Psychiatrist, Dr B

A District Health Board

A Report by the

Health and Disability Commissioner

(Case 07HDC06672)

Overview

In February 2007, a 22-year-old woman was admitted to a mental health unit. She had a long history of mental health problems, and had previously been diagnosed as having a major depressive disorder.

Following his review of the woman, a locum consultant psychiatrist concluded that she was suffering from a "factitious disorder",[1] and amended her treatment accordingly.

This report examines the process followed to make a significant change in a long-standing mental health diagnosis.

Parties involved

Ms A	Consumer/Complainant
Dr B	Provider/Consultant psychiatrist
Dr C	Psychiatrist
Dr D	Psychotherapist/psychiatrist
Dr E	Registrar
Dr F	Registrar
Dr G	Consultant psychiatrist
Dr H	Consultant psychiatrist
Dr I	Consultant psychiatrist
Dr J	Clinical director
Dr K	Former clinical director
The Unit	Mental health unit
The DHB	District health board/Provider

Complaint and investigation

On 23 April 2007 the Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by psychiatrist Dr B. The following issues were identified for investigation:

The appropriateness of care provided to Ms A by Dr B from 13 February to 22 May 2007.

[1] Factitious disorders are conditions in which a person acts as if he or she has an illness by deliberately producing, feigning, or exaggerating symptoms.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The appropriateness of care provided to Ms A by the District Health Board from 13 February to 22 May 2007.

An investigation was commenced on 19 October 2007. It has been delayed by a number of factors, including a slow response from the District Health Board to HDC's notice of investigation, and difficulty in obtaining expert advice.

Information was obtained from Ms A, Dr B and the DHB. Independent expert advice was obtained from psychiatrist Dr Richard Porter (see Appendix).

Information gathered during investigation

Background

Ms A has consulted psychotherapist and psychiatrist Dr D since August 2004. Dr D concluded following his first assessment of Ms A that she had at that time a four- to five-year history of depression complicated by physical health issues. Dr D commenced weekly psychotherapy sessions which continue to the present day. He summarised Ms A's previous admissions to hospital:

> "Since my first contact with [Ms A] she has had several lengthy admissions to [the Unit]. The first was between 18 June 2005 and 23 December 2005 and 2 March 2006 and 13 December 2006, a nine-month admission. She has received ECT [electroconvulsive therapy] whilst an inpatient in the past which resulted in some improvement in her mood. Diagnostically it was thought that on these admissions she was suffering from a major depressive disorder."

The DHB stated:

> "[Ms A] is someone who was well known in this service. There was a great deal of discussion about her treatment, often in settings where those discussions were not readily recorded in any detail, such as peer review group. There were many strongly held opinions about her, including considerable discomfort in her usual community team about the amount of medication she was taking."

Dr B

Dr B had worked for the DHB as a locum consultant psychiatrist since November 2006. He was on sabbatical leave from overseas. He has practised in psychiatry since 1990 and is a Fellow of both the Royal Australian and NZ College of Psychiatrists and the Royal College of Psychiatrists (UK). While at the DHB he was supervised by Dr C, who was the Service Clinical Director of the DHB Mental Health Services at the time.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The DHB stated that Dr C worked alongside Dr B, and they "were regularly able to observe each other's interactions with the clinical team and to jointly participate in clinical discussions with the team". The DHB added:

> "As [Dr B] was such an experienced practitioner it was not felt that it was necessary to define criteria for him with respect to matters that should be raised with [Dr C] or with other colleagues. [Dr B] willingly participated in discussions with staff. He also was a scrupulous attendee of clinical-academic and consultant meetings where there were opportunities for discussion about clinical presentations with his peers."

15 February to 3 April 2007

On 15 February 2007, Ms A was admitted to hospital having taken an overdose of tablets. Once she was medically fit, she was transferred to the Unit.

Dr C had been Ms A's psychiatrist prior to her admission. However, it was decided on her admission that Dr B would take over her care. Dr C explained that this was "to offer senior and fresh opinion on her presentation".

Dr B stated that, in his opinion, "there was no evidence of depression other than [Ms A's] self report in interview situations". On 23 February Dr B recorded in the clinical record:

> "There is no evidence of a major depression. [Ms A] is requesting reading material about personality disorders, probably to tailor her answers to any probe by the psychologist … The desire to enjoy a relationship and interest in pursuing vocational studies does not support the diagnosis of depression."

Dr B added that "the previous diagnosis was not dismissed but seriously considered".

On 24 February, Ms A made a request for a second opinion, and the following day the records note her concern that Dr B did not know her well enough to make a diagnosis of borderline personality disorder.

On 27 February, the clinical record notes that Ms A "wanted continuation of Quetiapine and Lithium, even when told that it is not benefiting her". She also repeated her request for a second opinion. On 28 February, it is recorded that she wanted to change consultants because Dr B intended to stop her medication.

On 1 March, registrar Dr E recorded that the plan was to discontinue the lithium and reduce the dose of quetiapine. The clinical record states:

> "[Ms A] did not agree with this because she thinks medications are helping her and she does not have any side effects from them. She says she might talk to [Dr D] [about the lithium] to discuss with [Dr B]."

On 1 March, the lithium was discontinued.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

On 6 March it is recorded again that Ms A wanted a second opinion. The nurse on duty that day recorded a conversation with Ms A, and the nurse concluded by suggesting that the nursing staff on duty the following day arrange a meeting between Dr D and Dr B.

Dr B stated:

> "[Dr D] if he wished could have participated in these weekly rounds by right needing no special invitation. It is possible that [Dr D] came to the ward without an appointment to see me. Because of my own caseload in addition to the cover I was providing for one or more Psychiatrists at any one time he may not have seen me in my office. I am not sure why he chose not to attend the ward meetings, the proper forum for such discussions."

On 14 March, Dr E recorded:

> "[Dr B] believes that the [auditory] hallucinations are not consistent with psychosis therefore [there is] no need for antipsychotic medication. [Dr B] also believes that if [Ms A] is able to attend the [University] she is well enough to be discharged and can be discharged … We are awaiting second opinion as [Ms A] requested for one."

Dr E also recorded that sodium valproate was to be reduced "gradually". (At this stage she was taking 600mg at night.[2])

On 15 March, Dr B recorded:

> "[Ms A's] demand for medication seems to indicate a desire to hold on to the 'sick role'. There is a strong element of gain in this behaviour."

On 16 March, Ms A was provided feedback on a test performed to assess personality disorders (MCMI — Millon Clinical Multiaxial Inventory). On the clinical assessment, a psychologist stated that the "highest scores were recorded on [post-traumatic stress disorder] and Major Depression scales". The psychologist also noted Ms A's concern that "[Dr B had] made up his mind that he would not be prescribing any medication".

The psychologist discussed Ms A's MCMI profile with Dr B. The psychologist recorded:

> "[Dr B] stated that he was not familiar with the test, and therefore could not comment on its usefulness. Discussed with him [Ms A's] concerns about being

[2] The dose was reduced to 200mg at night on 16 March, and the last dose was administered on 18 March.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

taken off all medication and her understanding that she would be discharged without any medication. He stated that that was indeed his plan.

Expressed my concern about risk as [Ms A] presented to [the Unit] in context of recent suicide attempt."

Dr B stated:

"I recall asking the psychologist whether [the] test she [administered had] a lye [sic] score which is incorporated in Eysenck's Personality Inventory with which I am familiar. She replied in the negative but said that there is an estimate of the probability of accuracy. This was not sufficient for my purpose."

Over the next few days, there were a number of comments recorded in the notes that indicate Ms A's dislike of Dr B, her disagreement with his treatment decisions, and her wish to be treated by a different consultant.

On 2 April, Dr E recorded:

"[Dr B] told that as he is not convinced with the effect of [auditory hallucinations] on [Ms A's] daily activities, he is not of the opinion to start her on any antipsychotic medication … As [Ms A] requested for a second opinion we are awaiting for second opinion and after that we will plan for future management accordingly."

Ms A was formally discharged on 3 April, and no second opinion had been provided prior to discharge.

Advice to HDC from other parties

Dr D
Dr D subsequently advised HDC:

"Diagnostically I think [Ms A] has a treatment resistant depressive disorder complicated by an ambivalent attachment style and supraventricular tachycardia of unknown cause. The reason I think she suffers from a depressive disorder is that she has signs and symptoms of depression; she suffered a serious life event at the onset of her symptoms … ; she has responded to antidepressants and ECT in the past; she has a family history of depression.

I do not think she has a personality disorder — she does not fulfil the DSM IV [Diagnostic and Statistical Manual of Mental Disorders] criteria for a borderline personality disorder, (in particular she has had the same boyfriend for the last three years and her previous boyfriend was a four year relationship). The psychological testing did not reveal any personality disorder. She denies that she 'prepared' for the testing and the test (the MCMI) is not readily available.

I do not think she has a factitious disorder. …

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Post discharge care
After discharge, on the 10th of April when I saw her for her usual weekly appointment she was distressed with racing thoughts, thoughts of self harm, auditory hallucinations and low mood. She asked me to restart her medication. I restarted her lithium and risperidone. I restarted her lithium as my experience has been that with [Ms A] this consistently stops her thoughts racing and decreases the incidence and intensity of her suicidal thinking. I restarted her risperidone because of her auditory hallucinations and because she has found it helpful in the past. At this stage she did not have a GP as her previous GP who she experienced as quite supportive had retired and no-one had replaced her. Subsequently [Ms A] enrolled with a GP in the student centre at [a tertiary institution]. She was also not engaged with a community mental health team.[3] I discussed my decision to restart her medication after it had been stopped in [the Unit] with my peer review group.

Since her discharge I have continued to see her weekly. She has self-harmed twice over the last six months. On the positive side she has managed to pass her University exams graduating with a BA, has been accepted into a three-year [course at a tertiary institution] and continues to be in a relationship with her boyfriend."

Dr C
Dr C advised HDC:

"While it may be the case that the experience of [Ms A's] previous inpatient stay informed the initial recommendation for a brief admission, the decision to vary that — actively made during MDT [multi-disciplinary team] discussion of her case — does not seem inappropriate.

From personal observation, discussion and review of her notes I cannot say that I saw clear difference in [Ms A's] presentation during her second admission (under [Dr B]) as opposed to her earlier admission (under my care).

From recent discussion with her community [consultant] I understand that [Ms A] has been maintained in the community on considerably less medication than in the past. This appears to me to be a positive outcome.

…

Documentation is always the Achilles Heel of any clinical service. [Ms A] was probably one of the most discussed clients of our service. It is not always feasible to record all discussions. The level of acuity on an acute admissions unit often outstrips the ability of clinicians to document contacts as fully as they might wish."

[3] The DHB stated that Ms A declined support from the community mental health team, and a discharge summary was sent to her GP instead, who was able to support her until Dr D's return from leave (he was overseas at the time of Ms A's discharge).

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The DHB

The former Clinical Director, Dr K, advised HDC:

> "When [Ms A] asked for a second opinion she spoke with the Charge Nurse Manager. The Charge Nurse Manager reports that she advised [Ms A] that she would arrange this but said that it could take some time. Following [Ms A's] request for a second opinion there was a discussion between the Charge Nurse and another senior [doctor] who works part time at [the Unit] about his availability to provide the second opinion. Regrettably a time for the second opinion was not decided upon and there was no clear timeframe given to [Ms A] as to when she could expect the second opinion to take place.
>
> …
>
> Our investigation into [Ms A's] complaint has highlighted inconsistencies and poor communication between the inpatient and community teams, and her psychotherapist. Inadequate communication has resulted in conflicting opinion being given to the service user with consequent confusion, splitting and less than best practice.
>
> The complaint further highlights the need for [the] Unit to review its practice when accessing a second opinion. The review needs to include timeframes within which the requested second opinion is provided.
>
> I have recommended that [all parties concerned with Ms A's] care will collaborate to produce an agreed comprehensive management plan by the end of May 2007, and am hopeful that improved consistency between the treating clinicians will lead to a better quality of service for [Ms A]."

In relation to the issue of communication between Dr B and other members of Ms A's clinical team, the DHB stated:

> "As I understand it … the differences in opinion between the various doctors involved in [Ms A's] care were not fully resolved and that the plan to reduce medication, which approach was supported by [Ms A's] community psychiatrist, was not discussed by [Dr B] with the liaison psychiatrist also actively involved in care.
>
> We accept that documentation of these discussions and observations was insufficient, although do not necessarily agree that such failure to record these matters in itself reflects a failure in the processes of oversight and supervision.
>
> We accept also that there appears to have been less than optimal joint agreement between the clinical team and [Ms A] regarding the approach to treatment."

The DHB accepts that the second opinion "was not completed in a timely fashion". The DHB stated:

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

"… [Ms A] requested a second opinion. [One] of the main difficulties in providing a second opinion was that the clinical team, rather than simply getting any other psychiatrist not directly currently involved in care, struggled to find a psychiatrist with no prior involvement of any sort, including involvement in any discussion about her presentation.

As noted above, [Ms A] had been discussed in a number of settings, many of which included other psychiatrists, such as team clinical meetings, peer review and the regular clinical forum. Some information about [Ms A] was therefore already available to other psychiatrists, who although 'independent' of her care, were likely to have reached some view of her presentation and treatment, influenced by the discussions.

…

We accept however that this process was slow and could have been better coordinated, but wish to note that had the service been not so focussed on finding a psychiatrist with no prior knowledge, the arrangement would have been much more timely."

Subsequent actions
A new Clinical Director has been appointed to the DHB Mental Health Services. He described the actions taken as a result of this case:

"Since taking up my role in this District Health Board I have begun to review aspects of the arrangements for oversight of doctors with provisional or general forms of registration who are practicing in the specialist area of psychiatry. This has included attention to aspects of the orientation and induction process for senior medical staff, as well as the nature of the arrangements for oversight and supervision.

Although this work is not yet complete, I am proposing that there be a more formal agreement with more explicit requirements documented for new practitioners made available to them prior to their taking up clinical responsibilities, setting out more clearly the nature of the arrangements for oversight and supervision, including attention to documentation and prescribing practice.

The scope of this work will encompass the roles of locum practitioners such as [Dr B], but will also include attention to requirements for Medical Officers in permanent positions, which category of medical staff I expect to become a more enduring feature of our medical workforce.

I hope to gain some benefit in this work, particularly with respect to oversight of Medical officers, from a visit [overseas currently planned] where, amongst other things, I will be meeting with senior medical leaders in a number of services [and] will have the opportunity to discuss the role of Staff Grade Psychiatrists and the extent of those roles, and their oversight.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

With regard to second opinions, it is now the practice that requests for second opinions are passed to the Unit Manager who approaches other consultants regarding their willingness and availability to offer an opinion. At times, for good reasons, they are unable to provide such opinions. Further, some clients want opinions from outside of the DHB. In these circumstances, we pay for independent opinions, although this in itself does not guarantee prompt response due to pressures of time on most practitioners."

Dr B's submissions

Dr B submitted:

"Diagnosis is critical for appropriate care. Extensive formal and informal consultations have taken place and the diagnosis was reached after all available data has been examined. In a case like this there is bound to be differing views. For an independent assessor none is more sacred than the other. Diagnosis is not a democratic process. It is a skill, a science and an art to reach the truth after examining ALL available evidence. It is not a consensus of opinions. As the responsible clinician I accept total responsibility for the diagnosis. Management without a diagnosis is style without substance. This consumer has received the benefit of all my experience and skill.

If this consumer's needs are accommodation to complete her university education it is something that I as a consultant psychiatrist could not have provided. It would be my duty not [to] prescribe medication that is harmful to her health. In my opinion factitious disorder/malingering must be spotted early and inappropriate admission and treatment withdrawn so that patient learns more mature coping methods. It would be wrong for professionals to reinforce this behaviour.

The appropriate follow up arrangements in the community was offered. [A community psychiatrist] attended the discharge planning meeting and accepted the patient.

…

All my records were contemporaneous. A clinician makes his observations all the time, not necessarily at interviews. We do make observations as we walk down the corridors or in the surrounding precincts, when we see the patient enjoying a cheerful laugh, or enjoying a bottle of Coco-cola walking across the car park for a psychotherapy session. We observe their demeanour and casual remarks in patient's unguarded moments. All this cannot find expression as contemporaneous notes particularly over months.

…

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

> I submit that I have made careful assessments and my decisions are professional and sound. It may not be to the liking to the patient. This is to be expected in such a diagnosis. I have nothing to apologise for."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights (the Code) are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

…

(2) Every consumer has the right to have services provided in a manner consistent with his or her needs.

…

(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Other relevant standards

Good Medical Practice — A Guide for Doctors (Medical Council of New Zealand, 2004):

"Domains of competence:

…

3. In providing care you must:

…

- keep clear, accurate, and contemporaneous patient records that report the relevant clinical findings, the decision made, the information given to patients and any drugs or other treatment prescribed."

Opinion: Breach — Dr B

Introduction
The main issue in this case is not whether Dr B's diagnosis of factitious disorder was correct, but whether he followed the correct process in reaching his diagnosis.

I accept the advice of my expert advisor, Dr Richard Porter, that a change in diagnosis from depression to a factitious disorder should have been made only after consultation with other professionals who knew and had cared for Ms A. Having performed that consultation, Dr B should have documented his reasons for such a change in diagnosis, and appropriately managed any change in treatment.

For the reasons given below, in my view Dr B breached the Code as he failed to consult adequately with his colleagues and he failed to adequately document the reasons for his change in diagnosis. In addition, he failed to expedite Ms A's request for a second opinion.

Change in diagnosis
Ms A was well known to the mental health service when she was admitted in February 2007. According to her psychotherapist, Dr D, Ms A had spent some months in hospital with depression in 2005 and 2006. Dr C, Ms A's usual psychiatrist, said that on her presentation in February 2007, he saw no clear difference in how she presented compared to previous admissions. Yet Dr B decided (in the words of my advisor) "relatively quickly to [reject] the previous diagnoses and to have applied a diagnosis of factitious disorder".

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

There is no evidence that Dr B discussed his change of diagnosis with Dr D, who for some years had been Ms A's psychotherapist (and is a psychiatrist himself). Although the clinical record contained a number of comments from nursing staff which should have prompted Dr B to make contact with Dr D, he did not do so.

Dr B suggested that Dr D could have come to him at any stage to discuss Ms A's care. Dr B has missed the point of my criticism. It was *his* decision to change Ms A's treatment based on a new diagnosis, and it was therefore *his* responsibility to discuss this with Dr D — not Dr D's to approach him.

Ms A was also assessed by a clinical psychologist who noted symptoms of post-traumatic stress disorder and depression, but there is no record from Dr B that these symptoms (which supported the former diagnosis) were assessed by him.

Up until this admission, Dr C had been Ms A's psychiatrist. However, there is no documented discussion between Dr B and Dr C regarding Ms A's treatment, and neither Dr C nor Dr B has advised that such a discussion took place. While I accept Dr C's point that it is not feasible to document *all* discussions between clinicians, had this discussion taken place, in my view it should have been recorded.

Dr Porter advised that there is "insufficient documented evidence in the clinical file to justify the change in diagnosis". This is particularly important as it was contrary to Ms A's belief, was very different to the previous diagnosis, and resulted in a change in treatment. Although, as Dr B notes, "diagnosis is not a democratic process", consultation with colleagues who know a patient well is fundamental to good clinical practice.

Medication changes

On admission in February 2007, Ms A was taking lithium and sodium valproate. Following Dr B's decision to alter her diagnosis, the lithium was discontinued on 1 March 2007; the dose of sodium valproate was reduced on 14 March, and discontinued altogether on 18 March 2007. Dr Porter advised that in his view "this was an unduly rapid discontinuation" of both drugs, but accepted that there was no consensus view on this point.

Request for a second opinion

From early in Ms A's admission she asked for a second opinion about her care. The first recorded request was on 24 February 2007, one day after she first met Dr B. The clinical records note a number of further requests, caused both by Ms A's disagreement with Dr B's diagnosis of factitious disorder, and what appears to have become a personal distrust of him.

In short, Dr B was aware that a second opinion was requested, but none was provided during Ms A's admission. Dr Porter has advised that it was "not acceptable that Dr B did not consult with a colleague and request in person a second opinion".

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Summary
As stated above, I make no findings whether Dr B was wrong in his diagnosis. I endorse Dr Porter's view that "[i]t is clearly not possible from the clinical file and in such a complex case to comment on diagnosis with any certainty". However, by failing to discuss his change in diagnosis with Ms A's usual clinicians, and by failing to obtain a second opinion, Dr B breached Right 4(5) of the Code. He failed to co-operate with his colleagues to ensure quality and continuity of services.[4] Finally, by failing to document the reasons for his change of diagnosis, Dr B breached Right 4(2). He did not satisfy the professional responsibility to keep clear, accurate patient records that justified the change in diagnosis.

Opinion: No breach — The District Health Board

Vicarious liability
Employers are responsible under section 72(2) of the Health and Disability Commissioner Act 1994 for employees' breaches of the Code. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from breaching the Code.

The DHB may therefore be responsible for Dr B's failure to discuss his change in diagnosis with Ms A's usual clinicians, to obtain a second opinion, and to document the reasons for his change in diagnosis.

I note that Dr B had been in post for only three months at the DHB when Ms A was admitted in February 2007. The question arises whether he received sufficient orientation, supervision and support.

The DHB explained that Dr C and Dr B worked closely together, and that there were plenty of opportunities available to discuss the care of his patients. The DHB noted that Dr B was a very experienced psychiatrist with full registration overseas. It submitted that there was "no failure in the processes of oversight and supervision", but that a second opinion process was "slow and could have been better coordinated".

In my view, although the clinical supervision of Dr B may have been less than optimal, there was support available to him, with Dr C working alongside him. I note that the DHB is taking steps to improve the oversight and supervision of new medical practitioners, including locum practitioners, with particular attention to documentation and prescribing practice.

[4] For another case of a psychiatrist found in breach of the Code for changing a patient's longstanding diagnosis without appropriate review, see case 02HDC01804, 15 December 2004.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

I also note that the clinical team was aware that Ms A had requested a second opinion. Although Dr Porter advised that the responsibility for obtaining this opinion lay with Dr B, in my opinion the clinical team as a whole should have worked together more effectively to expedite the obtaining of a second opinion. Nonetheless, I consider that the DHB took reasonable steps as Dr B's employer, and that it is not vicariously liable for his breaches of the Code.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand.
- A copy of this report, with details identifying the parties removed except the name of the expert who advised on this case, will be sent to the Royal Australian and NZ College of Psychiatrists, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix

Independent expert advice from psychiatrist Dr Richard Porter:

"**General Background**
The main issues underlying the complaint of [Ms A] are the change in diagnosis and subsequent ceasing of medication which [Dr B] undertook during her hospital admission beginning in February 2007. The other aspect to the complaint is [Ms A's] assertion that she was not adequately listened to by [Dr B] and that he appeared not to consult adequately with [Dr D], the Clinical Psychologist or with nursing Staff.

[Dr J] in his preliminary report (03.07.07) found that documentation provided to him was inadequate to reach a definite conclusion but that in particular there was lack of evidence of adequate consultation amongst professionals involved. I am now able to peruse extensive past clinical records in order to review these findings with more background available. This background is of particular significance in addressing the issue of the change of diagnosis and I will refer to this in detail below.

Background regarding clinical presentation and diagnosis
It is clearly not possible from the clinical file and in such a complex case to comment on diagnosis with any certainty. However, in a situation in which a change of diagnosis is at issue it is clearly useful to review past clinical files to understand previous clinical thinking in this regard. This then has implications for the degree of documentation and consultation which should have applied to a change in diagnosis.

Until 09 June 2006, [Ms A] had been extensively reviewed by three very experienced Consultant Psychiatrists ([Dr G], [Dr D] and [Dr C]). She had also been seen extensively by a Registrar, [Dr F], who wrote a very clear summary of the diagnostic issues in the clinical file (page 256 of 408, 09/06/06). He notes the repeated interviews by previous psychiatrists who had felt that these were strongly suggestive of MDE (major depressive episode). Secondly he noted her response to ECT which was positive, at least initially. Thirdly he noted that symptoms suggestive of borderline personality disorder reduced with ECT suggesting that, as is sometimes the case, these symptoms were markedly exaggerated by the co-existence of major depression.

Fourthly, he also noted a clear, although transient, elevation in mood, pressured speech and expensive and disinhibited actions after 4-5 treatments in both courses of ECT. This suggests an affective component to the illness as does the subjective complaint of racing thoughts and irritability which stopped after lithium was commenced.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[Dr F] noted at that point that [Ms A's] reading in mental health issues may have resulted in her "medicalising her language" and that there was evidence of emotional dysregulation, fear of abandonment, repeated self-harm, splitting of professional staff and regression into a dependent role in the ward. He further noted a lack of other key features of borderline personality disorder. At this stage therefore, there was certainly some complexity in the diagnosis but a very clear consensus that this was a major depression episode, perhaps with some suggestion that the diagnosis may have been of bipolar disorder (subtype - not otherwise specified). [Ms A] subsequently spent another five months in hospital during which the diagnosis continued to be under review but was essentially unchanged on discharge. I also note a family history of affective disorder, i.e. a brother with bipolar disorder and a cousin who had committed suicide.

During this admission [Ms A] was reviewed at intervals by [Dr H], another experienced Consultant Psychiatrist, who essentially agreed with the diagnosis. I note [Dr H's] suspicion of purging and vomiting but could find no other reference by [Dr H] to a possible diagnosis of factitious disorder and indeed her suspicion that this was an issue does not necessarily suggest that particular diagnosis. [Dr B] (in his undated reply to the HDC) refers to the same file entry of [Dr H] on 21.06.06 stating "[Dr H] also queries the possibility of faking symptoms". In fact what she said was "I remain suspicious that she may be purging/bulimic". Undisclosed purging is a very common symptom and does not in my opinion suggest a diagnosis of factitious disorder.

The only other diagnostic issue referred to in the file at this point is that of the possible influence of alcohol abuse ([Dr C] page 204, 24/07/06).

The first mention of factitious disorder is made by Consultant Psychiatrist [Dr I] (page 75 of 408, 22/01/07). The reason for the suggestion of this diagnosis is not made clear in the clinical file but is simply given in a list as follows: "Imp: 22 year old woman with unclear axis I diagnosis including MDD/dysthymic disorder/bipolar disorder/factitious disorder and axis II diagnosis supporting borderline/narcissistic personality structure." At this point I can find no clear justification in the clinical record for a diagnosis of factitious disorder or narcissistic personality structure at this point.

It had therefore been the well documented opinion of several very experienced psychiatrists that the diagnosis may be complex but that at least a large part of [Ms A's] issues were related to a mood disorder. These Psychiatrist's opinions have been formed over long periods of contact with the patient and had clearly been well thought out. Their opinions in some cases had been sufficiently clear to justify the prescription of ECT.

In my opinion therefore, the standard of consultation and documentation which should have occurred prior to making a radical change to such a diagnostic

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

formulation should have been very high and it is in this context that I will examine the care given to [Ms A] by [Dr B] and in particular the issues of clinical records and consultation.

Clinical Records

[Dr J] has commented on various issues regarding the admission notes and discussion of the reason for the plan for the admission. I agree that this is not always entirely clear in the notes but in general in my opinion the admission notes are adequate and the reply by [Dr C] to [Dr J's] report explains adequately the reason for [Ms A] being allocated to another consultant. In further dealing with this issue I will concentrate on the clinical notes justifying the change in diagnosis and withdrawal of medication. I will particularly concentrate on the medical notes justifying this diagnosis.

The first entry by [Dr B] is on 19/02/07 (page 60 of 408) where I note that the past diagnosis of depression was noted, as was the past history of treatment for this. At this point [Dr B] also suggests a personality profile, IQ assessment and various other clinical rating scales be done by the Clinical Psychologist. It appears therefore that he believed that it was important to assess the relative contribution of personality disorder.

The next entry by [Dr B] is on 23/02/07 (56 of 408). At this point under the heading 'Opinion' [Dr B] states very categorically "there is no evidence of a major depression". "She is requesting reading material about personality disorders, probably to tailor her answers to any probe by the psychologist".

On 26/02/07 (page 50 of 408) [Dr E] appropriately undertook a medication review and [Ms A] was seen again by [Dr B] on 27/02/07. It appears from this entry that the issue of discontinuing medication was already being raised and a note says "at interview she wanted continuation of Quetiapine and Lithium, even when told that it is not benefiting her".

A file note on 01/03/2007 (page 46 of 408) by [Dr E], notes that the plan was to stop Lithium Carbonate and reduce the dose of Quetiapine. At this point [Ms A] suggested that [Dr D] might discuss with [Dr B] the need for Lithium. There is still no evidence in the clinical file that [Dr B] had made any attempts to discuss this issue with [Dr D] or indeed any of the other psychiatrists who had seen [Ms A] previously.

In my opinion there are serious deficiencies in the record at this point particularly regarding documentation by the medical team of the rationale for the change in diagnosis and the plan to withdraw medication. In particular, the entry on 23/02/07 there is nothing documented clearly justifying the categorical statement of a lack of evidence of major depression or justifying the suggestion that she would deliberately mislead in a personality questionnaire. In my opinion, the statement "the desire to enjoy a relationship

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

and interest in pursuing vocational studies does not support the diagnosis of depression" is not sufficient to exclude such a diagnosis at this point. Many patients with major depression attempt to continue to realise their goals and aspirations. Further, when a plan was made on 01/03/2007 there is nothing in the clinical notes at this point to suggest that the opinions of other psychiatrists in the past who had clearly documented an improvement in racing thoughts on Lithium, was being taken into account and once again the certainty with which the conclusion that neither drug was benefiting [Ms A] is certainly not matched by adequate documentation. There is still no evidence in the file at this point that the diagnoses detailed very clearly and with adequate justification in the previous file (referred to in this report under Diagnosis) had been taken into account.

There is little else in the clinical record which directly justifies the change of diagnosis. The entry of [Dr B] on 15/03/2007 (p30 of 408) does states that "[Ms A's] auditory hallucinations are reported without distress, that she says contradictory things about suicidal ideation and that her experiences are described in general terms which could be obtained from her lectures". The entry says that her demand for medication indicates the desire to hold on to the "sick role" and that "there is a strong element of gain in this behaviour". It is not detailed exactly what the hypothesised gain was. In my opinion, although some of these phenomena could be construed as evidence of feigning of psychiatric symptoms, there is still insufficient documented evidence to support the change of diagnosis.

I note the feedback from [a] (Psychologist) (16/03/2007 – page 28 of 408) that the MCMI did not suggest significant personality disorder but had depressive and histrionic personality traits. I also note the high scores on the post traumatic stress disorder (PTSD) and major depression scales. Despite this feedback there is no record in the file of the response of the medical team to this information and of how this was incorporated into the diagnostic formulation. There is an entry on 08/03/2007 (page 37 of 408) stating that [Ms A] had told the staff nurse that she was reading information regarding borderline personality so that she would not present with this on the Millon Multiphasic Personality Inventory. If medical staff believed that this was what had happened this should be documented clearly and discussed with the psychologist who may have given the advise received by [Dr J] (from an experienced Psychologist) that it is difficult to deliberately mislead assessments on this instrument. There is no evidence at any point in the file that the issue of symptoms of PTSD had been assessed by the medical team.

The discharge meeting on 03/04/2007 was attended by [Dr B] and [a member of] the Community Mental Health Team. Also present were a social worker, staff nurse and two other staff, presumably from the base. The history is summarised with a diagnosis of factious disorder made. It appears that [the community psychiatrist] agreed with this diagnosis at this point. The

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

psychology report was discussed at this point and stated to be "not conclusive of any personality disorder". However, [the community psychiatrist] and the [Community Coordinator], noted that her presentation consisted of cluster B personality traits, particularly of the narcissistic type. Justifications for these assertions are not given in the file entry.

Discontinuation of Medication
I note that the plan was on 01/03/07 to discontinue the Lithium Carbonate from a dose of 750mg and that it was discontinued on that day (although 250mg given in error). In my opinion, lithium should generally be discontinued gradually unless there is a pressing need to do otherwise.

An entry by [Dr E] (14/03/2007 – page 32 of 408) notes that the sodium valproate would now be reduced. [Ms A] was seen by the Registrar on 16/03/2007, and sodium valproate stopped from 18/03/2007. Once again, in my opinion it is better to discontinue sodium valproate gradually.

Communication
As detailed to this point, there were clearly a number of professionals intimately involved in [Ms A's] care. This is a complex case and clearly it was appropriate for communication to occur between the treating team and a number of other professionals. In particular, in my opinion, there should have been extensive communication between the treating team and [Dr C] who had assessed [Ms A] over a very protracted period of time in the past, [Dr D], who had treated [Ms A] over a long period of time and continued to do so weekly during the admission to hospital, and [the clinical psychologist] who saw [Ms A] for a fairly extensive assessment.

I note in the reply to the initial report that [Dr C] (17.12.07) states that there was extensive discussion between himself and [Dr B] regarding [Ms A's] history. This is not well documented but as [Dr C] states this sort of discussion is often not documented in this sort of clinical situation. However, in my opinion, the basis for and the communication that led to the very radical change of diagnosis from a very reasoned and thorough formulation as written by [Dr F] (page 256 of 408, 09/06/06) and referred to previously in my report, to a diagnosis of factious disorder should have been documented very carefully.

In addition, there should certainly have been extensive communication with [Dr D], who continued to see [Ms A] weekly. There is no documented attempt by the medical team to contact [Dr D]. There are several references in the clinical file to a nurse wanting to organise a meeting between [Dr D] and [Dr B]. There is, however, an extensive note on 06/03/07 by [a registered nurse] (RN) (page 40 of 408), detailing the fact that [Ms A] believed [Dr D] wanted to speak to [Dr B]. There was also a plan made by the nurse to attempt to organise a meeting between [Dr B] and [Dr D]. This plan is repeated on

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

07/03/07 by the same nurse. There is a further entry by [the registered nurse], once again stating that she would organise a meeting (07/03/2007 – page 38 of 408).

In my opinion, although it is entirely appropriate and laudable that the nurse appreciated the need for this and also wished to help [Ms A] and take her wishes into account in this way, in my opinion the major responsibility in this regard was for the medical team to have direct contact with [Dr D]. At no point in the clinical file does [Dr D] document that he attempted to contact [Dr B]. However, [Dr D] states in his reply to the HDC (13.12.07) "When [Ms A] was an inpatient I made several attempts to meet with her team. I visited the ward on a number of occasions but no one was available to meet with me. I also contacted her consultant via email. I was not invited to a discharge meeting." This is rather corroborated by several documented meetings on the previous admission between [Dr D] and the treating team. [Dr B's] reply to the HDC does not refer to any attempt to contact [Dr D]. I can therefore only conclude that [Dr D] did make considerable attempts to contact the treating team but that the treating team made no attempt to reciprocate this.

[The clinical psychologist] assessed [Ms A] as requested by the medical team, administered the MCMI and provided feedback on the results of this, presumably in written form. She has not submitted a report to the Health and Disability Commissioner detailing her involvement. While it would be normal for clinical psychologists to attend multidisciplinary meetings and discharge meetings, I concede that this may not always be possible. However, in my opinion, once again given the nature of the change in diagnosis which was being proposed, it would have been appropriate for the treating medical team who were responsible for this change in diagnosis to discuss in person with the clinical psychologist the implications of the findings of the assessment which she had carried out. I note also the suggestion of the psychologist that post-traumatic stress disorder symptoms were important. There is no documentation that these symptoms were ever assessed during this inpatient admission. I therefore conclude that the treatment team did not communicate adequately with the clinical psychologist. Once again, in his reply to the HDC report, [Dr B] does not discuss communication with the psychologist at all.

Request for a Change of Doctor and Second Opinion

There is a documented request by [Ms A] for a second opinion on 24.02.07 (p54 of 408). [Dr B] was aware of this request on 27.02.07 (p50 of 408). An entry by [Dr E] (14/03/2007 – page 32 of 408) notes that the medical team was awaiting a second opinion implying that they were still fully aware of the request at this point. I note an entry on 19/03/2007 stating that [Ms A] was "awaiting second opinion and will need another professionals that he is going to work with her". I presume this is intended to mean that she was hopeful of having a different consultant psychiatrist/medical team. There is a further entry on 22/03/2007 by [Dr E] continuing to say "awaiting second opinion and

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

professional meeting after that". I presume that this means that the team intended to have a meeting with other involved professional after the second opinion is obtained. I also note an entry that indicates that [Dr B] was on leave at this point and that [Ms A] felt it acceptable that when she was seen by another consultant covering for him, this would constitute a second opinion. There is no entry of a meeting with a covering consultant or indeed by the Registrar again until 02/04/2007 when it appears that [Dr E] met [Ms A] with [Dr B], who presumably had returned from leave. It is at this point that it is documented that [Dr B] told [Ms A] that "it is unique for a person to have auditory hallucinations and being able to attend university classes at the same time". Following this, [Ms A] was clearly upset and the entry by the [staff nurse] states that [Ms A] would have liked [Dr C] to become her consultant, that [the community psychiatrist] was not available for two weeks (it appears that it was planned that she give the second opinion). The writer notes that [Dr G] was contacted and was coming at 2.00pm. In this case it is surprising that the entry also suggests that [another psychiatrist] was also being contacted. An entry later on this day states that it had been discovered that [Dr G] was unable to provide a second opinion since it was not court ordered.

It is acknowledged in the reply of [Dr K] to the HDC that a second opinion which was requested on 24.02.07 but was not completed during the inpatient stay (in-patient care continued until 03.04.07) was not completed in a timely fashion. I would note that there are several references in the file to nursing staff requesting a second opinion. It is usual sort of situation for the medical team to brief and discuss with another psychiatrist the need for a second opinion and to request that personally. Once again, there is no documentation of [Dr B] approaching any of his colleagues to obtain a second opinion, something which in my opinion was his responsibility in this circumstance.

Specific Opinion on Points Raised by [Dr J]

I agree with [Dr J] that there were significant deficiencies in the care provided by [Dr B] as evidenced by the information in the clinical records available to me (I do have some further clinical records which were not available to [Dr J]). I agree that the documentation is substandard and as noted I agree with [Dr J] that this is particularly the case in somebody presenting with such complex features. I note that the material available to [Dr J] did not contain detail of the prior psychiatric history. In my opinion having obtained this history this makes the documentation of [Dr B] it even more suboptimal given that he was making a change to a diagnosis arrived at after considerable consideration by a number of experienced psychiatrists.

I completely agree with [Dr J's] comment that there was not good communication with other people who knew [Ms A]. I note file entries suggesting that [Ms A] did not want communication with members of her or her partner's family, but clearly as noted there were several professional with whom, in my opinion, there should have been considerable communication.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

I note [Dr J's] last paragraph which states that "Perhaps the most significant (deficit) however, is that despite a number of other mental health agencies and staff being involved in the care of [Ms A] and despite the complex nature of her presentation and concerns about risks with which she presented, there is no evidence of coordination of all the views of these other parties." I fully concur with [Dr J's] conclusion in this regard and as noted under the heading "Communication" believe it was the responsibility of [Dr B] to ensure that this consultation took place. This is perhaps the most deficient area of the care which [Ms A] received in this case.

Summary
[Ms A] presents with a complex history and set of symptoms. These had been extensively assessed and good diagnostic formulations produced in the clinical file by a number of clinicians, notably [Dr F] who summarised the opinions of several previous psychiatrists. However, upon admission to [the Unit] (16.02.07), it appears that [Dr C], having found [Ms A] to be relatively treatment resistant on a previous admission, requested the "expertise" of [Dr B] as a second opinion and for ongoing care.

[Dr B] appears relatively quickly to have rejected the previous diagnoses and to have applied a diagnosis of factious disorder. This was very much (not surprisingly) contrary to [Ms A's] views and from an early point in the admission she requested a change of clinician and a second opinion. Medication which she and previous clinicians felt had helped was rapidly discontinued. Appropriately it was suggested that personality factors be further assessed by a clinical psychologist. [Ms A] continued to see her psychotherapist ([Dr D] who is also a consultant psychiatrist) throughout the admission. During the admission there was no communication between [Dr B] and [Dr D] and apart from a written report, there is no evidence of discussion between [Dr B] and the clinical psychologist.

In my opinion, and in agreement with [Dr J], this sequence of events was unacceptable in the following regards:

a) There is insufficient documented evidence in the clinical file to justify the change in diagnosis. As noted it is particularly important to document this since the new diagnosis was very much contrary to the patient's beliefs and wishes, it was very different to the previous diagnosis and it resulted in a very radical change of treatment.

b) There was insufficient consultation with other professionals in making this diagnosis and in formulating the treatment plan. Notably there was absolutely no communication with [Dr D] who had treated [Ms A] for some considerable time. There was no documented consultation with [Dr C]. However, I accept that this may have occurred informally and certainly [Dr C's] opinions are well documented previously in the clinical file. There was no documented meeting

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

with the clinical psychologist. This is particularly surprising since an assessment by the clinical psychologist was one of the first points in the management plan immediately after [Ms A] was admitted. In my opinion it was the responsibility of [Dr B] to ensure that adequate consultation with other professionals took place.

c) After admission medication was very rapidly discontinued. This is unusual and could have resulted in significant discontinuation symptoms.

d) A second opinion should have been arranged within a reasonable period of time after being requested. This should have been driven by the medical team. Clearly local circumstances determine how quickly such an opinion may be obtained but in my opinion it was not acceptable that [Dr B] did not consult with a colleague and request in person a second opinion.

Therefore, in my opinion, the care given by [Dr B] to [Ms A] departs from what an appropriate standard of care in a way which I would view with moderate disapproval.

Richard Porter, MA (Cantab) MBBs (Hons) MRC Psych (UK)
Associate Professor in Psychological Medicine"

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.