MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 266/03/109D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **PETER FISHER** medical practitioner of Invercargill

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chair)

Mrs J Courtney, Dr L Henneveld, Dr M Honeyman,

Dr A D Stewart (Members)

Ms G J Fraser (Secretary)

Mrs J Kennedy and Mrs P Dunn (Stenographers)

Hearing held in Invercargill on Monday 17 through to Friday 21 November 2003 and in Auckland on Wednesday 26 and Thursday 27 November 2003

APPEARANCES: Ms K P McDonald QC, Ms M McDowell and Ms T Baker for the Director of Proceedings

Mr C J Hodson QC and Ms H Janes for Dr P Fisher.

Introduction

1. Doctor Fisher is a registered medical practitioner. Doctor Fisher came to New Zealand from England in 1992 and gained full registration as a medical practitioner in New Zealand in March 1993. Initially Dr Fisher was employed as a psychiatric registrar by the Southland District Health Board (Southland DHB). His status changed to Medical Officer Special Scale (MOSS) during the course of 1994. Doctor Fisher held positions as a psychiatric MOSS at Southland Hospital and Seaview Hospital in Hokitika from 1994 to early 1999. In October 2000 Dr Fisher was again employed as a MOSS in the psychiatric department of Southland Hospital. Doctor Fisher was still employed as a MOSS at Southland Hospital when the events giving rise to this hearing occurred.

2. The term MOSS is used to describe a doctor who has general registration under the Medical Practitioners Act 1995 ("the Act") and who is employed in the public health system below the level of a vocationally registered practitioner (specialist). A MOSS may have considerable experience but is nevertheless not eligible to be registered as a specialist. There are a significant number of doctors practising as MOSS's in New Zealand's public psychiatric services. In some centres approximately 50% of the medical staff employed in the public psychiatric services are MOSS's. A psychiatric MOSS's

salary is generally about 80% of a specialist psychiatrist employed in the public health service.[1]

3. On 5 June 2003 the Director of Proceedings[2] laid disciplinary charges against Dr Fisher. Subsequently the Director of Proceedings amended the charge by deleting three particulars. The amended notice of charge is explained in paragraph 11 of this decision.

4. The charge contains a number of specific allegations. In essence the Director of Proceedings alleges Dr Fisher failed to adequately assess and review:

4.1 The mental state; and

4.2 The risks posed; and

4.3 The treatment and management;

of Mark Burton ("Mark") from the date of his admission to Southland District Health Board's Mental Health Services ("Southland MHS") on 10 February 2001 to his discharge on 30 March 2001 (and for a period following his discharge). The Director of Proceedings also alleges Dr Fisher failed to adequately document and record his assessments, reviews, treatment and plans for Mark during the period in question.

5. The charge alleges Dr Fisher's acts and omissions identified in the particulars either separately or cumulatively constituted disgraceful conduct in a professional respect[3] or, alternatively, professional misconduct[4].

6. The charge was heard by the Tribunal in Invercargill from 17 to 21 November (inclusive) and Auckland on 26 and 27 November. After receiving closing submissions from both counsel the Tribunal adjourned to consider its decision. Later on 27 November the Tribunal advised that it found 17 particulars of the charge proven at the level of

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1 Transcript p598 l.33
2 Section 15 Health and Disability Commissioner Act 1994
3 Section 109(1)(a) of the Act
4 Section 109(1)(b) of the Act

professional misconduct. The Tribunal received submissions on penalty on 5, 11 and 16 December.

7. The Tribunal orders:

7.1 Dr Fisher's registration as a medical practitioner be suspended for six months from the date of this decision; and

7.2 Conditions be imposed on Dr Fisher's ability to practise in the areas of psychiatry and psychological medicine for three years. The conditions imposed on Dr Fisher are that he be accepted into and participate satisfactorily in a vocational training programme in psychiatry for 3 years.

7.3 That Dr Fisher pay a total of $86,411.46 by way of costs to the Tribunal, Director of the Proceedings and Health and Disability Commissioner.

8. In this decision the Tribunal will explain the reasons why it has found the charge proven and its reasons for the penalties it has imposed.

9. From the outset the Tribunal wishes to explain five matters:

9.1 This decision is unusually long. The length of the decision reflects the fact that the Tribunal has had to consider 27 particulars in the charge. This decision is also very long because during the course of the six days of hearing evidence the Tribunal received in excess of 280 pages of evidence in chief, heard cross examination which is recorded in 722 pages of transcript and received and considered 5 large bound volumes of exhibits. The fact the Tribunal was able to receive and consider such a large amount of evidence in such a short time period is a commendable reflection upon the professionalism and co-operation of counsel for all parties in this case.

9.2 Doctor Fisher's management of Mark became the subject of careful scrutiny because the day after he was discharged Mark returned to Queenstown and killed his mother. The inquiries which followed ultimately resulted in the laying of

the disciplinary charges against Dr Fisher which the Tribunal has now heard and determined. It needs to be stressed that although the Tribunal has found Dr Fisher's management of Mark was seriously deficient in a number of significant respects it must not be thought that there is a causal link between Dr Fisher's errors and the tragic death of Mrs Burton. The Tribunal's decision should not be construed as suggesting Dr Fisher's acts and omissions caused Mrs Burton's death.

9.3 Two expert witnesses called to give evidence on behalf of Dr Fisher suggested there were deficiencies in the way Dr Fisher was supervised by specialist psychiatrists in the Southland MHS. Doctor Fisher himself did not attempt to apportion blame for his shortcomings on the consultants working in the Southland MHS in February and March 2001. Indeed, Dr Fisher believed he was not out of his depth when caring for Mark. The Tribunal did not hear evidence from any of the consultants from the Southland MHS. The Tribunal has accordingly not reached any conclusions about the adequacy or otherwise of the supervision of Dr Fisher when he was working in the Southland MHS.

9.4 Aside from Dr Fisher, all employees of the Southland DHB who gave evidence before the Tribunal sought orders suppressing their names. Those orders were sought and granted pursuant to s.106(2)(d) of the Act. It is unusual for the Tribunal to grant name suppression to witnesses whose evidence does not involve matters of a personal and/or intimate nature. The Tribunal agreed to grant name suppression to all of the witnesses because of a number of unique features in this case, namely:

9.4.1 In some instances witnesses provided compelling personal and medical reasons for having their names suppressed;

9.4.2 All witnesses had been the subject of intense pressure as a result of the events giving rise to the Tribunal's hearing. It became apparent to the Tribunal that most witnesses employed in the Southland MHS were very distressed by this case and that their ability to continue to function

as effective members of the Southland MHS was at risk unless they received the "protection" of name suppression.

9.4.3 It became apparent that although all witnesses were subpoenaed, the Tribunal's hearing may well have been disrupted and seriously frustrated by witnesses not responding to their subpoenas unless they were granted suppression of their name. Normally this consideration would not have influenced the Tribunal. However in the circumstances of this case the Tribunal agreed to factor this matter into its decision to grant name suppression for those witnesses who sought suppression of their names. The witnesses whose names have been suppressed are:

A
B
C
D
E
F
G
H
I

9.5 Doctor Fisher has been judged against the reasonable standards expected of a MOSS practising in a psychiatric unit in New Zealand in 2001. Doctor Fisher has not been judged against the standards expected of a consultant psychiatrist.

10. To assist readers, this decision has been divided into the following parts:

Part I **The Charge**

Part II **Summary of Evidence**

Part III **Summary of Case for Director of Proceedings**

Part IV **Summary of Case for Dr Fisher**

Part V **Evaluation of Evidence**

Part VI **Legal Principles**

Part VII **Findings in Relation to Each Particularised Allegation**

Part VIII **Summary of Findings**

Part IX **Penalty**

Part X **Conclusion**

Part 1 - The Charge

11. The particulars of the charge focus upon four phases of Mark's involvement with the Southland MHS from 10 February to 30 March 2001. Those four phases were:

    11.1 Mark's admission on 10 February 2001;

    11.2 Mark's period as an inpatient from 10 February to 21 March 2001;

    11.3 Mark's period of trial leave from 22 to 30 March 2001;

    11.4 Mark's discharge on 30 March 2001.

12. The particulars of the charge allege:

    "Admission

    1. On Mark Burton's admission to Southland District Health Board Mental Health Services on 10 February 2001 [Dr Fisher]:

    1.1 Failed to adequately assess Mark Burton's:

(a) Psychiatric and/or forensic and/or social and/or medical history; and/or

(b) Phenomenology of mental state; and/or

(c) Alcohol and drug history; and/or

(d) Precipitants for admission; and/or

(e) Prior response to and adverse effects of, his previous and current treatment; and/or

(f) Risk.

and/or

1.2 Failed to adequately document [his] assessment and/or diagnostic formulation of Mark Burton.

…

AND/OR

In-patient period 10 February 21 March 2001

2. Between 10 February 2001 and 21 March 2001, while Mark Burton was an in-patient on Ward 12, Southland District Health Board Mental Health Services [Dr Fisher]:

2.1 Failed to undertake and/or record a thorough and systematic review of Mark Burton's mental status.

and/or

2.2 Failed to undertake and/or record an adequate assessment of Mark Burton's risk

and/or

2.3 Failed to follow-up and/or review Mark Burton's:

(a) Alcohol and drug assessment; and/or

(b) Needs Assessment.

and/or

2.4 Failed to adequately develop and/or review Mark Burton's:

(a) Medication regime; and/or

(b) Treatment and management plan.

and/or

2.5 Failed to adequately document:

(a) Clinical interactions with Mark Burton; and/or

(b) Assessments of Mark Burton's care and management; and/or

(c) Management and treatment plans.

AND/OR

Trial Leave

3. In relation to Mark Burton's trial leave (the period between 22 March and 30 March 2001) [Dr Fisher]:

3.1 On or about 22 March 2001 failed to undertake and/or record a thorough and systematic review of Mark Burton's mental state prior to the commencement of his trial leave on 22 March 2001.

and/or

3.2 On or about 22 March 2001 failed to undertake and/or record a comprehensive risk assessment for Mark Burton prior to the commencement of his trial leave on 22 March 2001.

and/or

3.3 On or before 22 March 2001 failed to make adequate arrangements for a review of Mark Burton's mental state during his week of trial leave.

and/or

3.4 On or before 22 March 2001 failed to ensure a crisis plan was developed in partnership with Mark Burton and/or recorded.

AND/OR

Discharge

4. In relation to Mark Burton's discharge from in-patient care on 30 March 2001 [Dr Fisher]:

4.1 On or about 30 March 2001 failed to undertake and/or record a thorough and systematic review of Mark Burton's mental state.

and/or

4.2 On or about 30 March 2001 failed to undertake and/or record a comprehensive risk assessment for Mark Burton.

and/or

4.3 On or about 30 March 2001 failed to adequately review Mark Burton's management and/or treatment plan.

and/or

4.4 On or before 30 March 2001, failed to make adequate arrangements for Mark Burton's post-discharge care by:

(a) ensuring the adequate involvement of Mark Burton's key worker (Community Mental Health Team) in discharge planning; and/or

(b) ensuring the adequate and timely monitoring of Mark Burton's mental status and/or risk once he was discharged; and/or

(c) ensuring the adequate involvement of Mark Burton's family in discharge planning.

and/or

4.5 Between 22 March 2001 and 30 March 2001 failed to ensure a crisis plan was developed in partnership with Mark Burton and/or recorded."

Part II - Summary of the Evidence

Mark Burton

13. Sadly Mark's medical circumstances are not unique. At the time of his admission to the Southland MHS on 10 February 2001 he was a 19 year old who had been diagnosed as having schizophrenia and who also had a history of alcohol and drug abuse. Prior to his admission Mark lived in Queenstown. His father was a police sergeant in Queenstown. His mother was a school teacher. Mark has a younger brother and sister.

14. The Tribunal gained an insight into Mark's clinical history by:

14.1 Reviewing the medical files held by the Southland MHS relating to Mark's contact with psychiatric services in Queenstown and Invercargill from 6 July 1998 through to 6 February 2001, and

14.2 Hearing from Mark's father, Mr Trevor Burton, and

14.3 Hearing from health professionals who had either previously been involved in Mark's care prior to 10 February 2001 or who had reviewed the care he had received prior to that date.

15. Mark first came into contact with mental health services in July 1998 when his mother contacted the Queenstown Community Mental Health Team. Mark was observed to have features consistent with psychotic illness. He had a history of alcohol and cannabis use. Mark's parents were concerned about his aggressiveness and his excessive use of alcohol. Treatment was commenced by medication supervised by Mark's parents. During 1998 close contact was maintained between Mark, his parents and the Queenstown Community Mental Health Team. By early 1999 there appeared to be some improvement in Mark's condition although there continued to be concern about Mark's alcohol and drug problems.

16. Throughout 1999 Mark continued to receive medication and appeared to be a consistent user of alcohol. Mark and his family continued to have close contact with the Queenstown Community Mental Health Team through to early 2000. In the middle of 2000 Mark's mental state fluctuated. He returned to his parents' home. In mid 2000 Mark's parents expressed concern about the safety of Mark, his brother and sister. Mark was observed to be angry and displaying prominent psychotic symptoms. Mark was admitted as a voluntary in-patient to Ward 12 of Southland Hospital on 23 June 2000. His admission was for four weeks. There was an improvement in Mark's mental state. He was discharged back to Queenstown in late July 2000 when contact with the Queenstown Community Mental Health service resumed.

17. In mid August 2000 Mark's parents noted a period of deterioration in Mark's mental state. They attributed this downturn to alcohol use. In September 2000 a comprehensive management plan was re-visited. That management plan addressed issues such as exercise, a work roster, alcohol use, rules for living at home and medication management. Early warning signs of relapse were identified and a crisis plan developed.

18. During September 2000 Mark's parents continued to express concerns about Mark's motivation, compliance with medication and alcohol use.

19. In November 2000 it was thought Mark was displaying symptoms of a relapse. He was monitored closely by the Queenstown Community Mental Health Team. In December 2000 Mark's medication was changed by Dr Menkes to olanzapine 10mg daily. This change did not take effect until mid January 2001.

20. In mid January 2001 Mrs Burton expressed concerns about Mark's anger and his aggression towards her. Mark was observed to be restless, suffering disturbed sleep and conversing in a bizarre manner. This pattern of behaviour continued through to early February 2001. Mr Trevor Burton told the Tribunal:

> *"In early February Paddy [Mrs Burton] and I were concerned about Mark's use of cannabis and alcohol ... he was aggressive and agitated and being unco-operative at times".*[5]

21. On the night prior to 10 February 2001 Mark went out drinking with friends. The following morning (Saturday 10 February) Mrs Burton went to Mark's bedroom to see if he was home. Mark verbally abused his mother and threatened to attack her. Mr Burton went to Mark's bedroom. Mark had barricaded his door. Mark eventually opened the door. Mr Burton found his son in a highly agitated state. Mark alleged his mother and brother kept interfering with him at night and that he would get them and kill them. Mark also reiterated allegations he had previously made that his parents had stolen $76 million from him. Mr and Mrs Burton realised Mark needed urgent psychiatric help. Mark was able to be pacified and agreed to accompany his father to the Southland MHS. Mr Burton drove his son to Invercargill. During the drive south Mark reiterated his claims that his mother and brother were interfering with him. He also repeated the allegation that his parents had stolen $76 million from him. When they were close to Southland Hospital Mark commented that:

> *"…the Matrix is watching now, there are cameras all around here."*[6]

When Mark and his father arrived at Southland Hospital they were seen by Dr Fisher and nurse I. Mr Burton stayed with his son during the admission interview.

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[5] Evidence of Mr T Burton paragraph 26
[6] Evidence of Mr T Burton paragraph 46

22. Doctor Fisher made brief notes. A transcript of the notes made by Dr Fisher is set out in paragraph 25 of this decision. Normally an admitting doctor and nurse would have at their disposal a file of forms to be completed. The forms normally available include:

    22.1 A two page assessment of risk form;

    22.2 A two page risk alert form;

    22.3 A two page risk plan review form.

23. Doctor Fisher told the Tribunal that not all of the forms were available when Mark arrived because it was a weekend. It is apparent however Dr Fisher put a line through both pages of the assessment of risk form. He completed a small portion of the risk alert sheet. The risk plan forms in Mark's medical file were blank.

24. Doctor Fisher told the Tribunal he put a line through the assessment of risk forms because he thought that document would be completed by someone who had knowledge of the patient – namely a member of the Community Mental Health Team or the emergency team.[7] This topic is revisited later in this decision. Suffice to say at this juncture that the Tribunal had difficulty in reconciling Dr Fisher's understanding of who completes the assessment of risk forms with the Southland MHS written policy on clinical risk assessment and management which provides that the:

> *"Assessment of risk sheet [is] to be completed on admission for all patients by [the] admitting doctor and nurse and thereafter daily by [the] responsible clinician/psychologist and assigned nurse, until [a] routine observation level is reached."*

25. The handwritten note made by Dr Fisher in Mark's medical file on his admission reads:

> *"**Psych assessment***
>
> *First psych contact at 17 years.*
> *Grandiose thinking – thought he was JC*
> *[With] ideas of saving people*

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[7] Transcript p.335 l. 28-36

[Possible] paranoid thoughts including being put on cross/references from radio.
At the time working in kitchen.
Alcohol +
Cannabis ++
Flatting
Saw GP + psychiatrist
Started on risperidone – good compliance
Last year – relapse. Using THC [cannabis]
Came to Ward 12 – winter for 3 weeks
Discharged on risperidone – 6mgs
Went home to parents
Work for short periods – alt days at best
Finds radio disrupting
From father – school apparently OK, not great scholar, left to join joinery but firm folded
At the time deterioration in mental state noted, parents aware of THC use, doesn't return to normality when off THC
Saw Dr Menkes 6 days
EPS [Extra pyramidal symptoms] ++.
Poor motivation
Risperidone changed to olanzapine 10mgs
Since then alcohol ++, cannabis ++ not recently
No work lately
Kitchen spare hand job organised by friend/boss aware of Mark's condition
Now – threatening behaviour – especially towards mother
Deluded regarding parents having a quantity of his money
[There is no money in fact]
MSE – [mental state examination] reasonably calm and co-operative, some anxiety
A little pre-occupied
Believes being disturbed at night
Ideas of reference
Paranoid thinking
Vivid negative dreams
Cognitively unimpaired
Some insight – knows things are not right but probably doesn't accept illness, agrees to hospital
Impression schizophrenia (no family history – brother and sister well)
Plan – admit Ward 12, increase olanzapine to 15mgs daily use CPZ (chlorpromazine) as required (CMHT) I Queenstown Nadine)
Peter Fisher
MO"

Following the admission interview Mark was admitted to Ward 12 of Southland Hospital as a voluntary patient. Doctor Fisher amended Mark's medication on admission from 10 to 15mg olanzapine.

26. On 11 February Mr Trevor Burton wrote a detailed letter to Southland MHS. That letter was received in Ward 12 on 14 February 2001. The letter is very significant. It reads:

> *"TO WHOM IT MAY CONCERN,*
> *PSYCHIATRIC SERVICES, KEW HOSPITAL*
> *REFERENCE. MARK BURTON*
>
> *These are just a few notes to hopefully assist you in your treatment/understanding of Mark from our observations as his parents.*
>
> *From about the time of the change of Mark's medication from Risperidone to his present medication there has been a bit of a worsening in his condition. We suspect also about this time i.e. 3 to 4 weeks or more ago Mark has been using cannabis again. He may deny it but I am confident he was using. He has also been drinking alcohol. Whether beer or spirits I am not sure and probably only a few times a week maximum but probably in a quantity far in excess of what he should .*
>
> *About 3 weeks ago his behaviour became more unsettling in that he would be walking around the house with a fixed grin. He spoke to his mother about all of his limbs being disconnected from his body and re-connected and got very angry when his mother said that she had no such memory and in effect no such thing had happened. About two weeks ago he spoke to me about how his head had been split open when he was young and his brains had come out. Again, he became angry when I said I had no such recollection.*
>
> *Mark has a paranoia that his mother and myself have robbed him of all of his money. He seems to think that he had considerable wealth and that we have taken it all from him. This seems to be strongly in his mind and is a source of great anger to him that seems to verge on hate.*
>
> *He is strongly built and both his mother (and brother) are at times fearful of him. Up until now he seems to have managed to control the great anger that we see in him but from my observations of him as a parent and with 28 years services in the police I see real danger in Mark either in his family or to the community at large.*
>
> *On the morning of Saturday 10/2 Mark's mother, Paddy, poked her head into his room just to see if he had arrived home as he had gone out during the previous night (drinking at a night club). Mark was furious*

and shaped up with his arm drawn back to punch his mother and he demanded in obscene terms that she get out of it. This was as close as Mark has come to physical violence against his mother and he was barely in control.

I immediately went to speak with him. His room was barricaded but he removed what was there instantly at my insistence. We had an angry verbal clash wherein Mark insisted that his brother and his mother had been sneaking into his room and "touching him". I did not pursue what this "touching" consisted of but the inference was that it was of a sexual nature and he threatened to me that he would kill them for it. Again his language was totally violent and obscene. I immediately formed the impression that Mark was a real and immediate danger to his brother and mother and at one stage he said he would kill everyone in New Zealand when he "came back" and that he "had the power" to do it.

At this point I realised that Mark was totally out of it and I tried to calm him by suggesting he come down and have some breakfast. I told his mother (unbeknown to Mark) to ring the emergency mental health number.

Mark came down, still very angry. He paced the lounge in a very agitated state clenching and unclenching his fists and on the verge of striking out. The emergency team apparently suggested to his mother that he go back to his room and "lie down". I suggested this to him and he did so … only when it was agreed however that he be allowed to barricade his door. I meanwhile had removed a knife that was in his room and had been there for some period of time.

During the above time I suggested to Mark that he needed to be in hospital and that in any event I was not happy in him remaining in this house when he had such feelings of anger to his brother and mother.

Incidentally, Paul (14) and Mark have always got on very well and Paul had spent a few nights during the previous week out on the front drive playing cricket with Mark using a tennis racket and ball. They were getting on quite well. Never before had I heard Mark make any suggestion of being "interfered with" in the middle of the night by his mother or brother. (I note he still seems to believe that when he was at Kew Hospital about July? last year that at some time in the night someone came in and violently twisted his neck).

After Mark had been in his room for about 20 minutes he came out considerably subdued and seemingly quite remorseful and apologised to his mother for what he did (threatening her). He then came out into the lounge where I was and with no prompting from me whatsoever said that he thought he needed to "go into hospital for a few weeks". We agreed

he pack a bag and within a short period after communicating with the mental health emergency team we were on our way.

The journey was largely in silence and after about 40 minutes Mark, out of the blue said "They could be doing it under your nose." I asked what he was talking about and he again said that Paul and Paddy could be coming and interfering with him right under my nose without me knowing it. I asked him why he did not grab a hold of them when they were supposedly interfering with him and he said it was because he was asleep.

We carried on in silence until coming through Invercargill 5 minutes out from the hospital Mark said that there were cameras all around and that "The Matrix" was watching us (or something similar).

When we arrived at the hospital and sat in the waiting room there was a young male patient walking up and down in the hospital corridor crying about hating the hospital and wailing that he wanted out. Mark got up and watched this person with a fixed grin on his face and gave the impression he took pleasure and amusement from this person's anguish.

I hope the above is of some assistance.

OUR MAJOR CONCERN:

Mark has a paranoia about 1. His parents robbing him of vast sums of money. And 2. of being molested by his mother and brother (and perhaps myself, I am not sure). This causes great rage and apparent hatred.

I believe that Mark is a real danger and should he be discharged from this hospital while still holding such views and that he could cause serious injury/death within the family home. I base this on my observations of him as a parent and also a considerable amount of experience over 28 years observing violent behaviour as a front line policeman.

Mark seems to be able, most of the time, to keep his thoughts to himself or disguise what he is thinking. I WOULD THEREFORE ASK THAT PARTICULAR NOTE IS TAKEN OF MY CONCERN AS TO THE SAFETY OF MARK'S MOTHER AND YOUNGER BROTHER SHOULD HE RETURN TO THE FAMILY HOME.

Having said that, Mark needs security and some sort of supervision and we believe that the home is the best place he can get it. If he is to find lodgings in the community he would need quite constant monitoring by a mental health worker as to his medication and his involvement with

drugs/alcohol. He would also need assistance to finance a "life in the community" beyond the amount of money presently paid on his sickness benefit.

Mark will be welcome back here at home should he so desire and provided there is an assurance as far as is able, regarding his paranoia of his parents and family being under control.

I may be contacted at any time at home or at work. Home 4422102 and work at the Queenstown Police station 4427900

Thank you for taking the above into consideration and good luck with Mark. We appreciate any help that can be given to him.

TREVOR AND PADDY BURTON.
11/2/2001."

27. The Queenstown MHS notes and a risk assessment completed by a social worker in Queenstown were also received on 14 February. That day Dr Fisher re-visited the risk alert form in Mark's file and made further entries on that document. Mark's assessed level of risk had not altered (in Dr Fisher's view) since Mark's admission 4 days earlier.

28. Mark remained a voluntary in-patient in Ward 12 from 10 February to 30 March. On 22 March he went on a week's trial leave. The key events during the period Mark was an in-patient prior to going on trial leave have been extracted from thorough nursing notes made during the period of Mark's admission, as well as entries made in Mark's medical notes by Dr Fisher on 14, 19, 23, 26 February and 20 March.

29. Despite efforts by nursing staff and Dr Fisher, it is apparent Mark did not wish to discuss the issues which illustrated his paranoia and delusions. In particular Mark was very guarded and circumspect when efforts were made to explore his belief that his brother and mother had sexually interfered with him and that his parents had stolen $76 million from him. It is apparent from the nursing notes that Mark continued to display paranoia about his parents and siblings. Mark also expressed hatred towards his mother and sister. Notes which indicate Mark's psychosis were made by nursing staff on 13, 15, 17, 18, 21, 24 February and 1, 4, 15 and 20 March.

30. Mark displayed some signs of paranoia. For example on 19 February and 19 March he told nurse I that he placed a cassette tape on the door handle inside his room so that if someone entered his room at night he would be alerted.

31. Mark continued to demonstrate a propensity to abuse alcohol and drugs. For example on:

31.1 24 February Mark was seen going into a bar by a member of the hospital staff. When questioned about this Mark said he had not gone drinking. Later that evening he was seen hitting a wall and apparently he wanted to hit a security guard. The next day it was discovered Mark had vomited large quantities of what appeared to be pizza and beer.

31.2 On 28 February Mark and another patient left the ward. He was later found in possession of 1 dozen beer and a 750 ml bottle of whisky.

31.3 On 23 February and 17 March 2001 Mark was observed in circumstances which suggested to a staff member that he was trying to arrange a supply of cannabis. On 4 March he said he wanted to return to Queenstown because he "*wanted some dope*".

31.4 On 18 March Mark was involved in an incident in which cannabis utensils were found.

32. On occasions Mark displayed aggression and a propensity for violence. For example, the nursing notes for 24 February 2001 record Mark hit a wall and wanted to hit a security guard. There is a suggestion in the nursing notes for 1 March that Mark punched another patient that day. On 12 March Mark was involved in an incident in which he chased and punched a male patient who had "*sneaked up behind [Mark] and kissed him*".

33. It is important to emphasise that the incidents referred to in paragraph 30 to 32 above are interspersed with a number of very positive comments in the nursing notes. There are many references in the nursing notes to Mark being "*settled*" and "*interacting well with staff and fellow patients*". It is reasonable to conclude from an examination of the nursing and

medical notes that the incidents which constituted evidence of Mark's psychosis fluctuated during the time he was a patient in Ward 12, but were never resolved.

34. During Mark's period in Ward 12 consideration was given to finding a residential facility which would assist in addressing Mark's substance abuse. There is reference in the notes to exploring the possibility of Mark being placed with Odyssey House. The notes suggest that trying to place Mark in a programme such as Odyssey House was only tentatively examined primarily because Mark displayed no resolve to address his problems of alcohol and drug abuse. Mark did undergo an assessment at Rhanna Clinic, the Invercargill alcohol and drug rehabilitation unit. That assessment occurred on 12 March 2001. The counsellor who saw Mark advised the Tribunal that Mark was not willing to address his problems of alcohol and drug abuse. Mark told the counsellor that he would *"just play the game until released and would return to smoking and drinking"*.

35. It is evident that soon after Mark's admission Dr Fisher began focussing upon managing Mark's leave from Ward 12. The first reference to Mark having leave can be found in a note made by Dr Fisher on 14 February. That note states:

> *"Review*
> *Settled mentally*
> *May have day leave as required"*.

36. A referral for a needs assessment was initiated as early as 12 February 2001. In fact the assessment was not able to be commenced until 8 March. The assessment was never actually completed. The referral from nurse I on 12 February reads:

> *"It has been suggested to Mark that living in supported accommodation in Invercargill may be beneficial for him, so he can be closer to [Southland MHS] services."*

37. The nursing notes record Mark left Ward 12 on two occasions (24 and 28 February) in circumstances which constituted an abuse of his leave privileges. It was not until 2 March however that Mark's leave arrangements were modified to a requirement that he only have leave under escort. Two weeks later nursing staff recorded the intention to find accommodation in Invercargill for Mark. On 16 March Mark spoke to the District

Inspector "*to discuss his rights*" as he appeared to be still intent on returning to Queenstown. The nursing notes record that Mark later accepted he would look for a flat in Invercargill as had been planned. Mark went "flat hunting" with a social worker on 17 March. A flat was found which Mark was able to move into on 22 March. On 17 March Mark spoke to his father about returning his car from Queenstown. Mr Trevor Burton did not want Mark to access his car. Mr Burton wished to find out where Mark's flat was. Mark refused to allow the hospital staff to disclose to his father the location of Mark's flat. By 18 March Mark was still angry with his father for not agreeing to Mark having his car. Doctor Fisher then spoke with Mr Burton. After that discussion Mr Burton agreed to take Mark's car to him in Invercargill. Mr Burton told the Tribunal that when Dr Fisher telephoned him Mr Burton:

> *"…made it clear to Dr Fisher that we [Mr and Mrs Burton] did not see Mark coming back to Queenstown as an option because he had no place to stay and it was in too close proximity to his family".*[8]

Mr Burton ultimately agreed to bring Mark's car to Invercargill. Mr Burton and another police officer drove Mark's car to Invercargill on 22 March, the day Mark commenced a week's leave from Ward 12.

38. The nursing notes for 22 March record that Mark was placed on a week's trial leave that day. He was given a week's supply of medication and "*discouraged from using any illicit substances/alcohol*". A social worker was assigned to visit Mark's flat each working day. The social worker visited Mark on 23 March and noted Mark had a supply of beer and whisky. A further visit was made to Mark by the social worker on 26 March. The social worker remarked Mark had continued to drink beer and whisky. A similar entry is recorded in the nursing notes for 28 March.

39. A discharge planning meeting was held on 30 March. The meeting was held 1½ hours earlier than planned because Mark showed up at Ward 12 earlier than scheduled. The re-scheduling of the discharge meeting meant the key worker in the Community Mental Health

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[8] Evidence of T Burton paragraph 65

Team who had been assigned to Mark was unable to attend the discharge meeting. Doctor Fisher's note of the discharge meeting reads:

> *"Review*
> *Week at home – no longer problems – drinking a bit but taking medication.*
> *No talk of returning to Queenstown.*
> *Plan for discharge.*
> *olanzapine 15mg nocte".*

40. On the evening of 30 March Mark returned to Queenstown. Mr Trevor Burton was on duty. In the early hours of the morning of 31 March Mr Burton heard on his police radio that there was a fire at his house. He rushed to the scene. He found his wife dead on the porch of their home.

41. Mark was subsequently arrested and charged with the murder of his mother. In August 2001 a jury found Mark not guilty of murder by reason of insanity. Mark was committed as a special patient under the Criminal Justice Act 1985.

<u>Doctor Fisher</u>

42. Doctor Fisher graduated MBBS from London University in 1984. He became a registered medical practitioner in England in 1985. In 1989 Dr Fisher commenced training to become a specialist psychiatrist. The programme Dr Fisher entered was a four year course. Doctor Fisher was a member of the training programme for approximately two years based at Broadgreen Hospital in Liverpool and at the University of Liverpool. The position Dr Fisher had in Liverpool was equivalent to a psychiatric registrar's position in New Zealand[9]. Doctor Fisher told the Tribunal that Broadgreen Hospital was similar to Southland Hospital – a general hospital with a mental health unit[10]. Prior to going to Broadgreen Hospital Dr Fisher had 12 months experience working in an acute psychiatric unit at Peterborough in England.

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[9] Transcript p.289 l.37
[10] Transcript p.291 l.47

43. Halfway through the specialist training programme Dr Fisher decided to take a year out and travel to New Zealand. He took up a position at Southland Hospital in December 1992. A letter of reference written by Broadgreen Hospital in 1992 to Southland Hospital described Dr Fisher as being a *"very keen and highly motivated trainee"* who takes *"an active part in all aspects of his training and post graduate medical education"*. It was thought Dr Fisher was highly likely to pass the MRC Psych Part I assessment.[11]

44. Doctor Fisher was initially appointed as a psychiatric registrar at Southland Hospital. His description changed to MOSS in 1994. A reference from a psychiatrist formerly based at Southland Hospital during Dr Fisher's first six months in Invercargill described Dr Fisher as being *"very capable at assessing patients, managing their treatment, and providing them with ongoing support and supervision"*. Consistent with his *"... having had at least two years experience in psychiatry"*.[12]

45. Doctor Fisher remained a MOSS in psychiatry at Southland Hospital until January 1997. He returned to the United Kingdom for part of 1997 before returning to New Zealand to take up a position as a MOSS in psychiatry at Seaview Hospital in Hokitika. He held that position until May 2000 during which time he worked under the supervision of Dr Anderson and Dr Hall. Doctor Fisher worked as a general practitioner in Hokitika for a short period before returning to Invercargill in October 2000 where he was again employed as a MOSS in psychiatry.

46. When Dr Fisher was initially re-employed at Southland Hospital he was required to work in the Community Health Mental Health team and provide cover for in-patients at night and on weekends. However in December 2000 the in-patient psychiatry MOSS went on leave. Doctor Fisher was assigned to take on a small in-patient workload for the first three months of 2001. It was thought he would have capacity to manage 5 to 6 patients. In reality his responsibilities were confined to managing about 3 in-patients. In February and March 2000 the Southland MHS had 3 consultant psychiatrists and 3 MOSS's in its psychiatry department.

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[11] Exhibit 20

[12] Exhibit 21

47. By the time Mark became a patient of Dr Fisher on 10 February 2001 Dr Fisher had approximately 10 to 11 years experience in psychiatry, initially as a psychiatric registrar (for approximately 3 years) and as a MOSS in psychiatry (for approximately 7 to 8 years). At the time Dr Fisher commenced caring for Mark he was exempt from the general "oversight" requirements under the Medical Practitioners Act 1995. A requirement for "oversight" was not imposed until mid 2001.

48. The Tribunal unhesitatingly accepts Dr Fisher cannot be judged against the standards of a consultant psychiatrist. Although at times Dr Fisher was required to perform the role of consultant psychiatrist when employed as a MOSS in psychiatry[13] Dr Fisher never held himself out as having the training and qualifications of a qualified specialist psychiatrist. Doctor Fisher should not be viewed as a "de facto consultant psychiatrist". The Tribunal has assessed Dr Fisher's acts and omissions solely against the standards that the Tribunal reasonably expected of a MOSS practising in a psychiatric Unit in New Zealand in 2001.

Part III - Summary of the case for the Director of Proceedings

49. The case for the Director of Proceedings was substantially based upon the evidence of Dr M Patton. Dr Patton is a specialist psychiatrist. He graduated MBChB from the University of Otago in 1981 and became a Fellow of the Royal Australia and New Zealand College of Psychiatrists in 1989. From 1992 to 2003 Dr Patton held several senior psychiatric positions in Auckland. The positions he held included Clinical Director, Mental Health Service, Auckland; Director of Mental Health Services, Director of Area Mental Health Services, Central Auckland; Clinical Director, Mental Health Services, South Auckland; and Director of Area Mental Health Services, South Auckland. In 2003 Dr Patton took up a position in Tasmania as Clinical Director, Mental Health Services, Department of Health and Human Services. Dr Patton's current position includes an appointment as a senior lecturer at the University of Tasmania.

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[13] Evidence of P Fisher paragraph 8

50. Doctor Patton first became involved in assessing Dr Fisher's management of Mark when the Health and Disability Commissioner (Commissioner) invited him to chair a panel of expert advisors appointed by the Commissioner to advise on clinical issues associated with the care given to Mark from 10 February to 30 March 2001. In that capacity Dr Patton (and other members of the panel) interviewed Dr Fisher and a number of other persons associated with Mark's care.

51. Mr Hodson QC challenged the admissibility of Dr Patton's evidence. That challenge was based on concerns that Dr Patton:

    51.1 Lacked the requisite skills and qualifications to be an expert; and

    51.2 Formed his opinion on the basis of some evidence which was not before the Tribunal; and

    51.3 Lacked the requisite level of objectivity to be a reliable expert witness.

52. The Tribunal ruled on 17 November that it would receive Dr Patton's evidence. Written reasons for that decision were delivered by the Tribunal. The reasons set out in that decision need not be reiterated. During the course of his evidence it became more apparent to the Tribunal Dr Patton had the requisite skills to be an expert witness. It was during the course of cross examination that Dr Patton revealed his academic position and the fact he had previously given evidence as an expert. More importantly, the considered manner in which Dr Patton gave his evidence left the Tribunal in no doubt he was objective when commenting upon Dr Fisher's management of Mark.

53. In summarising the Director of Proceedings' case it is convenient to refer to the four phases of Dr Fisher's role in caring for Mark identified in the notice of charge, ie:

    53.1 Mark's admission on 10 February 2001;

    53.2 Mark's period as an in-patient from 10 February to 21 March 2001;

    53.3 Mark's period of leave from 22 to 30 March 2001;

53.4 Mark's discharge on 30 March 2001.

Admission on 10 February 2001

54. Dr Patton explained that when a patient is admitted into a mental health service the admitting clinician must undertake a comprehensive psychiatric assessment of the patient. This assessment must be properly documented. A proper psychiatric assessment involves:

54.1 Understanding the patient's relevant history. The patient's relevant history includes their psychiatric, forensic, substance use, social and medical history and should also include information about the patient's present and current responses to treatment.

54.2 Understanding the patient's phenomenological presentation. That is to say, the clinician must ascertain what phenomena or signs were present which were indicative of mental illness.

54.3 Assessing information about what prompted the patient's admission to hospital.

54.4 Determining what might have precipitated the patient's admission, including why admission was needed instead of treatment within the community.

55. Doctor Patton told the Tribunal that when a patient is admitted a mental state examination must be carried out so that a baseline condition is established against which changes in the patient's mental state can be measured.

56. Doctor Patton thought the admission documentation completed by Dr Fisher on 10 February 2001 was substandard and inadequate. The records that were made were uninformative. The circumstances precipitating Mark's admission were referred to only very briefly. There was very little reference to Mark's psychiatric history. The patient's social circumstances were referred to very briefly. There was limited history recorded. Doctor Patton believed further details should have been obtained about Mark's alcohol and drug use in order to develop an understanding of the relationship between his

symptoms and his use of substances. Doctor Patton was concerned that there were no details recorded in Dr Fisher's assessment of:

56.1 Mark's threatening behaviour or any precipitating factors;

56.2 The nature and content of the discussions between Mark and his father which illustrated delusional thoughts;

56.3 The presence or absence of forensic history;

56.4 Mark's medical history;

56.5 The key concerns of the patient's family.

57. Doctor Patton told the Tribunal that Dr Fisher failed to obtain sufficient information to properly assess risk in this case. The Tribunal was told Dr Fisher failed to obtain information that would allow a proper assessment of risk and to provide a base from which an immediate management plan, and treatment plan could be formulated.

58. Doctor Patton was also critical of the fact Dr Fisher failed to document a current working psychiatric diagnosis which in the case of Mark should have been identified as active exacerbation of schizophrenia along with alcohol and cannabis abuse.

<u>In-patient period 10 February 2001 to 31 March 2001</u>

59. The Director of Proceedings alleged Dr Fisher should have assessed and evaluated the concerns raised in Mr Trevor Burton's letter of 11 February as well as the issues documented in Mark's medical notes during the time he was an in-patient in Ward 12. In particular it was alleged Dr Fisher failed to adequately assess and evaluate information which suggested:

59.1 Mark continued to abuse alcohol and cannabis while he was an in-patient.

59.2 Mark continued to display symptoms of paranoia and delusion while he was an in-patient.

59.3 Mark exhibited signs of violence while he was in the Ward.

60. Doctor Patton was concerned that there were only six file notes made by Dr Fisher following Mark's admission. None of the file notes made by Dr Fisher after 10 February reflected an adequate assessment of Mark by Dr Fisher or an appropriate treatment plan.

61. Doctor Patton told the Tribunal Dr Fisher's assessments subsequent to admission should have recorded:

61.1 The outcome of attempts to demonstrate signs indicating mental illness;

61.2 Mark's willingness and/or ability to engage with staff and others on the ward;

61.3 Mark's demeanour;

61.4 Mark's interactions and behaviour in the ward setting and whilst being interviewed.

Doctor Patton was convinced that there was little evidence to suggest Dr Fisher tried to explore specific symptoms or to analyse Mark's thoughts and presentation.

62. The Tribunal was told that the efforts to locate a facility for residential rehabilitation and treatment for substance abuse were not adequately followed through. Similarly, there was criticism about the fact that a weekly assessment was commenced but not completed. Doctor Patton commented that Dr Fisher failed to recognise the importance and value of a comprehensive treatment plan for Mark.

63. Doctor Patton noted that after Mark was referred to the Rhanna Clinic Dr Fisher appears not to have familiarised himself with the assessment carried out by the alcohol and drug service. Doctor Patton told the Tribunal Dr Fisher should have actively attempted to ensure Mark benefited from an alcohol and drug treatment programme.

64. The Director of Proceedings witness referred to the fact Dr Fisher adjusted the dose of olanzapine administered to Mark. However, Dr Patton was concerned that there was no documented evidence to suggest Dr Fisher attempted to explore the effects of the change

in medication on Mark's psychotic experiences, or to consider an alternative medication regimen.

65. Doctor Patton was very concerned that no adequate risk assessment was completed at any time and that there was no documented formulation of risk factors that would lead to a comprehensive plan to reduce risk.

66. Incidents such as Mr Trevor Burton's letter of 11 February, Mark's abuse of alcohol on the ward and his occasional acts of violence did not result in a documented review of the patient's assessed level of risk. Doctor Patton thought this was very unsatisfactory and a failure by Dr Fisher to adhere to appropriate standards of care.

Trial Leave

67. Doctor Patton was very concerned that Dr Fisher did not properly assess Mark's mental state, or undertake and/or record a comprehensive risk assessment of Mark prior to Mark commencing trial leave on 22 March. The Director of Proceedings maintained Dr Fisher should have assessed whether or not there were persisting psychotic symptoms or other evidence of illness. Doctor Patton was also concerned that there had been an apparent failure to assess medication, and what would happen if Mark continued to use alcohol, and what Mark intended to do with his time while on trial leave. These matters, Dr Patton said, should have been canvassed and considered before Mark was allowed to leave the ward.

68. In addition to criticising Dr Fisher's failure to undertake a comprehensive risk assessment prior to Mark going on trial leave, Dr Patton also criticised the absence of a crisis plan which should also have been developed prior to Mark being allowed trial leave. Doctor Patton was concerned that no adequate arrangements were made to review Mark's mental state during the leave period.

Discharge on 30 March 2001

69. Doctor Patton was critical of the fact Dr Fisher appeared not to undertake, and/or record a thorough and systematic review of Mark's mental state prior to his discharge being confirmed. Doctor Patton was also concerned that there was no evidence Dr Fisher attempted to address Mark's alcohol intake whilst on trial leave, even though there was clear information available about the patient's use of alcohol during the trial leave period.

70. The Tribunal was told Dr Fisher failed to review Mark's management and treatment plan. Dr Patton was concerned a prescription for a three month supply of olanzapine was provided to Mark despite his treatment plan not having been reviewed.

71. Doctor Patton criticised the apparent failure by Dr Fisher to review and document risk factors associated with Mark's discharge despite the evidence of psychotic symptoms prior to discharge. A needs assessment had not been completed. Doctor Patton was concerned that it was not clear how Mark was able to care for himself and therefore there was no adequate assessment of the risk of self neglect.

72. Doctor Patton told the Tribunal that the absence of a risk assessment at the time of discharge hindered the development and implementation of a treatment plan which addressed Mark's clinical problems and risks associated with those problems.

73. The Tribunal was told Dr Fisher failed in his responsibilities by not assessing the implications of Mark having access to his car.

74. Doctor Patton criticised the adequacy of relying on a social worker to visit Mark during the post discharge period and the fact that Mr Trevor Burton did not participate in the discharge planning meeting held on 30 March.

75. In summary, Dr Patton thought that Dr Fisher's standards of documentation and record keeping fell well below accepted professional standards of care. Doctor Patton also thought Dr Fisher's clinical performance fell well below the standards of an "*unsupervised MOSS in a psychiatric setting*".

Trevor Burton

76. The Director of Proceedings called evidence from Mr Trevor Burton. They key aspects of Mr Trevor Burton's evidence has been summarised in Part II of this decision and need not be repeated. Suffice to say, the Tribunal was left in no doubt Mr Trevor Burton did all he could for his son and felt grossly let down by Dr Fisher and the Southland MHS. Mr Burton did his best to fully inform those health professionals caring for his son about his and his family's concerns.

<u>A</u>

77. The Director of Proceedings also called evidence from A a nurse employed in the Southland MHS's Community Mental Health Team. Ms A's role was to manage the needs of persons who had been acutely unwell and discharged from Ward 12. Ms A was appointed to provide Mark's community care in conjunction with an occupational therapist. Because of communication difficulties Ms A was not aware that Mark was planning to stay in Invercargill until Mark went on trial leave. She also did not learn until the week of 22 March that she was to be Mark's key worker on discharge. Ms A was not told of the change of time for Mark's discharge meeting on 30 March and accordingly did not attend that important meeting. Ms A had a number of concerns about the discharge process and that Mark was abusing alcohol and possibly using drugs whilst on leave. Ms A told the Tribunal that she:

> *"... was annoyed about not being at the discharge planning meeting on 30 March. [She] was surprised that Mark had been discharged. [She] felt that [she] had been left with the responsibility but not consulted in the discharge process."*[14]

<u>C</u>

78. C is a needs assessor employed in the social work department at Southland Hospital. Ms C told the Tribunal that a needs assessment for Mark was requested by nursing staff in Ward 12 on 12 February 2001. The needs assessment commenced on 8 March 2001. During the meeting with Ms C that day Mark said he planned to return to Queenstown.

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[14] Evidence of A paragraph 43

He also told Ms C that *"his mother and sister would come into his room and touch him*"[15]. Ms C judged that Mark was so stressed that she should discontinue the meeting. Ms C made contact with a drug and alcohol treatment facility in Christchurch, but by this time Mark was already on trial leave. Ms C was unaware of this development. She was "*surprised and disappointed that [she] had not been involved in the decision making process prior to Mark leaving the Ward."*[16] Ms C was never able to complete the needs assessment for Mark.

B

79. B is a drug and alcohol counsellor/care worker at the Rhanna Clinic. B interviewed Mark on 12 March and attempted to motivate Mark into addressing his alcohol and drug issues. At the end of the interview Mr B concluded Mark was not alcohol dependant but that he did abuse alcohol.

D

80. D was also called to give evidence by the Director of Proceedings. She was the team leader of the Community Mental Health team. Ms D explained the role and procedures of the Community Mental Health team. She had no direct involvement in Mark's care.

Part IV - Summary of Case for Dr Fisher

Dr Fisher

81. Doctor Fisher provided the Tribunal with a very detailed brief of evidence. He was cross examined extensively.

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[15] Evidence of C paragraph 21
[16] Evidence of C paragraph 34

82. From the outset Dr Fisher accepted that his medical records were *"deficient"*[17]. When addressing the particulars of the charge relating to the quality of his notes and records Dr Fisher acknowledged that many aspects of his management of Mark were not documented, and that the records which he did make were not adequate.

83. Doctor Fisher was equally adamant that the "*standard and extent*"[18] of his care of Mark was not accurately reflected in the notes. The basic tenet of Dr Fisher's evidence was that he adhered to the standards of a responsible doctor in his position but he did not record the work he undertook in Mark's case.

84. Doctor Fisher's evidence systematically addressed the particulars of the charge and can be conveniently summarised by reference to the four stages of his contact with Mark between 10 February and 31 March 2001.

Mark Burton's admission on 10 February 2001

85. Doctor Fisher first became involved in Mark's treatment when the Southland Mental Health Emergency team contacted Dr Fisher on 10 February 2001. Doctor Fisher was given a brief verbal summary of Mark's condition. Doctor Fisher learned Mark was a patient of Dr Menkes, a Dunedin based psychiatrist who regularly visited Mark at Queenstown. Doctor Menkes had recently changed Mark's medication from 4mg risperidone to 10mg olanzapine. Doctor Fisher was also told about Mark's abuse of alcohol and drugs and that he had previously had a voluntary admission to Ward 12 when a diagnosis of schizophrenia had been made. Doctor Fisher was told about Mark's threatening attitude to his mother that morning.

86. Doctor Fisher met Mark with his father and nurse I. Doctor Fisher told the Tribunal that a set of the mental health services assessment forms was not available on the weekend. Had the forms been available he would have used them.[19] During the interview Dr Fisher said Mr Burton expanded on the background information Dr Fisher had received from the

[17] Evidence of P Fisher paragraph 18
[18] Evidence of P Fisher paragraph 18
[19] Evidence of P Fisher paragraph 18

Southland Mental Health Emergency team. Doctor Fisher told the Tribunal that the incidents of difficulties in the Burton house relating to Mark did not differ significantly from the experiences of many parents of teenagers experimenting with alcohol and drugs, albeit exaggerated by Mark's schizophrenia.[20] Doctor Fisher was in no doubt however that Mark's aggressive behaviour on the morning of 10 February was *"clearly serious"*[21]. Doctor Fisher said he offered to meet with members of the Burton family. Ultimately however Mr Trevor Burton became the only point of contact between the family and the Southland MHS.

87. When commenting on the inadequacy of the note he made on 10 February in Mark's medical file Dr Fisher accepted he should have recorded a clear and detailed history and analysis as part of his assessment. Following the interview Mark became a voluntary patient in Ward 12. Doctor Fisher increased Mark's olanzapine to 15mg following discussions with Mark and his father.

88. Doctor Fisher told the Tribunal he was aware of the need to conduct a mental state examination on admission to establish the patient's current state of risk and to establish a base line condition against which changes in mental state could be measured throughout admission. Doctor Fisher said his analysis of Mark's phenomenology of mental state was not adequately recorded, but that it did form part of his assessment of Mark.

89. Doctor Fisher explained Mark did not participate extensively in the admission process. His inhibition did limit the effectiveness of the assessment process. Doctor Fisher also said that as Mark's clinical notes were to be forwarded by the Queenstown Mental Health Service he did not think it necessary to obtain a full "duplicate" history from either Mark or Mr Burton at the time of admission.[22]

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[20] Evidence of P Fisher paragraph 20

[21] Evidence of P Fisher paragraph 21

[22] Evidence of P Fisher paragraph 32

90. Doctor Fisher assessed Mark as *"an opportunistic user of substances"*[23] and alcohol. Doctor Fisher deduced from Mr Trevor Burton that the major concern about Mark's use of alcohol and drugs related to the company he was keeping in Queenstown.

91. The Tribunal was told by Dr Fisher that the precipitants for Mark's admission *"were very clearly obtained although ... not sufficiently recorded."*[24]

92. Although Dr Fisher explained he did not complete the initial assessment forms because they were not available, he did complete part of the risk alert sheet. Mark was assessed on the scale relevant to that form as a "one", meaning, no increased risk. Doctor Fisher told the Tribunal that a further assessment of risk would be completed when Mark was granted leave from the Ward or on discharge.[25] Doctor Fisher said he drew lines through the "clinical risk assessment and management" sheet as it was designed for use by the Community Mental Health Team and only to be completed in conjunction with someone who had known the patient.[26]

93. Doctor Fisher informed the Tribunal:

> *"…while Mark remained in hospital his risk remained low. The major risk identified was Mark's return to Queenstown and to any proximity to his family."*[27]

<u>In-patient period 10 February to 21 March 2001</u>

94. Doctor Fisher accepted he failed to record a thorough and systematic review of Mark's mental status whilst he was an in-patient. Doctor Fisher maintained however that he did undertake a thorough and systematic review of Mark's mental status during his admission in Ward 12.

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23 Evidence of P Fisher paragraph 34
24 Evidence of P Fisher paragraph 39
25 Evidence of P Fisher paragraph 42
26 Evidence of P Fisher paragraph 42
27 Evidence of P Fisher paragraph 45

95. The Tribunal was told by Dr Fisher that he routinely visited ward 12 each morning and afternoon. During those visits he discussed with staff any changes in his patient's condition. Doctor Fisher said the:

> *"…decision making process in relation to Mark's management arose through a combination of regular reviews with his assigned nurses, Monday morning clinical reviews, … weekly review meetings, and his consultation with Mr Burton."*[28]

96. Mark was granted day leave on 14 February 2001. Doctor Fisher said by this time Mark had improved and exhibited reduced signs of psychosis and paranoia.

97. Doctor Fisher explained that Mark soon worked out Dr Fisher's routine on the ward. Mark would meet Dr Fisher at the door of the ward where they would have discussions. Sometimes Dr Fisher took Mark into an interview room for an "assessment".[29] Doctor Fisher said that while evidence of a psychotic process remained, there was also evidence of quite significant improvement in Mark while he was an in-patient.[30] Doctor Fisher also suggested that some of Mark's partly delusional thoughts were able to be rationally explained. For example, the placing of a cassette on his bedroom door could be explained by the fact Mark had been assaulted in his room at night by another patient during his admission to ward 12 in 2000.

98. When referring to the four incidents of aggression or violence recorded in Mark's medical file during his period in ward 12, Dr Fisher said that each incident was investigated and decisions made that Mark had been provoked and that his "*responses had been proportionate and understandable in the circumstances"*.[31] Doctor Fisher also said that when Mark accessed alcohol he did not become more aggressive and remained directable by nursing staff.[32] Doctor Fisher said Mark's level of risk was assessed following each incident, but not documented.[33] The only entry made in the risk alert sheet after Mark's admission occurred on 14 February when Dr Fisher read Mr Trevor

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[28] Evidence of P Fisher paragraph 51
[29] Evidence of P Fisher paragraph 57
[30] Evidence of P Fisher paragraph 59
[31] Evidence of P Fisher paragraph 65
[32] Evidence of P Fisher paragraph 64

Burton's letter. Doctor Fisher did not alter Mark's risk alert status and no further entries were made in the risk alert sheet because Mark's observation levels remained routine.[34]

99. Doctor Fisher said he referred Mark to the Rhanna Clinic for an alcohol and drug assessment, but he did not recall seeing the assessment until an inquest was held into the death of Mrs Burton. Doctor Fisher explained he was not able to initiate more assertive interventions because Mark generally refused to accept that he had an alcohol and drug problem.

100. Doctor Fisher explained he did not attach any urgency to a needs assessment for Mark primarily because there were no services readily available that could assist Mark.[35]

101. In response to the allegation that he failed to adequately develop and/or review Mark's medication regime Dr Fisher said that the medication regime he put in place on Mark's admission was reconsidered and reviewed. Similarly, Dr Fisher was adamant that the treatment plan for Mark was developed and constantly reviewed.[36]

Trial Leave 22 to 30 March 2001

102. Doctor Fisher refuted the allegation that he failed to undertake a thorough and systematic review of Mark's mental state prior to the commencement of his trial leave on 22 March 2001. Doctor Fisher did acknowledge however that the reviews he believes were carried out were not adequately recorded.[37]

103. The Tribunal was told by Dr Fisher that he met Mark on 20 March specifically to discuss with him his trial leave. Doctor Fisher said he specifically reviewed whether or not there was evidence of Mark's psychotic features or other evidence of his illness. Doctor Fisher was of the view that "*all outward evidence of overt psychosis was largely suppressed*"[38] and that Mark's overall improvement constituted a significant change from

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33 Evidence of P Fisher paragraph 66
34 Evidence of P Fisher paragraph 70
35 Evidence of P Fisher paragraph 88
36 Evidence of P Fisher paragraph 92
37 Evidence of P Fisher paragraph 94
38 Evidence of P Fisher paragraph 97

his time of admission, and also a significant change from his admission in 2000.[39] Doctor Fisher did acknowledge that Mark remained guarded and reserved when questioned about his family and the events which had precipitated his admission. Doctor Fisher also explained that he conferred with Mr Trevor Burton on 21 March about Mark's trial leave and explained that Mark did not want his parents to know the location of his flat.

104. Doctor Fisher responded to the allegation he failed to undertake and/or record a comprehensive risk assessment for Mark prior to the commencement of his trial leave by acknowledging that there was no record of a comprehensive risk assessment.[40] However Dr Fisher told the Tribunal that a risk assessment was developed in conjunction with other members of the Southland MHS. Part of the assessment involved a social worker visiting Mark on a daily basis when he was on trial leave to monitor Mark while he was away from the ward. Doctor Fisher explained that Mark's case was discussed at the weekly review meeting on 21 March and that no-one involved in his care believed there was any reason why the planned trial leave should be stopped. Doctor Fisher acknowledged he appreciated Mark would resort to alcohol while he was on leave. Doctor Fisher considered and assessed the increased risk that existed if Mark had access to a motor vehicle. He did not believe this was significant because Mark had said he did not want any involvement with his family on discharge.[41]

105. Doctor Fisher acknowledged that he did not adequately record any arrangements to review Mark's mental state during his week of trial leave.[42] However, Dr Fisher was adamant that appropriate arrangements were put in place to review Mark's mental state during the period he was on trial leave. These arrangements primarily involved the daily monitoring of Mark by a social worker. In addition, Dr Fisher personally saw Mark three times during his week of trial leave.

106. Doctor Fisher responded to the allegation he failed to ensure a crisis plan was developed on or before Mark's trial leave by explaining that a crisis plan was dependent on a risk

[39] Evidence of P Fisher paragraph 97
[40] Evidence of P Fisher paragraph 102
[41] Evidence of P Fisher paragraph 108
[42] Evidence of P Fisher paragraph 110

assessment being prepared by the Community Mental Health Team. Doctor Fisher also suggested that an informal crisis plan was developed by Mark's social worker, Mr Burton and himself. This informal crisis plan involved the social worker alerting Dr Fisher about any signs of Mark's health deteriorating.

Discharge

107. Although he acknowledged there was no record of a thorough and systematic review of Mark's mental state at the time of his discharge,[43] Dr Fisher was certain he did undertake an appropriate review of his patient's mental state prior to his discharge. Doctor Fisher told the Tribunal that Mark's discharge plan covered:

107.1 Management of Mark's ongoing medication;

107.2 Follow up arrangements;

107.3 How Mark should respond to problems that might emerge;

107.4 Warning signs that Mark should respond to; and

107.5 How Mark should avoid a relapse.

108. Doctor Fisher told the Tribunal he discussed the discharge plan with Mr Trevor Burton on 29 March, and that Mr Burton appeared to support the arrangements put in place for his son.

109. Doctor Fisher explained how the discharge planning meeting was held earlier than originally scheduled. He did not believe that it was crucial that Ms A attended even though she was designated as the Community Mental Health Team key worker for Mark on his discharge. Doctor Fisher said that all who were present at the discharge planning meeting on 30 March took account of Mark's mental state. The discussions held at that meeting included:

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[43] Evidence of P Fisher paragraph 133

109.1 References to the alcohol Mark had consumed while on trial leave;

109.2 The fact Mark had not used his car while on trial leave, and therefore posed no risk to his family;[44]

109.3 What Mark should do if problems emerged; and

109.4 References to Mark applying for a job.

110. Doctor Fisher told the Tribunal he was encouraged by the relationship that had developed between Mark and his social worker. He also insisted that he and other members of the Southland MHS were very aware of the concerns expressed in Mr Trevor Burton's letter of 11 February. Doctor Fisher said that during the meeting Mark made no reference to returning to Queenstown.

111. Doctor Fisher's response to the allegation that he failed to undertake and/or record a comprehensive risk assessment for Mark was that Mark's risk assessment was comprehensively reviewed prior to the commencement of his trial leave on 22 March 2001.[45] Doctor Fisher told the Tribunal that he continued to assess the risk Mark posed to his family but was reassured that Mark appeared intent in remaining in Invercargill and that "*the whole overall picture of his mental health was quite different*"[46] from when Mark was admitted to Ward 12. Doctor Fisher did acknowledge however "*that the recording of the risk assessment [at this time] was inadequate*".[47]

112. Doctor Fisher responded to the allegation that he failed to adequately review Mark's management and/or treatment plan at the time of his patient's discharge by telling the Tribunal that in effect he intended to remain involved in Mark's care until such time as the Community Mental Health Team were in a position to be involved in Mark's discharge. It was anticipated this would occur on 6 April. Doctor Fisher said that essentially Mark was

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[44] Evidence of P Fisher paragraph 125
[45] Evidence of P Fisher paragraph 134
[46] Evidence of P Fisher paragraph 140
[47] Evidence of P Fisher paragraph 143

still on leave for another week and that there was no real justification for him remaining an in-patient.[48]

113. The Tribunal was told by Dr Fisher that Mr Trevor Burton continued to be involved *"In Mark's care right up to the discharge planning."*[49] Doctor Fisher said this in response to the allegation that he failed to ensure the adequate involvement of Mark's family in his discharge planning.

114. Doctor Fisher's response to the final particular of the charge (that he failed to ensure a crisis plan was developed between 22 and 30 March 2001 in partnership with Mark and/or record it) by reiterating that a crisis plan was developed between the social worker, Mark and himself before Mark went on trial leave on 22 March.

115. Doctor Fisher also called evidence from:

115.1 I

115.2 H

115.3 G

115.4 F

115.5 E

115.6 Dr Ian Goodwin

115.7 Dr Alan Fraser

[48] Evidence of P Fisher paragraph 146
[49] Evidence of P Fisher paragraph 149

I

116. Ms I is an experienced nurse employed in the Southland MHS. Ms I first cared for Mark in July 2000. Ms I recommenced nursing Mark on 10 February 2001. She was present with Dr Fisher when Mark was admitted to Ward 12. Nurse I completed part of the risk alert form. Ms I had very regular contact with Mark during the period 10 February to 30 March 2001. She was assigned to nurse Mark on 19 shifts during that period. She regularly discussed aspects of Mark's care with other members of the nursing staff. Ms I explained to the Tribunal her observations of Mark during each of the shifts she cared for him, and the reasons for the course of management adopted by the nursing staff. Ms I told the Tribunal that during his admission in February and March 2001 Mark appeared to have matured compared to his admission the previous year. Ms I thought Mark appeared to appreciate the need for him to be in the mental health unit. Ms I was not overly perturbed by the fact Mark drank alcohol while on trial leave. She said:

> *"If Mark had not suffered from schizophrenia his level of alcohol and cannabis consumption would not have been a problem."*[50]

117. Ms I played a leading role in managing Mark's discharge. She believed *"... Dr Fisher was well aware of where Mark's mental health was at."*[51] She was aware that Dr Fisher had a number of undocumented discussions with Mark and nursing staff about Mark's progress. Ms I also explained that she documented an interim crisis plan on the discharge plan for Mark.

118. The Tribunal was told by Ms I that at the time of Mark's admission to Ward 12 in 2001 any assessments or reports from services outside of Ward 12 would not be referred to staff on the Ward unless there was something unusual or important information that needed to be passed on. Ms I said there was no expectation that in-patient staff would proactively pursue staff from other services undertaking assessments of in-patients.

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[50] Evidence of I paragraph 78
[51] Evidence of I paragraph 88

119. In commenting on contact between the ward staff and Mark's family Ms I observed Dr Fisher liaised between the family and the ward. This was quite unusual as normally the nurses co-ordinate between the patient's family and ward staff.

H

120. Ms H was a staff nurse in Ward 12 at the time of Mark's 2001 admission. Ms H became Mark's assigned nurse on 20 February 2001. Ms H spoke to Mr Trevor Burton by telephone that day. Mr Burton relayed to Ms H his concerns about the family's safety if Mark returned to Queenstown. When Ms H spoke to Mark on 20 February he denied having any further delusional thoughts.

121. Ms H also told the Tribunal that drug and alcohol assessments, as well as needs assessment reports were not integrated into the patient's ward file at the time of Mark's admission. Ms H advised that so far as the ward staff were concerned, the obligation was on assessors to notify ward staff if there was a major concern.

122. Ms H informed the Tribunal that:

> "*Mark's trial leave was no different to anyone else's trial leave except that in [his] case instead of going on leave to his family he was on leave in a flat with a social worker and key worker assigned to him, in place of his family*".[52]

123. Ms H explained that in-patient nurses were definitely not responsible for looking after a client when they were on leave because there were no resources available for this.

G

124. Ms G is also an experienced nurse. She was assigned to care for Mark on 7 shifts between 14 February and 14 March 2001. Ms G said that:

> "*At no time during Mark's admission in February/March 2001 did [she] believe that Mark was a risk to others on the Ward, or to*

[52] Evidence of H paragraph 32

> *himself ... obviously, there were issues and concerns relating to Mark's family, but as they were in Queenstown Mark was a low risk while an in-patient in the Unit."*[53]

125. Ms G was present when Mrs C commenced a needs assessment for Mark on 8 March 2001. She agreed Mark was agitated during the interview but in her view *"the incident was not as significant as it has now been made out by Ms C"*.[54]

F

126. Ms F is a senior nurse employed by the Southland MHS. Ms F first met Mark when he was admitted to Ward 12 in 2000. Ms F saw Mark when he returned to Ward 12 on 10 February. She also cared for Mark on 11, 17, 19, 20, 21 February and 1, 3, 4, 7 and 8 March 2001. Ms F told the Tribunal about her role in Mark's care on the days she was assigned as his nurse.

127. Ms F told the Tribunal that a patient in Ward 12 is continually reviewed for risk. These reviews may not be documented unless there are changes in the patient's behaviour and the risk categories change.[55] Ms F advised the Tribunal that everyone in the Unit was aware of Mr Burton's letter of 11 February and that Mark was an increased risk to his family. Ms F also said there was no evidence Mark was a risk to anyone else.[56]

128. The Tribunal was told by Ms F that she regarded the way Mark's discharge was planned to be the responsibility of all the health professionals involved with Mark, rather than one particular person within the group.[57]

E

129. Ms E is a registered nurse. She became the acting team leader of the Mental Health In-patient Unit in April 2000. She became the permanent team leader of the Unit in April

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[53] Evidence of G paragraph 8
[54] Evidence of G paragraph 18
[55] Evidence of F paragraph 48
[56] Evidence of F paragraph 50
[57] Evidence of F paragraph 63

2001. At the time of Mark's admission to Ward 12 in February 2001 Ms E was responsible for employing staff, managing the Unit's budget and reviewing/developing Unit policy.

130. Ms E explained that at the time Mark entered Ward 12 on 10 February 2001 staff morale was very low and that other problems in the Unit included concerns that:

130.1 The Unit was unsafe for patients;

130.2 The Unit comprised both compulsory and voluntary patients;

130.3 At many times patient numbers exceeded the Unit's budget;

130.4 The patients acuity mix was undesirable;

130.5 The skill mix of staff was a concern; and

130.6 The Unit suffered from a lack of doctors with psychiatric training.

Ms E explained to the Tribunal the difficulties experienced in retaining staff for the Mental Health Unit.

131. Ms E was not directly involved in Mark's care. She was however able to provide the Tribunal with a helpful overview of how nursing responsibilities were discharged in the Unit. The essential message which Ms E conveyed to the Tribunal was that no one nurse was expected to do the things that a primary nurse might normally carry out. Ms E said that the reality in the mental health Unit was that nurses shared responsibilities.[58]

132. Ms E did familiarise herself with aspects of Mark's care while he was in ward 12. For example, she read Mr Burton's letter of 11 February and discussed its contents with Dr Fisher. Ms E also attended the team review meetings that took place on 14 and 22 February, 1, 8, 15 and 22 March when Mark's case was discussed. Ms E gained the

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[58] Evidence of E paragraph 19

impression that as the reviews progressed Dr Fisher and other staff gained confidence about Mark's mental state. Ms E told the Tribunal that:

> *"…the message [she] was getting was that Mark was very much improved from when he was first admitted on 10 February 2001."*[59]

133. Ms E explained to the Tribunal that the policy relating to risk assessments meant Mark's risk assessment sheet was not re-visited after 14 February because his risk alert level remained constant.

134. Ms E referred to the incidents in Mark's medical notes concerning his accessing alcohol and violence. She explained that each of these matters was examined at the time and decisions made that Mark did not pose an increased risk because of these events.

135. The Tribunal was told by Ms E that she was aware the needs assessor's comments were not integrated into Mark's medical notes. Ms E was not aware at the time of Mark's discharge that his needs assessment had not been completed.

136. Ms E told the Tribunal that the in-patient service did not have the training or resources to arrange follow up of Mark's alcohol and drug assessment.

137. Ms E referred to the apparent lack of connection between the Community Mental Health Team and the in-patient services and said:

> *"There was no excuse for [the Community Mental Health Team] not being fully aware of the mental health status and/or clinical needs of any of the patients that were referred to them."*[60]

138. Ms E supported Mark's trial leave particularly because of the rapport he had with the social worker assigned to visit Mark in his new flat. Ms E thought the arrangements put in place for Mark's trial leave reflected the desire to ensure Mark had the best support which could be offered to him at this time.

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[59] Evidence of E paragraph 35

[60] Evidence of E paragraph 55

139. When addressing issues associated with the discharge meeting Ms E said that from her perspective there was adequate consultation between the staff and appropriate arrangements were made to consult with Mark's family.

Dr I Goodwin

140. Doctor Goodwin became a fellow of the Royal Australian and New Zealand College of Psychiatrists in 1996, having graduated MBChB from the University of Otago ten years previously. Doctor Goodwin is currently a consultant psychiatrist at the Regional Forensic Psychiatry Services in Auckland (Mason Clinic). He is also currently the Chair of the Training Committee of the New Zealand Branch of the College.

141. Doctor Goodwin provided the Tribunal with very helpful evidence. He believed Dr Fisher's psychiatric experience in New Zealand had been restricted:

> "*…and limited only to areas offering a narrow range of services within the context of chronic staffing shortages*".[61]

142. Doctor Goodwin stressed that Dr Fisher is not a psychiatrist, even though his position description with the Southland DHB refers to "the psychiatrist" in two places. Doctor Goodwin believed Dr Fisher's position in the Southland MHS appeared to be largely that of a consultant psychiatrist and did not recognise the need for supervision of a non vocationally registered MOSS such as Dr Fisher.

143. Doctor Goodwin agreed with the observations of others (including Dr Fisher) that Dr Fisher's documentation and record keeping was inadequate.[62] Doctor Goodwin observed that:

> *"Dr Fisher appears to have been reactive to the comments made by nursing staff and other clinicians rather than being particularly proactive in management and the formulation of treatment plans."*[63]

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[61] Evidence of I Goodwin paragraph 18
[62] Evidence of I Goodwin paragraph 28
[63] Evidence of I Goodwin paragraph 29

Doctor Goodwin thought this reflected Dr Fisher's junior role in the Southland MHS.

144. Doctor Goodwin also told the Tribunal that:

> *"There appears to have been significant confusion in Dr Fisher's mind over exactly what his role was in any risk assessment process and, in particular, the contribution that other clinical staff (particularly nursing staff) may make to a formal risk assessment process ...Dr Fisher appears to have focused on [Mark's] risk to others in one environment only and not to have considered the wider ramifications of risk to others associated with an unstable mental state, alcohol and drug abuse, and [Mark's] enduring lack of insight."*[64]

Doctor Goodwin thought these deficiencies reflected Dr Fisher's relative lack of experience. Doctor Goodwin also suggested Dr Fisher's overall clinical performance was commensurate with the systems of care and standards of care within the in-patient Unit in which he was working.[65]

145. Doctor Goodwin was concerned that although Dr Fisher believed he was in a position to consult senior psychiatrists in the Southland MHS, it was not necessarily appropriate to rely on Dr Fisher to raise problems with his superiors.

146. Doctor Goodwin suggested Dr Fisher may not fully have appreciated the deficiencies in his level of knowledge and clinical practice. Doctor Goodwin also observed that Dr Fisher's lack of appreciation of his own deficiencies did not excuse these deficiencies:

> "*...but may provide some degree of understanding as to the level of practice that Dr Fisher felt was both adequate and normal within the setting that he practised ...".*[66]

<u>Dr A Fraser</u>

147. Doctor Allen Fraser is one of New Zealand's most experienced and respected psychiatrists. He became a Fellow of the Royal Australian and New Zealand College of

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[64] Evidence of I Goodwin paragraph 30

[65] Evidence of I Goodwin paragraph 33

[66] Evidence of I Goodwin paragraph 44

Psychiatrists in 1981 having obtained his MBChB from Otago in 1969. Doctor Fraser has qualifications in professional ethics and psychological medicine. He has recently been elected Chairperson of the New Zealand Branch of the College.

148. Doctor Fraser provided the Tribunal with a very thorough and comprehensive opinion on Dr Fisher's role in the management of Mark in February and March 2001. Doctor Fraser's opinion addressed Dr Fisher's conduct in relation to Mark's:

148.1 Admission.

148.2 Period as an in-patient (10 February to 21 March 2001).

148.3 Period of trial leave (22 to 30 March 2001).

148.4 Discharge (30 March 2001).

Admission

149. Doctor Fraser believed that because Mark was already known to the Southland MHS a different standard could be expected from Dr Fisher when admitting Mark, compared to the standard which would be expected in relation to a patient making an initial presentation. Doctor Fraser thought that:

> *"…as an admission assessment in an emergency and on a weekend … the range of information gathered was reasonable, despite the lack of detail".*[67]

150. Doctor Fraser informed the Tribunal that if Dr Fisher failed to inquire whether or not Mark had a history of violence then such an admission would have been a possible error by Dr Fisher.[68]

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[67] Evidence of A Fraser paragraph 18
[68] Evidence of A Fraser paragraph 21

151. Doctor Fraser believed Dr Fisher conducted a mental status examination when interviewing Mark on 10 February 2001, but that the record of the consultation indicated the mental status examination lacked depth.[69]

152. Doctor Fraser was concerned that during the admission interview Dr Fisher appeared to pay little attention to the relationship between the change in Mark's medication in January 2001 and the circumstances which led to the need for admission. Doctor Fraser said he:

> *"…would have expected an attempt would have been made at the initial assessment to work out with Mark Burton and his father the true relationship between the stopping of risperidone, the change to olanzapine, compliance with the medication and the deterioration of mental state leading to admission."*[70]

153. Doctor Fraser was not particularly concerned that Dr Fisher had not used the standard documentation and admission forms when assessing Mark. Doctor Fraser:

> *"… was more concern[ed] that Dr Fisher's notes convey[ed] insufficient information for any other person to be certain of the details of any aspect of the assessment. Another doctor becoming involved in the patient's care would either have to accept Dr Fisher's interpretations, without the opportunity to assess the information that led to those assessments, or seek the information elsewhere…"*[71]

154. Overall Dr Fraser thought that in the circumstances, Dr Fisher's admission note was barely adequate,[72] and that Dr Fisher:

> *"…conducted a reasonable assessment of the immediate situation he was faced with on the day of admission."*[73]

Dr Fraser said that although Dr Fisher's assessment was *"incomplete"* it should be judged on the basis that it was made at the time of admission and that the missing details

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[69] Evidence of A Fraser paragraph 24
[70] Evidence of A Fraser paragraph 27
[71] Evidence of A Fraser paragraph 30
[72] Evidence of A Fraser paragraph 33
[73] Evidence of A Fraser paragraph 43

would be completed within a few days of admission.[74] Dr Fraser thought the assessment note correctly conveyed the various details but was, nevertheless, *"unsatisfactory"*[75] and *"fell short of a reasonable standard"*[76]. Doctor Fraser believed the deficiencies should have been reviewed when Mark's medical file arrived, that is to say, on or about 14 February 2001.

Period as an in-patient (10 February to 21 March 2001)

155. Doctor Fraser was concerned about the quality of care provided to Mark whilst he was a patient in Ward 12. Doctor Fraser explained that a reasonable standard of care would involve:

155.1 Ensuring all the necessary information to inform treatment intentions had been gathered;

155.2 The early formulation of goals of admission; and

155.3 Regular evaluation by all members of the team of the patient's progress towards these goals.

Doctor Fraser said clinical assessments should focus on the patient's particular symptoms, and that the notes of all staff should reflect this.[77]

156. Doctor Fraser was concerned that Dr Fisher's notes of his meetings with Mark on 14, 19, 23, 26 February and 20 March made no reference to an assessment being made of Mark's mental state. Doctor Fraser's views about the inadequacy of Dr Fisher's evaluations of Mark whilst he was in Ward 12 were conveyed in a number of ways in his evidence. Doctor Fraser noted:

156.1 *"Dr Fisher failed to spend the amount of time at a single interview that would be necessary to systematically re-evaluate Mark Burton's thinking."*[78]

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[74] Evidence of A Fraser paragraph 43
[75] Evidence of A Fraser paragraph 44
[76] Evidence of A Fraser paragraph 50
[77] Evidence of A Fraser paragraph 56

156.2 *"It would have been reasonable practice to have continued to regularly evaluate the presence of [Mark's] delusions."*[79]

156.3 *"Furthermore, ... a Medical Officer Special Scale, or any other doctor subject to general oversight and/or supervision ... [should] ... at the very least have raised this issue [evaluation of delusions] at the weekly review meeting and preferably have asked one of the specialist psychiatrists to have interviewed Mark Burton."*[80]

156.4 Doctor Fisher knew Mark's admission stemmed from his threatening behaviour to his mother.

"A reasonable standard of care for an in-patient in these circumstances would be to regularly re-evaluate both the delusions and [Mark's] feelings towards his mother (in particular). There is no indication in the notes made by Dr Fisher, nor in his subsequent statement and responses that he did that."[81]

156.5 *"Doctor Fisher appears to have not formally re-evaluated the level of dangerousness resulting from the ongoing psychosis, which he also appears to have inadequately assessed. Such continual formal assessment is standard practice, especially when dangerousness has been the reason for admission."*[82]

157. Doctor Fraser believed the shortcomings he identified needed to be viewed in context. In his view it was inappropriate for Dr Fisher to have been left with the responsibility of initiating referral to a consultant.[83]

158. Doctor Fraser's analysis of the circumstances surrounding Dr Fisher's alleged failure to obtain a competent needs assessment for Mark was that there was a failure of the needs assessment service to complete the assessment in a timely fashion rather than a failure on Dr Fisher's part to seek a needs assessment.

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[78] Evidence of A Fraser paragraph 69
[79] Evidence of A Fraser paragraph 69
[80] Evidence of A Fraser paragraph 70
[81] Evidence of A Fraser paragraph 71
[82] Evidence of A Fraser paragraph 73
[83] Evidence of A Fraser paragraph 76

159. Doctor Fraser was concerned that there had been too much emphasis placed on Mark's abuse of alcohol and cannabis, and insufficient attention paid to his inadequate response to medication. Dr Fraser said:

> *"Rather than referring him elsewhere, the team needed to have had a focus on his mental illness."*[84]

Doctor Fraser was particularly concerned that there appeared to have been no examination of the correlation between changes in Mark's medication in January 2001 and his subsequent deterioration in mental health between his medication being changed and his admission. Doctor Fraser thought there should have been consultation and liaison between the Southland MHS and Dr Menkes, the psychiatrist who had altered Mark's medication in January 2001.

160. Doctor Fraser said he:

> *"… would have hoped Dr Fisher would have paid more attention than it seems he did, to the reports and notes of the nursing staff and of ongoing psychotic symptometology. His documentation should have reflected an awareness and consideration of these continuing psychotic symptoms."*[85]

Period of trial leave (22 to 30 March 2001)

161. Doctor Fraser was concerned:

> *"Doctor Fisher did not undertake a comprehensive re-evaluation of Mark Burton's mental state at any time after the admission interview. The longest assessment he conducted was apparently 15 minutes, and it is acknowledged that Mark Burton was guarded in what he would talk about. A reasonable expectation would be that he would have been re-assessed shortly before going on trial leave, and the results of that assessment clearly recorded, so as to form a 'base line' against which*

[84] Evidence of A Fraser paragraph 93
[85] Evidence of A Fraser paragraph 106

his state during the trial leave could be measured. This did not happen, and indicates a failure of practice."[86]

162. Further, Dr Fraser said in his evidence in chief:

"Reasonable practice would be a re-assessment of Mark Burton's pre-occupation with his delusions, his thoughts about and feelings towards his family (in particular his mother), and his use of alcohol both before and during the period of trial leave."[87]

163. Doctor Fraser told the Tribunal that it would be reasonable to expect a MOSS with 10 years experience to assess and treat most patients. However the complexities of Mark's case was such that in Dr Fraser's view Mark required the attention of a consultant psychiatrist before leaving Ward 12.[88]

Discharge (30 March 2001)

164. Doctor Fraser suggested the circumstances relating to the change in the discharge planning meeting on 30 March encapsulated the source of error in Mark's case. Doctor Fraser thought it instructive the meeting was brought forward 90 minutes to suit Mark and in order to ensure maintenance of the rapport between Mark and staff. As a consequence, at the time of discharge:

"... no one had assessed Mark Burton's ongoing delusions, and established the risk of violent action in response to those ideas."[89]

Doctor Fraser noted that Dr Fisher's

"...assessment of [Mark Burton's] mental state and consequently of the danger he posed to his mother remained as superficial as it had been throughout the in-patient process."[90]

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86 Evidence of A Fraser paragraph 110
87 Evidence of A Fraser paragraph 117
88 Evidence of A Fraser paragraph 119
89 Evidence of A Fraser paragraph 126
90 Evidence of A Fraser paragraph 128

Doctor Fraser believed that Dr Fisher's discharge assessment needed to be scrutinized by a specialist.

Part V - Evaluation of Evidence

165. The Tribunal has carefully evaluated the evidence presented to it and taken into account the helpful submissions made by counsel.

166. When assessing the accuracy of the memories of persons giving evidence of fact the Tribunal is mindful that Mrs Burton's death and the subsequent investigations by:

166.1 The Police,

166.2 The Invercargill Coroner, and

166.3 The Health and Disability Commissioner

as well as Mark's trial in August 2001 generated considerable stress for Dr Fisher and the other staff of the Southland DHB who gave evidence to the Tribunal. The stress caused by the tragic death of Mrs Burton and multiple investigations may well have affected the accuracy of the memories of some witnesses. If that has occurred it is very understandable. The Tribunal is in no doubt the Southland MHS has had to withstand penetrating scrutiny and that many within the service are feeling fragile as a consequence. The Tribunal will comment on its assessment of Dr Fisher's evidence in paragraphs 168 to 169 of this decision. It is not necessary for the Tribunal to comment on its assessment of the honesty and reliability of the nurses and other employees of the Southland DHB who gave evidence to the Tribunal. The Tribunal believes that although some of the memories of these witnesses have become affected by events since Mark's discharge, all endeavoured to give honest and helpful evidence to the Tribunal.

167. The Tribunal is particularly grateful for the expert testimony provided by doctors Patton, Goodwin and Fraser. There are aspects of the evidence of each of the experts' opinion which the Tribunal accepts and some aspects which it rejects. All three experts strived to provide the Tribunal with impartial, objective and meaningful evidence. The Tribunal has endeavoured to identify and justify what parts of the experts' opinion it has accepted when explaining its decision in relation to each particular of the charge.

168. The Tribunal has accepted some but not all of Dr Fisher's evidence. The Tribunal believes Dr Fisher has reconstructed some aspects of the events to caste him in the best possible light. In particular the Tribunal does not accept that Dr Fisher carried out the detailed mental state and risk assessments of Mark which he is now convinced he carried out between 14 February and 30 March 2001 (inclusive). The Tribunal very carefully assessed Dr Fisher's demeanour while he gave evidence and found itself obliged to draw some adverse conclusions about Dr Fisher's credibility. Aspects of Dr Fisher's evidence were either inconsistent with previous statements he had made or were difficult to follow, let alone accept. For example:

168.1 Doctor Fisher accepted he told the Invercargill Coroner that he *"only recorded in the medical notes [his] specific interactions with Mark."*[91] But he also said to the Tribunal that he had many *"… specific interactions with Mark while he was on the Ward that are not recorded in the notes."*[92]

When asked about the inconsistencies between these two statements Dr Fisher simply suggested that there was no consistency in his note keeping.[93] He did not satisfactorily explain the fundamental discrepancy between what he had previously told the Coroner (that he only recorded his specific interactions with Mark) and his suggestion to the Tribunal that there were many unrecorded specific interactions between Mark and himself.

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[91] Transcript p.421 l. 10-18
[92] Transcript p.420 l. 12-17
[93] Transcript p.421 l.38

168.2 Doctor Fisher was challenged why he had not told Mr Trevor Burton about Mark's use of alcohol and other incidents that occurred when Mark was in Ward 12 to enable Mr Trevor Burton to provide informed input into Mark's trial leave/discharge. In a series of confusing and conflicting responses Doctor Fisher said:

> *"Mr Trevor Burton was aware of Mark's behaviour so far as alcohol was concerned;"*[94]
>
> And acknowledged he (Dr Fisher)
>
> *"…did not tell Mr Trevor Burton about Mark's alcohol use or the incidents that had occurred on the Ward;"*[95]
>
> But that he expected Mr Trevor Burton to give his input with the information he required;[96]
>
> And
>
> *"[Mr Burton] asked for the information he wanted;"*[97]
>
> And he, (Dr Fisher)
>
> *"… didn't know what [Mr Trevor Burton] knew and what he didn't know."*[98]
>
> Dr Fisher also said he could not volunteer information to Mr Trevor Burton about Mark because of the constraints of the Privacy Act 1993.[99] But he also acknowledged that Mark had signed a form consenting to the disclosure of information about himself to his father,[100] and that he (Dr Fisher) thought this meant

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[94] Transcript p.430 l.48
[95] Transcript p.431 l. 1-4
[96] Transcript p.431 l.11-12
[97] Transcript p.431 l.20
[98] Transcript p.431 l.25-26
[99] Transcript p.431 l.31-38
[100] Transcript p.431 l.31-38

he could not volunteer information to Trevor Burton about Mark.[101]

168.3 Doctor Fisher's failure to fully utilise the risk assessment and risk alert forms on Mark's admission were also difficult to comprehend.

- Doctor Fisher said *"…the mental health service assessment forms [were] not available to [him] over the weekend. Had the forms been available [he] would have used them".*[102] In fact Dr Fisher had access to at least two of the forms

- When questioned why he put a line through the risk assessment form on 10 February Dr Fisher told the Tribunal that he knew that the Southland MHS policy on clinical risk assessment and management required the *"assessment of risk sheet to be completed on admission for all patients by [the] admitting doctor and nurse and thereafter daily by [the] responsible clinician/psychiatrist and assigned nurse, until routine observation level is reached."*[103]

- Doctor Fisher suggested the policy referred only to the risk alert sheet,[104] which Dr Fisher had partially completed.

- When questioned further about the Southland MHS policy specifically referring to the risk assessment sheet Dr Fisher suggested the policy *"lacked clarity"*[105]

- Doctor Fisher was adamant that despite the wording of the Southland MHS policy he was only obliged to complete the risk alert sheet.[106]

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[101] Transcript p.431 l.44-49; p.495 l.14-29
[102] Evidence of P Fisher paragraph 18
[103] Transcript p.336 l. 25-35
[104] Transcript p.336 l.35
[105] Transcript p. 336 l.40
[106] Transcript p.339 l.6-10

- Doctor Fisher also said the risk alert sheet was:

  "A document of a risk assessment"[107]

  and

  "… assumes a knowledge of the matters to be contained in a risk assessment".[108]

- Doctor Fisher also said the risk assessment sheet was to be completed by the Community Mental Health Team, a member of the emergency team or a person familiar with the patient.[109]

- Doctor Fisher also told Dr Patton that the assessment of risk sheet would be completed at the time of Mark leaving the Ward.[110]

In fact the assessment of risk form for Mark was never completed.

169. The Tribunal was not impressed by Dr Fisher's contradictory and confusing statements about responsibility for completing the risk assessment form. In making these comments the Tribunal also accepts that failure to complete the prescribed forms is not in itself a serious matter provided the information sought by the forms is properly recorded in the patient's notes. Doctor Fisher did not do this.

Part VI – Legal Principles

Standard and Onus of Proof

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[107] Transcript p.339 l.15-21
[108] Transcript p. 339 l.27-32
[109] Transcript p.339 l.28-36
[110] Evidence of M Patton paragraph 50

170. The allegations levelled against Dr Fisher are very serious. Accordingly the onus placed upon the Director of Proceedings to establish the charge requires a high standard of proof. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand*[111] where the High Court adopted the following passage from the judgment in *Re Evatt: ex parte New South Wales Bar Association*[112]

> *"The onus of proof is upon the Association but is according to the civil onus. Hence proof in these proceedings of misconduct has only to be made upon a balance of probabilities; Rejfek v McElroy.[113] Reference in the authorities to the clarity of the proof required where so serious a matter as the misconduct (as here alleged) of a member of the Bar is to be found, is an acknowledgement that the degree of satisfaction for which the civil standard of proof calls may vary according to the gravity of the fact to be proved".*

171. The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand*[114] where it was emphasized that the civil standard of proof must be tempered "having regard to the gravity of the allegations". This point was also made by Greig J in *M v Medical Council of New Zealand (No.2)*[115]:

> *"The onus and standard of proof is upon the[respondent] but on the basis of a balance of probabilities, not the criminal standard, but measured by and reflecting the seriousness of the charge".*

172. In *Cullen v The Medical Council of New Zealand*[116] Blanchard J adopted the directions given by the legal assessor of the Medical Practitioners Disciplinary Committee on the standard required in medical disciplinary fora.

> *"The MPDC's legal assessor, Mr Gendall correctly described it in the directions which he gave the Committee:*
>
> *'[The] standard of proof is the balance of probabilities. As I have told you on many occasions, ... where there is a serious charge of professional misconduct you have got to be sure. The degree of certainty*

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111 (1984) 4 NZAR 369
112 (1967) 1 NSWLR 609
113 [1966] ALR 270
114 [1989] 1 NZLR 139 at 163
115 Unreported HC Wellington M 239/87 11 October 1990
116 Unreported HC Auckland 68/95, 20 March 1996

> *or sureness in your mind is higher according to the seriousness of the charge, and I would venture to suggest it is not simply a case of finding a fact to be more probable than not, you have got to be sure in your own mind, satisfied that the evidence establishes the facts'".*

173. In this case where the Tribunal has made findings adverse to Dr Fisher it has done so because the evidence satisfies the test as to the onus of proof set out in paragraphs 170 and 172 of this decision. Indeed, the particulars where the Tribunal finds Dr Fisher's conduct constitutes professional misconduct the Tribunal believes the evidence against Dr Fisher is very compelling.

Disgraceful Conduct in a Professional Respect

174. The Director of Proceedings urged the Tribunal to find Dr Fisher guilty of disgraceful conduct. A charge of "disgraceful conduct in a professional respect" is reserved for the most serious instances of professional disciplinary offending. Doctors found guilty of disgraceful conduct in a professional respect are at risk of having their name removed from the register of medical practitioners. In *Duncan v Medical Practitioners Disciplinary Committee*[117] the Court of Appeal said:

> *"A charge of disgraceful conduct in a professional respect has been described by the Privy Council as alleging conduct deserving of the most serious reprobation."*[118]

This observation succinctly conveys the seriousness of a charge of disgraceful conduct in a professional respect.

175. Mr Hodson QC accepted that clinical acts and omissions by a doctor can amount to disgraceful conduct. That concession was appropriate in light of the High Court's decision in *Director of Proceedings v Parry*[119] in which Paterson J said that:

> *"…serious negligence of a non deliberate nature can in appropriate cases constitute disgraceful conduct,"* and

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[117] [1986] 1 NZLR 513
[118] Citing *Felix v General Dental Council* [1960] AC 704; *McEniff v General Dental Council* [1980] 1 All ER 461.
[119] Unreported, High Court, Auckland, AP61-SWO1, 15 October 2001

> *"... under the definition of 'disgraceful conduct' as I find it to be, a practitioner can commit an offence by one act of gross negligence if that act, although not deliberate, is an abuse of the privileges which accompany registration as a medical practitioner".*

176. In relation to the seventeen particulars which the Tribunal finds proven it is satisfied Dr Fisher's acts and omissions fall short of disgraceful conduct. The Tribunal records however that many of Dr Fisher's failings were very serious and have come close to constituting disgraceful conduct when viewed cumulatively. In making this assessment the Tribunal has carefully evaluated its findings and compared Dr Fisher's errors to other doctors found guilty of disgraceful conduct.

<u>Professional Misconduct</u>

177. In recent years, those attempting to define professional misconduct have invariably commenced their analysis by reference to the judgment of Jefferies J in *Ongley v Medical Council of New Zealand*[120]. In that case his Honour formulated the test as a question:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? ... The test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the position of the Tribunal which examined the conduct."*

178. In *Pillai v Messiter* [No.2][121] the New South Wales Court of Appeal signalled a slightly different approach to judging professional misconduct from the test articulated in *Ongley*. In that case the President of the New South Wales Court of Appeal considered the use of the word "misconduct" in the context of the phrase "misconduct in a professional respect". In his view, the test required more than mere negligence. At page 200 of the judgment Kirby P. stated:

> *"The statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession. Something more is*

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120 supra.

121 (1989) 16 NSWLR 197.

> *required. It includes a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner."*

179. In *B v The Medical Council*[122] Elias J said in relation to a charge of "conduct unbecoming" that:

> *"... it needs to be recognised conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards".*

Her honour then proceeded to state:

> *"That departure must be significant enough to attract a sanction for the purposes of protecting the public. Such protection is a basis upon which registration under the Act, with its privileges, is available. I accept the submission of Mr Waalkens that a finding of unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which is unfair to impose. The question is not whether the error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligation."*

Her Honour also stressed the role of the Tribunal and made the following invaluable observations:

> *"The inclusion of lay representatives in the disciplinary process and the right of appeal to this Court indicates the usual professional practice while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the Court to determine, taking into account all the circumstances including not only usual practice, but patient interest and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards."*

180. In *Staite v Psychologists Board*[123] Young J traversed recent decisions on the meaning of professional misconduct and concluded that the test articulated by Kirby P in *Pillai* was the appropriate test for New Zealand.

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[122] Unreported HC Auckland , HC11/96, 8 July 1996

[123] (1998) 18 FRNZ 18.

181. In referring to the legal assessor's directions to the Psychologists Board in the *Staite* case, Young J said at page 31:

> *"I do not think it was appropriate to suggest to the Board that it was open, in this case, to treat conduct falling below the standard of care that would reasonably be expected of the practitioner in the circumstances – that is in relation to the preparation of Family Court Reports as professional misconduct. In the first place I am inclined to the view that "professional negligence" for the purposes of Section 2 of the Psychologists Act should be construed in the Pillai v Messiter sense. But in any event, I do not believe that "professional negligence" in the sense of simple carelessness can be invoked by a disciplinary [body] in [these] circumstances ...".*

182. In *Tan v Accident Rehabilitation Insurance Commission*[124] Gendall and Durie JJ considered the legal test for "professional misconduct" in a medical setting. That case related to a doctor's inappropriate claims for ACC payments. Their Honours referred to *Ongley* and *B v Medical Council of New Zealand.* Reference was also made in that judgment to *Pillai v Messiter* and the judgment of Young J in *Staite v Psychologists Registration Board.*

183. In relation to the charge against Dr Tan the Court stated at page 378:

> *"If it should happen that claims are made inadvertently or by mistake or in error then, provided that such inadvertence is not reckless or in serious disregard of a practitioner's wider obligations, they will not comprise "professional misconduct". If however, claims for services are made in respect of services which have not been rendered, it may be a reasonable conclusion that such actions fell seriously short of the standard required of a competent and reasonable practitioner. This may be especially the case if such claims are regularly made so as to disclose a pattern of behaviour".*

184. In the Tribunal's view, the test as to what constitutes professional misconduct has changed since Jefferies J. delivered his judgment in *Ongley*. In the Tribunal's view the following are the crucial considerations when determining whether or not conduct constitutes professional misconduct:

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[124] (1999) NZAR 369

- The first portion of the test involves an objective evaluation of the evidence and answer to the following question:

  Has the doctor so behaved in a professional capacity that the established acts and/or omissions under scrutiny would be reasonably regarded by the doctor's colleagues and representatives of the community as constituting professional misconduct?

- If the established conduct falls below the standard expected of a doctor, is the departure significant enough to attract a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the doctor?

185. The words "representatives of the community" in the first limb of the test are essential because today those who sit in judgment on doctors comprise three members of the medical profession, a lay representative and chairperson who must be a lawyer. The composition of the medical disciplinary body has altered since Jeffries J delivered his seminal decision in *Ongley*. The new statutory body must assess a doctor's conduct against the expectations of the profession and society. Sight must never be lost of the fact that in part, the Tribunal's role is one of setting standards and that in some cases the community's expectations may require the Tribunal to be critical of the usual standards of the profession.[125]

186. This second limb to the test recognises the observations in *Pillai v Messiter, B v Medical Council, Staite v Psychologists Board* and *Tan v ARIC* that not all acts or omissions which constitute a failure to adhere to the standards expected of a doctor will in themselves constitute professional misconduct.

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[125] *B v Medical Practitioners Disciplinary Tribunal* (supra); *Lake v The Medical Council of New Zealand* (unreported High Court Auckland 123/96, 23 January 1998, Smellie J) In which it was said: "If a practitioner's colleagues consider his conduct was reasonable the charge is unlikely to be made out. But a Disciplinary Tribunal and this Court retain in the public interest the responsibility of setting and maintaining reasonable standards. What is reasonable as Elias J said in *B* goes beyond usual practice to take into account patient interests and community expectations".

187. In *McKenzie v MPDT*[126] Venning J endorsed the two question approach of this Tribunal when considering whether or not a doctor's acts/omissions constitute professional misconduct. The same judgment of the High Court cautioned against reliance in this country upon the recent judgment of the Privy Council in *Silver v General Medical Council.*[127] In that judgment it was said the general Medical Council could take into account subjective factors relating to the circumstances in which a doctor practised when assessing whether or not the doctor should be held liable in respect of a disciplinary charge. The Director of Proceedings submitted that the judgment of Venning J prevented the Tribunal from following the approach taken by the Privy Council in *Silver.* Mr Hodson accepted the Tribunal was bound to follow what was said in *McKenzie.*

<u>Conduct Unbecoming</u>

188. Mr Hodson alluded to the possibility of the Tribunal considering a finding of conduct unbecoming a medical practitioner pursuant to s.109(1)(c) of the Act. Even if, as a matter of law, such a finding were possible the Tribunal believes Dr Fisher's errors and omissions were so serious they could never be objectively regarded as conduct unbecoming a medical practitioner.

Applying the Correct Test

189. It was suggested on a number of occasions on behalf of Dr Fisher that *"he did not know what he didn't know"*[128], and that Dr Fisher's lack of appreciation of his own clinical limitations should be taken into account in assessing his culpability. The Tribunal disagrees. The truism that Dr Fisher *"did not know what he didn't know"* does not provide an answer to the questions posed in paragraph 184 of this decision. In assessing Dr Fisher's liability the Tribunal has answered the questions set out in paragraph 184 to each particular allegation in the notice of charge.

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[126] Unreported, High Court Auckland, CIV 2002-404-153-02, 12 June 2003, see also *F v MPDT* High Court Auckland, AP113/02, 20 November 2003, Frater J

[127] [2003] UK, PC33

[128] Transcript p.619 l. 1-9

Part VII – Tribunal's Findings in Relation to Each Particularised Allegation of the Charge

190. In this part of its decision the Tribunal explains its findings in relation to all 27 particulars and sub-particulars of the charge. It is convenient however to record in a generic manner the Tribunal's findings in relation to the allegations in the charge Dr Fisher failed to record, or adequately record his clinical observations, findings, assessments, and plans. These allegations can be found in 12 paragraphs and sub-paragraphs of the charge, namely 1.2, 2.1, 2.2, 2.5(a), (b), (c), 3.1, 3.2, 3.4, 4.1, 4.2 and 4.5.

191. Each of the allegations relating to inadequate record keeping referred to in paragraph 190 have been established. The Tribunal has found Dr Fisher's record keeping failed to adhere to the standards reasonably expected of a MOSS practising in a psychiatric unit in New Zealand in 2001. Furthermore, Dr Fisher's failure to adhere to the standards expected of him are sufficiently serious to justify a disciplinary finding against him for the purpose of protecting the public and maintaining professional standards.

192. All of the experts who gave evidence commented on Dr Fisher's poor record keeping. Doctor Patton described Dr Fisher's entries in Mark's medical notes for 10 February as *"scanty"*[129], and that his brief notes made for the balance of Mark's admission fell well below accepted professional standards of care.[130] Doctor Goodwin agreed that Dr Fisher's documentation was *"inadequate"*.[131] Doctor Fraser thought aspects of the admission note *"as a guide to the immediate and short term management [of Mark]"*[132] were barely adequate. In other respects Dr Fraser thought the level of documentation provided by Dr Fisher was inadequate, and fell below reasonable standards.[133] Doctor Fisher candidly acknowledged his notes and record keeping were deficient.[134] In cross examination Dr Fisher acknowledged that his record keeping in this case was *"woefully inadequate"*[135].

[129] Evidence of M Patton paragraph 35
[130] Evidence of M Patton paragraph 144
[131] Evidence of I Goodwin paragraph 28
[132] Evidence of A Fraser paragraph 33
[133] Evidence of A Fraser paragraphs, 42, 44 and 50
[134] Evidence of P Fisher paragraph 18
[135] Transcript p.422 l.50, p.423 l.1

These observations were entirely appropriate. After *Mark*'s admission on 10 February Dr Fisher made just six very brief entries in *Mark*'s notes. These entries were made on 14, 19, 23 and 26 February, 20 and 30 March. It is not necessary to repeat those entries in this decision. They are very brief, uninformative and grossly inadequate.

193. It is necessary to stress the importance of clear and informative medical notes. These observations relate to all branches of medicine but are particularly pertinent to disciplines such as psychiatry where the care and management of a patient is a team effort. The Tribunal fully endorses Dr Patton's comments,[136] supported by Dr Fraser,[137] that full and clear documentation of mental state assessments is critical for the following reasons:

193.1 Documentation of mental state in a particular admission provides the base line against which the patient's mental state and progress of treatment can be measured. This is especially important at critical points of the patient's care – admission, leave and discharge.

193.2 As multi disciplinary teams are the common model of care, documentation provides an important and often primary means of communication between members of the team.

193.3 In chronic relapsing illnesses, documentation of a patient's progress and presentation permits future clinicians involved in the patient's care to analyse patterns of illness and to take into account relevant history in assessment and treatment of the presentation (which is particularly important in the assessment of risk).

194. It is also "*exceedingly important*"[138] that a medical practitioner such as Dr Fisher charged with the responsibility of caring for patients like Mark fully and accurately record their clinical observations, management, treatment and crisis plan. Doctor Fisher failed to adequately discharge his responsibility to perform these basic tasks.

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[136] Evidence of M Patton paragraphs 139 – 144 inclusive
[137] Transcript p.640 l.30 p.642 l.1
[138] Transcript A Fraser p.640 l.36

Particular 1.1 On 10 February 2001 Dr Fisher failed to adequately assess Mark Burton's:

(a) **psychiatric and/or forensic and/or social and/or medical history; and/or**

(b) **phenomenology of mental state; and/or**

(c) **alcohol and drug history; and/or**

(d) **precipitants of admission; and/or**

(e) **prior response to, and adverse affects of, his previous and current treatment; and/or**

(f) **risk.**

195. The Tribunal has found that although there were a number of significant deficiencies in Dr Fisher's assessment of Mark on 10 February, the deficiencies do not justify a disciplinary finding. That is to say, the Tribunal has applied the second limb of the test of professional misconduct in favour of Dr Fisher. The Tribunal has reached this conclusion because of Dr Fraser's advice that deficiencies in the admission assessment could be excused because:

195.1 The admission was an emergency; and

195.2 Occurred on a weekend; and

195.3 It would be normal for a full and thorough assessment to be completed within a few days of admission to remedy deficiencies that occurred at the time of admission.

Having made these findings, the Tribunal notes that Dr Fraser's experience in a very big urban psychiatric unit may not mirror the circumstances Dr Fisher faced on 10 February. Although it was a weekend and the admission was an emergency Dr Fisher did not suggest he was labouring under the constraints of time or other pressures. Nevertheless, the Tribunal believes a MOSS practising in Dr Fisher's circumstances could be excused for deficiencies in an admission assessment provided these deficiencies were remedied when the patient's full medical file was made available to Dr Fisher (ie on or about 14 February 2001). However particular 1.1 of the charge focuses only on Dr Fisher's conduct on 10

February and does not permit the Tribunal to find against him (in relation to particular 1.1) for his ongoing deficiencies after 10 February 2001.

196. The Tribunal will briefly explain why it regards aspects of Dr Fisher's admission assessment to have been deficient and below the standard expected of a MOSS practising in a psychiatric unit in New Zealand in 2001 (even though a disciplinary finding is not justified in relation to this particular of the charge).

Relevant psychiatric, forensic, social and medical history

197. Doctor Patton told the Tribunal Dr Fisher failed to obtain sufficient information about Mark's relevant psychiatric, forensic, social and medical history on admission. Doctor Fisher refuted this saying that he obtained the relevant information but failed to adequately record that information in Mark's notes.

198. The Tribunal is satisfied Dr Fisher probably did obtain an overview of Mark's psychiatric, social and medical history from the Southern Mental Health Emergency Team when they contacted Dr Fisher on 10 February and asked him to assess Mark. Doctor Fisher also obtained brief information about Mark's psychiatric, social and medical history from Mr Trevor Burton during the admission interview.

199. The Tribunal is also satisfied Dr Fisher made no inquiry about Mark's forensic history. Mr Trevor Burton told the Tribunal

> *"There was no discussion [during the admission interview] about any history of violence with Mark. To the best of [his]knowledge Mark had been diverted only once, in relation to theft … none of that was discussed at the admission interview."*[139]

200. The Tribunal was impressed by Mr Trevor Burton's honesty and his clear willingness to ensure Dr Fisher obtained all relevant information about Mark. The Tribunal accepts Mr Trevor Burton's recollection of events and believes Dr Fisher failed to make any inquiries about Mark's forensic history. This conclusion is reinforced by the fact that there is no

[139] Evidence of T Burton paragraph 53

reference to forensic history in the admission note of 10 February. The nurse present at the admission did not suggest Dr Fisher inquired into Mark's forensic history.

201. Both Dr Patton and Dr Fraser stressed the importance of obtaining information about a patient's forensic history on admission.[140] Information about a patient's forensic history is crucial to assessing their level of risk.

<u>Phenomenology of Mental State</u>

202. Doctor Fisher thought that he had obtained *"a clear picture of [Mark Burton's] mental state"*[141] on admission. Doctor Fisher was concerned not to *"push or force"*[142] Mark into engaging, as he would have plenty of time to assess him during his admission.

203. Doctor Patton told the Tribunal that Dr Fisher recorded insufficient detail about phenomenology on admission. He believed a full mental state examination was essential in order to ascertain the acuity of the patient's illness, the treatment that should be implemented and to provide a base line against which to measure progress and changes. At the very least there should have been inquiry about Mark's delusional thoughts.[143]

204. Doctor Fraser also expressed concerns about Dr Fisher's limited exploration of Mark's ideas of reference and paranoia.[144]

205. The Tribunal is in no doubt Dr Fisher failed to fully and properly examine Mark's mental state on admission. Mental state examinations are rudimentary. They are often undertaken by psychiatric nurses and house surgeons. Doctor Fisher should have been able to discharge this basic requirement. He did not do so adequately, and in accordance with the standards expected of a MOSS practising in a psychiatric unit in New Zealand in 2001.

<u>Alcohol and Drug History</u>

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[140] Transcript p.158 l.31-48, Evidence of A Fraser paragraphs 19-21
[141] Evidence of P Fisher paragraph 31
[142] Evidence of P Fisher paragraph 31
[143] Evidence of M Patton paragraphs 31 and 32
[144] Evidence of A Fraser paragraph 17

206. Mr Trevor Burton told the Tribunal Dr Fisher did not attempt to ascertain the extent of Mark's alcohol and drug use.[145] Doctor Fisher did make some inquiries about Mark's alcohol and drug use. His admission note refers to:

> *"Alcohol +*
> *Cannabis ++"*

Doctor Fisher said that he gained the impression Mark presented as *"an opportunistic user of substances."*[146]

207. As with most aspects of the admission process there was an inadequate exploration of the extent of Mark's use of alcohol and drugs in order to enable those caring for Mark to gain an appreciation of the relationship between his symptoms and use of substances. Doctor Fisher should have explored and analysed in a meaningful way the quantity, frequency of use, circumstances of use and features of Mark's dependency (if any).

<u>Precipitates for Admission</u>

208. Doctor Fisher understood the precipitating event to be Mark's threats to his mother and his barricading of himself in his bedroom. Although he gained little information about the events precipitating admission Dr Fisher appears to have gained the minimal acceptable amount of information that could be expected in the circumstances.

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[145] Evidence of T Burton paragraph 51
[146] Evidence of P Fisher paragraph 22

Response to and Adverse Effects of Previous Treatment

209. Doctor Fisher did obtain information about Mark's current and past medication regimens prior to his arriving at Ward 12. However, there appears to have been insufficient consideration given to exploring the effect of terminating risperidone, the change to olanzapine, compliance with the medication and the deterioration in Mark's mental state leading to his admission. Doctor Fraser said he would have expected an attempt to have been made on admission to explore the relationship between Mark's deteriorating mental state and changes to his medication in January 2001.[147]

Risk Assessment

210. Doctor Fisher completed part of the Southland MHS risk alert form. He and nurse I recorded on the risk alert sheet that Mark was category one, ie "no increased risk". The risk alert form requires an assessment to be made of the patient's risk of harm to others, suicide/self harm, sexual risk and the risk of unauthorised departure. A full assessment of risk also addresses other domains of risk including non adherence to a treatment programme, and the risk of substance abuse.[148]

211. Like Dr Fraser, the Tribunal is not overly concerned that Dr Fisher appears to have completed only part of the risk alert sheet. The risk alert sheet, and assessment of risk forms provide persons in Dr Fisher's position with an easy to follow set of guidelines. If Dr Fisher had incorporated in the patient's notes the information which the forms attempted to elicit then he could not have been criticised by the Tribunal.

212. Of significant concern is that Dr Fisher appears to have had a myopic view of assessing risk. He told the Tribunal that risk assessment related only to the patient's level of risk while on the Ward.[149] Both Dr Patton and Dr Goodwin told the Tribunal that an adequate assessment of risk should include an assessment of the patient's risk to others who may or may not be in the Ward. Doctor Patton said:

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[147] Evidence of A Fraser paragraph 27
[148] Evidence of M Patton paragraph 43
[149] Evidence of P Fisher paragraph 41

> *"... without knowing whether someone might have ideas of risk of harm to themselves or other people, no proper decision could be made about what level of observation should be provided to them while an in-patient, or whether they should have leave from the Ward."*[150]

Doctor Goodwin was also concerned that:

> *"Dr Fisher appears to have focussed on Mr Burton's risk to others in one environment only and not to have considered the wider ramifications of risk to others associated with an unstable mental state, alcohol and drug abuse, and Mr Burton's enduring lack of insight".*[151]

213. Doctor Fisher told the Tribunal he had no formal training in undertaking risk assessments. However, conducting a risk assessment is a fundamental requirement for any doctor working in a psychiatric unit. Doctor Fisher was familiar with the Ministry of Health's guidelines on conducting assessments, and the Southland MHS's policy on risk assessment. Furthermore he acknowledged in cross examination that he could undertake risk assessments.[152]

214. The Tribunal believes any reasonable and competent MOSS working in a psychiatric unit in New Zealand in 2001 should be able to undertake a full and comprehensive risk assessment. The risk assessment performed by Dr Fisher was inadequate in that it did not properly and fully evaluate Mark's potential risk to his mother and other members of his family. This was a significant deficiency.

215. Having identified the deficiencies in Dr Fisher's admission assessment, the Tribunal reiterates that it accepts that Dr Fisher's shortcomings on 10 February can be excused on the grounds that it was an emergency weekend admission. The shortcomings which have been referred to by the Tribunal should have been remedied within a few days of Mark's admission. The fact they were not does not enable the Tribunal to make adverse findings in relation to particular 1.1 of the charge which is confined solely to Dr Fisher's conduct on 10 February 2001.

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150 Evidence of M Patton paragraph 44

151 Evidence of I Goodwin paragraph 30

152 Transcript p.306 l.25-28

Particular 2.1 - Between 10 February and 21 March 2001 Dr Fisher failed to undertake and/or record a thorough and systematic review of Mark's mental state.

216. The Tribunal has already recorded its finding that Dr Fisher failed to record a thorough and systematic review of Mark's mental state for the period he was an in-patient.

217. The Tribunal is also satisfied Dr Fisher failed to undertake a thorough and systematic review of Mark's mental state between 10 February and 21 March 2001. Doctor Fisher's failure to perform this basic task was a significant breach of the standards reasonably expected of a MOSS practising in a psychiatric unit in New Zealand in 2001. Furthermore, Dr Fisher's failings in this regard justify a disciplinary finding against him in order to protect the public and maintain professional standards.

218. The evidence which the Tribunal has relied upon when reaching its conclusion in relation to allegation 2.1 of the charge can be succinctly stated.

219. Doctor Fisher maintained he undertook systematic reviews of Mark's mental state on many occasions during the period Mark was a patient in Ward 12, but that he failed to record the details of those reviews. Doctor Fisher told the Tribunal that his reviews of Mark occurred through his regular:

219.1 Contact with the patient;

219.2 Discussions with nursing staff;

219.3 Reference of Mark's case to weekly unit review meetings;

219.4 Reference of Mark's case to weekly clinical reviews; and

219.5 Discussions with Mr Trevor Burton.

Doctor Fisher accepted that Mark's "psychotic process remained"[153] throughout the time he was an in-patient. He also believed that there was evidence of Mark improving through his demeanour, general interactions and behaviour in the ward setting.

220. The Tribunal believes Dr Fisher conducted only cursory reviews of Mark's mental state while he was a patient in Ward 12. The Tribunal's reasons for reaching this conclusion are:

220.1 None of the six entries made by Dr Fisher during the time Mark was a patient reflect evidence of either a comprehensive assessment of the patient or an appropriate approach to treatment. There is nothing in the clinical notes to suggest that an assessment of Mark's delusions was properly explored. There is also nothing to suggest that specific incidents (such as some acts of aggression on 24 February and 12 March) were properly explored by Dr Fisher.

220.2 Doctor Fraser was clearly concerned about the inadequacy of Dr Fisher's review of Mark's mental state during his period as an in-patient. Basing his opinion on Dr Fisher's notes, Dr Fisher's brief of evidence and Dr Fisher's responses to the inquiry chaired by Dr Patton, Dr Fraser said:

> *"Doctor Fisher failed to spend the amount of time at a single interview that would have been necessary to systematically re-evaluate Mark Burton's thinking."*[154]

Doctor Fraser also said he:

> *"…would have hoped that Dr Fisher would have paid more attention than it seems he did to the reports and the notes by nursing staff of ongoing psychotic symptomentology."*[155]

220.3 Doctor Patton's evidence, based on his assessment of the medical notes and his interview of Dr Fisher caused him to conclude Dr Fisher did not adequately explore Mark's specific symptoms and/or deal specifically with identified positive

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[153] Evidence of P Fisher paragraph 59
[154] Evidence of A Fraser paragraph 69

symptoms. Doctor Patton opined that if Dr Fisher was not able to explore issues about a patient's mental state then he should have raised those concerns with a consultant. More specifically Dr Patton was concerned that Dr Fisher failed to properly and actively explore incidents which should have alerted Dr Fisher to the need to examine Mark's thought processes. Doctor Patton believed the incidents relating to misuse of alcohol, threatening behaviour, and the placing by Mark of a cassette tape to his door handle were examples of incidents that should have prompted further inquiry by Dr Fisher.

221. The Tribunal is in no doubt Dr Fisher believed he was:

221.1 Not out of his depth and fully able to conduct a mental state assessment of Mark; and

221.2 Failed to appreciate the mental state assessments he did conduct were inadequate.

Particular 2.2 – Between 10 February and 12 March Dr Fisher failed to undertake and/or record an adequate assessment of Mark Burton's Risk.

222. It is not necessary to reiterate the Tribunal's finding that Dr Fisher failed to adequately record an assessment of Mark's risk while he was a patient.

223. Doctor Fisher did make entries on the risk alert sheet on 14 February. He again assessed Mark's risk as category one. Doctor Fisher undertook this exercise after he received Mr Trevor Burton's letter.[156] Again Dr Fisher adopted an narrow and inappropriately restrictive view of risk assessment. He believed that while Mark remained an in-patient he was not a risk to his mother and family and therefore, these concerns were not relevant to risk assessment.

224. The Tribunal is in no doubt Dr Fisher failed in his duty to ascertain the extent and nature of Mark's delusions, and what these delusions meant in terms of his ongoing level of dangerousness. A MOSS practising in a psychiatric unit in New Zealand in 2001 should

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[155] Evidence of A Fraser paragraph 106

[156] Evidence of P Fisher paragraph 68

readily have identified and explored these matters as part of their obligation to undertake an adequate assessment of the patient's risk. The Tribunal finds itself fully agreeing with the following observations of Dr Fraser when he said:

> *"Connected with the failure to ascertain the extent and nature of Mark Burton's continuing delusions, is the failure to adequately assess what these delusions meant in terms of his ongoing level of dangerousness. Dr Fisher knew that admission resulted from threatening behaviour by Mark Burton towards his mother, and he was made aware that the family believed these threats were the result of his delusions. A reasonable standard of care for an in-patient in these circumstances would be to regularly re-evaluate both the delusions and his feeling towards his mother (in particular). There is no indication in the notes made by Dr Fisher, nor in his subsequent statement and responses, that he did that.*
>
> *Dr Fisher reported in his statement (page 20) that on 20 March 2001 Mark Burton was still having delusional thinking, and "*his belief that his brother and mother went into his bedroom while he was asleep was also still present." *There is no indication in the medical record that any member of the staff, including Dr Fisher, evaluated this in respect of the potential danger Mark Burton thereby posed to his mother and siblings, either then or at any other time during the inpatient stay.*
>
> *Other than repeating (on 14 February 2001) his initial evaluation of risk as "not increased" (apparently in response to the arrival on the ward of Mr Trevor Burton's letter), Dr Fisher made no further entries in the file with respect to evaluating whether or not he believed that Mark Burton would act aggressively as a consequence of his delusions. It is obvious that Dr Fisher did not expect the dreadful events that followed discharge, and it is also true that nor did anyone else. Nevertheless, Dr Fisher appears to have not formally re-evaluated the level of dangerousness resulting from the ongoing psychosis, which he also appears to have inadequately assessed. Such continued formal assessment is standard practice, especially when dangerousness has been the reason for admission.*[157]

225. Doctor Fisher's failure to undertake an adequate assessment of Mark's risk while he was an in-patient was a significant error. Doctor Fisher's failings in this regard justify a disciplinary finding in order to protect the public and maintain professional standards.

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[157] Evidence of A Fraser paragraph 71 to 73

Particular 2.3 – Between 10 February and 21 March 2001 Dr Fisher failed to follow up and/or review Mark Burton's:

(a) Alcohol and drug assessment; and/or

(b) Needs assessment.

226. The Tribunal has found in favour of Dr Fisher in relation to both limbs of this particular allegation of the charge.

227. The Tribunal has concluded Dr Fisher did not fail in his duty when he refrained from "following up and/or reviewing" Mark's alcohol and drug assessment. The Tribunal has reached this conclusion because it accepts Dr Fisher had sound grounds for believing there were no residential and counselling programmes available to Mark because he displayed no willingness to desist from abusing alcohol and drugs. In these circumstances Dr Fisher can be forgiven for not following up and/or reviewing Mark's alcohol and drug assessment.

228. The Tribunal has concluded that whilst it was unfortunate no one appears to have "followed up" the obtaining of a needs assessment report on Mark, Dr Fisher cannot be held accountable for this shortcoming. The needs assessment was requested by nurse I on 12 February 2001. The needs assessment interview commenced on 8 March, but was never completed. In the multi-disciplinary environment of Ward 12 it is reasonable to have expected one of the nursing staff to have followed up the obtaining of the needs assessment for Mark. Whilst Dr Fisher has to share some of the responsibility for this omission, it is not reasonable to hold him accountable in a disciplinary forum for the failure to follow up the obtaining of a needs assessment for Mark whilst he was an in-patient.

Particular 2.4 – Between 10 February and 21 March 2001 Dr Fisher failed to develop and/or review Mark Burton's:

(a) Medication regime; and/or

(b) Treatment and management plan.

229. The Tribunal has found both limbs of this particular allegation of the charge proven. Doctor Fisher failed in his responsibilities to adequately develop and/or review Mark's medication regime. He also failed to discharge his responsibilities to adequately develop and review Mark's treatment and management. These omissions were serious and justify a disciplinary

finding against Dr Fisher for the purpose of protecting the public and maintaining professional standards.

Medication

230. Doctor Fisher increased the dose of olanzapine administered to Mark from 10 to 15mgs on admission. He said Mark *"appeared to settle well on this dose."*[158] Doctor Fisher said consideration was given to increasing the dose of olanzapine further but that course of action was not pursued because of Mark's concerns about the side effects of olanzapine namely, weight gain.[159]

231. All of the experts that gave evidence thought there had not been adequate assessment of how well Mark responded to olanzapine, particularly in light of his ongoing delusions. Doctor Goodwin told the Tribunal that before discharging a patient diagnosed with schizophrenia who was still suffering from delusions a clinician should maximise medication to try and control the delusions.[160] Doctor Fraser was concerned that:

> *"Because of the absence of appropriate assessments during the admission of Mark Burton's mental state, and the recording of his state in terms such as 'settled', 'appropriate' or 'pleasant' the team missed the fact that his illness was showing no response of any significance to the olanzapine."*[161]

There is no record in Mark's medical notes or in the weekly review notes to suggest an appropriate review was taken of Mark's medication regime. This should have been done. As the doctor primarily responsible for Mark's care whilst he was in Ward 12 Dr Fisher should have initiated and undertaken a review of Mark's medication regime. It is reasonable to expect a MOSS practising in a psychiatric unit in New Zealand in 2001 to have undertaken a proper review of Mark's medication regime. Dr Fisher's failure to do this was a serious breach of his professional responsibilities.

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[158] Evidence of P Fisher paragraph 90
[159] Evidence of P Fisher paragraph 90
[160] Transcript p.612 l.31-42
[161] Evidence of A Fraser paragraph 99

Treatment and Management Plan

232. Doctor Fisher told the Tribunal that he and other team members met on a daily basis and were constantly in discussion about Mark's treatment and management.[162]

233. Doctor Fisher's meetings and discussions with other members of the Ward did not constitute an adequate development and review of Mark's treatment and management plan.

234. The Tribunal was concerned Dr Fisher resolved that Mark should leave Ward 12 for a week's trial leave in the following circumstances:

234.1 Mark's delusions remained unexplored and had never been properly examined whilst he was in Ward 12;

234.2 Mark had a poor flatting history;

234.3 Mark was to go into a flat by himself;

234.4 Mark had no family or friends in Invercargill; and

234.5 The flat that Mark was going to had no telephone (there was a public phone nearby).

235. The decision to "treat and manage" Mark by allowing him to go flatting was poorly thought through by Dr Fisher. Leave arrangements should have been planned on a graduated basis and in circumstances where Mark's ability to care for himself had been properly evaluated. Doctor Fraser thought that Dr Fisher's management plan was "relatively simple" and "not inappropriate"[163] but Dr Fraser also told the Tribunal that leave should have been managed on a graduated basis, starting with short periods of leave and building up to a week.

236. The Tribunal believes Dr Fisher failed to comprehensively develop and implement a management plan for Mark. The "treatment" plan was cursory and inappropriate in Mark's circumstances. Doctor Fisher's failure to discharge his professional responsibilities in this

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[162] Evidence of P Fisher paragraph 92

[163] Evidence of A Fraser paragraph 101

regard were serious and justify a disciplinary finding against him for the purposes of protecting the public and maintaining professional standards.

Particular 3.1 - On or about 22 March 2001 Dr Fisher failed to undertake and/or record a thorough and systematic review of Mark Burton's mental state prior to the commencement of his trial leave on 22 March 2001.

237. Doctor Fisher told the Tribunal that *"although not adequately recorded a thorough and systematic review of Mark Burton's mental state prior to his trial leave on 22 March did occur".*[164] Doctor Fisher believes Mark's mental state was the subject of ongoing review by him in conjunction with the nurses and other staff in Ward 12. Doctor Fisher also said a specific review of Mark's mental state was considered in anticipation of his trial leave because when he was on leave Mark would not be under direct nursing and medical supervision. Doctor Fisher saw Mark on 20 March specifically to discuss his trial leave. He told the Tribunal that he:

> *"…reviewed the presence or otherwise of his persisting psychotic features or other evidence of his illness."*[165]

Doctor Fisher thought that Mark displayed significant improvement from his admission; although he continued to remain guarded when questioned about his thoughts towards his family and the events which precipitated his admission. On 21 March the weekly review team was told that Mark did not want his parents to know where he was going to be living and that he wanted nothing further to do with his family.

238. The Tribunal is in no doubt Dr Fisher failed to undertake an adequate, let alone a thorough and systematic review of Mark's mental state prior to his going on trial leave. Doctor Fisher's attempts to assess Mark's mental state at any time between 10 February and 30 March 2001 were only cursory and failed to properly evaluate and explore Mark's psychosis. Doctor Fisher's failure to properly evaluate Mark's mental state before going on trial leave was a serious shortcoming and justifies a disciplinary finding against Dr Fisher for the purpose of protecting the public and maintaining professional standards.

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[164] Evidence of P Fisher paragraph 94
[165] Evidence of P Fisher paragraph 97

239. It is not necessary to reiterate the reasons why the Tribunal believes Dr Fisher never conducted a proper mental assessment of Mark when he was caring for Mark. Suffice to say for present purposes the Tribunal adopts the following passage in the evidence presented by Dr Fraser:

> *"Doctor Fisher did not undertake a comprehensive re-evaluation of Mark Burton's mental state at any time after the admission interview. The longest assessment he conducted was apparently 15 minutes, and it is acknowledged that Mark Burton was guarded in what he would talk about. A reasonable expectation would be that he would have been re-assessed shortly before going on trial leave, and the results of the assessment clearly recorded, so as to form a 'baseline' against which his state during the trial leave could be measured. This did not happen and indicates a failure of practice".*[166]

Particular 3.2 - On or about 22 March 2001 Dr Fisher failed to undertake and/or record a comprehensive risk assessment for Mark Burton prior to the commencement of his trial leave on 22 March 2001.

240. Doctor Fisher said he:

> *"…accept[ed]" that a comprehensive risk assessment is not recorded but a risk assessment for Mark going on trial leave was comprehensively assessed by [him] in conjunction with all members of the team."*[167]

Doctor Fisher said he was acutely aware of the increased risks associated with Mark going flatting and that it was thought the most effective way to manage these risks was to have a social worker visit Mark on a daily basis. Doctor Fisher was influenced in his management of Mark's trial leave by Mark having said he did not intend returning to Queenstown. Doctor Fisher thought this indicated there was no serious increase in risk to Mark's family by his having access to his car whilst he was on trial leave. Taking all matters into account Dr Fisher said that the risks associated with Mark's trial leave were acceptable.

[166] Evidence of A Fraser paragraph 110
[167] Evidence of P Fisher paragraph 102

241. The Tribunal is very satisfied that Dr Fisher failed to undertake a comprehensive risk assessment for Mark prior to the commencement of his trial leave. The Tribunal is in no doubt Dr Fisher's failure to undertake a proper risk assessment at this time was serious and justifies a disciplinary finding against Dr Fisher for the purpose of protecting the public and maintaining professional standards.

242. The risk assessment which Dr Fisher did perform was cursory and inadequate. Doctor Patton told the Tribunal:

> *"Assessment of mental state prior to leave at that time ought to have explored the presence or otherwise of persisting psychotic symptoms or other evidence of illness. Mr Burton's intentions regarding how he would spend his time during the period of leave, and discussion of what to do with medication. There should have been discussion, given prior concerns regarding alcohol use and other drug use, about any further use.*
>
> *There is no evidence of a risk assessment prior to leave (in terms previously described). This is a significant failing."*[168]

243. Doctor Fraser also expressed concern that Dr Fisher failed to properly evaluate Mark's dangerousness before going on trial leave. He reminded the Tribunal that Dr Fisher should have had regard to Mark's ongoing delusions and his apparent hostility towards his family. If Dr Fisher could not explore those issues satisfactorily then he should have sought assistance from a supervising consultant psychiatrist.[169] Doctor Fisher failed to perform the basic requirements of a risk assessment before permitting Mark to commence trial leave.

Particular 3.3 - On or before 22 March 2001 Dr Fisher failed to make adequate arrangements for a review of Mark Burton's mental state during the week of trial leave.

244. The Tribunal has determined Dr Fisher did make adequate arrangements to review Mark's mental state during the week of trial leave. The arrangements put in place were:

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168 Evidence of M Patton paragraphs 108 and 109

169 Evidence of A Fraser paragraph 113

244.1 Mark was to be visited each working day by a social worker. Although the social worker lacked the skills to assess Mark's mental state, it was reasonable to expect the social worker to note and report any significant change in Mark's demeanour, presentation and general well being. This in turn should have been sufficient to alert Dr Fisher to fully review Mark's mental state.

244.2 By prior arrangement Mark was seen by Dr Fisher on 27 March. This afforded Dr Fisher with an opportunity to re-evaluate Mark's mental state. In addition, Mark visited the Ward's workshop during the week of his trial leave. This provided a further opportunity for others to observe Mark and report if there were any notable changes in his presentation.

245. Although these arrangements were not ideal they do nevertheless indicate thought was given to trying to monitor Mark while he was on trial leave. For this reason the Tribunal believes it would not be appropriate to make a finding against Dr Fisher in relation to particular 3.3 of the charge.

Particular 3.4 - On or before 22 March 2001 Dr Fisher failed to ensure a crisis plan was developed in partnership with Mark Burton and/or recorded.

246. Doctor Fisher said that an "*informal crisis plan*" was developed by Mark's social worker, Mr Trevor Burton and himself.[170] The Tribunal understands this "*informal crisis plan*" to have been dependant on the social worker relaying any concerns about Mark to Dr Fisher. Doctor Fisher also said that a formal crisis plan was not developed because a risk assessment had not been undertaken by the Community Mental Health Team.[171]

247. Doctor Fisher's reference to an "*informal crisis plan*" illustrates that a full and proper crisis plan was not developed at the time of Mark's trial leave. Doctor Patton informed the Tribunal that:

> *"A plan of action in case signs of relapse emerged should have been developed prior to leave. This would commonly be known as a crisis plan, or relapse presentation plan. A crisis plan is a combination of*

[170] Evidence of P Fisher paragraph 115
[171] Evidence of P Fisher paragraph 114

> *early warning signs (of deteriorating mental health) and what to do about them. The development of such a plan should avert the crisis, that is, draw attention to early signs of relapse and identify what to do to ensure further deterioration does not occur. It is important that such [a] plan be developed and documented prior to a patient being given leave or discharged from the in-patient Unit."*[172]

248. The Tribunal agrees with Dr Patton's opinion in relation to this aspect of the case. The Tribunal believes it reasonable and sound practice for a MOSS practising in a psychiatric unit in New Zealand in 2001 to have prepared a proper crisis plan before his patient left the ward on a week's trial leave. Doctor Fisher failed to do this. His omission was serious and justifies a disciplinary finding for the purpose of protecting the public and maintaining professional standards.

Particular 4.1 - On or about 30 March 2001 Dr Fisher failed to undertake and/or record a thorough and systematic review of Mark Burton's mental state.

249. Doctor Fisher told the Tribunal that although there is no record, a comprehensive review of Mark's mental state was undertaken by all who had attended the discharge meeting held on 30 March 2001. Doctor Fisher noted that those who attended the discharge meeting included Mark's social worker and nurse I who had a good rapport with Mark.[173]

250. The Tribunal is in no doubt Dr Fisher failed to undertake a proper review of Mark's mental state before his discharge. A thorough and systematic review of Mark's mental state should have been carried out on or before 30 March 2001.

251. The Tribunal finds itself agreeing with Dr Fraser's observations that Dr Fisher's assessment of Mark's mental state at the time of discharge:

> *"… remained as superficial as it had been throughout the in-patient period."*[174]

and that:

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[172] Evidence of M Patton paragraph 110
[173] Evidence of P Fisher paragraph 124
[174] Evidence of A Fraser paragraph 128

> *"the standard of assessment before discharge was inadequate …".*[175]

252. Doctor Fraser attributed part of the blame for the inadequate review of Mark's mental state at discharge on the lack of involvement of a specialist psychiatrist.

253. Doctor Fraser and Dr Patton were concerned that at discharge there was no proper evaluation of Mark's ongoing psychosis. This should have occurred. If Dr Fisher felt unable to properly explore Mark's delusions and the risks these posed for his family, then he should have enlisted the assistance of a specialist. It was a serious breach of professional responsibilities for Dr Fisher to agree to Mark being discharged when his delusions had not been properly assessed and evaluated. These omissions meant Dr Fisher's standard of care fell well below what could reasonably be expected of a MOSS practising in a psychiatric unit in New Zealand in 2001. These omissions also justify a disciplinary finding for the purpose of protecting the public and maintaining professional standards.

Particular 4.2 - On or about 30 March 2001 Dr Fisher failed to undertake and/or record a comprehensive risk assessment for Mark Burton.

254. Doctor Fisher acknowledged that the records of the risk assessment were inadequate.[176] He believes however that a comprehensive evaluation of Mark's risk was undertaken prior to Mark's discharge. At the time of Mark's discharge Dr Fisher thought his delusions were suppressed but he acknowledged they were not resolved. Nevertheless Dr Fisher thought Mark's mental state had materially improved over the 7 weeks he had been an in-patient.[177]

255. Doctor Patton reminded the Tribunal that a comprehensive risk assessment should have:

255.1 Recognised and evaluated Mark's psychotic symptoms;

255.2 The risk Mark posed to his mother and family;

255.3 The importance of alcohol abuse in evaluating risk;

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[175] Evidence of A Fraser paragraph 129
[176] Evidence of P Fisher paragraph 143
[177] Evidence of P Fisher paragraph 140

255.4 The likelihood of non compliance with treatment;

255.5 The importance of Mark's poor engagement with the treatment team; and

255.6 Recognised no needs assessment had been completed.[178]

Doctor Patton said that:

> *"…failure to undertake an assessment of risk in the foregoing terms was a breach of accepted standards of care. A risk assessment is really only complete when it leads to development and implementation of a treatment plan that addresses the clinical problems of risks associated with them. Failure to address risk as part of an overall treatment plan increases the possibility of adverse events occurring that are associated with illness."*[179]

256. The Tribunal agrees entirely with Dr Patton's observations which were substantially supported by Dr Fraser. Doctor Fisher failed to place due weight on the fact that his patient was still psychotic at the time of discharge. He had consumed significant quantities of alcohol while on trial leave. Mark had a history of decompensation associated with substance abuse. He was in a flat by himself without social or family support. He by now had his car which offered him the opportunity to quickly return to Queenstown. These factors could not be outweighed by Mark's improved sociability. Doctor Fisher's failure to undertake a comprehensive risk assessment of Mark prior to his discharge constituted a serious breach of the standards expected of a MOSS practising in a psychiatric unit in New Zealand in 2001. Doctor Fisher's omissions in this regard were serious and justify a disciplinary finding for the purposes of protecting the public and maintaining professional standards.

Particular 4.5 - On or about 30 March 2001 Dr Fisher failed to adequately review Mark Burton's management and/or treatment plan.

257. Doctor Fisher acknowledged that the Community Mental Health Team had not become adequately involved with Mark's management at the time of his discharge. Doctor Fisher took comfort from the fact that Mark's social worker would continue to visit Mark until the

[178] Evidence of M Patton paragraph 124
[179] Evidence of M Patton paragraph 125

Community Mental Health Team's key worker assigned to Mark could commence visiting him.

258. Doctor Fisher also believed that his telephone call to Mr Trevor Burton on 29 March 2001 *"to touch base"*[180] should be considered as part of the development of Mark's discharge management plan.

259. Doctor Patton identified a number of deficiencies in the discharge treatment and management plan for Mark. Those deficiencies included:

259.1 A failure to review the treatment and management plan in light of the evidence of Mark's consumption of significant quantities of alcohol while on trial leave;

259.2 Doctor Fisher agreeing to prescribe olanzapine for three months to meet Mark's convenience. Doctor Patton was concerned that this amount of medication was prescribed to a patient who had previously had difficulty in adhering to his medication regimen. Three months supply of olanzapine also signalled that Dr Fisher was not likely to review the medication treatment for Mark during the ensuing three months. This was a matter of concern. Further, Dr Patton was worried about the absence of monitoring Mark's compliance with his medication for the period subsequent to his discharge.

259.3 Inadequate assessment of Mark's ability to drive.

259.4 Inadequate evaluation or follow up and monitoring of Mark in the community.

260. The Tribunal agrees with Dr Patton's assessment of the deficiencies in Dr Fisher's discharge treatment and management plan. These deficiencies were serious and constituted a failure by Dr Fisher to adhere to the standards expected of a MOSS practising in a psychiatric unit in New Zealand in 2001. Doctor Fisher's failings in this regard justify a disciplinary finding against him for the purpose of protecting the public and maintaining professional standards.

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[180] Evidence of P Fisher paragraph 120

Particular 4.4 - On or before 30 March 2001 Dr Fisher failed to make adequate arrangements for Mark Burton's post discharge care by:

(a) ensuring the adequate involvement of Mark Burton's key worker (Community Mental Health Team) in discharge planning; and/or

(b) ensuring the adequate and timely monitoring of Mark Burton's mental status and/or risk once he was discharged; and/or

(c) ensuring the adequate involvement of Mark Burton's family in discharge planning.

261. The Tribunal has determined no disciplinary sanction is warranted in relation to Dr Fisher's role in not ensuring Mark's key worker from the Community Mental Health Team was present at the discharge planning meeting. The Tribunal shares Dr Fraser's concern that the discharge planning meeting was brought forward by 90 minutes primarily to suit Mark's convenience and as a consequence the Community Mental Health Team key worker missed the meeting. Other members of the team have to share responsibility for not ensuring the key worker from the Community Mental Health Team was contacted directly and told of the change in the time of the discharge planning meeting. Dr Fisher is partially at fault over the unfortunate failure to ensure the key worker from the Community Mental Health Team was present at the meeting. However, it would, in the Tribunal's assessment, be unreasonable to hold Dr Fisher liable in a disciplinary forum for communication errors which occurred on the morning of 30 March.

262. The Tribunal is satisfied Dr Fisher did not put in place appropriate arrangements to ensure that Mark's mental state and/or risk were monitored in a timely fashion once he was discharged. The Tribunal was concerned that Mark was discharged without the key worker from the Community Mental Health Team being involved in his discharge planning. The key community worker needed to be actively and fully involved in planning Mark's discharge. Doctor Fisher envisaged that the Community Mental Health Team would become involved in planning Mark's discharge at a further discharge meeting which he scheduled for 6 April 2001. In the Tribunal's view it was not appropriate for the Community Mental Health Team to become involved in planning Mark's discharge a week after he had in fact been discharged. As a consequence, the arrangements put in place to monitor Mark's mental status and risk once he was discharged were unsatisfactory. They were in essence the same

as for the period of Mark's trial leave. However, the key difference between the trial leave period and the discharge period is that Mark was meant to be under the care of the Community Mental Health Team from 30 March onwards. The lack of formal involvement of the key worker from the Community Mental Health Team meant that attempts to monitor the mental status and/or risk of Mark were unsatisfactory and clearly failed to comply with the protocols for discharge issued by the Southland MHS.

263. Doctor Fisher's failure to ensure adequate arrangements were in place to monitor Mark's mental state and/or risk once he was discharged constituted a breach of the standards of care expected of a MOSS practising in a psychiatric unit in New Zealand in 2001. Doctor Fisher was aware of the Southland MHS discharge policy. He should have adhered to the clear requirements of the policy. His failure to do so justifies a disciplinary finding against him for the purpose of protecting the public and maintaining professional standards.

264. Doctor Fisher did not adequately involve Mr Trevor Burton in planning Mark's discharge. The Southland MHS policy clearly requires *"consultation and involvement of [the] patient's family…"*[181] when planning a patient's discharge.

265. Doctor Fisher said he telephoned Mr Trevor Burton on 29 March to *"touch base"* and during that telephone call he advised Mr Burton that:

> *"…if the discharge meeting on 30 March was successful, we planned to discharge Mark the following day."*[182]

266. It is clear to the Tribunal that Mr Trevor Burton was not invited to attend the discharge planning meeting.[183] He would in any event have required more than a day's notice to travel to Invercargill. Of even greater concern to the Tribunal is that Dr Fisher did not tell Mr Trevor Burton about key incidents that had occurred while Mark was in Ward 12 and on trial leave. Mr Trevor Burton did not learn until many months after his son's discharge that Mark had abused alcohol and continued to be psychotic. Mr Trevor Burton told the Tribunal:

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[181] Southern MHS discharge policy, p.2 para 2

> *"It was only some months later, after Paddy's death, that I learned about Mark's alcohol consumption, his wish to have drugs, his anti feelings towards his family (including his sister Jodie which had never been raised by Mark before), that he had placed a cassette tape on his door as a warning device, that he continued to show paranoia, that he had drug utensils in his room, that he vomited following the consumption of alcohol".*[184]

The Tribunal accepts that if Mr Trevor Burton had known about these matters he would have opposed Mark's discharge. Mr Trevor Burton is an intelligent and informed parent. He was very willing to ensure his son received appropriate medical care. It was essential that he be involved in planning Mark's discharge. Doctor Fisher's failure to ensure this happened constituted a breach of the standards expected of a MOSS practising in a psychiatric unit in New Zealand in 2001. This breach of standards by Dr Fisher also warrants a disciplinary finding against him for the purpose of protecting the public and maintaining professional standards.

Particular 4.5 - Between 22 March 2001 and 30 March 2001 Dr Fisher failed to ensure a crisis plan was developed in participation with Mark Burton and/or recorded.

267. The Southland MHS discharge policy required a crisis plan be developed in consultation with Mark and his family and documented on the discharge plan.[185] Doctor Fisher's *"informal crisis plan"* did not meet the minimum requirements expected of a discharge crisis plan. Doctor Fisher's suggestion that a formal crisis plan would be developed with the key worker from the Community Mental Health Team once she became available after Mark's discharge[186] illustrates Dr Fisher did not develop and record a proper discharge crisis plan prior to Mark being discharged. Doctor Fisher's shortcomings in this regard constituted a failure to adhere to the standards reasonably expected of a MOSS practising in a psychiatric unit in New Zealand in 2001 and justifies a disciplinary finding against him in order to protect the public and maintain professional standards.

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182 Evidence of P Fisher paragraph 120
183 Evidence of T Burton paragraph 79
184 Evidence of T Burton paragraph 78
185 Southern MHS discharge policy p.2 para 7
186 Evidence of P Fisher paragraph 155

Cumulative Charge

268. As indicated earlier in this decision the Tribunal gave very careful consideration to finding that the cumulative effects of Dr Fisher's errors and omissions constituted disgraceful conduct. The Tribunal has weighed Dr Fisher's conduct against that of the very small number of doctors who have been found guilty of disgraceful conduct because of their failure to discharge their clinical responsibilities. Although the Tribunal believes Dr Fisher's errors and omissions were serious it has decided that the cumulative effect of his conduct falls short of disgraceful conduct in a professional respect. Accordingly the "maximum finding" against Dr Fisher is that he is guilty of professional misconduct.

Part VIII - Summary of Findings

269. The Tribunal is satisfied that Dr Fisher's clinical records of his assessments, treatment and plans for Mark were grossly inadequate and constitute professional misconduct.

270. The Tribunal is also satisfied Dr Fisher failed at any time to:

270.1 Undertake an adequate (let alone thorough and systematic) review of Mark's mental status;

270.2 Undertake an adequate assessment of Mark's risk;

270.3 Develop and/or review Mark's medication and/or treatment and/or management plans; and

270.4 Ensure a crisis plan for Mark was developed.

Doctor Fisher also failed to ensure adequate monitoring of Mark's mental status once he was discharged and that Mark's family was involved in planning his discharge.

271. Doctor Fisher's acts and omissions constituted a failure to adhere to the standards reasonably expected of a MOSS practising in a psychiatric unit in New Zealand in 2001. His shortcomings were serious and justify disciplinary findings against him for the purposes of protecting the public and maintaining professional standards.

Part IX - Penalty

272. In determining the penalty which must be imposed the Tribunal has paid special regard to its:

272.1 Need to ensure (as best it can) the safety of the public is protected;

272.2 Obligations to maintain professional standards;

272.3 Desire to assist in "rehabilitation" of Dr Fisher; and

272.4 Duty to impose an appropriate punishment having regard to Dr Fisher's circumstances.

Public Protection and "Rehabilitation"

273. Section 3(1) Medical Practitioners Act 1995 emphasises that a primary purpose of the statute which creates and regulates the Tribunal is "to protect the health and safety of members of the public". The Tribunal proceeds on the basis that this is the primary principle it must follow when determining the appropriate punishment for Dr Fisher.

274. The Tribunal's duty to protect the health and safety of the public is best achieved by imposing strict conditions upon Dr Fisher's ability to practise psychiatric medicine in New Zealand.

275. The Tribunal is aware that in 2001 Dr Fisher voluntarily undertook a competence review. As a consequence of that review the Medical Council of New Zealand determined under s.61(3)(b) of the Medical Practitioners Act 1995 that:

> *"Dr Fisher may practise only under strict and intense supervision by a vocationally registered medical practitioner working in the same branch as him."*

276. The Tribunal proposes to place conditions on Dr Fisher's ability to practise medicine which compliment the Medical Council's decision. The Tribunal's order however will be confined to placing restrictions on Dr Fisher's ability to practise in the areas of psychiatry and psychological medicine. The Tribunal has not had an opportunity to assess Dr Fisher's abilities to practise in other branches of medicine and it would therefore not be appropriate to place restrictions on him, by way of penalty that extend beyond his ability to practise in the fields of psychiatry and psychological medicine.

277. The maximum period conditions can be imposed under s.110(1)(c) of the Medical Practitioners Act 1995 is three years. The Tribunal believes it appropriate to impose restrictions on Dr Fisher's ability to practise for the maximum term prescribed by the legislation. Its reasons for reaching this conclusion are:

    277.1 Although the Tribunal's findings relate to Dr Fisher's management of one patient, the period covered by the charge was significant and related to many aspects of psychiatric care. It will be apparent from this decision the Tribunal could find few redeeming features in Dr Fisher's care and management of Mark. Doctor Fisher has had 17 separate findings of professional misconduct established against him. Doctor Fisher's shortcomings were serious and must be reflected in the period restrictions are imposed on his ability to practise psychiatry and psychological medicine.

    277.2 The Tribunal was very concerned Dr Fisher failed to appreciate his own short comings and inadequacies in this case. Despite the overwhelming evidence of three psychiatrists Dr Fisher continued to labour under the impression that his performance was satisfactory (other than in relation to record keeping). This lack of insight by Dr Fisher was at times distressing to observe.

278. The Tribunal has given considerable thought to the appropriate conditions that should be imposed upon Dr Fisher. The Tribunal believes that Dr Fisher requires considerable

retraining before he practices without restriction in the area of psychiatry and psychological medicine. The Tribunal believes that Dr Fisher requires more than supervision. He in fact requires supervision coupled with re-training. The Tribunal believes that public safety, and its desire to assist Dr Fisher's "rehabilitation" is achieved if he is required to be accepted and participate satisfactorily in a vocational training programme in psychiatry for three years as a condition to him practising psychiatry and psychological medicine. The Tribunal believes that the vocational training programme in psychiatry is the only programme that can provide Dr Fisher with the level of training and supervision he requires. The vocational training programme takes longer than three years to complete. The Tribunal's order cannot extend beyond three years. The Tribunal hopes however that Dr Fisher will complete the training programme.

Professional Standards

279. The Tribunal need not reiterate that over the seven week period covered by the charge Dr Fisher habitually failed to adhere to the standards reasonably expected of a MOSS practising in a psychiatric unit in New Zealand. His failure to adhere to appropriate professional standards is a factor that has weighed heavily upon the Tribunal in assessing the appropriate penalty it should impose. In part, the Tribunal's need to uphold professional standards is achieved by the imposition of conditions on Dr Fisher's ability to practise medicine. However, Dr Fisher's errors and omissions are so significant that professional standards must also be enforced by the imposition of an additional penalty on Dr Fisher. That additional penalty is explained in the following paragraphs.

Penalty and Dr Fisher's personal circumstances

280. Regrettably, there must be a punitive element to the penalty the Tribunal imposes. The reason for this relates to the seriousness and magnitude of Dr Fisher's errors and omissions. Furthermore, if the Tribunal were not to impose a penalty over and above imposing conditions on Dr Fisher's ability to practise psychiatry and psychological medicine, Dr Fisher would effectively emerge from the disciplinary process unpunished. The reason for this is to some extent acknowledged in Mr Hodson's submissions on penalty when he says:

> *"There is in reality no sanction by way of conditions that the Tribunal can impose that the Medical Council has not already imposed."*[187]

281. In assessing the appropriate penalty the Tribunal is very aware of the following facts:

281.1 Doctor Fisher has not been in paid employment as a medical practitioner since October 2002 because of consequences which flowed from his care and management of Mark in February/March 2001.

281.2 Doctor Fisher has been through two intensive inquiries conducted by the Invercargill Coroner and the Commissioner.

281.3 Doctor Fisher has never sought suppression of his name and as a consequence he has received considerable adverse publicity. The nature of the negative publicity Dr Fisher has received is such that he may not gain employment as a medical practitioner in New Zealand in the immediate future.

281.4 As a consequence of being unemployed Dr Fisher has incurred considerable financial difficulties. He now has only meagre savings and a mortgaged property in the United Kingdom.

282. The Tribunal considered imposing a substantial fine in addition to the conditions that it imposed on Dr Fisher's ability to practise medicine. However the gravity and seriousness of Dr Fisher's shortcomings in this case weighs against the appropriateness of a fine by way of punishment in addition to the imposition of conditions on his ability to practise psychiatry and psychological medicine.

283. The Tribunal believes there is no option other than to suspend Dr Fisher. The period of suspension can be less than the maximum because of the conditions the Tribunal has imposed on Dr Fisher's ability to practise medicine, and the mitigating circumstances identified in this decision.

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[187] Submissions on penalty C Hodson QC paragraph 3.5

284. The Tribunal orders that Dr Fisher's registration as a medical practitioner be suspended for a period of six months from the date of this decision.

Costs

285. Section 110(1)(f) of the Act confers on the Tribunal jurisdiction to order a medical practitioner to pay part or all of the costs and expenses of and incidental to:

285.1 The investigation made by the Health and Disability Commissioner in relation to the subject matter of the charge;

285.2 The prosecution of the charge by the Director of Proceedings; and

285.3 The hearing by the Tribunal.

286. In this case:

286.1 The Director of Proceedings has sought costs

pursuant to s110(1)(f)(i) and (iii).
The costs sought by the Director of Proceedings are: $99,881.79

286.2 The costs of the hearing by the Tribunal are: $92,917.49

287. Professional disciplinary hearings are notoriously expensive. For example, in *Vasan v Medical Council of New Zealand*[188] the costs awarded against the practitioner were $210,000 (inclusive of GST).

288. The Tribunal believes a distinction can be drawn when assessing the costs Dr Fisher should pay in relation to the costs incurred by the Health and Disability Commissioner/Director of Proceedings and the costs incurred by the Tribunal.

289. In *Vasan* the High Court said in relation to the costs incurred by the Tribunal "*... the choice is between the [doctor] who was ...found guilty ... and the medical profession*

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[188] *Vasan v The Medical Council of New Zealand*, unreported, High Court Wellington, AP No. 43/91, 18 December 1991.

as a whole". These observations arise from the fact that the costs of running the Tribunal are met in the first instance by the entire medical profession.

290. In balancing the circumstances of a doctor found guilty of a disciplinary offence against the interests of the "medical profession as a whole" the High Court has said that it is not unreasonable to require a professional person to pay 50% of the costs incurred by the professional disciplinary body.[189] Of course, before making any award of costs the Tribunal must take account of the total amounts involved and the doctor's ability to pay costs.

291. The Tribunal is aware Dr Fisher is in a very weak financial position and that he may personally struggle to pay any award of costs. Nevertheless, the Tribunal believes it important to make a determination as to what costs Dr Fisher should be required to pay on a fair and reasoned basis.

292. Doctor Fisher has not questioned the Tribunal's costs. The Tribunal has weighed all relevant factors in determining Dr Fisher should pay 50% of the costs of the Tribunal in this case, namely, $46,458.74

293. The offices of the Health and Disability Commissioner and Director of Proceedings are funded by the State. In assessing the costs incurred by these offices it is not necessary to take account of the interests of "the medical profession as a whole". When assessing the amount of costs Dr Fisher should pay the Health and Disability Commissioner and the Director of Proceedings in relation to the subject matter of the charge, the Tribunal derives some guidance from the key principles which apply to awards in High Court civil proceedings, namely:

293.1 A doctor found guilty of a disciplinary hearing should expect to pay costs to the Health and Disability Commissioner and Director of Proceedings. The extent to

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[189] See for example *Neuberger v Veterinary Surgeons Board*, unreported, High Court Wellington, AP No. 103/94, 7 April 1995, Doogue J. and *Cooray v Preliminary Proceedings Committee* unreported, High Court Wellington, AP23/94, Doogue J.

which a prosecution succeeds is a relevant factor for the Tribunal to take account under this heading.

293.2 Costs awards should reflect the complexity and significance of the proceeding.

293.3 Costs should reflect a fair and reasonable rate being applied to the time taken to investigate the complaint as well as preparing for and conducting the prosecution. The emphasis is on reasonable as opposed to actual costs.

293.4 In this case Dr Fisher has not been found guilty of the maximum charge brought against him by the Director of Proceedings. Furthermore, ten particulars have not been established.

294. The Tribunal has carefully assessed:

294.1 The reasonableness of the costs incurred by the Director of Proceedings;

294.2 Doctor Fisher's financial circumstances;

294.3 The fact Dr Fisher has been found guilty of professional misconduct in relation to seventeen particulars of the charge,

and the other matters urged upon the Tribunal by counsel in their full and thorough submissions. The Tribunal has determined the Director of Proceedings is entitled to $39,952.72 being 40 % of the amount claimed.

Part X - Conclusions

295. Dr Fisher has been found guilty of professional misconduct in relation to seventeen particulars of the charge brought against him by the Director of Proceedings.

296. Doctor Fisher's registration as a medical practitioner in New Zealand is suspended for a period of six months from the date of this decision.

297. Conditions are imposed upon Dr Fisher's ability to practise psychiatry and psychological medicine in New Zealand. Dr Fisher is required to be accepted and participate satisfactorily in a vocational training programme in psychiatry for three years.

298. Doctor Fisher is ordered to pay $86,411.46 costs to the Tribunal and Director of Proceedings.

DATED at Wellington this 22nd day of December 2003

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D B Collins QC

Chair

Medical Practitioners Disciplinary Tribunal