of areas of concern regarding Dr Maher's practise and competency. The report contains the following summary of Dr Elliott's concerns:

"...he [Dr Maher] would need to be considerably more skilled in his use of the English language. He would need intensive direct, ongoing monitoring of his work (more akin to that required by an intern) and would need much further education in both psychiatric practises and relationship skills."

[14] Dr Elliott's report went on to conclude that it appeared to him:

"...that his [Dr Maher's] motivation to undertake these not inconsiderable tasks is low."

[15] Dr Maher felt that Dr Elliott was hostile towards him and asked Dr Aimer to arrange another supervisor. Dr Aimer agreed to this request and arranged for Dr Christopher Gale, a consultant psychiatrist employed by CMDHB, to supervise Dr Maher. Dr Gale observed Dr Maher's consultations on two occasions. He wrote a report to Dr Aimer dated 10 February 2005 which concluded:

"Summary

Dr Nazir (sic) is well below the standard of a senior registrar. I do not think he could practice as a member of a team. I examine final year medical students interviewing actors; if any of them acted as I have seen Dr Nazir do so I would not allow them to

pass. His current practice is below an acceptable standard."

[16] On 14 February Dr Aimer wrote a report to MCNZ enclosing the reports of Drs Elliott and Gale. Her report summarises Dr Maher's performance as follows:

"Summary

Dr Maher has had the opportunity for expensive orientation to our service, and has been given every opportunity to learn from the feedback given and to show an ability to develop better standards of care. He has not done this, and has consistently worked at a level below that expected of a 1st year Registrar."

[17] Dr Aimer had already provided MCNZ with a preliminary report dated 27 January 2004. This report contains minor criticisms of Dr Maher's clinical knowledge and skills, expresses concerns about his ability to understand and communicate in English with patients and staff, and her concern that he would not acknowledge any of the issues that had been raised with him by way of feedback and that he did not appear to accept responsibility for those issues.

(ii) the prescribing incident

[18] On 3 February Dr Gale and Suzanne Kerruish, the team leader of the Manukau Community Mental Health Team, meet with Dr Maher to discuss a concern a key worker, Rose Norton, had raised with Dr Gale. This concern was that Dr Maher had failed to record a change he had made to a patient's medications, failed to advise Ms Norton of the change and had denied he had changed the medications when asked directly. They showed him a bottle of clonazepam with Dr Maher's name as the prescribing doctor.

[19] Dr Maher says he told Ms Norton and Ms Kerruish and Dr Gale that he told Ms Norton he could not recall prescribing the clonazepam to the patient in question and that he would need to see the patient's records.

[20] Ms Kerruish wrote to Dr Maher later on 3 February recording the allegations raised during the meeting:

- • Failed to record the prescription of a medication (clonazepam) in the client file, including the medication chart
- • You did not communicate with the key worker nurse about the change in treatment of this client
 - • When asked by the key worker whether you had prescribed the medication (as she had become aware the client was taking clonazepam) you denied prescribing the medication."

[21] The letter goes on to advise that Dr Verity Humberstone, Clinical Head - Core Adult Mental Health Services, had been consulted, that she considered the concerns posed a serious risk to the safe treatment and management of clients in Dr Maher's care and that until the investigation into the allegations was concluded Dr Maher was to cease all client contact and continue with other clinical administrative duties.

[22] Steps were then taken to convene an investigation panel pursuant to clause 43 of the MECA. This provision provides comprehensive guidelines for an investigation into concerns regarding clinical practice. For the purposes of this determination it is unnecessary to reproduce the entire clause, the relevant sections of which are:

43. Investigations of clinical practice

43.1 The purpose of this clause is to address performance concerns relating to clinical practice and its impact on patient safety. It is not intended for use where the concern, on the face of it, does not reflect adversely on the practitioner's clinical competency.

43.2 The employer shall investigate fairly, thoroughly and as quickly as reasonably possible any complaints it receives or concerns it may have that raise serious questions about the employee's standards of clinical practice.

[23] A panel of Clinical Heads was duly convened in accordance with clause 43 to investigate the prescribing incident. Dr Maher was represented throughout the process, and was consulted regarding the selection of panel members and the process of the investigation. The panel concluded its investigation on 17 March 2005 and released its findings and recommendations on 15 April 2005. The panel made a number of findings and recommended that the restrictions imposed on 3 February continue and that the matter be referred to the Clinical Director and General Manager.

[24] For the purposes of this determination the key panel finding concerns Dr Maher's alleged denial to the key worker, Ms Norton, of the clonazepam prescription:

"Allegation 3

Denial of prescribing this medication when questioned by the said key worker

Panel Finding in regard to Allegation 3

It is the opinion of the Panel that denial of medication prescribing is harder to establish, as it is dependant solely on testimony of Rosemary Norton as to the nature of conversations she had with Dr Maher. Rosemary Norton's testimony is supported by testimony by Dr Gale and Suzanne Kerruish and these stand in contrast to testimony provided by Dr Maher.

Dr Maher could recall that he had given the prescription to the client. He could recall that the prescription was not folded over as was the testimony of Rosemary Norton. He could recall giving a detailed explanation to [patient] about the risks and benefits of clonazepam and he could recall presenting that information in the daily meeting.

The Panel find it difficult to accept that Dr Maher would have such specific recall of the details of prescribing yet subsequently he had no recall of writing the prescription and even when shown his prescription and the medication bottle he still could not recall.

The Panel find that the weight of the evidence suggests that Dr Maher was directly asked by the key worker about providing a prescription to the patient and that he denied giving a prescription to the client."

(iii) disciplinary investigation

[25] On 17 May 2005 Ian McKenzie, General Manager, Mental Health, Community and Intermediary Care CMDHB, wrote to Dr Maher's barrister raising the following disciplinary allegations and setting out the factual basis of those allegations:

(i) that Dr Maher's response to Ms Norton's enquiry about the medications prescribed to the patient could be seen as untruthful and an attempt to "put off" any further inquiries and that conduct could constitute serious misconduct in terms of the CMDHB's discipline and dismissal policy;

(ii) that Dr Maher had mislead CMDHB about his performance at Wanganui DHB;

(iii) that the MCNZ supervisory restrictions on Dr Maher's practice raised issues in the nature of frustration of contract; and

(iv) that the reports of Drs Elliott and Gale indicated Dr Maher's performance was less than what could be expected of a senior clinician. [26] The letter advised that CMDHB wished to meet with Dr Maher to discuss these

allegations, that the meeting would be disciplinary in nature and that dismissal could be a possible outcome of the disciplinary process.

[27] On 20 May MCNZ wrote to Mr McClelland advising that Dr Maher would be issued with an interim practising certificate with the following restriction:

- that Dr Maher would have to undertake an independent assessment of his performance and that until such time his medical practice would be restricted to non-clinical work.

[28] MCNZ reached this decision following consideration of information including the supervisory reports of Drs Aimer, Elliott and Gale and submissions made on all information before the MCNZ made on behalf of Dr Maher by Mr McClelland.

[29] On 10 June Mr McKenzie wrote to Mr McClelland advising of CMDHB's intention to include the content and implications of MCNZ's 20 May correspondence in the disciplinary meeting which had been scheduled for the following week.

[30] On 15 June Mr McClelland requested an adjournment of the following days scheduled disciplinary meeting to the following Monday. The reason for this request was to enable Dr Maher to have a representative present from his union, ASMS, Mr Henry Stubbs. Mr McKenzie denied this request.

[31] On 15 June Mr McClelland requested further information concerning the allegations made in Mr McKenzie's letter of 17 May. This request was complied with.

[32] The disciplinary meeting proceeded on 16 June. Dr Maher was present and represented by Mr McClelland who presented a written submission on his behalf in response to the disciplinary allegations. Ms McKenzie and Dr Aimer were present on behalf of the CMDHB. Notes of that meeting have been made available to me.

[33] On 20 June Mr McKenzie wrote to Mr McClelland advising that:

"The Clinical Director and I have considered these [the 16 June disciplinary meeting and Mr McClelland's submissions]. I now advise as follows:

- 1. We accept that Dr Maher did not mislead us about any restrictions as these were not known to him at the time he was appointed. We withdraw that complaint unreservedly. Thank you for the clarity of your explanation.*
- 2. We stand by our assertion that the continuation of Dr Maher's restrictions on clinical practice means that he is unable to perform the major component of services to CMDHB for which he was employed. This is totally unacceptable.*

3. *Both the Panel investigations and Supervisors' reports have continued to raise performance issues despite considerable efforts by the Clinical Director, team leader of the service and others to improve these shortcomings.*

4. *We find Dr Maher's denial of prescribing medications a matter of serious misconduct."*

[34] The letter then describes Mr McKenzie's deliberations as to penalty:

"However the fact that he [Dr Maher] denied prescribing medication when asked, and continued to deny it when shown the medication, goes beyond questions of proof of competence at some future time. No acceptable explanation has been provided about this serious issue."

[35] The letter then records the decision as to penalty is to dismiss Dr Maher from his employment with CMDHB effective Friday 24 June 2005.

The Law

[36] Section 103A sets out the applicable test for justification:

"...the question of whether a dismissal or an action was justifiable must be determined, in an objective basis,

by considering whether the employer's actions, and how the employer acted, were what a fair and reasonable employer would have done in all the circumstances at the time the dismissal or action occurred."

[37] The following summary of the section 103A principles, as articulated in *Air New Zealand v Hudson*¹, is set out in *Angel v Fonterra Co-operative Group*²:

"1. Justification for dismissal must be determined on an objective basis from the point of view of a

neutral observer. It is not enough that an employer makes a decision which falls within an acceptable range of responses.

1. *1. The standard against which the actions of an employer are objectively judged is that of a fair and reasonable employer.*
2. *2. The Court may reach a different conclusion from the employer provided it is the result of an objective inquiry rather than a substitution of the Court's decision.*
3. *3. The inquiry into justification must focus on all the circumstances which were relevant at the time of the inquiry and the dismissal."*

Discussion

[38] CMDHB dismissed Dr Maher because it found his conduct regarding the prescribing incident amounted to serious misconduct and given his failure to provide an acceptable explanation for that incident, the performance concerns noted by his supervisors and the restrictions on his practising certificate it was open to it to dismiss. Was there a fair and reasonable basis for this decision?

[39] The basis of Mr McKenzie's finding that Dr Maher had been untruthful to the key worker was the finding of the panel in relation to this issue and his finding that Dr Maher had made a further denial to Dr Gale and Ms Kerruish. Mr McKenzie considered the panel findings, reviewed the evidence that was presented to the panel and following submissions made on behalf of Dr Maher reached the conclusion that Dr Maher had denied prescribing the medications.

[40] In his submissions Mr Bartlett has characterised those findings as neutral. I do not accept that submission. The panel's finding was that the weight of evidence suggested Dr Maher was directly asked by Ms Norton if he prescribed the medication to the patient and that he denied giving a prescription to the patient.

[41] There is no question that the panel members had the necessary qualifications and experience to consider issues of clinical practise and determine the necessary factual issues. Notwithstanding, Mr McKenzie did not rely on the panel's findings as to the allegation of serious conduct because they made no such findings. This is not a situation where the employer erred in relying on the investigation of a third party that was not properly qualified to undertake such an investigation³.

[42] Putting aside the dispute as to what Dr Maher said to Ms Norton, I understand Dr Maher says his explanation, that he could not recall prescribing the clonazepam, was an acceptable explanation. Mr McKenzie concluded that this was not an acceptable explanation. He had a reasonable basis for this conclusion given the following findings of the Panel:

"If a Doctor has prescribed a medication but cannot recall having done so the onus of responsibility to clarify that issue remains primarily with the Doctor. This would usually be clarified by consultation with the clinical notes. Given that Dr Maher failed to record prescribing information, Dr Maher had a responsibility when queried to clarify the information either through contacting the pharmacy or through discussing with the client.

It is the opinion of the Panel that in the face of concerns raised by Rosemary Norton that the onus lay on Dr Maher to clarify what medication he had prescribed and to communicate this with the key worker. Dr Maher

1 (2006)3 NZELR 155

2 CC13/06, 13 December 2006, Judge Shaw, at paragraph 73

3 *Reti and Carter Holt Harvey Ltd*, AA 479/05, 12 December 2005, Yvonne Oldfield, at paragraph 74.

failed in this responsibility."

[43] In his consideration of penalty Mr McKenzie weighed the supervisors' concerns about Dr Maher's performance. There can be no doubt that Dr Maher's clinical supervisors held serious concerns about his performance. Mr Bartlett has submitted, and it was put to Mr McKenzie, that these concerns were overstated and unreasonable and were motivated by hostility towards Dr Maher. The performance concerns were raised consistently with Dr Maher in feedback sessions throughout the short period of his clinical work for CMDHB. These concerns were based on direct observation of Dr Maher's patient interviews, staff interaction and file reviews. Though I accept the supervision period was short, given the high level of skill and experience of the supervisors, Dr Maher's qualifications and experience and the consistent theme of feedback he received from an early stage, I do not accept that the supervisors could not form well founded views of his performance and his ability to address their concerns.

[44] The supervisors' concerns were put to Dr Maher to comment on at in the MCNZ hearing. The MCNZ findings were released prior to Mr McKenzie's disciplinary investigation. These findings, along with Dr Maher's submissions to the MCNZ formed part of Mr McKenzie's investigation. I find that there was no unfairness to Dr Maher occasioned by supervisors' reports to MCNZ or the consideration of those reports by Mr McKenzie; Dr Maher was able to comment on them before Mr McKenzie reached any conclusion as to their reasonableness or the weight they should be given in the consideration of penalty.

[45] It was appropriate that the supervisors' concerns were considered by Mr McKenzie in his deliberation as to penalty. It was reasonable for Mr McKenzie to conclude these concerns were well founded and that they formed part of the relevant circumstances at the time of the inquiry and dismissal.

[46] Dr Maher was employed by CMDHB as a senior medical officer working in a community mental health team. I accept that a high level of trust resides in an employee in such a position and that a failure to give an acceptable explanation, in the circumstances described, would erode that trust to a serious degree. For the reasons set out above I find that Dr Maher's dismissal was justified in all the circumstances.

Costs

[47] Costs are reserved. The parties are invited to attempt to resolve this issue themselves. If they cannot they have leave to file memoranda as to costs.

Marija Urlich

Member of Employment Relations Authority