MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

PO Box 24463, Manners Street, Wellington • New Zealand
13th Floor, Mid City Tower • 139-143 Willis Street, Wellington
Telephone (04) 802 4830 • Fax (04) 802 4831
E-mail mpdt@mpdt.org.nz
Website www.mpdt.org.nz

PUBLICATION OF THE NAME OR ANY DETAILS OF THE DOCTOR IS PROHIBITED	**DECISION NO:**	306/03/115C
	IN THE MATTER	of the Medical Practitioners Act 1995
		-AND-
	IN THE MATTER	of a charge laid by Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against S medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Miss S M Moran (Chair)

Dr R S J Gellatly, Dr A R G Humphrey, Dr J L Virtue,

Mrs H White (Members)

Ms K L Davies (Hearing Officer)

Mrs G Rogers (Stenographer)

Hearing held at Wellington on Monday 26 through to and including Thursday 29 April and Thursday 17 June 2004

And Tribunal convened to deliberate on 8 July 2004

APPEARANCES: Ms K P McDonald and Ms J Hughson for Complaints Assessment Committee ("the CAC")

Mr C W James for Dr S.

Introduction

1. Dr S is a registered medical practitioner practising in xx as a general practitioner with a special interest in occupational medicine.

The charge

2. On 7 October 2003 a Complaints Assessment Committee (CAC) laid a charge of professional misconduct against Dr S pursuant to s.93(1)(d) of the Medical Practitioners Act 1995 alleging that Dr S:

    1. On or about the 28th February 2001 refused to accept the diagnosis of leptospirosis (which is an occupational illness and therefore covered by the Accident Compensation Act) made at xx Hospital during the in-patient stay of A from 18th February to 25th February 2001.
    2. During the period from 28th February to 15th March 2001:
        a. Failed to recognise the ACC requirement for acceptance that a complaint merits cover is the "balance of probabilities" and that the Accident Compensation Act does not require absolute proof.
        b. Refused to provide Mr A with the certification to enable him to claim compensation from ACC.

c. Contributed to a climate of confrontation with the patient which resulted in unnecessary hardship and stress and may have been prejudicial to his recovery.

3. During the period 15th April 2001 to 16th September 2001, despite other medical practitioners having formed a contrary view, did not accept that Mr A's chronic malaise and fatigue were due to the after-effects of leptospirosis and therefore did not provide ACC certification during this period resulting in major stress and financial hardship for Mr A.

4. In the course of his dealings with Mr A breached the fundamental principles of non maleficence, beneficence and justice as set out in the Guidelines on Ethics and Professional Misconduct for Occupational Physicians of the Australian Faculty of Occupational Medicine.

Interim Application for name suppression by Dr S

3. Following an application by Dr S for an order suppressing publication of his name and any identifying features, a defended hearing took place before the Tribunal on 8 April 2004. On 23 April 2004, the Tribunal granted name suppression on an interim basis only until the Tribunal had determined the charge against him.

4. The issue of name suppression is dealt with at the end of this decision under the heading of "Conclusion and Orders".

Witnesses for the Complaints Assessment Committee

5. The Complaints Assessment Committee called six witnesses:

(a) The complainant Mr A, a freezing worker residing at xx.

(b) Ms B, Mr A's partner.

(c) Dr D, a registered medical practitioner, now of xx but formerly of xx.

(d) Dr H, a registered medical practitioner of xx employed by xx as a physician/geriatrician.

(e) Dr E, medical practitioner of xx who is a specialist in infectious diseases.

(f) Dr Christopher Bernard Walls, a registered medical practitioner of Auckland who

holds vocational registration in occupational medicine. Dr Walls was called as an expert.

(g) Dr Kevin Alec Morris, a registered medical practitioner of Wellington who is employed as the corporate medical adviser to the Accident Compensation Commission (ACC).

Witnesses for Dr S

6. Dr S gave evidence on his own behalf and also called two expert witnesses:

(a) Dr David Iain McBride, registered medical practitioner of Dunedin

(b) Professor Desmond Frances Gorman, registered medical practitioner of Auckland.

Expert Witnesses

7. The Tribunal was appreciative of the expert testimony provided by Dr Walls, Dr McBride and Professor Gorman.

Legal principles

Onus of Proof

8. The onus of proof is on the Complaints Assessment Committee whose Counsel accepted at the outset that it was for her to produce the evidence which proves the facts upon which the charge is based and to establish that Dr S is guilty of the charge, that is, professional misconduct.

Standard of Proof

9. As to the standard of proof, the Tribunal must be satisfied that the relevant facts are proved on the balance of probabilities. The standard of proof varies according to the gravity of the allegations and the level of the charge. If the charge against the practitioner is grave then the elements of the charge must be proved to a standard commensurate with the gravity of what is alleged.

Professional Misconduct

10. The starting point for defining professional misconduct is to be found in the judgement of Jefferies J in *Ongley v Medical Council of New Zealand* (1984) 4 NZAR 369. The Court posed the test in the following way:

> *"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."*

11. In *B v The Medical Council* (unreported HC Auckland, HC11/96, 8 July 1996) 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."

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

(a) There needs to be an objective evaluation of the evidence and an 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?

(b) 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?

13. The words *"representatives of the community"* in the first limb of the test are essential because today those who sit in judgement on doctors comprise three members of the medical profession, a lay representative and a chairperson who must be a lawyer. The composition of the medical disciplinary body has altered since Jeffries J delivered his decision in *Ongley* in 1984. 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: *B v Medical Practitioners Disciplinary Tribunal*. In *Lake v The Medical Council of New Zealand* (unreported High Court Auckland 123/96, 23 January 1998, Smellie J) the learned Judge stated:

"If a practitioner's colleagues consider his conduct was reasonable the charge is unlikely to be made out. <u>But</u> 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."*

14. This second limb to the test recognises the observations in *Pillai v Messiter* [No. 2] (1989) 16 NSWLR 197, *B v Medical Council, Staite v Psychologists Board* (1998) 18 FRNZ 18 and *Tan v ARIC* (1999) NZAR 369, namely, 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.

15. In the recent High Court case of *McKenzie v MPDT and Director of Proceedings* (unreported High Court Auckland, CIV 2002-404-153-02, 12 June 2003), Venning J endorsed the two question approach taken by this Tribunal when considering whether or not a doctor's acts or omissions constitute professional misconduct. He stated:

> *"[71] In summary, the test for whether a disciplinary finding is merited is a two-stage test based on first, an objective assessment of whether the practitioner departed from acceptable professional standards and secondly, whether the departure was significant enough to attract sanction for the purposes of protecting the public. However, even at that second stage it is not for the Disciplinary Tribunal or the Court to become engaged in a consideration of or to take into account subjective consideration of the personal circumstances or knowledge of the particular practitioner. The purpose of the disciplinary procedure is the protection of the public by the maintenance of professional standards. That object could not be met if in every case the Tribunal and the Court was required to take into account subjective considerations relating to the practitioner."*

Conduct Unbecoming

16. The Medical Practitioners Act 1995 provides three offences, namely, "disgraceful conduct in a professional respect", "professional misconduct" and "conduct unbecoming".

17. In *B v Medical Council* (above) Elias J stated at p.14:

> *"The scheme of the Medical Practitioners Act 1968 establishes a hierarchical conduct for disciplinary purposes. In ascending order of gravity the categories are unbecoming conduct (a category introduced by the amendment to the Act*

> *in 1979) professional misconduct and disgraceful conduct. …There is little authority on what comprises 'conduct unbecoming'. The classification requires assessment of degree. But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale must be conduct which departs from acceptable professional standards. … The threshold is inevitably one of degree. Negligence may or may not (according to degree) be sufficient to constitute professional misconduct or conduct unbecoming".*

18. In *McKenzie v Medical Practitioners Disciplinary Tribunal and The Director of Proceedings* Venning J referred to *"a trilogy of disciplinary offences in an ascending order of gravity and penalty"* and observed that the penalties imposed by the 1995 Act for "conduct unbecoming" and "professional misconduct" are exactly the same.

He further observed:

> *"The term 'professional' within 'professional misconduct' is not to be interpreted as within a simple rising scale in which it necessarily starts above 'conduct unbecoming a practitioner' in gravity. In law the professional misconduct offence could be of equal or even lesser gravity".*

Summary of Evidence and Findings of Fact

19. Mr A is a 38 year old A-grade butcher who, at the time of the hearing, had been employed for the previous 16 years by xx at its meat processing works at xx near xx. There are approximately 850 persons employed at the works. He resides with his partner, Ms B, and three of their eight children.

20. In February 2001 he was working as a butcher on the slaughter floor in the "bleed area" or "stunning area" where his main job was to cut the pelts (mainly of sheep) after slaughter. Bobby calves and goats were also processed. The evidence established that this is an area recognised as being potentially contaminated with urine from the stunned or dead animals and hence a high risk area for leptospirosis. Urine is the most common infective vehicle.

21. The evidence also established that wherever the exact location of Mr A's work, he was potentially exposed to blood and other body fluids, particularly urine, the most likely

medium for the transmission of infection from the carcasses he was processing at the works.

22. Prior to becoming unwell with leptospirosis, Mr A had not been off work for any long periods of time, either for holidays, accidents or sickness; and apart from an odd bout of hayfever and lower back pain, he had had no medical illnesses or injuries, or surgery.

23. Dr S has been in sole practice in xx since 1980 as a general practitioner, with a special interest in Occupational Medicine. He also obtained in December 2000 a Diploma in Industrial Health from Otago University.

24. Since 1982 Dr S has been the visiting medical practitioner for xx . This involves him conducting morning clinics at the xx Plant. His general duties require attendance to workers who have sustained work-related injuries. In addition, Dr S's duties include (among others) identifying and advising management of potential hazards related to the workplace and compliance with the Health and Safety in Employment Act 1992.

25. Dr S stated that after completing the Diploma of Industrial Health (Otago) and graduating in December 2000, he decided to proceed to higher learning and entered the training programme conducted by the Australasian Faculty of Occupational Medicine. Although accepted for the course in February 2001 it was not until November of that year (due to personal reasons) that he was able to take what he described as his first step with regard to the programme by attending an occupational medicine clinic run by Professor Gorman in Hastings. Professor Gorman invited Dr S to join the Registrar Training Programme at Auckland the following year. Dr S commenced the Training Programme in January 2002.

26. Dr S said that he does dinics with Professor Gorman who is his supervisor and makes presentations of cases to him as part of the programme. At the time of the hearing he said he was about halfway through the Registrar Training Programme.

27. On 12 February 2001 while at work Mr A felt very unwell. He thought he saw Dr S (but was not sure) as he needed to get "signed off" as he wanted to go off work and needed a certificate. In any event he left work early that day. Dr S said that he did not consult with

him that day, and there is no written record of it. The Tribunal accepts and finds that no consultation took place on that date.

28. The following day, 13 February 2001, Mr A saw Dr W, a GP at xx. Mr A had a sore lower back followed by a fever and headache. He felt sick, had a dry cough and was not eating. Dr W thought he had a virus. He gave him a certificate to go off work and prescribed some medication.

29. Over the next few days Mr A felt worse.

30. Dr D is a registered medical practitioner, now semi-retired residing in Christchurch doing some locum GP work. Between 1975 and 2002 he practised as a general practitioner at xx and was Mr A's general practitioner.

31. On 16 February 2001 Mr A saw Dr D. Mr A felt no better. He had a bad headache and a fever. Dr D told Mr A he thought he might have contracted leptospirosis.

32. In view of Mr A's clinical presentation (in particular the fever) and as Dr D was aware that Mr A was a freezing worker at xx he could not help but consider that Mr A might have contracted leptospirosis from his work on the slaughter floor of the works. Dr D said he was well aware from his experience working as a general practitioner in a rural area and having a number of patients who worked at xx that meat processing workers were in the "at risk" category of occupations for leptospirosis infection. As he could not rule out the possibility that Mr A might have contracted leptospirosis he took blood and urine samples to be sent away for testing. He also prescribed antibiotics.

33. It is appropriate to describe here the two kinds of tests regarding detection of leptospirosis. Dr E described the differences.

34. Dr E is presently employed by the Nelson Marlborough District Health Board as an infectious diseases and internal medicine physician and medical micro-biologist. Between April 1999 and April 2003 he worked as an infectious diseases specialist and medical

micro-biologist in xx, working primarily for xx at xx Hospital. Occasionally he also saw patients at a private clinic.

35. He referred to the screening test which was used at xx (xx) during this time, known as a flocculation-method test (sometimes referred to as the rapid local screen method or the leptospirosis screening antibody test). That test sought to establish the presence of any type of antibodies to proteins on the surface of any serovar (strain) of *Leptospira* species. He said it was a "yes or no" test that answers the question "has the patient had a recent infection with any strain of leptospirosis".

36. In contrast, a confirmatory test is a quantitative microscopic agglutination titre (MAT) assay that will show how much antibody is present and the specific serovar (strain) of leptospira. Dr E normally refers to this as the confirmatory leptospirosis antibody test. Antibody tests for leptospirosis start to become positive several days to several weeks after the onset of symptoms, as it takes this long for the patient's immune system to make significant quantities of antibodies against the bacteria.

37. Professor Gorman referred to this latter test (the confirmatory test) in slightly different terms. He said that the strict criteria for the diagnosis of leptospirosis are:

(a) Isolation of leptospirosis from the clinical specimen; or
(b) A four fold or greater risk in leptospiral microscopic agglutination titre (MAT) between acute and convalescent sera; or
(c) A single high antibody titre ? 800 in the MAT; plus
(d) A clinically compatible illness.

38. By Sunday 18 February 2001, Mr A felt so unwell that he saw Dr X at xx. The medical centre he normally attended was closed. Mr A was advised to attend at the emergency department of xx Hospital immediately, which he did.

39. On arrival at hospital, Mr A was admitted to the medical ward (Ward 25) under the care of Dr H.

40. Mr A presented with a history of feeling generally unwell, having had black vomit which was assumed to be altered blood (haematemesis) with ongoing vomiting of anything he tried to eat or drink.

41. At the time of Mr A's admission to hospital the main concerns were those of acute renal failure (with kidney tests indicating severe impairment) and marked abnormalities of his liver function tests. Mr A was also found to be dehydrated. He was admitted and treated with vigorous intravenous fluid resuscitation and antibiotics for a presumed leptospirosis infection.

42. On 19 February 2001 Dr D received the results of the tests which he had taken on 16 February 2001. The results were negative for leptospirosis. On learning that Mr A was in hospital, Dr D forwarded the results by facsimile to the house surgeon at the hospital that same day. 19 February 2001. In his letter he pointed out that the leptospirosis titre (the antibody titre) had not yet been done.

43. Dr H is a Fellow of the Royal Australasian College of Physicians. She is a general physician and geriatrician employed by xx at xx Hospital.

44. On 19 February 2001 Dr H saw Mr A while he was in hospital. She examined him and took a history.

45. Dr H told the Tribunal that while the blood tests which Dr D had organised on 16 February and forwarded on 19 February had shown the negative leptospirosis screen, the blood test which the hospital undertook on 18 February 2001 returned as positive and that there was a subsequent positive on 3 March 2001 following further blood tests.

46. While in hospital, Mr A also had a range of cultures taken, besides blood, to identify whether there was some other cause of his illness or some other infective agent.

47. In terms of criteria for clinical diagnosis of leptospirosis, Dr H stated that either leptospira (organism) in a clinical specimen must be demonstrated and taken into consideration

alongside the patient's clinical picture, or a sero-conversion of the antibody titres on MAT testing must be shown.

48. Dr H said that in her view the demonstration of an antigen in Mr A's blood as at 18 February 2001 when the leptospira screen was positive confirmed her belief, given the clinical picture including Mr A's occupational exposure (from working in a meatworks) that Mr A was suffering from leptospirosis.

49. She added that while she had seen a number of patients who have possible leptospirosis when they present with a febrile (fever) illness and possible occupational exposure, she had never seen a case like Mr A's where she was more convinced that he had leptospirosis given the clinical picture (including where he worked) and the evidence of the antigen of blood on the 18 February screen test.

50. Dr H explained that because the antibody titres showed the body's response to the infection and because it can take some time for a response to be mounted, it is not unusual in the early stages of infection for the titres to be negative even though a leptospirosis screen may be positive, as was the position in Mr A's case.

51. Dr H stated that with Mr A's clinical picture which included renal and hepatic damage, and given his occupational exposure, she had no dinical doubt that Mr A was suffering from leptospirosis.

52. Accordingly, Dr H asked her hospital team to complete ACC details for a claim of occupation exposure causing leptospirosis. Her house surgeon, Dr T, attended to this and completed a medical certificate for Mr A to give to his employer, xx.

53. Dr H added that if she had any uncertainty or clinical doubts about her diagnosis of leptospirosis she would not have had her house surgeon complete an ACC certificate at that time.

54. In 2001 xx was an accredited employer under the ACC Partnership Programme. xx Group Limited (xx) were engaged by xx as its injury management services provider and were organising Mr A's accident compensation claim.

55. While Mr A was in hospital, Ms Adrienne Lopdell, a case manager for xx visited Mr A there to ask him some questions about his illness.

56. Dr H confirmed that xx was advised by her house surgeon, Dr T, in a letter of 23 February 2001 (the day of Mr A's discharge) that blood results had confirmed Mr A had leptospirosis. This was a reference to a positive leptospirosis screen taken on 18 February 2001. The post script at the bottom of Dr T's letter noted "Titres for leptospirosis are awaited".

57. Also on the day of Mr A's discharge from hospital, Dr D forwarded to xx Mr A's medical records regarding his consultations with Dr W and with himself on 13 and 16 February 2001 respectively.

58. Dr S's evidence was that Mr A first attended him at the works clinic in November 1988 and between then and February 2001 he had attended on him on approximately 33 occasions for work-related matters. He said his relationship with Mr A was cordial.

59. On 28 February 2001 Mr A saw Dr S at the works and handed to him the patient's copy of the hospital's discharge summary, the haematology and biochemistry results, the other laboratory results, the letter of 23 February 2001 from Dr T, and the ACC form which had been signed by Dr T confirming the diagnosis of leptospirosis, all of which Dr S read. Mr A's evidence, which the Tribunal accepts, was that the principal purpose of his visit to Dr S was to give him the ACC certificate. He said Dr S told him he could not accept the hospital diagnosis and that he wanted to check the blood test results himself with the laboratory.

60. Dr S said he noted there was no leptospirosis result and said he told Mr A he would have to check them. He telephoned the laboratory at MedLab at xx and was informed that the

result of a screening test taken on 16 February was negative while one taken on 18 February was positive. He said, as he recalled it, he did this in Mr A's presence.

61. Dr S said he then examined Mr A and checked his blood pressure and weighed him. He decided that Mr A was not particularly well and that he would repeat the liver function tests, renal function tests and leptospirosis titres. He said he explained to Mr A that he would arrange a blood test for this purpose and gave him the appropriate form to take to one of the laboratories to have blood tests taken. He gave Mr A an appointment to see him again on 7 March by which time he said he expected to have the results.

62. Dr S told the Tribunal it was his view that Mr A had suffered a leptospirosis illness but that he needed to await the results of the titres for confirmation and asked MedLab to track them down. He explained that the antibody tests are done to confirm leptospirosis and thus identify the serovar (that is, the strain or type) of leptospirosis which may have an occupational association.

63. He said he explained to Mr A the need for confirmation and the consequences.

64. He said he also discussed with Mr A non-occupational causes of leptospirosis which would need to be excluded such as from animals and household pets.

65. On 1 March 2001 Mr A consulted Dr D and told him of Dr S's refusal to accept the diagnosis.

66. Mr A said he was not well enough to recommence work on 5 March and saw Dr S at the works on 7 March 2001. Mr A said Dr S told him his results were "abnormal" and that he had made some enquiries with the laboratory about them but that he was waiting for some further information from the laboratory and that until he heard from the laboratory he could not accept the hospital's diagnosis or the ACC certificate. Mr A said Dr S told him he thought that he may have gallstones or some other problem not concerning leptospirosis; that he should not go back to work; and that he would send him to have an ultrasound scan at xx. He advised Mr A to get an emergency benefit from WINZ to tide him over until he returned to work.

67. Dr S's explanation of what occurred at this consultation does not differ in any significant way from Mr A's. He said he had received the results from MedLab and that from the haematology tests the liver function showed signs of a possible obstruction with damage and a cholestatic variant of hepatitis. He decided that because on the initial notes it was shown that the pancreas was only partially seen it would be worthwhile to repeat the ultrasound to get a better picture of the pancreas and the liver. With regard to the results of the further blood test taken on 3 March he said that the leptospirosis screening tests serology was shown as positive.

68. Dr S said he advised Mr A he was not fit for work and explained to him that the positive screening test by itself which he had on the papers was not sufficient for a diagnosis of leptospirosis for certification purposes. He explained that he had asked MedLab to refer for titres; that MedLab sends off the blood samples to ESR Porirua; and that it could take a week or two to get the results back. Dr S said Mr A did not say anything or confront him at that stage as to why he was carrying out or requesting that more assessment be undertaken. He said he gauged that Mr A understood why he could not give him certification. He added that he had not turned his mind to the fact that in the previous documentation, which he had on file, Mr A's certificate "not fit to work" had expired on 5 March but added that Mr A did not raise the matter with him. Dr S said Mr A did not tell him at this consultation he was seeing his GP, Dr D. He said he advised Mr A to return to his next clinic on 12 March at which time he would have some results available.

69. Following this consultation, Mr A said he telephoned Ms Maevis Watson, an officer with the Meatworkers Union (of which he was a member) in Auckland for help. He said he was mainly worried about his money situation and did not think he should have to go to WINZ.

70. On 12 March 2001 Mr A said he saw Dr S again who told him that the ultrasound scan which he had on 9 March 2001 had come back "clear" – there were no gallstones. He said Dr S also told him he was waiting for more blood test results and that Mr A could not claim ACC because the hospital's diagnosis had not been confirmed. Dr S said he told Mr A that he had received the titres back from ESR printed on 7 March 2001 which

indicated there had been no rise in the titre and that he could therefore not confirm the leptospirosis.

71. Mr A explained feelings of anxiety, frustration, distress and anger regarding Dr S's refusal to accept the diagnosis of leptospirosis.

72. Dr S said that when he told Mr A that he was recommending a further test be carried out to give confirmation Mr A became angry with him and raised his voice challenging why Dr S was disagreeing with the diagnosis that he had from Dr D, Dr T and Dr H. Dr S said that Mr A demanded in a forceful manner that he give him certification and that he became very agitated and shouted, saying words to the effect, *"Why are you doing this to me, I deserve ACC payments, why aren't you giving the go ahead for them"*.

73. He said that Mr A's demeanour caused him to be fearful as he was standing over him waving his arms around and remonstrating with a raised voice.

74. Dr S said he did his best to explain to him that he was not disagreeing with the diagnosis of leptospirosis but that he was having trouble getting the diagnosis confirmed to enable him to certify. He said that after a while Mr A calmed down but remained agitated.

75. Dr S said he wrote down Dr D's number and tried telephoning his rooms on three occasions but his line was engaged. He said he regretted that he did not speak to him that day. Dr S added that reflecting now on the matter retrospectively, he also regretted not having dealt with the matter better and that after this incident he should have liaised with other health professionals (including Mr A's general practitioner) and called a case conference probably involving xx and works management to try and get a management view on the management of the case.

76. Following this consultation Dr S said he spoke briefly to Mr F, the works' Health and Safety manager enquiring if xx could provide any financial assistance to Mr A to give relief in the meantime until the titre results were clarified. (Mr A said xx paid an advance of $600).

77. On returning to his surgery in xx Dr S said he telephoned Ms Lopdell of xx telling her there was "confusion" in the leptospirosis results with negative titres and that Mr A was angry with him during the consultation.

78. The following day Mr A said he telephoned Ms Lopdell at xx who told him that his ACC claim could not be accepted until she had heard from Dr S regarding the result of further blood tests.

79. On the morning of 16 March 2001, before consulting again with Mr A, Dr S telephoned ESR and was informed that there had been a titre shift to 1600 for leptospirosis pomona. In addition, the serovar showed an occupational illness from cattle, sheep, and goats as secondary host species.

80. At the consultation Dr S said he reassured Mr A (who was anxious about the result) that he had been able to confirm leptospirosis on the blood test that he had requested on 3 March 2001; and that as his (Mr A's) liver function tests were improving and as he was feeling better, he might like to return to light alternative work. He said Mr A agreed and that the alternative work would start on 18 March.

81. However, Mr A was not happy about this as he was still feeling unwell. He said he did not understand why Dr S was so concerned about the blood tests because as far as he was concerned the hospital had diagnosed him with leptospirosis. Dr S signed a backdated ACC certificate covering him for the period 12 February to 17 March 2001 (although, in retrospect, Dr S could see there was a period of 11 days for which Mr A did not receive money). The certificate stated that Mr A would be fit to return to work on 18 March although on light duties with review on 26 March.

82. The Tribunal notes there is a difference between what Dr S said regarding Mr A feeling better and Mr A stating that he was still feeling unwell. The Tribunal accepts that Mr A was still feeling unwell.

83. Consistent with this, Mr A telephoned Ms Lopdell at xx to relay his concerns and to state that he was going back to his GP. Ms Lopdell undertook to speak to Dr S, which she did, and confirmed later that day to Mr A that his ACC claim could now be accepted.

84. Mr A said that during this particular period he had been under significant financial pressure despite the $600 which xx had paid him in advance as it was not enough for him and the members of his family on which to survive. As a result, he and his partner had to send some of their children to live elsewhere with other family members.

85. On 18 March 2001 Mr A returned to work on light duties working outside.

86. However, on 21 March 2001 Mr A saw Dr S a few days ahead of a pre-arranged appointment. He reported that he felt so tired there were occasions when he had to lie down and have a sleep during working hours.

87. Dr S questioned Mr A about his diet and undertook an examination which included his abdomen, liver, spleen and both kidneys and took his weight and blood pressure. He suggested a repeat of the blood tests (haematology and biochemistry) to look at the liver function tests and renal function.

88. Mr A said Dr S refused his request to go off work on the basis that when he had been off work with leptospirosis the company had not been able to make contact with him. Mr A said Dr S told him he must continue working and could do light duties outside.

89. Dr S said that when Mr A requested home leave, he indicated to Mr A that because he was on light duties he may be better to stay at the works because Dr S had learned that the company had endeavoured to contact him at home without success. He said he received that information from the company suggesting that Mr A was malingering. Dr S told the Tribunal that this was not the case as there had been trouble with Mr A's phone. He added that Mr A agreed to continue alternative outside work.

90. The Tribunal notes there is a difference in Mr A's and Dr S's account regarding the issue of home leave. Where there is conflict here, the Tribunal prefers the evidence of Mr A.

91. On 26 March 2001 Mr A saw Dr S again as he was due for the ACC review and recertification. By this time Dr S had received the results of the blood tests which showed considerable improvement.

92. Mr A said Dr S told him he had to keep doing outside work while Dr S said he suggested that Mr A continue with outside work and he would review him again on 2 April. Dr S completed another ACC certificate that he was to continue alternative work until review on 2 April.

93. On 2 April 2001 Mr A saw Dr S again due to feeling unwell although coping with light duties. Dr S examined him again. They had a discussion about a "return to work programme". Mr A said Dr S told him he had to return to his normal work "inside" as soon as possible. Mr A said he started to get the feeling all xx and Dr S were interested in was getting him back to full time and not his health. He said this "stressed [him] out" because he did not know how he would be able to do full time work feeling like he was.

94. Dr S said that at this consultation Mr A seemed to be coping reasonably well with alternative work and agreed with his suggestion that he try light work up on the slaughter board.

95. Dr S said he would review Mr A on 11 April and gave him an ACC certificate to carry him through to that date.

96. On 11 April 2001 Mr A said his feelings of tiredness and headaches were still present when he saw Dr S again. Dr S put Mr A on two days' light duties and certified that he should return to his normal full time work on 17 April.

97. Mr A said it was obvious to him that Dr S was refusing to accept what he was telling him about how unwell he was and how tired he was feeling all the time. He said he was feeling angry with Dr S who he found difficult to trust and that all Dr S seemed to care about was the company and not Mr A or his health.

98. Dr S's version of what occurred at this consultation is at some variance with Mr A's. Dr S said he suggested that Mr A could return to normal work with which Mr A agreed. The Tribunal accepts Mr A's evidence that he communicated his feelings of unwellness to Dr S.

99. Dr S completed an ACC form certifying return to normal duties on 17 April. Dr S said Mr A mentioned that he had missed out compensation for two days (11 and 12 April 2001) for which Dr S covered him. Dr S said no further reviews needed to be arranged.

100. Dr S did not have any further consultations with Mr A over the ensuing 4½ months.

101. Mr A described his state of health between the period 17 April and 16 September 2001. He returned to full time work on 17 April 2001. In the ensuing weeks until the off season in June/July he said he managed to work some days but had to take a number of days off or go home early as he still felt very tired and was still getting headaches. It reached the point where he was feeling exhausted even before he left home each morning to go to work.

102. He again consulted Ms Watson of the Union who accompanied him to a meeting with xx management towards the end of May 2001. The meeting discussed how unwell Mr A was and how it was affecting his work. He was put off work and given some holiday pay.

103. When Mr A returned to work after the off-season in June/July 2001, he had to sleep about 11 or 12 hours at night, was short of breath and occasionally had a sore back. He became fearful of what was causing his unwellness and concerned about what this would mean for him and his family financially. He was receiving a reduced income and was not well enough to do overtime. He was struggling to pay the mortgage and put food on the table.

104. Ms B confirmed Mr A's frustration and, at times, anger, regarding Dr S's refusal to accept the hospital diagnosis of leptospirosis in late February 2001. She also confirmed Mr A's physical symptoms of fatigue following his return to work in late April 2001. She further confirmed the financial pressures their family were under and the stress which this caused. She stated that as a result, she had to continue working until two weeks prior to her having

her and Mr A's baby (born 8 September 2001) and that she had to return to work three weeks after the birth due to their precarious financial situation. Ms B also confirmed that, prior to Mr A contracting leptospirosis, he was energetic, sporty, spent time with the children and assisted with household and domestic chores. Following his illness he was not able to do any of those things.

105. In late August 2001 Mr A vomited a dark brown blood which looked like instant coffee after only two handles of beer.

106. Mr A said when he saw Dr S on 3 September 2001, he explained that before he got leptospirosis he could drink a few beers now and again but since he had been sick he was only ever able to manage a couple of drinks otherwise he would feel "awful". At that consultation he said he also mentioned to Dr S that he had no energy and was feeling "awful" most of the time and that he had felt like that ever since he had contracted leptospirosis. He said Dr S examined him and did some tests. He could not find anything wrong with him but mentioned something to him called helicobacter.

107. Dr S said Mr A did not tell him of ongoing fatigue. He prescribed synermox (penicillin) which he said was just in case there was further leptospirosis developing. He said he explained this to Mr A and the need for further blood tests in order to check out whether he had a stomach infection (helicobacter pylori).

108. Dr S stated that Mr A's symptoms at this consultation appeared to have little, if any, connection with leptospirosis. He said his presumptive diagnosis at this consultation was helicobacter gastritis as this appeared to be a recurrence of symptoms from when Mr A was in hospital (in February) with haematemesis, when investigations were requested but not implemented. Dr S issued Mr A with a Minor Claims Certificate for alternative outside work with a review on 7 September 2001.

109. On 7 September 2001 when reviewing Mr A, Dr S told him that his blood test results were normal although his blood pressure was high; that he thought he might have helicobacter (which he described as something like an ulcer); and that he was waiting for

the test results to confirm this. He said he would sign an ACC certificate for one day of light duties but that from 10 September Mr A would be fit to go back to work.

110. Mr A said he returned to work the following week and struggled on although he felt exhausted, almost as bad as he had felt with the leptospirosis.

111. The next consultation was on 17 September 2001. Dr S said he had received the blood tests confirming antibodies to helicobacter pylori. He said he explained these results to Mr A and explained the treatment which was helicosec for which he gave him a prescription. He said he suggested to Mr A that if there were no improvement then a referral to his own GP for endoscopy would be the next step. He continued Mr A on alternative work for one week (on full compensation) and suggested a further consultation follow up in two weeks.

112. Mr A's version of events differs from Dr S's. Mr A said that when he saw Dr S at this consultation he asked Dr S why he was always so exhausted and had no energy and that Dr S had replied that apart from the helicobacter he did not think there was anything else wrong with him. Mr A said he asked Dr S if the helicobacter had anything to do with the leptospirosis to which he said Dr S replied it had nothing to do with it. He said Dr S told him he must keep working, saying he could do light duties; and that if he felt no better at the follow-up appointment in two weeks' time then he would be referred for further tests, through his GP, Dr D.

113. Dr S stated he was not aware of the extent of Mr A's difficulties with working or of his fatigue. He added that he gave Mr A light duties because he had had a severe degree of leptospirosis and felt sorry for him; and that the requirement with anyone with a medical complaint who could not do full duties would be that they had to leave the work site altogether and were not offered alternative work. Dr S said he decided to offer Mr A light duties outside which involved mainly sweeping around the amenities block. He said Mr A did not indicate to him that he was finding this just as hard as normal work. Dr S said that as Mr A was on full pay doing only light duties, this was considered one of the "plush alternative work jobs on site".

114. Following this consultation, Mr A said he felt very angry as he believed Dr S was treating him as if he were not telling the truth about how exhausted he felt. Again, he contacted Ms Watson at the Union about his concerns, who undertook to take up the matter with xx, and suggested they both see Dr D for his opinion.

115. The following day, 18 September 2001, Ms Watson accompanied Mr A to see Dr D. At this consultation Mr A complained how he constantly felt tired and exhausted and had been like that since he had contracted leptospirosis in February. He described low back pain and said that he had been having recurring headaches that could last several hours. He also complained of occasional dizziness and muscle pain. Dr D took blood and urine samples. After consideration of all of Mr A's symptoms, Dr D made a provisional diagnosis of Chronic Fatigue Syndrome.

116. Dr D explained to the Tribunal that as Mr A had complained he had suffered from those symptoms since he had had leptospirosis which was more than six months earlier, and there being no other explanation for them apparent to him on examination, he believed the chronic fatigue stemmed from the leptospirosis and was therefore a work-related illness. As a consequence he filled out an ACC form certifying that Mr A would be unable to resume any duties for work for 14 days.

117. Dr D said he believed Mr A needed complete rest for at least two weeks if he were going to be given a chance to recover properly. He remembered both Mr A and Ms Watson expressing their concerns about Dr S's approach to Mr A's illness. He recalled Mr A mentioning Dr S thought he had an ulcer and had prescribed him some medication for it but Dr D did not find anything in Mr A's account or during his examination of him which indicated he had an ulcer.

118. Mr A returned to xx that day to hand in Dr D's ACC certificate but Dr S was not available.

119. He saw Dr S the following day, 19 September 2001, with a Union representative (he believed it was a Mr Peter Thompson as he was the Union site delegate) and handed to Dr S Dr D's ACC certificate. He told Dr S what Dr D had said regarding the ulcer

medication Dr S had given him and that Dr D had diagnosed him with Chronic Fatigue Syndrome.

120. Mr A said Dr S declined to accept Dr D's ACC certificate saying he did not agree with the opinion that Mr A had Chronic Fatigue Syndrome and that as far as he was concerned all that was wrong with Mr A was the helicobacter/ ulcer which had nothing to do with leptospirosis; and added that his opinion always overrode that of a general practitioner.

121. Mr A said Dr S stated he was "cancelling" Dr D's ACC certificate. Mr A challenged this and said he would be asking the Union to intervene. He said Dr S asked him if he was threatening him to which Mr A said he replied "No, I'm telling you". He said that Dr S then said that Mr A would never be able to prove his illness was leptospirosis related and that "For all we know you were bitten by a rat". Mr A said he started to get angry with Dr S at which point Dr S called Mr F into the room. Mr A said Dr S then told him he could go off work on sick leave for a week but after that he had to keep working and said he would organise alternative work for him.

122. Dr S gave a varying account of what occurred at this consultation. He said that Mr A attended with a Union representative, Mr Marsh. He said they insisted on seeing him without an appointment and that both men went into his small consulting room and immediately closed the door behind them. Dr S said he found the stance of both men and the way they stared at him intimidating. Where they stood blocked his exit and he felt insecure, trapped and threatened in a similar way to a previous experience he had at the site (with someone else). He activated the panic button for assistance. Mr F, who was working with him at the time, immediately opened the door and stood in the doorway.

123. Dr S said Mr A then told him of Dr D's diagnosis, which differed from his, and of Dr D's opinion of the prescription which Dr S had given which Dr D considered excessive in view of the absence of ulcer symptoms.

124. Dr S said he was surprised at these statements because he had had no communication from Dr D and was not aware that Mr A had seen him up until then. He said he was further surprised at this alternative diagnosis of further leptospirosis as the recent blood

tests had not supported this. He said there was no mention of chronic fatigue and he did not recall saying "what I say goes round here". He said that the reference to "brown rats" was the example he used at shed meetings talking about non-occupational causes.

125. Dr S said that Mr A and Mr Marsh continued to hold their position in the room and in the end he decided to hastily cancel the non-insurance medical certificate and issue Mr A with a medical certificate for the first week off work for helicobacter gastritis. Dr S said he regretted cancelling the certificate but it occurred under extreme pressure and was not intended to expunge the ACC certificate issued by Dr D. He added that Dr D's certificate was never presented to him. Dr S said that at that stage he was rattled and had difficulty working for about three quarters of an hour later. He said he did not contact Mr A's general practitioner, Dr D, although on reflection he should have liaised with him at that time but he was still trying to get his composure together at the end of this consultation.

126. When cross-examined about this Mr A said he had an angry session with Dr S once. He said he raised his voice but never swore and was not physical; put forward his concerns and "that was it". He thought this was more than likely at the consultation on 19 September. However, he said that he did not just walk into Dr S's office but had to make an appointment to see him through Mr F.

127. The Tribunal finds that Dr S did say to Mr A at this consultation that his opinion always overrode that of a general practitioner and did made the comment about the rat in the way Mr A described.

128. Following this consultation, Mr A gave Ms Watson authority to act for him from then on. He described his feelings of anger towards Dr S and believed something needed to be done about the way he was treating him.

129. Dr S said that following this "confrontation" he discussed with Mr F his intention to withdraw from all further consultations with Mr A.

130. Mr A was put on light alternative work outside at xx from 3 to 17 September 2001 on full pay and then went off work for approximately one month as certified by Dr D.

131. Mr A said he was feeling very unwell ("terrible") and that Dr S's attitude towards him had made him feel worse. When he was off work he said he had no money coming in at all and was not receiving any ACC compensation because Dr S had "cancelled" Dr D's certificate.

132. As Dr S had declined to accept Dr D's ACC certificate, Mr A said Ms Watson told him she would try and have Mr A assessed by a specialist as this appeared to be the only way he was going to be able to get ACC due to Dr S's attitude. Ms Watson made contact with Ms Lopdell of xx.

133. It is the Tribunal's view, on the evidence before it, that it was Ms Watson's efforts which caused Ms Lopdell to arrange a consultation with Dr E.

134. Dr E said he received a facsimile from Ms Lopdell informing him that xx needed his assistance to determine whether Mr A was entitled to ACC; to determine the cause of his symptoms at that time; and to determine if he could return to alternative work that had apparently been offered to him. Ms Lopdell's facsimile reported that Mr A's unwellness at that time had been diagnosed by Dr D as a relapse from the leptospirosis but that Dr S had said there were other causes.

135. On 11 October 2001 Dr E assessed Mr A at xx Hospital. He took a full history from Mr A, examined him and reviewed his medical records. Dr E formed the view that Mr A had almost certainly had leptospirosis in February 2001 as he had been working at the freezing works at xx and therefore was in the high risk category of occupations in terms of the likelihood of contracting it. He also had the classic symptoms and complications, and sero-conversion by Medlab Central Laboratories lepto screening tests.

136. Dr E reached his view that Mr A most likely had leptospirosis in February 2001 without knowledge about the antibody tests sent to the ESR on 3 March 2001 or their results which had shown a definite positive result for *leptospira interrogans var. pomona* showing a fourfold increase in titres.

137. Dr E said it was not until 19 March 2004 (when he was preparing his brief of evidence for this hearing) that he became aware of this when he saw the results within a faxed copy of Dr S's file on Mr A.

138. Dr E said he had hitherto only been aware of two negative confirmatory (titre) test results (16 and 18 February 2001). He added that if he had known about this definite positive result at the time he assessed Mr A in October 2001, he would not have needed to have required him to have had another leptospiras antibody test later on in that week. The only reason he asked him to have the further test was because he understood the diagnosis of leptospirosis that had been made in February 2001 was uncertain. He was of the view that if the further test (which he arranged) was positive this would support the February 2001 diagnosis.

139. Dr E said as it transpired the further test he sought was negative. Although he had requested full antibody testing the sample was only tested using a rapid local screen method. However, he was of the view that this negative result did not rule out leptospirosis eight months earlier as the levels might have waned in the intervening period. In any event, despite not knowing at the time of his October 2001 consultations with Mr A about the positive ESR confirmatory test, on the information before him and his examination and assessment of Mr A he diagnosed him as having had probable leptospirosis in February 2001.

140. Dr E further concluded that since discharge from hospital in February 2001, Mr A had had classic symptoms of Chronic Fatigue Syndrome. Dr E explained this syndrome does not have a definitive laboratory diagnosis but is said to exist when the following criteria are present:

(a) Fatigue that is unexplained, persistent or relapsing for six months or more and that is of new or definite onset, not the result of ongoing exertion, not substantially alleviated by rest and results in substantial reduction in previous levels of occupational, educational, social or personal achievements; and

(b) Four or more particular concurrent symptoms that had been persistent for six months or more and did not predate the fatigue.

141. Of the symptoms Mr E outlined, Mr A had the fatigue criteria (in (a)) and at least three of the concurrent symptom criteria (in (b)). Mr E said that leptospirosis is one of the most common precipitants of Chronic Fatigue Syndrome.

142. Dr E concluded that he did not think Mr A's symptoms were all in his head or that there was any evidence of depression. Nor was there any evidence from his history, examination findings or blood tests that he had any other serious disease other than his blood pressure being slightly high. Accordingly, he formed the view that Mr A's Chronic Fatigue Syndrome was a complication of the leptospirosis he had contracted earlier in the year. He concluded that the natural history of Mr A's symptoms were that they would eventually go away although there was no cure. There was, however, a need for Mr A to carefully balance his physical activity so that he maintained some regular exercise but he did not overdo it. His view was that if Mr A could stay at work then that would be very good but believed that he might not be able to work a full day or undertake heavy duties. He explained that when people have Chronic Fatigue Syndrome there is a natural tendency to withdraw from work and physical and social activities because patients find those activities very tiring and uncomfortable. This is problematic in that the patients then lose their self-esteem, their physical fitness deteriorates further, their social network gets smaller and they tend to decline. Therefore the recommendations are that they should do some work and some physical activity and some social activity so that life continues without spiralling into a downhill depressive and withdrawn situation. However, if they try to do too much then it can be uncomfortable and "wipe them out" for several days. It is therefore neither too much nor too little but is a difficult balance. This was the advice he gave to Mr A.

143. Dr E prepared a written report the same day, 11 October 2001, which he sent to Ms Lopdell of xx with copies to Dr D, Dr S and Mr A. In his report, it was readily apparent that Dr E was making the probable diagnosis of leptospirosis in February 2001 while being unaware of the confirmatory antibody test sent to ESR on 3 March 2001.

144. On 24 October 2001 Dr S wrote to Dr E' regarding the latter's report. Dr S's letter included some further information relating to the result of a *helicobacter pylori* antibody

test Dr S had done on 7 September 2001 and which had come back positive. Dr S stated in his letter that it was apparent that the symptoms, clinical findings, and laboratory results (regarding the helicobacter) had not been disclosed by Mr A during his consultation with Dr E. In the Tribunal's view the letter was an implied criticism of Mr A particularly in light of the fact that Dr S' letter did not disclose to Dr E the positive confirmatory test for leptospiro pomona from ESR on 3 March 2001, of which Dr S was aware and of which, obviously, Dr E was unaware.

145. With regard to *helicobacter pylori*, Dr E explained it is a bacterium which lives harmlessly in the stomach of 20% of New Zealanders. In a minority of cases it causes inflammation which can lead to a stomach or duodenal ulcer. If someone is vomiting blood or showing other symptoms of a stomach ulcer it is important to test for it and treat it. Dr E stated that helicobacter pylori would not have been the cause of Mr A's chronic fatigue symptoms and has no relationship to the leptospirosis. He had never read nor heard of helicobacter pylori causing or contributing to the fatigue symptoms. He said that if the bacterium had caused a stomach or duodenal ulcer and there was anaemia or bleeding then that might cause fatigue but Mr A had no symptoms or blood test evidence of anaemia or bleeding. It may have contributed however to the vomiting of blood that Mr A had when he first presented to hospital in February 2001 with the leptospirosis and it may also have contributed to the vomiting of blood he had in September 2001 after he had the two handles of beer.

146. Dr E said that neither he nor Dr H thought to test for helicobacter pylori and that Dr S had done well to have tested for it. Dr E thought that while it was right to have treated Mr A for helicobacter pylori that did not detract in any way from Mr A's leptospirosis or the diagnosis of Chronic Fatigue Syndrome. He added that there were many reasons why Mr A could have vomited blood when he was first admitted to hospital in February 2001 with leptospirosis. One reason was that he was acutely and severely ill with renal failure and that it is quite common in such patients for there to be blood from the stomach lining due to shock. As Dr H had pointed out in her evidence, Mr A had been vomiting and when one vomits for a time the stomach can tear and can leak blood. Another reason was that Mr A had had some voltaren in the days leading up to his admission to hospital. A further reason

was that Mr A had had doxycycline which, as an antibiotic, can have the side effect of causing gastric irritation which would have caused some bleeding. Accordingly, when Mr A presented to hospital vomiting blood in February 2001 the helicobacter pylori was one of five possible reasons which could have caused it.

147. On 15 October 2001, Mr A received a letter from Ms Lopdell of xx informing him that Dr E had confirmed that he appeared to be suffering from Chronic Fatigue Syndrome which appeared to be a consequence of the leptospirosis illness he had suffered in February 2001.

148. He was informed that Dr E had strongly recommended that he continue a normal active life which might take some time to resolve but it included staying at work and gradually improving his fitness levels. Ms Lopdell referred to preparing a recovery plan which was to be managed and monitored by the occupational nurse at the works in consultation with Dr S. The letter went on to state that copies of the programme would be sent to Dr D; and if the symptoms had not resolved by the end of January 2002 it was recommended that he be referred back to Dr E for further assessment.

149. With regard to the medical certificates from Dr D certifying him as being unfit from 18 September 2001, Ms Lopdell advised that Dr S had recommended alternative work which was made available with the assistance of Mr F. Her letter concluded that any time that Mr A had not attended work he would not be financially compensated as there was alternative work available for him at all times.

150. Mr A said he was angry and upset when he received this letter. He felt desperate because of the financial situation he was in and that it became so bad he had to arrange a loan from his bank to see him through.

151. On 17 October 2001 Mr A saw Dr D who had also received a copy of Ms Lopdell's letter.

152. Dr D said in evidence that having read Ms Lopdell's letter he made some notes at the end of it recording his view of the possible ethical problem associated with Dr S supervising Mr

A's recovery plan. He queried in his own mind whether it was appropriate that Dr S should be doing so because he was a paid employee of xx, Mr A's employer. He agreed with Dr E' diagnosis of Chronic Fatigue Syndrome (he having made the same diagnosis himself when he saw Mr A on 18 September 2001). Dr D also referred to the medical certificate which he had given Mr A that day for two weeks off work because if he had not done so he believed there would have been no attempt to resolve matters. By that he meant that the appropriate treatment for Mr A was for him to have a complete rest for at least two weeks and that if he did not have that then he would not have a proper chance to recover. That was a clinical decision. He also noted that he thought it seemed unfair that Mr A would not be compensated for any time he had off work because of his illness.

153. Mr A said it was around this time of 17 October 2001 that the bank started chasing him to commence paying back the loan. He said he felt "stressed out" and wondered what he was going to do about it.

154. On 18 October 2001 he saw the occupational nurse at the works who discussed putting together a return to work programme involving some physiotherapy at the gymnasium at xx. The occupational nurse made a follow-up appointment for early November 2001 when the work plan could be discussed again.

155. On 22 October 2001 Mr A returned to work. Due to Dr E' diagnosis he was able to start receiving compensation for the reduced hours he was working.

156. On 29 October 2001 Ms L of xx wrote to Mr A advising him that his entitlement to income compensation had been approved by ACC and would be paid through xx's payroll in the normal manner. He was advised of his entitlements for short term compensation covering the period 19 February 2001 to 18 March 2001 and long term compensation covering the period from 19 March 2001. He was advised that to be eligible for income compensation xx required a medical certificate from his doctor which covered the period for payment and indicated his work capacity.

157. Mr A said he had never received any ACC for all of the days he had off work or the reduced hours he worked between 17 April and 22 October 2001 either because Dr S

had never signed an ACC certificate covering him for those days (17 April to 16 September 2001) or because he "cancelled" Dr D's ACC certificate of 18 September 2001.

158. Mr A stated that right from the time when he returned to work on 22 October 2001 it was obvious to him that Dr S, xx and xx were doing all they could to get him back to full time work. He said he attended a lot of meetings with Dr S or the occupational nurse and other xx management to discuss his return to work plan. He found those meetings intimidating and always felt that what he had to say was not taken seriously.

159. On 29 October and 22 November 2001 he consulted Dr D. Dr D said the consultations centred mainly around reviewing Mr A and discussing the return to work plan which the occupational nurse was developing. The plan was to increase Mr A's hours gradually so that eventually he would be fit enough to return to normal full time work. Dr D also spoke to the occupational nurse during this period.

160. Mr A said that throughout November and December he still felt very tired most of the time but managed to work four hours a day. Towards the end of December 2001 there was some talk of increasing his hours to five hours a day which he thought he could probably manage but felt anxious that he might suffer a relapse.

161. On 20 December 2001 Mr A saw Dr D again. Dr D said that Mr A presented looking tired at that consultation. He agreed with Mr A that if his hours were increased too quickly then there was a possibility he might have a relapse but suggested that the hours be increased to five per day and he would review the situation in a month's time.

162. Dr D said that his experience of Chronic Fatigue Syndrome was that too rapid an increase in work could lead to a disappointing result and further increase the frustration and anxiety of the patient which could eventually lead to mild depression. He discussed this with both Mr A and the occupational nurse.

163. Mr A said that by the end of January 2002 he was still unwell and took a couple of days off work during January as he felt so exhausted.

164. On 30 January 2002 Mr A saw Dr D again. On that occasion, Dr D completed an ACC medical certificate for Mr A authorising him to work for four hours per day for the following 91 days. At that consultation, Mr A told Dr D he would be seeing Dr E that evening. Dr D did not see or speak to Mr A again after that consultation as he was retiring. Thereafter, Mr A continued to consult the xx Medical Centre and either saw locum doctors or Dr W who is still his general practitioner.

165. That evening, 30 January 2002, Mr A saw Dr E. That consultation was at the request of Ms L of xx who sought a further review of Mr A's condition and any suggestions for his ongoing management. Dr E said that Mr A remained much the same from his earlier consultation with him in October 2001. Dr E wrote to Ms L the following day noting that the most likely diagnosis was acute leptospirosis with consequential Chronic Fatigue Syndrome.

166. In February 2002 xx sent Mr A to see Dr G in xx for a further assessment.

167. By the end of April 2002 Mr A's hours were increased to 4.5 a day four days a week. He was still complaining to his GP of tiredness and headaches. Mr A continued to consult his GP throughout 2002 who advised him that she had been kept informed of his return to work progress.

168. Mr A stated that as his hours gradually increased he felt increasingly exhausted with good days and bad days and was barely able to cope with working four hours a day. He described feelings of fear, frustration and stress as, prior to contracting leptospirosis, he had been a very fit and energetic person. He was also afraid of losing his employment at xx if he could not return to his normal full time duties.

169. As time moved on he said he thought more and more about how Dr S had not been supportive of him when he first contracted leptospirosis and all the problems he had had, including financial ones.

170. In September 2002 he said xx sent him to be assessed by a clinical psychologist who in November and December 2002 put him through a rehabilitation programme which helped

him to learn to relax but he could still not shake off his anger about the attitude of Dr S and xx who he said had not been supportive.

171. On 30 January 2003 Dr E had a further and last consultation with Mr A. Mr A was accompanied by Ms Watson of the Union.

172. Mr A told Dr E he was still tired, particularly when he undertook physical work and had little energy. He also told him of his worry and stress, particularly over work and his family's financial situation. He described his need for excessive sleep while still feeling tired, feeling lightheaded and having back pain.

173. Dr E (who at that time was still not aware of the confirmatory ESR antibody tests of March 2001) reported to Mr A's GP (with copies to Ms L and Mr A) that he still believed Mr A had suffered leptospirosis infection in February 2001 complicated subsequently by Chronic Fatigue Syndrome. He could find no evidence that Mr A had any other medical illness. He told Mr A and Ms Watson at this consultation that it could take Mr A anywhere between two and six years to recover from his illness.

174. Dr E told the Tribunal that a review published in the Medical Journal of Australia in 2002 reported that only 36% of patients had fully recovered by five years and many others had only made a partial recovery by that time. The review also reported that if a person still had Chronic Fatigue Syndrome after five years there was a 63% chance that the person would improve over the subsequent three years. He concluded that although many people improve or recover over the first five years, there are some patients who continue to have symptoms for much longer.

175. It would appear from Professor Gorman's evidence that he undertook a clinical review of Mr A in June 2003 on behalf of xx. The review was conducted as a trainee clinical review with Dr G. As a commissioned agent for xx, Professor Gorman said that a conventional doctor/patient relationship was not established between himself and Mr A.

176. Dr Walls was called as an expert by the CAC. For the past 13 years Dr Walls has practised full time in the specialty of occupational medicine. For 40% of his time the

Occupational Safety and Health services (OSH) of the Department of Labour employ him as a departmental medical practitioner. He holds an appointment as honorary clinical lecturer at the Centre for Public Health Research at Massey University. The balance of his time is spent consulting with patients or companies on occupational health and safety issues. Included in this time is a regular clinical attachment in New South Wales. His industrially based practice in occupational medicine has included working for the primary aluminium smelting industry, the food industry, the steel manufacturing industry and for timber processing and logging companies.

177. Dr Walls made some general observations. He stated that leptospirosis is recognised as New Zealand's most common occupationally acquired infectious disease. He added that meat processing workers have proportionally the highest rates of the disease and that those workers are in the "high risk" category of occupations in terms of contracting the disease.

178. He said that the xx works is one of the few plants in New Zealand to experiment with and install engineering solutions to control exposure and would be considered one of the better performers in this area, and that Dr S, in his view, would have played some part in that.

179. He explained that early intervention with antibiotics dramatically improves the symptoms and aborts the progression of the disease. However, he said it is also well recognised that such early treatment can prevent the development of antibody titres which show the body's response to the leptospiros infection. It is not unusual in his experience that the titres take some time to come through as positive as it can take time for the body to build up its response. The diagnosis of leptospirosis therefore relies on proven or possible exposure, appropriate symptoms and response to such therapy and, ideally, antibody response.

180. With regard to ACC's requirements, he understood that acceptance of cover for leptospirosis/occupational diseases was proof of the disease on the "balance of probabilities".

181. It was Dr Walls' opinion that the *"occupational physician's primary responsibility is always to the patient; in occupational medicine, an employee"*; and that while the occupational physician's clinical responsibility is for work-related conditions, the

occupational physician will negotiate with the family or the nominated treating doctor (the general practitioner) of the employee to ensure that factors are not overlooked or unrealistic demands made on the patient or to ensure that the general practitioner is aware of the treatment and aware of features of any return to work programme.

182. Dr Walls stated that occupational physicians are often consulted about non work-related conditions. He said that the treatment and management of these are the provenance of the family or treating doctor who is usually the general practitioner. Treatment, provided it was suggested by the occupational physician, should always be communicated (preferably before commencing treatment) to the family doctor and with their approval.

183. It was Dr Walls' opinion that when dealing with non- clinical issues such as work-related non-treatment issues, the occupational physician must always exercise the highest standards of evidence based medicine, medical commonsense and compassion. Where the occupational doctor was acting to determine causation only (that is, no treatment role was intended) all parties to the arrangement must be informed.

184. Dr Walls pointed out that mistrust of the occupational doctor by employees is inherent in this branch of medicine and that it is best addressed by clear communication copied to all parties, by solutions backed with evidence, by maintaining the patient's long-term well-being as being paramount, and by being prepared to acknowledge when diagnoses or suggested policies prove incorrect.

185. Dr Walls said it was extremely important when the occupational physician was solely involved in determining causation that he/she explained this and its potential consequences.

186. With regard to return to work programmes, Dr Walls said the occupational physician should (a) ensure that medical communications between the providers is faultless; (b) ensure all parties are clear about the occupational physician's view on suitable duties; (c) ensure that where the occupational physician has influence all parties fulfil their parts of the return to work duties so that modified duties are provided as a reality (Dr Walls added that the default position was to preserve the recuperating employee from risk so that where, as an example, there is a failure to provide modified duties on the part of the employer, an

occupational physician would certify the employee is unfit for work on the appropriate sickness or ACC form); (d) personally oversee and supervise the employee's abilities to cope with those duties by observing them working in the role; and (e) if necessary confront the employee with the occupational physician's view that the employee could do more and offer some evidence or reasoning as to how that conclusion was arrived at.

187. Where the nominated treating doctor and the occupational physician cannot agree on appropriate interventions and duties or where the doctor/patient relationship has broken down the occupational physician should withdraw from direct involvement and use a colleague to oversee the disputed aspects of the programme.

188. In Dr Walls' view, Dr S's refusal to accept the hospital diagnosis was inexplicable and intentionally or unintentionally resulted in temporary benefit for his employer, xx and/or their insurer, at Mr A's expense.

189. In this regard, in Dr Walls' opinion, Dr S fell below the standards expected of an experienced doctor practising as in industrial medical officer and holding clinics in an "at risk" industry.

190. With regard to particular 2(a) and (b) of the charge, Dr Walls stated that whether a person received cover for ACC was a legal issue and not a medical one.

191. He said it was the role of the treating doctor to determine the diagnosis and appropriate treatment, as Dr H did. The occupational physicians add to the role by considering causation, that is, whether the disease was occupationally acquired, in order to focus on preventive measures,

192. In Dr Walls' view, it was not best practice or even common practice to not accept or not certify that Mr A was suffering from probable leptospiral infection in the period from 28 February 2001 through to 16 March 2001.

193. Dr Walls said that Dr S should have lent his support to Mr A to ensure he received whatever statutory entitlements were available to him given the hospital diagnosis, based as

it was on a positive leptospiros screen as at 18 February 2001, the clinical picture (which included severe renal and hepatic damage), and Mr A's occupational exposure. Dr S should have been recommending to xx during the above period as early as 28 February 2001 that cover be accepted.

194. If Dr S had any concerns about clarifying the diagnosis then he should have mentioned those and provided timelines for such clarification when discussing the diagnosis and ACC claim certification with xx.

195. Dr Walls said he would have expected a doctor in Dr S's position, holding clinics at a meat processing works, to be familiar with the symptoms and signs of leptospirosis disease and to encourage xx to accept cover on ACC's behalf. Even if he believed there were significant concerns about the exact circumstances of causation, in his view Dr S should have recommended that the diagnosis be accepted, even on a provisional basis, so that Mr A's claim could be processed and he could start receiving compensation and/or entitlements as soon as possible.

196. Dr Walls added that it was not an uncommon situation for a diagnosis to be changed or for causation to be decided as non-work related once more information became available. His understanding of the process was that ACC would then either write off the moneys they had paid or some swap would go on with the employer against leave without pay, sick leave, holiday leave and other entitlements.

197. With regard to particular 2(c) of the charge Dr Walls said that he did not necessarily believe that the delays, confrontation, and "stress" which Mr A said he suffered as a result of the climate of confrontation which developed in the period between 28 February and 16 March 2001 delayed or hindered Mr A's recovery. However, Dr Walls was confident that Mr A would not have been as able to deal with those problems competently while he was in the state which he maintained he was in (as did his partner Ms B) and that the delays, confrontation and "stress" would have made the feelings of fatigue and the like more intolerable; that is, those factors would not necessarily have delayed recovery but are likely to have made the symptoms seem more severe.

198. With regard to particular 3 of the charge, Dr Walls referred to the consultations which Mr A had with Dr S on 3, 7 and 17 September 2001.

199. In Dr Walls' opinion, it would have been expected practice at each of those consultations for Dr S to have considered the reported symptoms of fatigue as being a not unreasonable consequence of a severe infection which had led to acute renal failure; that is, a consequence of the leptospirosis.

200. While it was not unreasonable for Dr S to have considered other causes of ongoing fatigue, such as helicobacter, one would expect some compelling evidence if the diagnosis of leptospiral infection were to be rejected.

201. While accepting that it was necessary to investigate a patient history of coffee ground vomitus, Dr Walls opinion was that by not investigating further or acting on the patient's reports of ongoing tiredness and low energy levels and not appearing to have considered or appreciated whether or not there might be a link between those symptoms and the leptospirosis Mr A had suffered in February, Dr S did not meet accepted standards of practice.

202. Dr Walls stated that chronic fatigue was a well recognised complication of the leptospiros infection and he would have expected an experienced doctor like Dr S, holding clinics in an "at risk" industry to have recognised or at least considered those symptoms as being an after-effect of the patient's leptospiral infection six months earlier.

203. Dr Walls referred to Mr A's evidence regarding the consultation he had with Dr S on 19 September 2001. In that consultation Mr A had presented Dr S with the ACC certificate which Dr D had signed the day before certifying him as suffering from chronic fatigue syndrome post leptospirosis and unfit for work for the following 14 days. Dr S had "cancelled" the certificate.

204. In Dr Walls' opinion Dr S should have sought permission from Mr A to contact Dr D to discuss the reasons why he disputed his diagnosis. He said that if it were found that Dr S did not contact Dr D then it was Dr Walls' belief it was unwise and unacceptable for Dr S

not to have done so particularly in circumstances where he would have, or ought to have, been well aware of the implications for his patient of him not having accepted and/or overridden Dr D's diagnosis and ACC certificate. Dr Walls said that Dr S's primary obligation was to his patient, Mr A, and he should have been motivated by the need to resolve the matter of the disputed diagnosis as expeditiously as possible.

205. Further, if Mr A's evidence was accepted that it was Ms W, the Union representative, who arranged for xx to have Mr A referred to a specialist (Dr E) and if Dr S took no action, then in Dr Walls' opinion that was shortsighted and unacceptable. The Tribunal has accepted Mr A's evidence in this regard.

206. Given the confirmation by Dr E of Dr D's diagnosis of chronic fatigue as an after effect of the leptospirosis, it was Dr Walls' view that in all the circumstances Dr S should have issued Mr A with the appropriate ACC certification to have enabled him to claim compensation for the reduced hours and time off work he had in the period from 17 April to 16 September 2001 and in the period from then to 22 October 2001.

207. With regard to particular 4, Dr Walls outlined the *Guidelines On Ethics And Professional Conduct For Occupational Physicians* of the Australasian Faculty of Occupational Medicine (the Guidelines).

208. The Guidelines contain a statement in Section 1 that doctors working in occupational health may face some ethical issues that are uncommon in other situations. Those ethical issues:

> *"…often relate to potential conflicts because of the involvement of third parties. At different times occupational physicians have responsibilities to individual patients under their care, workers in a particular workplace, employers, the general public and specific responsibilities under legislation. Responsibilities to these parties may conflict. Problems are most likely to arise if these potential conflicts are not recognised; particularly if one party is not aware that the occupational physician has other responsibilities."*.

209. That passage needs to be read in the context of the opening statement in Section 1 under *"General principles"* which commences:

> *"In many ways the ethics of occupational medical practice are exactly the same as those for doctors in other forms of practice, but doctors working in occupational health may face some additional ethical issues that are uncommon in other situations."*

210. "Non maleficence" is defined in the Guidelines under *"General principles"* as:

> *"… the doctrine of not doing harm. In occupational medicine this is complicated by having multiple clients (workers, patients and employers) who all claim the right not to be harmed. The relative merit of competing claims is often the subject of ethical debate"*.

211. "Beneficence" is defined as:

> *"… doing good. This is more than the opposite of non maleficence, it is a positive action to do good. There is of course a danger that beneficence may conflict with autonomy. Taken to extreme, beneficence becomes patronisation."*

212. "Justice" under this section is referred to as follows:

> *"Justice should temper all considerations. This is very much the issue in many workplace situations."*

213. In a question from the CAC Counsel, Dr Walls agreed that these principles were generally applicable to medicine across the board.

214. Section 7 of the Guidelines relates to "workers compensation and rehabilitation". This section states:

> *"Workers compensation schemes often have structures available specifically to support injured workers to return to work. Occupational physicians have an important role in these structures. While respecting the wishes of their patient, occupation physicians should provide information about capability of the patient, suitable duties and restrictions to rehabilitation co-ordination and management and encourage their patients to co-operative with rehabilitation processes."*

215. Section 6 of the Guidelines relates to "relationships with others". Section 6.1 deals with "other doctors" and states:

> *"Occupational physicians may need to discuss the working conditions of an employee with that person's treating doctor."*

216. The Guidelines state at the end of Section 1 under "General principles" that:

> *"When in doubt, occupational physicians should discuss the issues with senior medical colleagues and/or obtain advice from professional bodies such as medical indemnity associations, the relevant medical registration board, medical professional associations, impaired doctors' groups or equal employment opportunity bodies."*

217. Dr Walls expressed the view that on the basis of the information which he had reviewed in relation to this case, Dr S fell short of the standards with respect to maleficence (on 28 February 2001 by not accepting the hospital diagnosis when Mr A presented him with a copy of the hospital's ACC certificate dated 23 February 2001, and not making a presumptive diagnosis in the period immediately after) and justice (not accepting the hospital diagnosis and certifying appropriately, at least until some more solid reasons for doubt in relation to the validity of the diagnosis existed).

218. Dr Walls further stated that in his opinion Dr S fell short of acceptable standards and breached the principle of maleficence by refusing to accept that Mr A's chronic malaise and fatigue were an after effect of the leptospirosis in refusing to issue him with the relevant ACC certification to enable him to claim compensation and entitlements to cover him for the period from 17 April 2001 through to 16 September 2001 (and from 16 September 2001 through to 22 October 2001 if that were the case). He stated that if Mr A's evidence as to the significant stress and financial hardship he suffered in those periods was accepted, then it must be said that Dr S's conduct certainly did not promote Mr A's wellbeing and probably "harmed" Mr A. He added that in his opinion it is perhaps the justice factor where occupational doctors must provide patients with the benefit of doubt (with respect to certification and compensation issues) rather than providing the employer or insurer with such benefit at the patient's expense.

219. In Dr Walls' view Dr S's conduct was consistent with him having provided his employer, xx and/or xx, with such benefit at Mr A's expense.

220. With regard to the return to work programme, Dr Walls said there appeared to have been deficits in communication with Mr A's general practitioner, Dr D. If it were accepted that Dr S did not contact Dr D to discuss his views about Mr A's fitness to return to work in the period mid September/mid October 2001 then, in Dr Walls' opinion, Dr S fell short of the standards expected of a practitioner practising as a medical officer in an "at risk" industry.

221. Dr Walls stated that maintaining trust in such professional relationships can be difficult and is dependent on the personalities of all parties, the work and political environment at large, and the experience of all parties in the particular work environment.

222. Dr Walls commented that he had not seen any evidence that Dr S consulted with senior colleagues or sought advice as to the diagnostic issues in February/March 2001 or as to the contentious return to work programme in or around September/October 2001. Dr Walls stated that if that were the case then, in his opinion, Dr S fell below the standards expected of a doctor practising as an industrial medical Officer.

223. The Tribunal also heard from Dr Kevin Morris.

224. Dr Morris is a corporate medical adviser to ACC and has been since 1992. His work for ACC includes giving advice to claims staff on applications for cover for occupational diseases and infections. He holds a Diploma in Occupational Medicine (among other qualifications) and is a Fellow of the Royal New Zealand College of General Practitioners.

225. Dr Morris stated that the standard of proof for all ACC decisions in respect of cover is the "balance of probabilities".

226. Under the relevant legislation regarding Mr A's situation, for ACC to have given cover for an occupational disease it needed to be satisfied on the "balance of probabilities" first that there was a disease or infection present and, secondly, that the disease or infection was occupationally acquired/work-related.

227. This standard of proof did not require conclusive proof of a disease or infection and/or whether or not it was occupationally acquired.

228. Dr Morris stated that xx would have been "self managing" xx employees' ACC claims and would have been making the decision as to whether or not cover should be accepted in any given case. Decisions in respect of cover were decisions xx was making on ACC's behalf. When making those decisions xx was required to comply with the relevant provisions of the Accident Insurance Act 1998 and therefore would or should have been well aware of the requirements for acceptance of cover and the relevant standard of proof.

229. In relation to whether or not, on the balance of probabilities, there was a disease present, Dr Morris stated that on the basis of the evidence on behalf of the CAC (that is, the fact of Dr D's provisional diagnosis on 16 February 2001, the severe kidney and liver impairment around the time of Mr A's admission to hospital, Mr A's occupational exposure, and the positive leptospirosis screening test on 18 February 2001) he (Dr Morris) would have been satisfied on the balance of probabilities that Mr A had a diagnosis of leptospirosis in February 2001.

230. The second consideration for Dr Morris was whether this disease had been the result of and/or caused by an occupational exposure.

231. Dr Morris referred to section 33 of the Accident Insurance Act 1998 which sets out the criteria for an occupational disease.

232. In summary, section 33 required that (a) a person performed an employment task that had a particular property or characteristic; or worked in an environment that had a particular property or characteristic that caused or contributed to the disease; (b) that the particular employment task or employment environment was not found to any material extent in the non-employment activity or environment of the patient; (c) and that the risk of suffering from that disease was significantly greater for persons who performed that employment task or worked in that employment environment than persons who did not perform that employment task or work in that employment environment.

233. It was necessary for all of (a), (b) and (c) to be satisfied in order to conclude that a disease was an occupationally related one.

234. Taking into account that Mr A worked in a meat processing plant on the slaughter floor in the stunning area hanging up carcasses which was high in potential exposure; that he was doing the type of work which put him at significantly greater risk of contracting leptospirosis than persons who do not do that type of work; that at the time that Mr A contracted leptospirosis he had stated to his employer that he had not been around animals at home and that there was no other evidence that he was at risk of catching leptospirosis in his non-work environment, Dr Morris would have concluded on the balance of probabilities that Mr A had leptospirosis and that it was occupationally acquired.

235. This would have meant that as soon as Dr Morris had been given the ACC certificate completed by the hospital on 23 February 2001, he would have advised ACC claims staff that ACC cover should be given and Mr A's ACC certificate would then have been processed. In the event that the ESR confirmatory leptospirosis antibody test (MAT testing) later failed to confirm the diagnosis, then cover could and would have been revoked at that time.

236. Dr McBride was called as an expert by Dr S. He is a senior lecturer in occupational medicine at the University of Otago and is departmental medical practitioner to the Otago regional office of the Occupational Safety and Health Service of the Department of Labour.

237. In 1993 Dr McBride became a member of the Faculty of Occupational Medicine of the Royal College of Physicians of London and in 2000 graduated with a PhD in occupational medicine from the University of Birmingham. He has post-graduate certification in applied statistics and forensic medicine.

238. Dr McBride confirmed that he was Dr S's academic course leader during the time that Dr S was enrolled in the post graduate Diploma in Industrial Health at the University of Otago during the year 2000. That course taught the basic competencies required of trainee occupational physicians by the Australasian Faculty of Occupational Medicine.

239. Dr McBride said that Dr S was a diligent student graduating from the course with a credit pass and that he noted during the teaching sessions that Dr S had considerable practical experience in occupational medicine.

240. With regard to the first particular of the charge, Dr McBride was of the view that Dr S was correct in his clinical actions. Having received an ACC certificate from xx Hospital Dr S was following the guidelines for diagnosing occupationally related leptospirosis (that is the ESR ones) and that in doing so he was not refusing to accept the diagnosis but required further information.

241. Dr McBride referred to the ACC processes where revocation can take place some time after the claim has been made and the client can be left without cover for the period of incapacity and that was why one had to be very careful with work-related cases and gather the maximum amount of information.

242. Dr McBride referred to the fact that leptospirosis is a notifiable disease both to the Medical Officer of Health and to the OSH Service of the Department of Labour, of which he said Dr S was aware.

243. With regard to the second particular (part (a)) of the charge, Dr McBride said that the standard of evidence required as a clinical level of proof will vary according to the context even within the meaning of the ACC legislation. In his view the balance was adequately shifted in an occupational case of leptospirosis by knowledge of the source of the infection, in particular the strain of the organism.

244. With regard to the second particular (part (b)) of the charge, Dr McBride stated it was appropriate to defer the decision to certify leptospirosis until further information was to hand and that Dr S did not have the titre results until 16 March 2001. In his view it would have been wrong for Dr S to certify Mr A as suffering from occupational illness until the criteria were satisfied.

245. With regard to the second particular (part (c)) of the charge, regarding the climate of confrontation, Dr McBride said the role of an occupational physician unfortunately does

contribute to a climate of confrontation especially when a certification process is involved. He added that what contributed to Mr A's stress was that he was receiving contrary messages from his medical advisers.

246. With regard to the third particular of the charge, regarding the chronic fatigue syndrome, Dr McBride stated that the investigations instigated by Dr S regarding the coffee ground vomitus were logical, appropriate and justified.

247. Similarly, when Dr S saw Mr A again on 17 September it was appropriate to instigate treatment for helicobacter pylori and that giving Mr A light duties and telling him he would be referred to Dr D if symptoms persisted was logical and appropriate. Dr McBride added that in most cases, patients seemed to do better if they stay at work. He referred to Dr D's ACC certificate of 18 September certifying Mr A for two weeks off work due to chronic fatigue syndrome. Dr McBride stated that while he agreed with the diagnosis he did not agree with the recommended treatment and that in his experience the best form of management was to keep the person in work but ensure that fatigue is minimised by modifying the duties.

248. With regard to the fourth particular, Dr McBride stated that the Diploma of Industrial Health completed by Dr S had a module covering ethics.

249. Dr McBride said that bioethics experts recognise that occupational health practice can, by its nature, be confrontational. This is due to the nature of the decisions which must be made, not all of which may benefit the individual. In his experience, the clinical example most likely to give rise to grievance is the very circumstance under consideration in this case, that is, the certification of incapacity.

250. Dr McBride stated that in these cases "the certifying practitioner is not in a doctor-patient relationship, but in a doctor-client relationship". He said the two roles should not necessarily be mutually exclusive but, in the latter case, especially if a third party is involved, the doctor must remain strictly impartial. He said the balance in impartiality can be shifted by the professional role of the practitioner. If a general practitioner, then that person is more likely to be an advocate for the patient and less likely to consider the

implications for the employer. If an occupational physician, then a similar shift in favour of the employer may be perceived, whether it is real or not. The occupational physician is more likely to consider his/her responsibility to the employer.

251. Dr McBride said that appropriate and open communication is a very important feature and referred to Dr S's explanation to Mr A as to why he was embarking on further tests (titre tests) and the reasons why he could not certify the condition. Dr McBride said he could also picture that this explanation may not have readily been accepted by Mr A especially in the circumstances where he had received, in effect for him, confirmation of the diagnosis from other practitioners. Dr McBride said that a situation in which the occupational physician is particularly likely to face conflict because of perceived bias is when, because of technical expertise, training, but most of all knowledge of the work place, the occupational physician disagrees with the diagnosis or suggested management of another doctor.

252. In Dr McBride's opinion, both those instances had happened in the present case. He said Dr S was simply using the correct tool, that is, the ESR criteria, but that this did not help his relationship with Mr A who began to view Dr S as a "company" man. He said this naturally frustrated Mr A and because of the laboratory delays may have begun to embitter him. The delay in receiving the laboratory results was not Dr S's fault and, for those reasons, he did not believe that Dr S was in breach of the ethical guidelines.

253. Dr McBride said the second set of problems began to occur because of a difference of opinion between Dr S and Dr D. Dr S was aware that the best form of rehabilitation for chronic fatigue syndrome, whatever the cause, was to try and stay at work. He added that as the relationship with Mr A had obviously deteriorated by that stage Dr S would have been much better either to have handed the case over or to request the situation be reviewed by way of a case conference. However, he did not believe that he was in breach of the ethical guidelines for not doing so.

254. Dr McBride made some general observations about the case.

255. One was that the ACC process is often a frustrating one for the claimant due to several factors, the main one being a delay in acceptance, or otherwise, of a claim which may be due to various reasons including conflicting opinions from medical practitioners, the need for further referral, or the requirement for further tests. He said those factors were especially important in work-related claims. Another major factor to which he had already referred was the likelihood of withdrawal of cover if the diagnosis was in error.

256. Dr McBride observed that Dr S was not the only person involved with Mr A's case. He said that Mr A's supervisors, line manager, health and safety manager, case manager and general practitioner all had responsibilities to help manage the case. He added that better communication between those parties would have helped to avoid some of the conflict.

257. In cross-examination, Ms McDonald put it to Dr McBride that there were some passages in Dr McBride's written brief of evidence that were "strikingly similar" to the passages in Professor Gorman's brief of evidence. Dr McBride stated he had received a copy of Professor Gorman's brief of evidence after he started to prepare his own brief and before he had completed it.

258. In answer to a questions from Ms McDonald, Dr McBride accepted that certification of leptospirosis does occur on the basis of the ACC "balance of probabilities" criteria. He confirmed that nobody was disputing the ACC test is the balance of probabilities.

259. Ms McDonald referred Dr McBride to the teaching material which was provided to Dr S when he undertook the post graduate Diploma in Industrial Health. Dr McBride agreed that there was nothing in those course materials which required that a "definitive" diagnosis was required before certification could be made.

260. Dr McBride further agreed that all cases need to be dealt with on a case by case basis looking at the entire circumstances although one must also take a global view of one's practice in order to have consistency when making diagnostic decisions.

261. Dr McBride agreed in cross-examination that based on the fact that there are only eight serovars of leptospirosis occurring in New Zealand, and that only two of them would not arise at the xx plant, it was very likely that the leptospirosis came from the plant. (Dr S similarly agreed, during cross-examination.)

262. Dr McBride also agreed with Ms McDonald that he might have made a different diagnosis from Dr S, under the circumstances, bearing in mind the kind of work that Mr A was doing, where he was working on the slaughter floor, the fact that he had been asked and confirmed that there were not any obvious exposure risks in terms of his domestic situation and that there was an exceedingly small chance that he could have contracted the leptospirosis anywhere else other than his place of work. Most of the strains were carried by the stock with which he was working.

263. With regard to the issue of Chronic Fatigue Syndrome, Dr McBride said that in his experience it was not an uncommon complaint; and that with a patient like Mr A who had had severe leptospirosis in February and later presented with severe fatigue that might well indeed be a possible reason for the fatigue.

264. In answer to a question by Ms McDonald, Dr McBride said that if he were presented with a patient such as Mr A who was complaining that he "had no energy" on 3 September 2001, given Mr A's history, that would be something which he would certainly want to explore.

265. Dr McBride said that the helicobacter did not rule out chronic fatigue which could have been connected to the leptospirosis.

266. Dr McBride confirmed that the Guidelines, which were produced by Dr McBride at the hearing, were part of the course material for the ethics module of the Diploma of Industrial Health at Otago University which Dr S undertook and was given.

267. Dr McBride was asked a number of questions by members of the Tribunal regarding the differences, as he saw them, between the doctor/patient relationship and the doctor/client relationship.

268. He said that the doctor/client relationship was clearly when someone was not attending the person as their personal medical physician but on behalf of a third party who required information in order to make a decision on something which would have an impact on the client.

269. When asked by a member of the Tribunal whether at different times doctors in occupational medicine might be acting in all three capacities, that is, monitoring, treating and certifying, Dr McBride replied that could indeed be the case. In occupational medicine practice a person might attend for a consultation in the workplace and the doctor may have to take all those matters into consideration. Dr McBride said that the Guidelines were clear that when the doctor was having a private consultation with the individual, the individual would be given advice that was going to be best for that person in the long term regarding health and work without regard to the employer.

270. Dr McBride agreed that he would not expect a patient such as Mr A to understand the niceties of which role the doctor was in when consulting with him.

271. Dr McBride was questioned by another member of the Tribunal as to how the patient would know when the doctor slipped from one role into the other. Dr McBride said that in some cases it would be clear to the patient what is occurring but in other cases the doctor would have to make it clear to the patient the role in which the doctor was acting. He said it would depend how the consultation evolved and the way in which the "patient" or "client" reacted but that it was something that they were trained to recognise and deal with appropriately so that the patient was not disadvantaged and that it was nearly always the patient that the doctor was dealing with, in fact.

272. Dr McBride was asked by a member of the Tribunal how the doctor's obligations differed when the doctor's role changed from doctor/patient relationship to doctor/client relationship, that is when the "patient" became the "client". Dr McBride replied that the doctor had to make sure that the patient had the opportunity to pursue alternative courses or understood what was going to happen and could take alternative actions to the action that the doctor proposed or the way that the doctor said that the case should be managed.

273. When asked whether the doctor had a continuing obligation when the "patient" became the "client" to make the client aware of that, Dr McBride replied that it was difficult to generalise but that was quite likely to be the case and the doctor "should continue to support the client as a patient".

274. When asked whether he taught any advanced communication skills in his study programme, Dr McBride said that he does as part of the programme but it is simply giving people guidelines and pointing them towards what may be best practice. He confirmed that Dr S had participated in the module on communication skills dealing with both the oral and the written communications.

275. Professor Gorman was called as an expert by Dr S. He has a personal professional chair in medicine at the University of Auckland; is director of admissions for medicine and the head of occupational medicine for the University of Auckland. He is the Censor in Chief for the Faculty of Occupational Medicine (AFOM) in the Royal Australasian College of Physicians (RACP). Professor Gorman has been in specialist occupational medicine practice since 1984. Among his degrees he holds a Doctor of Philosophy in Medicine and is a Fellow of RACP in occupational medicine.

276. Professor Gorman agreed that in terms of the general medical ethical requirements to do no harm, do good, and to be fair and just, those were requirements with which he would expect all doctors to be familiar.

277. In answer to a question from a member of the Tribunal, Professor Gorman agreed that at all times Dr S, with regard to Mr A, had assumed both the role of the treating doctor and the non-treating doctor. Further, he did not endorse the fact that Mr A was not cognisant of the shifting roles. He added that in his opinion the duality had been reasonably well exercised by Dr S but poorly communicated.

278. In answer to a further question by a member of the Tribunal that there may also have been a lack of communication or understanding by Dr S of Mr A's position and what that meant to him, Professor Gorman replied that one of the observations he had already made was that reading the various transcripts he found it hard to understand "how this went so sour so fast" and that he made the presumptive statement that "there had to be ill will or ill feeling to explain this disintegration of collegiality". Professor Gorman added "this story [did] not make sense to [him]".

279. Professor Gorman said he endorsed Dr S's approach to certification diagnosis in this context and Dr S was correct in advising Mr A that he could not provide ACC certification of a diagnosis of leptospirosis until it was confirmed by the titre results on 16 March 2001. If Dr S had done so beforehand Professor Gorman would have considered this premature and bad practice.

280. As stated above, in June 2003 Professor Gorman undertook a clinical review of Mr A on behalf of xx in circumstances such that a conventional doctor/patient relationship was not established. Mr A attended with Ms B and both impressed as accurate historians. Professor Gorman had no reason to consider Mr A's history to be suggestive of either a fictitious disorder or of malingering. He concluded that it was almost certain that Mr A's infection was acquired at work and that his ongoing malaise and fatigue were probably the result of the infection. There was a reasonable causal chain from the work-related disease to the current disability.

281. Professor Gorman said he agreed entirely with Dr S's rationale for his delaying completing and forwarding an ACC certificate at that time. He added that when medical certification has notifiable and compensable outcomes, there is an increased need for diagnostic rigour

and that not only was ACC involved but also OSH as leptospirosis is a notifiable disease. However, in the Tribunal's view, this is a scientific rationale, and not a clinical one.

282. Professor Gorman said he thought it wrong for Dr S to be portrayed as the company doctor who, because of pedantic diagnostic testing regimes, had improperly stood in the way of Mr A's rights to receive compensation at an earlier stage.

283. Professor Gorman referred to the allegation that Dr S failed to recognise the ACC requirement as to the "balance of probabilities" test. Professor Gorman said this allegation confused the role of medical practitioner as certifier and that of the ACC which is entirely responsible for determining entitlement. He said the standards by which the ACC acts to decide cover should not be extrapolated to medical decision-making as the latter must often conform to very different standards. He said these latter standards were not regulated by ACC. In this setting, Professor Gorman stated he would not have certified a diagnosis of leptospirosis until he had a confirming test, as was sought by Dr S. He added that he could understand that in many clinical situations a balance of probabilities would suffice but that this was not the case for this particular situation because of the occupational and OSH consequences.

284. Professor Gorman stated that the premise that a doctor should provide ACC certification on the basis of a "balance of probabilities" was in his opinion nonsensical unless the balance was defined in the context. It was his opinion that the balance of probabilities should be very much greater in the context of formally receiving an occupational diagnosis. He asserted that any "balance of probabilities" defined by the ACC must be primarily actuarial and does not by itself constitute any clear basis for ethical medical practice.

285. With regard to the suggestion of haematemesis, Professor Gorman considered that the diagnosis of suspected peptic ulceration was appropriate given the history obtained. He considered that the range of investigations which Dr S ordered was a reasonable response.

286. Professor Gorman referred to the Guidelines on ethics and professional conduct for occupational physicians. He stated that Dr S had a number of different roles. One was as a company doctor providing occupational medicine advice to xx. In that role Dr S

operated as the commissioned agent for a third party. A second role was as a medical practitioner acting on behalf of the ACC. Again, in this context, he operated as a commissioned agent of a third party. The third role was as a treating medical practitioner, that is, he had a therapeutic interaction with an individual. In these circumstances, Professor Gorman said Dr S had a prime responsibility to the patient. While there was no ethical reason why Dr S could not offer primary healthcare to employees of xx it should be made overt to all parties that a consultation in this context invokes a doctor/patient relationship.

287. Professor Gorman said that when Dr S sees an individual on behalf of a third party, the responsibilities associated with therapeutic relationships alter. He gave as an example that ethically and legally a medical practitioner cannot tacitly or overtly condone a diagnosis to ACC if the doctor believes it to be in error.

288. Professor Gorman said that where Dr S sees patients as a practitioner of occupational medicine working for xx, his obligation is again to a third party and not to the individual. However, he added, the nature of these latter two interactions should be explicitly stated at the time of consultation.

289. Professor Gorman stated that any suggestion that another medical practitioner overturning a general practitioner's diagnosis or medical certificate is committing an unsafe act is untenable for a number of reasons. He said that diagnoses are not fact but an analysis of facts and classical medicine is presented as a list of alternative explanations in order of decreasing frequency. This is known as the differential diagnosis and, as facts change, the diagnosis may change.

290. Professor Gorman referred to the hierarchical practice of medicine where some may have expertise and higher training than others and are therefore less likely to make a diagnostic error.

291. With regard to Dr Walls' evidence, Professor Gorman stated that while Dr Walls was an experienced occupational physician and a valued colleague he strongly disagreed with some of his comments.

292. He said that Dr Walls' evidence was based on two fundamental assumptions. The first was that the doctor/patient relationship always has primacy and the second is that a diagnosis can be made generically at a presumptive level of likelihood. He agreed with Dr Walls' criticism of Dr S's communications with Mr A. However, he said similar criticism could be made of the other medical practitioners involved and that the situation in Mr A's case appeared to have been adversarial and not collegial, almost from the outset.

293. Professor Gorman said that the viewpoint that the doctor/client interactions are invariably doctor/patient interactions and that the doctor's first obligation is always to the patient is wrong. He said the role of the occupational physician in particular is various and may change during a single meeting, interview and/or consultation. He said that he discussed this issue at a recent Board of Censors' meeting at which he discussed this issue in generic terms. He said that the Board agreed with his perception of a conflict between the ethical guidelines and any presumption of an invariable doctor/patient primacy. He said that the opinions expressed by Dr Walls in this context are not those of his professional college.

294. Professor Gorman also disagreed strongly with Dr Walls' criticism of Dr S in that a diagnosis of leptospirosis was clinically obvious and hence both treatment exhibition and certification were justifiable. He said there was no doubt that a definitive diagnosis of this infection could not be made until the ESR titre results were received.

Summary of the Case for the CAC

295. With regard to particular 1, the allegation was that on 28 February 2001 Dr S refused to accept the diagnosis of leptospirosis made at xx Hospital during the in-patient stay of Mr A in the period from 18 February 2001 through to 25 February 2001.

296. With regard to particular 2 of which there were three sub-parts, the CAC alleged that during the period 28 February 2001 through to 15 March 2001 Dr S failed to recognise that the ACC requirement for acceptance of cover was on the "balance of probabilities" and that for the purposes of the Accident Insurance Act 1998 (which applied in Mr A's situation) the test did not require absolute proof of an occupationally acquired illness. Dr S should have made a presumptive diagnosis of leptospirosis and not refused to provide Mr

A with the certification to enable him to claim compensation from ACC in the periods from 28 February 2001 to 5 March 2001 (which was the period covered by the ACC certificate completed at xx Hospital on 23 February 2001) and that in the period from 6 March 2001 through to 16 March 2001 when Mr A remained off work with and/or recovering from leptospirosis. The CAC alleged further that Dr S's actions in this regard contributed to a climate of confrontation with Mr A, which resulted in unnecessary hardship and stress and may have been prejudicial to his recovery.

297. The third allegation was that despite other medical practitioners, that is Dr D and Dr E, having formed the view (on 19 September 2001 and 11 October 2001 respectively) that Mr A's chronic malaise and fatigue in the period from 15 April 2001 through to 16 September 2001 were due to the after-effects of leptospirosis, Dr S did not provide Mr A with the relevant ACC certification (back-dated) to cover him for that period, thereby resulting in major stress and financial hardship for Mr A.

298. Counsel for the CAC submitted that the fourth allegation was self explanatory. It was alleged that the fundamental principles of non-maleficence, beneficence, and justice, as set out in the Guidelines on Ethics and Professional Misconduct for Occupational Physicians of the Australian Faculty of Occupational Medicine, are general principles and/or do not differ from the fundamental principles which apply to all doctors in all forms of practice.

Summary of the Case for Dr S

General

299. In support of Dr S's defence of the charge, Mr James tendered in evidence a number of character references which he submitted provided a powerful and compelling picture of an honest, competent practitioner of high integrity and that they portrayed a conscientious practitioner of exemplary professional standards of behaviour and conduct. In reaching its findings and conclusion, the Tribunal took these references into account.

300. Mr James pointed to some of the pieces of evidence and directly challenged Mr A's credibility. In particular, he referred to the consultations of 3, 7 and 17 September 2001 and submitted that there was conflict on the topic of lethargy and chronic malaise. He

submitted that discrepancies in the evidence indicated that either Mr A was not an accurate historian or alternatively was somewhat "gilding the lily". The Tribunal does not agree with this submission. It found Mr A to be a credible witness.

301. Mr James submitted that Dr S was not a person who would take an unjustified or improper stance merely on principle such that a worker would be deprived of his rights or be delayed in receiving his compensation; nor was he a person who would ignore complaints, symptoms, and a clinical picture and embark on an exploration of helicobacter when another condition was there to be diagnosed; and nor was he a person who would slavishly protect the employer's interests regardless of how this would affect the worker.

302. He submitted that Dr S did all that was properly required of him. He referred to the experts who had given evidence and suggested that there might well be "two schools of thought in this vexed area of certification, balance of probabilities and role of the occupational medicine practitioner". The Tribunal does not accept that there are "two schools of thought" in the way submitted. What this submission overlooks is that one has to take into account the reality of the situation regarding the doctor/patient relationship.

303. Mr James denied that Dr S contributed or caused a climate of confrontation and submitted that to place Dr S's conduct in this category was to accord blame which was not justified. The Tribunal does not accept that submission and finds to the contrary, that is, Dr S did contribute to a climate of confrontation.

304. With regard to Dr S's concession that it would have been prudent to make arrangements for a case conference, Mr James submitted that this was not a specific particular of the charge but a concession which showed a frank acknowledgement by Dr S that in the circumstances he could have done better. He submitted that such a concession was indicative of insight and a willingness to acknowledge shortcomings with an open acceptance on the part of Dr S that he can learn from the experience.

305. With regard to the period between 15 April and 16 September 2001, Mr James emphasised that Dr S had not seen Mr A over the previous 4½ months; that he had appropriately investigated the haematemesis; and that apart from being informed by Mr A

(on 3 September 2001) he had no energy there was no indication at that consultation or the ones which followed, according to Dr S, of longstanding malaise or chronic fatigue symptoms. The Tribunal finds differently regarding this evidence.

306. With regard to the consultation of 19 September 2001, Mr James submitted that by its very nature the confrontational climate occasioned by the "unexpected and threatening visit" was hardly conducive to a proper professional review of matters and did not constitute a failure to accept the condition of chronic malaise and fatigue being due to the after effects of leptospirosis.

307. He submitted that in order to keep the matter in perspective Mr A's own general practitioner and other practitioners involved in the treatment of Mr A subsequent to the 19 September 2001 consultation could well have taken steps with regard to ACC.

308. Mr James submitted that Dr S acted in good faith throughout and should be judged at the level of a general practitioner with a diploma in occupational medicine with an interest and experience in the general occupational medicine field.

309. He submitted that with regard to the evidence that Dr S's communication with Mr A and other professional/case workers was inadequate, this was not particularised in the charge.

Decision

First Particular

On or about the 28th February 2001 Dr S refused to accept the diagnosis of leptospirosis (which is an occupational illness and therefore covered by the Accident Compensation Act) made at xx Hospital during the in-patient stay of A from 18th February to 25th February 2001.

310. The Tribunal finds this particular proved.

311. Dr S admitted in cross-examination that he never doubted the diagnosis from a clinical point of view and that Mr A was entitled to ACC for leptospirosis but that it depended on

the confirmation of the titre shift so that he could certify that the illness was occupationally acquired.

312. Dr S maintained that the leptospirosis screen test results were abnormal and questioned why there was a negative screen on 16 February 2001 and a positive screen on 18 February 2001. He recorded that the 18 February result could have been a "false positive". Dr Morris was cross-examined about a possible "false positive" which he thought was "a minor part in the picture" they had of Mr A.

313. Dr S required further investigation, including more blood tests and an ultrasound to check Mr A's pancreas. He also investigated drug-induced renal impairment, obstructive hepatitis and obstruction to bile drainage.

314. Dr S had the relevant information from the hospital papers which Mr A provided and his own enquiry of the laboratory revealed that the screen test on 18 February 2001 was positive for leptospirosis.

315. He was in possession of the same information which Dr H had at the time Mr A was discharged from hospital when she arranged for the hospital to provide Mr A with the ACC certificate.

316. Further, in cross-examination Dr S agreed with Dr E' evidence that without the titres he would be 98% sure (and later said 95% sure), based on the clinical picture, that Mr A had leptospirosis.

317. The Tribunal agrees with the opinion of Dr Walls that in view of the information available at that time it would have been common and acceptable medical practice for Dr S to have accepted the hospital diagnosis of leptospirosis.

318. Dr S maintained that his reason for not assisting in the process of the hospital ACC certificate on 28 February 2001 was because he was working on the basis he required a definitive diagnosis of leptospirosis based on the ESR criteria before he could certify for ACC purposes. However, when his evidence was tested in cross-examination, Dr S was

unable to identify any direction or instruction that ACC required a "definitive" diagnosis before the certificate could be processed and a decision made on cover.

319. Dr S maintained that it was his understanding from what he had been taught by Dr McBride that ACC invariably required a definitive diagnosis before there could be certification.

320. However, Dr McBride's evidence did not substantiate this assertion. He was aware of ACC's requirement for proof on the "balance of probabilities". He confirmed that in his written statement of evidence and in his cross-examination. When questioned further, Dr McBride said that he did not believe there were any words in the diploma material (which Dr S had) which stated that a definitive diagnosis was required before certification.

321. Dr S volunteered during cross-examination that he formed his views about the way he handled Mr A's case regarding certification not only through the teaching and experience and his tutelage but also with the peer group meetings he had amongst all the general practitioners in the xx district who had come to a consensus opinion about how to certify ACC cases for leptospirosis. Counsel for the CAC was permitted by the Tribunal to provide evidence in rebuttal in the form of affidavits from Dr D and Dr W who deposed that no such consensus opinion was ever discussed or reached. The Tribunal does not make any findings concerning Dr S's credibility regarding these pieces of evidence. They did not affect the Tribunal's thinking one way or the other regarding proof of the charge and the particulars.

322. When it was put to Dr S that this was a "blindingly obvious case of leptospirosis from occupational exposure"; that it was an appropriate case to have certified; and that if by some remote possibility the titre results were not confirmatory then the matter could have been remedied, Dr S agreed that this had occurred to him and that retrospectively looking back on the matter if there had not been a change by 16 March 2001 he "would have certainly moved in that direction". He conceded that he was not "flexible enough around that period".

323. In this regard, the Tribunal agrees with the CAC's submission that this is inconsistent with Dr S's own position that he required a definitive diagnosis prior to certifying.

324. When questioned further that there was nothing that the CAC counsel had seen that stated that invariably in every case one has to work on the basis of the ESR diagnostic criteria before the doctor can certify, Dr S replied that it was "a grey area". When questioned further that this must mean that cases need to be dealt with on a case by case basis taking into account the individual circumstances, Dr S agreed that would be correct.

325. The Tribunal observed that Dr McBride also agreed with the proposition that all cases need to be dealt with on a case by case basis looking at the entire circumstances. The Tribunal has already referred to Professor Gorman's evidence in this regard which is not consistent with the requirement by ACC of proof on the "balance of probabilities".

326. When it was put to Dr Walls in cross-examination that "there are two schools of thought abroad", Dr Walls said it was his belief that the majority of his specialist colleagues would certify when "faced with a gross exposure and appropriate clinical symptoms". The Tribunal accepts this evidence.

327. It was Dr S's evidence that the reason that he could not accept the hospital's ACC certificate on 28 February 2001 (and at the subsequent consultations prior to 16 March 2001) was because he was not able to say for certain whether or not Mr A's leptospirosis was occupationally acquired. However, when it was put to Dr S in cross-examination that he had "a good lead" as to the source of the leptospirosis in Mr A's case he replied that he would be 95% certain it was occupational exposure.

328. Further, Mr A gave evidence, which the Tribunal accepts, that Dr S asked him questions about whether he could have contracted leptospirosis from some non work-related activity such as if he had animals at home. Mr A thought that he had been asked those questions when he took his ACC certificate to Dr S after he had been discharged from hospital. Dr S, while unsure when this discussion occurred, thought it was around the time of the 27th or 28th February 2001.

329. The Tribunal finds that Dr S did have this discussion with Mr A on 28 February 2001.

330. With regard to the source of the leptospirosis, the Tribunal refers also to a series of questions and answers in cross-examination of Dr S when he agreed that of the eight strains or serovars occurring in New Zealand there were only two that could not have arisen at the xx plant and that if one added up the percentages relating to each serovar there was a 95% chance that the source of the leptospirosis came from the plant.

331. This matter was put to Dr McBride in cross-examination. He also agreed that it was very likely that the leptospirosis came from the works.

332. Dr S agreed that he was one of the advisers on whom xx relied for advice about whether someone should be receiving ACC or whether there should be a recommendation for ACC cover.

333. The Tribunal finds that Dr S's actions were consistent with him refusing to accept the hospital diagnosis as at 28 February 2001 as he took no steps to process the hospital's ACC certificate by xx.

334. The Tribunal finds that xx were relying on Dr S's advice; that Dr S advised xx that ACC cover could not be accepted until there had been a definitive diagnosis based on the titre tests; and that xx made their decision on cover following Dr S's advice on 16 March 2001 once the titre results for leptospirosis pomona were known.

335. The Tribunal accepts Dr Walls' evidence that, if necessary, Dr S should have recommended acceptance of cover for ACC at least pending receipt of the confirmatory antibody test results which can take some time to come through. In the unlikely event that those later results did not confirm the hospital diagnosis then Dr S could have informed xx and xx could then have made a decision in relation to revocation of cover.

336. The Tribunal also accepts Dr Walls' evidence that it was not Dr S's responsibility as the medical officer for xx to accept or refuse a claim for ACC cover on the basis of ACC certification which had been completed by another doctor (xx Hospital).

337. The Tribunal further accepts Dr Walls' evidence that if the diagnosis was disputed by ACC or by xx due to the lack of development of titre levels as at 28 February 2001, then Dr S should have lent his support to ensuring Mr A, (who was doing at risk work in an at risk industry with appropriate symptoms and clinical signs and a hospital diagnosis of a work-related infection) received whatever statutory entitlements he was entitled to.

338. The evidence established that Dr S did not contact Dr H as he did not see the necessity to do so. The Tribunal finds that in the circumstances he should have done so.

339. Mr James submitted that Professor Gorman encouraged and supported the conservative approach displayed by Dr S and that Professor Gorman himself would not have certified a diagnosis of leptospirosis until he had the confirming test sought by Dr S.

340. The Tribunal does not agree with Professor Gorman's approach in these circumstances. Where there is a difference among the experts regarding this particular, the Tribunal prefers the evidence of Dr Walls.

341. Mr James made a "post-script" submission with reference to a passage in the Guideline booklet put out by the Department of Labour and approved by ACC (Exhibit 9 page 21) regarding a test which can be used with samples of blood or urine which will prove the presence of leptospirosis within 24 hours but will not show what serovar has caused the infection.

342. The words added are – "*This can be a problem for people wanting to claim compensation for leptospirosis as an occupational disease through ACC*". He submitted that this statement amounts to an acknowledgement that this area is problematical.

343. What this submission overlooks is that in Mr A's case, the presentation was clear cut, obvious and classical.

344. Bearing in mind all the relevant evidence and circumstances, the Tribunal agrees and accepts the submission of counsel on behalf of the CAC that Mr A should have been given

the benefit of any doubt with respect to the hospital's diagnosis and ACC certification as at 28 February 2001; and at least pending confirmation of the hospital diagnosis by the confirmatory antibody testing. It agrees also with the submission that Dr S's actions in refusing to accept the hospital diagnosis were inexplicable and resulted solely in a benefit for xx (his employer) and its insurer (xx) at Mr A's expense.

345. In this regard the Tribunal agrees with the opinion of Dr Walls and accepts the submission of counsel on behalf of the CAC that Dr S fell below the standards expected of an experienced doctor practising as an industrial medical officer and holding clinics in an "at risk" industry.

Particular 2

During the period from 28th February to 15th March 2001 Dr S:

a. Failed to recognise the ACC requirement for acceptance that a complaint merits cover is the "balance of probabilities" and that the Accident Compensation Act does not require absolute proof.

b. Refused to provide Mr A with the certification to enable him to claim compensation from ACC.

c. Contributed to a climate of confrontation with the patient which resulted in unnecessary hardship and stress and may have been prejudicial to his recovery.

346. The Tribunal finds proved all the three above sub-particulars.

347. The Tribunal finds Dr S's attitude was inflexible and intransigent. Dr S himself admitted that reflecting on the whole matter he could have been more flexible.

348. The Tribunal accepts the submission of counsel for the CAC that this case is not about debating or challenging the ESR criteria which enable a diagnosis of leptospirosis to be confirmed conclusively but rather whether on the balance of probabilities (being the level of proof required by ACC) as at February 2001 and in the period from then through to 15

March 2001, Dr S should have been certifying Mr A as suffering from probable leptospirosis.

349. The Tribunal also agrees with the submission of counsel for the CAC that all but Professor Gorman seemed to agree that Dr S either could or should have been certifying Mr A in this period.

350. The evidence established on Dr S's own admission that during this period he did not recommend to xx that Mr A be given cover on the basis of the hospital's ACC certificate which had certified Mr A unfit to work until 5 March 2001. The Tribunal finds it inconsistent that on the one hand Dr S conceded in evidence that he was 95% certain that there was leptospirosis which was occupationally acquired, yet on the other would not recommend to xx that cover be accepted because he had not received the results of a titre shift.

351. We refer to the above evidence of Dr Walls, which the Tribunal accepts, that it was not best practice or even common practice to not accept or not certify in these circumstances during this period for the reasons already given.

352. It is the Tribunal's view that Dr S should have recommended to xx that cover be accepted in order that Mr A's claim could be processed and so that he could commence to receive compensation or his other entitlements without delay.

353. The Tribunal had difficulty in accepting Dr S's evidence that, until the disciplinary charge was laid against him, he was unaware of ACC's requirement for acceptance of cover on the basis of the balance of probabilities. In this regard, all of the evidence is at variance with Dr S's claimed belief.

354. Dr S had been the industrial medical officer at xx for almost 20 years when the events, giving rise to the charge, arose.

355. xx's own written reference (produced by Dr S at the hearing) established that in 1998 xx initiated a preferred medical provider scheme under the ACC Accredited Employer

programme and that Dr S was selected as a preferred medical provider through "a rigorous process".

356. On his own evidence (during cross examination), Dr S agreed that he was aware of and involved in the ACC requirements for certification and accreditation at xx for ACC purposes.

357. Further, both Dr McBride and Professor Gorman in their evidence-in-chief acknowledged that ACC's requirement for proof is on the balance of probabilities; and that prior to the events involving Mr A in 2001, Dr S had undergone tutelage by Dr McBride in industrial medicine at the University of Otago.

358. In this regard, the Tribunal refers also to the evidence of Dr Morris (referred to above) that he expected xx to be well aware of ACC's requirements for acceptance of cover and standard of proof.

359. The Tribunal has referred also to the evidence of Mr A (which it accepts in this regard) that by 12 March 2001 he had become "anxious, frustrated and upset" when it became clear to him that he had not received ACC because of Dr S's refusal to certify him. The Tribunal has already referred to the consultation of 12 March 2001 when Mr A became angry and referred to the fact Dr D had told him he had leptospirosis and was entitled to receive ACC immediately, as had the hospital.

360. Again the Tribunal accepts the evidence of Dr Walls (referred to above) that in a situation such as this, bearing in mind Dr S's experience, that he should have withdrawn from Mr A's treatment when it became clear they were locked into a confrontational relationship. Dr S should have allocated his medical responsibilities to another doctor.

361. In cross-examination, Dr S acknowledged that he was aware of Mr A's financial pressures as at the consultation of 12 March 2001.

362. The Tribunal accepts Mr A's description of his feelings and concerns arising from his consultations with Dr S and further accepts Dr Walls' evidence that Mr A would have

been unable to deal with these problems while he was in the state he was in and that the delays, confrontations and stress would have made his feelings of fatigue more intolerable.

363. The Tribunal accepts the submission of counsel of the CAC that the overwhelming inference to be drawn from Dr S's actions during this period is that his primary focus was on protecting xx. The Tribunal finds there was little or no focus placed on Mr A's needs. As counsel has submitted, Dr S disputed and/or did not want to accept the diagnosis of occupationally acquired leptospirosis. All of his investigations were to look for other possible non work-related causes of Mr A's illness.

364. When challenged in cross-examination by Ms McDonald, as to what harm or downside there would have been in Dr S making the certification at the earlier time bearing in mind he was 95% certain that it was leptospirosis occupationally acquired, Dr S agreed the downside was the monetary side in terms of increasing xx's premiums if he provided a certificate when he did not have a confirmed diagnosis although he said he did not put his mind to that.

365. All members of the Tribunal, having heard the evidence and submissions of counsel and having perused the documents, were left with the distinct impression that Dr S's actions were focused on the consequences for xx of a diagnosis of work-related leptospirosis rather than the needs of and consequences for his patient, Mr A.

Particular 3

During the period 15th April 2001 to 16th September 2001, despite other medical practitioners having formed a contrary view, Dr S did not accept that Mr A's chronic malaise and fatigue were due to the after-effects of leptospirosis and therefore did not provide ACC certification during this period resulting in major stress and financial hardship for Mr A.

366. The Tribunal finds this particular proved.

367. The Tribunal has referred to Mr A's evidence regarding his unwellness during the period 15 April to 16 September 2001, which it accepts. Other than one consultation with Dr D in May 2001 regarding a chest infection, Mr A had no other consultations with Dr D or Dr

S until 3 September 2001. Mr A's explanation for this, which the Tribunal accepts, was that despite his unwellness he was able to manage as there was an off season at the Works for approximately six to eight weeks during the June/July period when he did not have to work.

368. There was a difference between Dr S and Mr A regarding what Mr A told Dr S at the consultations of 3, 7 and 17 September 2001 regarding his fatigue. Mr A's evidence was that when he saw Dr S on 3 September 2001 he told him he had no energy and was feeling "awful" most of the time and stated he remembered clearly telling Dr S he had been feeling like that ever since he had got leptospirosis. When cross-examined on this particular matter, Mr A did not depart from his evidence-in-chief. In re-examination, counsel for the CAC asked him what period of time he was referring to when he referred to "feeling awful". It was apparent to members of the Tribunal from his answer that he was referring to the time from when he was discharged from hospital.

369. Further, when asked by a member of the Tribunal whether he had spoken to anyone at the works as to how he was feeling between March and September 2001 Mr A said that every day he was going to the Medical Centre at the works and telling Mr F how he was feeling. He did not know whether or not this was recorded. However, he needed to do this in order to have permission to go on leave or to go home early. He also told his foreman.

370. The Tribunal observes that Dr S's notes for the 3 September consultation record "no energy". Dr S said that Mr A did not tell him that he had fatigue or that it was long-standing. However, in cross-examination Dr S was asked what history he took from Mr A when he said "no energy" and whether Dr S asked him how long that had been going on. Dr S replied *"At that stage I bracketed it around the 2 week period. I didn't sort of expand on that. I admit going back over my notes that I should have expanded on that."* Dr S said he now accepted that when Mr A was reporting to him that he had "no energy" at the 3 September consultation, he should have been making enquiries of Mr A about that given the severity of Mr A's earlier illness

371. The Tribunal agrees.

372. While the Tribunal cannot find with certainty exactly what passed between Mr A and Dr S at the 3 September consultation regarding Mr A's ongoing fatigue, it finds that, on all of the evidence, it is most likely that Mr A did tell Dr S that he was feeling exhausted and it is most unlikely that he would have limited his description to the words "no energy". In any event, that was something which Dr S himself accepts he should have queried further.

373. While Dr S told the Tribunal that at the consultation on 3 September 2001 he did not draw the association back to leptospirosis as he had not seen Mr A for some 4 ½ months and therefore did not make the connection, he was aware of Mr A's illness in February, Mr A did tell him of his fatigue (which the Tribunal finds) and Dr S was aware that chronic fatigue or persistent tiredness was a well-recognised consequence of leptospirosis.

374. The Tribunal also notes that at this consultation Dr S prescribed Synermox (penicillin). His explanation was that he thought there may have been further leptospirosis developing because of Mr A's previous severe illness and because he had been back working on the slaughterboard in an area where he was at risk.

375. The Tribunal finds Dr S's evidence in this regard to be inconsistent. On the one hand he said he did not connect the lack of energy to the leptospirosis but on the other hand he prescribed Synermox for it, in case it were developing, so he did make the connection. Further, while he arranged for further tests to investigate helicobacter pylori (a non work-related illness) he did not arrange for any investigations to test for leptospirosis.

376. When queried about this in cross-examination Dr S's explanation was that his reason for not arranging for any investigations for leptospirosis was that he *"may have thought of it but left it out of the tick box or left it out of the request form"*.

377. In this regard the Tribunal refers also to an answer from Dr McBride in cross-examination that if he were presented with a patient such as Mr A on 3 September reporting no energy and with fatigue and bearing in mind his history of severe leptospirosis in February/March, the leptospirosis could certainly be a reason for the fatigue and it would be something he would want to explore.

378. Counsel for the CAC submitted that it was inconceivable that Mr A would not have complained to Dr S about ongoing tiredness and fatigue at the consultations in September because within 24 hours of seeing Dr S on 17 September 2001, he saw Dr D and was diagnosed by him as having leptospirosis-related tiredness and fatigue.

379. There is much force in this submission. The Tribunal finds that Mr A did tell Dr S that he was exhausted and feeling "awful" and that it was implicit that his fatigue did not arise of itself but would have been present for some period of time. It was incumbent on Dr S to have investigated that further with Mr A.

380. Further, and in support of this finding, if Mr A had felt that his concerns were being taken seriously when he consulted Dr S again on 17 September there would have been no reason for him to have seen Dr D the following day on 18 September nor return to see Dr S with a Union representative on 19 September with Dr D's ACC certificate. Dr D's certificate certified that Mr A was suffering from related tiredness and fatigue as a result of leptospirosis (based on Mr A's complaints of tiredness and headaches) and was unfit to work for the following 14 days. The reason Mr A saw Dr D was because he was so angry that Dr S did not seem to believe him about his reports of exhaustion.

381. While it was reasonable and appropriate for Dr S to have considered and investigated helicobacter pylori, the Tribunal accepts the evidence of Dr Walls and finds that it would have been expected practice in the circumstances at each and every one of the consultations in September for Dr S to have considered the reported symptoms of fatigue as being a not unreasonable consequence of the severe infection (leptospirosis) which had led to Mr A's acute renal failure.

382. With regard to the consultation of 19 September 2001 there can be no doubt that it was confrontational.

383. While Dr S denied "cancelling" Dr D's ACC certificate and said that what he cancelled was a previous non-insurance medical certificate which he had issued, there is no doubt that he did decline to accept the contents of Dr D's certificate and disputed Dr D's diagnosis. Dr S disputed Mr A's evidence that he had been handed Dr D's ACC

certificate at the 19 September consultation. Dr S said the first time he saw the certificate was during the discovery process for preparation for this hearing. He was questioned at some length by Ms McDonald regarding this.

384. The Tribunal finds that even if Dr S did not see a paper copy of Dr D's certificate at the consultation of 19 September, he was aware of its contents at that consultation because he had seen a copy of it on the company computer and he had taken some information from it and recorded it in his notes of 19 September.

385. The Tribunal agrees with the CAC's submission that it was significant that the medical certificate which Dr S did issue at that consultation would have enabled Mr A to go off on sick leave rather than on ACC; and that it is not clear why he did not simply accept Dr D's certificate if he felt so intimidated.

386. The Tribunal accepts and agrees with Dr Walls' evidence that where a doctor is faced with certification from another doctor with which he disagrees, he would expect the doctor who disputed the diagnosis to contact the second doctor with the patient's permission in order to discuss their diagnostic differences, agree on a joint management and investigation plan and, where no such agreement could be obtained, inform the patient of their suspected diagnoses and plans and detail the conditions that would allow the patient to return to work safely. In this case, it was Dr Walls' opinion that Dr S should have sought permission from Mr A (which the Tribunal believes would have been readily given) to contact Dr D in order to discuss the reasons why he was disputing his diagnosis.

387. The evidence establishes that Dr S made no attempt to contact Dr D about his diagnosis at this time.

388. The Tribunal finds, on the evidence, that Dr S's primary obligation was to his patient, Mr A. He should have been aware of the implications for Mr A in failing to accept or overriding Dr D's diagnosis and ACC certificate and he should have been motivated by a need to resolve the issue of the disputed diagnosis as expeditiously as possible.

389. Mr A was put off work for the period 19 September to 20 October 2001. The Tribunal finds that during this period Mr A did not receive ACC earnings-related compensation as a result of Dr S's actions or advice to xx in disputing Dr D's diagnosis.

390. In this regard we refer to the evidence of Mr A, which the Tribunal accepts, who said that the attitude of Dr S had made him feel worse. The Tribunal observes that he had to take out a bank loan while he was off work.

391. As referred to above, Mr A had to be formally assessed by Dr E before Dr S would accept that Mr A had a work-related illness and before his ACC claim could go forward.

392. The Tribunal refers to the evidence above that although Dr E had diagnosed Chronic Fatigue Syndrome as a consequence of "probable" leptospirosis, Dr S never brought to Dr E' attention the fact that there had been confirmatory tests as a result of the titre shift. It was perfectly plain from any fair reading of Dr E' report of 11 October 2001 that he did not have this information and yet Dr S did not provide him with it. Instead, he provided other information to Dr E suggesting that Mr A had not given an accurate history (which the Tribunal took to be an implied criticism of Mr A) and pursued the helicobacter issue.

393. The Tribunal finds that Dr S failed to complete backdated ACC certificates enabling Mr A to claim compensation for all of the time that he had off work and for his reduced hours when he was at work covering the period 15 April to 16 September 2001. The Tribunal also finds that Dr S did not complete certificates to cover Mr A for the period from 16 September to 22 October 2001. This was of concern to the Tribunal bearing in mind that there had been a diagnosis of chronic fatigue as an after-effect of leptospirosis not only from Dr D but also from Dr E.

394. The Tribunal accepts the evidence of Dr Morris (the corporate medical adviser to ACC) that backdated medical certificates are not an uncommon situation for ACC; and that there may be exceptional circumstances when the doctor who has signed the backdated certificate has not seen the patient during the period covered by the certificate. He gave examples of situations where that might occur such as when the patient may have been seen by another doctor in the hospital setting. Dr Morris agreed that with chronic fatigue

syndrome a patient may have to have the symptoms for six months before it can be diagnosed and that would be one circumstance of backdating certificates for ACC purposes.

395. The Tribunal finds that Dr S should have issued Mr A with the appropriate backdated ACC certificates.

396. Dr S was cross-examined about Mr A's financial situation. He agreed that he did not take any steps to ensure that Mr A got cover from 19 September 2001 onwards. When it was put to Dr S in cross-examination that he was involved to the extent that he was supervising the back-to-work programme and dealing with Dr E over the disputed diagnosis, Dr S replied that he supposed he *"should have been involved on the financial side to see that [Mr A] was fully recompensed"*. He agreed that would have been consistent with looking after the best interests of the patient. The Tribunal agrees.

397. The Tribunal refers to the CAC's submission that the overwhelming inference that is to be drawn from Dr S's actions in September 2001 (his failure to accept Dr E' and Dr D's diagnoses of chronic fatigue syndrome and his emphasis on diagnosing helicobacter) is that his primary focus was on protecting his employer and that he was clearly not focusing on Mr A's needs.

398. The Tribunal finds that whatever was motivating Dr S, he certainly was not focusing on Mr A's needs; and nor was he making it clear to Mr A who he was the agent for at any particular time.

399. The Tribunal is of the view that Dr S was blurring his various roles and did not appear to be addressing his mind to which role he was undertaking and for whom at any given time.

400. Whatever Dr S's motivation, we agree with the submission for the CAC that he had become rigid in his thinking as a result of which Mr A was adversely affected.

401. The Tribunal finds that whatever was motivating Dr S, his actions in refusing to provide certificates to Mr A to enable him to claim compensation for the period 15 April to 16

September 2001, despite the diagnoses of Dr D and Dr E, fell short of the standards expected of a doctor in the circumstances that Dr S found himself in at that time; and that his refusal resulted in major stress and financial hardship for Mr A.

Particular 4

In the course of his dealings with Mr A the actions of Dr S breached the fundamental principles of non maleficence, beneficence and justice as set out in the Guidelines on Ethics and Professional Misconduct for Occupational Physicians of the Australian Faculty of Occupational Medicine.

402. The Tribunal does not agree with Mr James' submission that the Guidelines (which he said are for occupational physicians) could not be properly applied to Dr S as strict protocols or guidelines to the same extent as if he were an occupational physician.

403. The Tribunal accepts the submission of counsel for the CAC that while Dr S was not at the time of the events in question (nor at the time of hearing) vocationally registered in occupational medicine, he was nevertheless at the time of the relevant events an experienced rural/semi-rural general practitioner who had a Diploma in Industrial Health from Otago University (taught by Dr McBride) and who had worked as an industrial medical officer at the works for almost 20 years since 1982 and who had a special interest in occupational medicine.

404. Dr S maintained that at the time of his management and treatment of Mr A he was not aware of the Guidelines. The Tribunal finds this difficult to accept. Dr McBride gave evidence that the Guidelines were part of the course material for the ethics module of the Diploma of Industrial Health at Otago University (which Dr S undertook) and produced to the hearing a copy of the Guidelines and other material from the module.

405. The statement in *"General Principles"* of the Guidelines at section 1 relating to the ethics of occupational medicine, recognises that in many ways the ethics of occupational medicine are the same as those for doctors in other forms of practice but that doctors working in occupational health may face some ethical issues that are uncommon in other situations.

406. The principles which Dr S is charged with breaching relating to non-maleficence, beneficence and justice set out in the Guidelines are essentially the same as the general ethical principles applying to all doctors, that is, to do no harm, to try and help the patient and to be fair.

407. While Dr S stated that he had not heard of the terms used in the Guidelines, he did accept that he was aware of the general ethical principles. Professor Gorman agreed in cross-examination that he would have expected Dr S to have been so aware.

408. Dr S's own evidence regarding the general medical ethical principles by which he was bound at the time of the events affecting Mr A was that:

> *"Basically you are not doing, if you are in a patient doctor relationship your relationship with the patient is such that you are not supposed to do them any harm, you have to treat them with respect and compassion … fairness. Everything you do, you do it to the highest degree of whatever you are practising."*

409. The Tribunal finds that Mr A was Dr S's patient and that Dr S was "treating" him. There is ample evidence of this and, when pressed in cross-examination, Dr S accepted this.

410. None of the experts disagreed that when Dr S was in a treating role with Mr A his primary responsibility was to his patient.

411. Dr Walls took issue with Professor Gorman's opinion that with regard to matters of certification Dr S was operating as a commissioned agent of a third party and that this therefore altered in some way Dr S's responsibilities to Mr A. However, when questioned by a member of the Tribunal, Professor Gorman accepted that Dr S had assumed both the role of treating doctor and non-treating doctor at all times in relation to certification. Where there is any difference between the evidence of Dr Walls and Professor Gorman in this regard, the Tribunal prefers the evidence of Dr Walls.

412. Dr McBride responded to a question from the Tribunal that when the "patient" became "the client" the doctor's continuing obligation was "to support the client as a patient".

413. All experts were of the same view that if a patient was in a consultation with a doctor primarily attending in a doctor/patient relationship and matters arose which might affect the doctor's thinking or obligations in terms of the employer or a third party which could have an adverse effect on the patient, then the doctor must make it clear to the patient in express terms in what role the doctor is acting and that the doctor may not be acting in the patient's best interests. Professor Gorman (while critical of others involved) thought that Dr S poorly communicated to Mr A his duality of roles.

414. The Tribunal finds that Dr S fell below the standards of non-maleficence by failing to accept the hospital diagnosis on 28 February 2001 and by not making a presumptive diagnosis in the period from then to 16 March 2001; and that he fell below the standards of the principle of justice by failing to accept the hospital diagnosis and certifying appropriately at least until there was some solid reason for doubt in relation to the validity of the diagnosis which did exist. The Tribunal accepts and agrees with Dr Walls' evidence in this regard.

415. When cross-examined on this issue, Dr S was unable to direct the Tribunal to any specific statement which directed a doctor in his position to refuse to certify for leptospirosis until the ESR criteria had been met.

416. The Tribunal finds that Dr S fell below acceptable standards and breached the principle of non-maleficence by declining to accept that Mr A's chronic malaise and fatigue were an after-effect of the leptospirosis and declining to issue him with the appropriate ACC certification so that Mr A could claim compensation and entitlements and gain cover for the period from 17 April to 16 September 2001 and from the latter date until 22 October 2001. Again, the Tribunal agrees with Dr Walls' evidence in this regard.

417. Dr Walls said that it was perhaps the justice factor where occupational doctors must provide patients with the benefit of doubt with regard to certification and compensation issues rather than providing the employer or insurer with such benefit at the patient's expense.

418. The Tribunal agrees and finds that Dr S's actions were consistent with him providing his employer and/or the insurer with the benefit of doubt with respect to clarification and compensation issues at Mr A's expense.

419. Counsel for the CAC referred to the evidence of Professor Gorman regarding the hierarchy of medical practitioners involved in Mr A's case. Professor Gorman said that he would place Dr S at the top of the hierarchical tree as a result of his Diploma in Industrial Medicine. Professor Gorman said that the hierarchy was with specific reference to the certification of occupational disease and that he would have expected Dr S to have a more demanding perspective of certification diagnosis in an occupational setting.

420. With regard to this evidence, counsel for the CAC submitted that if the Tribunal accepted Professor Gorman's evidence in this regard then the standards the Tribunal should apply to Dr S in relation to the certification issues must be high standards reflecting Dr S's position as a medical practitioner with an occupational medicine qualification.

421. The standards which the Tribunal applies to Dr S are those of an experienced rural/semi-rural general practitioner who had a Diploma in Industrial Health, who had worked as an industrial medical officer at the works for almost 20 years at the time of the relevant events, and who had a special interest in occupational medicine.

422. Counsel for the CAC referred to the module on communication skills which was part of the diploma in industrial medicine which Dr S undertook. Counsel submitted that despite this Diploma, it was clear on the evidence before the Tribunal that Dr S did not communicate well with Mr A; that proper histories were not taken at the relevant times (particularly on Dr S's own evidence in September 2001); that he did not deal with conflict appropriately and at appropriate times (either in March or September 2001); that he was the only person who disputed the diagnosis and certification in the February/March period and in September 2001; and yet he never communicated with either Dr H or Dr D. Counsel for the CAC submitted that contrary to the evidence of Professor Gorman this is not a case where there has been a generic failure of communication and that the only communication failure lies with Dr S.

423. The Tribunal is of the view that even if there was a generic failure of communication, for present purposes there was a distinct and clear failure of communication on the part of Dr S.

424. The Tribunal agrees with Dr Walls that with regard to Mr A's return to work programme and the deficits in communication with Mr A's GP (Dr D), Dr S fell below the standards expected of a practitioner practising as a medical officer in an at risk industry. As counsel pointed out, Dr S never contacted Dr D to discuss his diagnosis of a post-leptospirosis condition nor to discuss his views about Mr A's fitness to return to work in the period mid-September/mid-October 2001.

Professional Misconduct or Conduct Unbecoming?

425. Mr James submitted that the evidence did not "stack up" sufficiently to justify the Tribunal finding Dr S guilty of the charge as formulated in the particulars; and that Dr S was only guilty of being particular and cautious. He added that being particular and cautious is not an attitude or manner of practice or conduct which is deserving of the Tribunal's disapprobation if such particularity and caution accords with practice and standards set by Dr S's peers.

426. The Tribunal does not accept this submission. It is a submission which is contrary to the evidence heard by the Tribunal.

427. The Tribunal, having found all the particulars proved, then went on to consider whether the charge which was laid as professional misconduct should be altered to conduct unbecoming.

428. Having carefully considered the relevant legal principles applying to both professional misconduct and conduct unbecoming, and applying those principles to the proved facts, the Tribunal reached the view that the charge of professional misconduct was properly laid and that the charge should not be altered to conduct unbecoming.

Conclusion and orders

429. The Tribunal is satisfied that the charge laid against Dr S in all its particulars is established and that Dr S is guilty of professional misconduct.

430. Counsel for the CAC is to lodge submissions as to penalty not later than 10 working days after receipt of this decision.

431. Submissions as to penalty on behalf of Dr S are to be lodged not later than 10 working days thereafter.

432. The Tribunal observes that an interim order was made prohibiting publication of the name of Dr S pending the determination of this charge. As the charge has now been proved, it is the view of the Tribunal that the interim order should be discharged. However, in fairness to Dr S the interim order will remain in place until counsel for Dr S has had an opportunity to make submissions on that matter, if he wishes to do so. Such submissions should be filed at the same time as any submissions on behalf of Dr S as to penalty.

DATED at Wellington this 2nd day of December 2004

.....

S M Moran

Senior Deputy Chair

Medical Practitioners Disciplinary Tribunal