Doctor, Dr B

A Report by the

Health and Disability Commissioner

(Case 16HDC01138)

Table of contents

Executive summary..1

Complaint and investigation 1

Information gathered during investigation..2

Relevant standards 5

Opinion: Dr B — breach...6

Recommendation 7

Follow-up actions..7

Appendix A: Independent clinical advice to the Commissioner 8

Executive summary

1. Ms A, aged 26 years, has a medical history that includes depression, anxiety, and difficulty sleeping. Between 2014 and 2015, Ms A was in a romantic relationship with Dr B.

2. Dr B prescribed various medications for Ms A during the relationship. He prescribed paracetamol and other forms of analgesia, ranitidine (for heartburn), zopiclone for insomnia (a psychoactive medication with some potential for dependence), tramadol (a form of pain relief), and oral contraceptive medication. Dr B did not keep any record of the frequency and dosages prescribed.

3. Dr B said that he prescribed medication to Ms A because she was a student at the time she was living with him, and she had financial burdens. Dr B stated that he is aware that prescribing to family and friends is not correct practice, and in general must be avoided. He accepts that prescribing for Ms A was an error of judgement.

Findings

4. By prescribing medication to his partner at the time, Ms A, including psychoactive medication, and by failing to keep a record of the care provided to Ms A or to provide information to her GP regarding the prescriptions, it was found that Dr B failed to provide services that complied with professional standards, and breached Right 4(2)[1] of the Code of Health and Disability Services Consumers' Rights.

Recommendations

5. It was recommended that the Medical Council of New Zealand consider whether a review of Dr B's competence is warranted, and report back to HDC on the outcome of that review.

Complaint and investigation

6. The Commissioner received a complaint from Ms A about the services provided by Dr B. The following issue was identified for investigation:

- *Whether Dr B provided an appropriate standard of care to Ms A in 2014 and 2015.*

7. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Dr B	Provider

[1] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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8. Information from the district health board, the Ministry of Health, and a former flatmate of Dr B and Ms A was also reviewed.

9. In-house clinical advice was obtained from general practitioner Dr David Maplesden (**Appendix A**).

Information gathered during investigation

Background

10. Ms A, aged 26 years, has a medical history that includes depression, anxiety, and difficulty sleeping, and has been a regular visitor to her GP.

11. Dr B qualified as a doctor in 2012 and, in 2013, was registered within a general scope of practice.

12. Between 2014 and 2015, Ms A and Dr B were in a romantic relationship. During 2015, Ms A lived with Dr B and two other flatmates.

Prescribing of medication, including psychoactive medication

13. Ms A told HDC that during their relationship, Dr B prescribed drugs for her. She said that prescriptions were written for her under her name, and also using the names of their friends, but the medication was for her. Ms A stated: "[S]pecifically I remember a large amount of tramadol given under [the name of] [Ms X]." Ms A said that when Dr B prescribed medication for her, he was aware of her medical history of depression, anxiety, and trouble sleeping.

14. HDC attempted to locate records of Dr B's prescribing for Ms A. HDC contacted the Ministry of Health (MOH) Sector Services Payment Processing team, which ran searches for pharmacy claims against Ms A's National Health Index (NHI) number and names. These searches did not locate any claims for the time period in question. MOH advised that at the time of these events, NHI numbers were not required for claiming prescriptions. Additionally, if Ms A's name had been spelled incorrectly on the prescription, or entered at the dispensing pharmacy incorrectly, these prescriptions would not appear against searches.

15. Dr B acknowledged to HDC that he prescribed various medications for Ms A during his relationship with her. He said that he prescribed paracetamol and "other forms of simple analgesia (for her severe menstrual cramps)", ranitidine[2] (for heartburn),

[2] Ranitidine is a histamine blocker. It works by reducing the amount of acid the stomach produces, and is used to treat and prevent ulcers in the stomach and intestines. It also treats gastro-oesophageal reflux disease and other conditions in which acid backs up from the stomach into the oesophagus, causing heartburn.

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zopiclone[3] (a psychoactive medication with some potential for dependence), as "she suffered from insomnia from time to time", tramadol,[4] and "occasional refills" of the oral contraceptive medication AVA 20.

16. Dr B told HDC: "Regrettably, I did not keep any record of the frequency and dosages prescribed." He said that to the best of his recollection:

> "I prescribed medications at the commonly accepted therapeutic dose and frequency. Ranitidine 150mg BD and Zoplicone 7.5 mg (14 tabs at a time) no more than three times over a two year period. In respect to Tramadol, I believe I prescribed [Ms A] Tramadol 50–100mg QID with an amount not totaling more than two weeks, on two occasions."

17. Regarding the zopiclone, Dr B said that Ms A had told him that previously she had been prescribed zopiclone with good effect.[5] Dr B stated that he was aware of Ms A's "psychological issues", and said: "I did not prescribe Zopiclone despite knowing this, but rather because of this." He further said:

> "With the exception of melatonin (which is not subsidised in New Zealand) Zopiclone was the sleeping pill with least potential for dependence that was appropriate and is generally accepted to have a role in the adjunct management of anxiety and depression. With that being said I am very aware that my actions were at the least inappropriate."

18. Dr B stated: "I observed no concerning symptoms following my prescribing; rather [Ms A] only reported the medication helped her."

19. Dr B denies prescribing drugs for Ms A under other people's names.

Further information from Dr B

20. Dr B said that he prescribed medication to Ms A because she was a student at the time she was living with him, and she had financial burdens. He stated that he "felt compelled by [Ms A] to write prescriptions for her for simple medications to help her alleviate her financial stress including the cost of seeing her GP". He further said: "At no time did I volunteer to provide her with any drugs, especially drugs with addictive potential. Rather, [Ms A] herself put pressure on me to prescribe for her and always at her request."

21. Dr B said that he "always encouraged [Ms A] to seek help from her own doctor and there were many times [when he] took time off work to drive her to appointments to ensure that she got the help she needed".

[3] A hypnotic agent used in the treatment of insomnia.
[4] Used to treat pain.
[5] Ms A's GP notes document that she had been prescribed zopiclone previously by her GP in March 2015.

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22. Dr B stated that he is aware that prescribing to family and friends is not correct practice, and in general must be avoided. He accepts that prescribing for Ms A was an error of judgement. He said: "Whilst it may have been misguided, my only intention was to help her. … My actions, although misguided, were never aimed at taking advantage, manipulating or harming [Ms A]."

23. Dr B stated:

> "I will never again prescribe medication to a person with whom I am in a relationship with or close with. … It is with regret, disappointment (in me) and shame that I have had to learn this lesson. To say that this matter has been a learning process for me is an understatement."

24. Dr B stated that since receiving notice of Ms A's complaint to HDC, he has reviewed the Medical Council of New Zealand (MCNZ) June 2013 guidelines on providing care to those close to you, and he sought collegial advice. He stated:

> "I have raised this matter appropriately with senior colleagues and reflected on my actions and how I responded to the pressures placed upon me. I am certain that I would respond in a different way if this situation will occur [sic] again. … I can say with certainty that I will never again prescribe medication to myself or to a person with whom I am in a relationship with or close with."

Statement from flatmate

25. Dr B told HDC that Ms A placed pressure on their flatmates, who are also doctors, asking for "medical consultations" on a number of occasions. Dr B said that they declined Ms A's requests.

26. One flatmate provided a statement to HDC. He said:

> "[Ms A] would ask [Dr B] for his medical opinion and ask for prescriptions of various drugs. [Dr B] encouraged her to seek help from her own GP …
>
> [Ms A] would frequently ask me for my medical opinion on various health complaints and request I examine her. Myself and another flatmate told her on several occasions that she should see her own GP for this and that we are not in a position to be her doctor given we were her flatmates."

27. In response to my provisional opinion, Ms A disputed the suggestion that she pressured her flatmates into prescribing for her or examining her medically.

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Relevant standards

Medical Council of New Zealand

28. At the time of these events, the Medical Council of New Zealand's "Statement on providing care to yourself and those close to you"[6] provided the following relevant standards:

> "(i) The Medical Council recognises that there are some situations where treatment of those close to you may occur but this should only occur when overall management of patient care is being monitored by an independent practitioner. Wherever possible doctors should avoid treating people with whom they have a personal relationship rather than a professional relationship. Providing care to yourself or those close to you is neither prudent nor practical due to the lack of objectivity and discontinuity of care.
>
> (ii) The following are specific situations when you must not treat yourself, family members, people you work with and friends:
>
> - Prescribing or administering drugs of dependence.
> - Prescribing psychotropic medication.
>
> (iii) … in any other situation where there is no reasonable alternative to providing care to yourself or someone close to you, you should take extra care to ensure that:
>
> - The care involves an adequate assessment of the patient's condition, based on the history and clinical signs and an appropriate examination.
> - You refer the patient to another doctor, when indicated.
> - The details of the consultation are recorded in clear, accurate and contemporaneous patient records that report the relevant clinical findings, the decisions made, the information given to the patient and any drugs or other treatment prescribed.
> - The care is monitored by another doctor."

Responses to provisional opinion

29. Ms A and Dr B were given the opportunity to respond to relevant sections of my provisional opinion.

30. Ms A's response has been incorporated into this report where relevant.

31. Dr B acknowledged that his actions were inappropriate.

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[6] Medical Council of New Zealand, "Statement on providing care to yourself and those close to you" (June 2013).

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Opinion: Dr B — breach

Prescribing medications to Ms A

32. While Dr B acknowledges that he prescribed some drugs for Ms A, I also note that his and Ms A's outline of events differ. Namely, Ms A alleges that medications were provided to her under her own name, as well as under the names of different consumers. Dr B denies supplying medications to Ms A under anyone else's name. Owing to the conflict in evidence, I am unable to conclude whether or not prescriptions were made under the names of others for Ms A's benefit. However, Dr B has acknowledged that he provided prescriptions to Ms A without keeping any record of what he prescribed and, as noted by my in-house clinical advisor, Dr David Maplesden, "evidently without information provided to [Ms A's] GP regarding the prescriptions". There is no written record of any consultations between Ms A and Dr B.

33. Furthermore, Dr Maplesden advised that he is concerned that Dr B acknowledged that he was aware that Ms A had psychological issues but still prescribed her zopiclone (a psychoactive medication with some potential for dependence), as well as prescribing a weak opioid medication to her in the form of tramadol.

34. Dr Maplesden further advised that he is concerned that the prescribing occurred on a number of occasions and was often for medications that "would be difficult to justify there was any urgency in access".

35. Dr Maplesden said that "international evidence suggests both self-prescribing and prescribing for intimates by physicians is a common practice". However, I also note his advice that "the relevant Medical Council guidance is fairly explicit and, although not necessarily universally agreed, the content of the guidance is well known".

36. There is no dispute that Dr B prescribed zopiclone, a psychoactive medication, and tramadol, an opioid medication, to Ms A while they were in a personal relationship. Ms A was a regular visitor to her GP and, given that the situations in which Dr B acknowledges that he prescribed medications to Ms A were not an emergency, Dr B should not have prescribed medication to Ms A.

Documentation

37. As stated above, when Dr B prescribed medication to Ms A, he did not document any discussion with her about symptoms, the frequency and dosage of the medications prescribed, or any information about their side effects. The "Statement on providing care to yourself and those close to you" specifies that if a practitioner provides care for a person close to him or her, the practitioner is to record details of consultations in clear, accurate, and contemporaneous patient records, which also record relevant clinical findings, decisions made, information given to the patient, and the drugs prescribed. Dr B failed to document any details pertaining to his prescribing of medications for Ms A. That was unacceptable.

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Conclusion

38. While I note that prescribing for people with whom the prescriber is in a close personal relationship is relatively common practice, the MCNZ guidelines are clear. Such situations are undesirable and should be avoided where possible. In relation to the prescribing of drugs of dependence and psychotropic medications, such as zopiclone and tramadol, the guidelines are even clearer in stating that in these specific circumstances practitioners must not treat themselves, family, or friends.

39. By prescribing medication to Ms A (his partner at the time), including psychoactive medication, and by failing to keep a record of the care provided to Ms A or to provide information to her GP regarding the prescriptions, Dr B failed to provide services that complied with professional standards, and breached Right 4(2) of the Code.[7]

Recommendation

40. I recommend that the Medical Council of New Zealand consider whether a review of Dr B's competence is warranted, and report back to HDC on the outcome of that review.

Follow-up actions

41. A copy of this report with details identifying the parties removed will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name.

42. A copy of this report with details identifying the parties removed will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[7] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden on 14 September 2015:

"1. Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice. I have reviewed the available information: complaint from [Ms A]; response from [Dr B].

2. [Ms A] presents this scenario: she was in a relationship with [Dr B] for two years and [lived with him for a year] until the end of 2015. During that period [Dr B] provided her with prescriptions for a variety of medications including tramadol and zopiclone. The prescriptions were written variously under [Ms A's] name, [Dr B's] name, or the name of some of their friends (including a prescription for tramadol written under the name of [Ms X]). However, the medications were for [Ms A]. [Ms A] suffered from depression and anxiety during the latter part of her relationship with [Dr B] which she attributes to the way [Dr B] treated her. She states [Dr B] was aware of her psychological issues but continued to prescribe her medication.

3. [Dr B] presents this scenario: he was in a relationship with [Ms A] and lived with her and two other flatmates for a year prior to the relationship ending [in] 2015. He states he has had no contact with [Ms A] since that date. [Dr B] admits prescribing various medications for [Ms A] over this period, at her request: oral contraceptive Ava 20; paracetamol and other forms of simple analgesia for menstrual cramps; ranitidine for heartburn; zopiclone for insomnia. [Dr B] did not keep any record of the prescribing. He states he prescribed [Ms X] tramadol for her own use for the treatment of migraines. He has occasionally prescribed himself zopiclone. [Dr B] states his motivation to prescribe for [Ms A] was to relieve her of the financial burden of seeing a GP (she was a student of limited means), although he encouraged her to see her GP and assisted her in getting to appointments when able. He notes [Ms A] often sought medical advice from [Dr B] and the flatmates (who I presume had medical backgrounds). He implies he was aware of [Ms A's] anxiety issues. in late 2015 [Dr B] states he became aware that [Ms A] had a diagnosis of Borderline Personality Disorder and had been involved with mental health services. [Dr B] states that he has never prescribed medication for friends or family prior to or since the events in question and deeply regrets the events that have transpired. He denies ever abusing [Ms A] or abusing his role as a doctor. He has reviewed the relevant Medical Council of New Zealand guidelines and states he will never again let himself be placed in a position where he is under pressure to prescribe to friends or family.

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4. The Medical Council of New Zealand (MCNZ) is in the process of revising its guideline Statement on providing care to yourself and those close to you. The 2013 version[8] relates to the events in question. Relevant extracts include:

> (i) The Medical Council recognises that there are some situations where treatment of those close to you may occur but this should only occur when overall management of patient care is being monitored by an independent practitioner. Wherever possible doctors should avoid treating people with whom they have a personal relationship rather than a professional relationship. Providing care to yourself or those close to you is neither prudent nor practical due to the lack of objectivity and discontinuity of care.
>
> (ii) The following are specific situations when you must not treat yourself, family members, people you work with and friends:
>
> - Prescribing or administering drugs of dependence.
> - Prescribing psychotropic medication.
>
> (iii) … in any other situation where there is no reasonable alternative to providing care to yourself or someone close to you, you should take extra care to ensure that:
>
>> The care involves an adequate assessment of the patient's condition, based on the history and clinical signs and an appropriate examination.
>>
>> You refer the patient to another doctor, when indicated.
>>
>> The details of the consultation are recorded in clear, accurate and contemporaneous patient records that report the relevant clinical findings, the decisions made, the information given to the patient and any drugs or other treatment prescribed.
>>
>> The care is monitored by another doctor

5. Limited data suggests self-prescribing amongst physicians is common[9]. A study published in 2009 found that three quarters of Canadian clinicians took care of their own medical needs when they could. A survey in 2005 found that more than half of physicians in Norway in their fourth and ninth years after graduating from medical school had self-prescribed at least once during the previous year. And a study in 1998 suggested that around half of US resident physicians had self-

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[8] https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-providing-care-to-yourself-and-those-close-to-you.pdf Accessed 29 Sep 2016.
[9] Moberly T. Physician, don't heal thyself: the perils of self-prescribing. BMJ 2014;349:g7401 http://www.bmj.com/bmj/section-pdf/816196?path=/bmj/349/7987/Feature.full.pdf Accessed 29 Sep 2016

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prescribed. However, regulatory authorities internationally generally discourage the practice as does the MCNZ.

6. A 2015 article on the ethics of physicians treating family and friends[10] noted there is scant information regarding the validity of concerns laid out in statements by various regulatory authorities (including MCNZ) as to why such actions should be avoided. Surveys indicate that physicians treat family and friends frequently. Although doing so can cause physicians distress, it is unclear whether medical errors are more common when treating intimates. Many physicians could cite personal experiences of treating a family member or a friend in which their judgment was clouded by their emotional involvement. However, we tend to better recall experiences that confirm our fears, like a bad outcome, rather than uneventful ones that fail to confirm our fears.

7. While there is some international evidence that physicians treating themselves and intimates is common, the MCNZ is clear in the statement cited that such situations are undesirable, and note actions that should occur if such prescribing is unavoidable. Based on the scenario presented by [Ms A], I have the following concerns:

(i) prescriptions were provided to [Ms A] without any record kept of the associated consultations and evidently without information provided to [Ms A's] GP regarding the prescriptions

(ii) medications were provided to [Ms A] having been obtained from prescriptions issued in the names of different consumers

(iii) [Dr B] was aware that [Ms A] had psychological issues but still prescribed her zopiclone which is a psychoactive medication with some potential for dependence[11]

(iv) while detail on all prescriptions provided is limited (including names of drugs, amounts prescribed etc) it is apparent weak opioid medication was prescribed for [Ms A] in the form of tramadol on at least one occasion

(v) the prescribing evidently occurred on numerous occasions over the two-year period in question, and was often for medications that it would be difficult to justify there was any urgency in access. […]

(vi) [Ms A] reports that [Dr B] threatened her in an effort to keep his prescribing for her confidential

I feel the issues raised in this scenario would be met with at least moderate disapproval by my peers.

[10] Hojman H. A friend's request for treatment. AMA Journal of Ethics. 2015;17(5): 428–431. http://journalofethics.ama-assn.org/2015/05/ecas3-1505.html Accessed 29 Sep 2016

[11] BPAC. Overuse of benzodiazepines: still an issue? Best Practice Journal. 2015; Issue 66

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8. Based on the scenario presented by [Dr B] I have the following concerns:

(i) he self-prescribed a limited amount of a psychoactive medication (zopiclone)

(ii) he failed to keep any record of the medications prescribed for [Ms A] or the nature of any consultation undertaken in relation to the prescribing

(iii) he was aware [Ms A] had psychological issues but prescribed her limited amounts of a psychoactive medication (zopiclone)

(iv) he apparently prescribed for [Ms A] on numerous occasions over a two-year period

9. Mitigating factors to consider in this scenario (based on [Dr B's] response rather than forensic analysis of the prescribing) include:

(i) there was generally sound clinical indication for the prescribing
(ii) the dosages prescribed were consistent with accepted practice
(iii) there was apparently no prescribing of controlled drugs
(iv) prescriptions were issued only in the name of the recipient
(v) [Ms A] was still receiving GP care and [Dr B] tried to facilitate this
(vi) international evidence suggests both self-prescribing and prescribing for intimates by physicians is a common practice

I think the features of this scenario would be met with mild to moderate disapproval by my peers noting the relevant Medical Council guidance is fairly explicit and, although not necessarily universally agreed, the content of the guidance is well known.

10. To resolve the significant differences in recollection between [Ms A] and [Dr B] would likely require some form of forensic analysis of his prescribing in 2014 and 2015 and I am not sure how practical that would be. The issue of prescribing for [Ms X] could presumably be clarified by her. A reasonable option might be to refer this case to the Medical Council whichever scenario is preferred."

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