Locum General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 06HDC14100)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Dr B	Provider/Locum general practitioner
Mr C	Registered psychologist
Dr D	Psychiatry Registrar
Mrs E	Counsellor
A Medical Centre	Medical Centre 1
A Medical Centre	Medical Centre 2

Complaint

On 20 September 2006 the Commissioner received a complaint from Mrs A about the services provided by Dr B. The following issues were identified for investigation:

- *The adequacy and appropriateness of Dr B's diagnosis and treatment of Mrs A for depression between December 2002 and September 2006 while they were living as partners.*
- *The appropriateness of Dr B adding the medication Paradex to prescriptions for Mrs A.*

An investigation was commenced on 9 October 2006.

Information reviewed

- Information from Mrs A, including lists of prescriptions from four pharmacies
- Information from Dr B
- Notes from a telephone conversation with Mr C
- Letter from Medical Centre 1
- Letter from Medical Centre 2
- Report from Dr D
- Notes from a telephone conversation with a neighbour
- Notes from a telephone conversation with a Community Constable
- Report from Mrs E
- Mrs A's records from a Community Mental Health Clinic

Independent expert advice was obtained from rural general practitioner Dr Tony Birch.

Information gathered during investigation

Dr B
Dr B is registered with the Medical Council of New Zealand within a vocational scope of general practice. During the period under investigation, he worked at a tertiary institution and as a locum general practitioner one day a fortnight at a Medical Centre.

Dr B and Mrs A's relationship
Around 1998, Mrs A and Dr B became friends. Their friendship developed into a de facto relationship, and in December 2002 they began living together. Mrs A described herself as Dr B's "common law wife".

They separated for a period in 2005, then resumed cohabitation, before finally breaking up acrimoniously in May 2006.

Diagnosis of depression
Mrs A said that about a week after she moved in with Dr B in December 2002, he told her that she was depressed and prescribed her paroxetine (Aropax), a selective serotonin reuptake inhibitor (SSRI) medication used to treat depression. Dr B admits that he diagnosed and treated Mrs A for depression while she was his partner.

Dr B stated that in the early stages of their relationship he was concerned about Mrs A's "periodic rages and her periods of lethargy and inactivity". He insisted that she get help to address these problems, and Mrs A saw Mr C, a clinical psychologist. Dr B said that his assessment at the time was that Mrs A was suffering from depression and that she confirmed to him that Mr C had told her she had depression.

Mr C confirmed that Mrs A consulted him weekly from 24 January until 26 June 2002. He said that she had relationship problems and suffered from low self- esteem and a lack of confidence but was not depressed. She consulted him again on one occasion on 5 December 2002. At this appointment, Mrs A told him that she had moved in with an "academic" man who isolated her and was controlling. Mrs A told Mr C that she was not taking any medication except birth control pills.

Dr B explained that Mrs A had told him of her previous mental health history, including abuse by former partners, depression, and other psychological difficulties. He said that based on this information, his understanding that Mr C had told her she was

depressed, and his observations of her behaviour, he felt she was suffering from depression. Mrs A denies experiencing rages.

Prescriptions for Aropax
Mrs A provided a list of prescriptions written by Dr B dating from April 2003 to May 2006. She was unable to get copies of medications dispensed between December 2002 and April 2003 because the pharmacies told her they could not retrieve them from its computers. However, dispensing information has been obtained from four pharmacies as follows:

- Pharmacy 1 — medications dispensed on 12 March 2003 and 12 June 2005;
- Pharmacy 2 — medications dispensed on 10 occasions from 24 April 2003 to 26 February 2005.
- Pharmacy 3 — medications dispensed on six occasions from 22 August 2003 to 1 April 2005;
- Pharmacy 4 — medications dispensed on 21 occasions from 30 October 2003 to 22 April 2006.

Of the above prescriptions written by Dr B, 29 were for Aropax. Aropax was dispensed on the following dates: 24 April, 21 May, 25 June, 24 July, 22 August, 12 September, 20 October, 21 November and 24 December 2003; 13 January, 25 February, 24 March, 28 April, 28 May, 12 July, 23 August and 17 November 2004; 26 February, 28 July, 19 August, 27 September, 4 November, 9 and 17 December 2005; 6 January, 10 February, 10 March, 10 and 22 April 2006.

There were also prescriptions for Paradex (paracetamol and dextropropoxyphene napsylate, a mild narcotic analgesic structurally related to methadone), Trisequens (hormone replacement therapy), Losec (omeprazole, a proton-pump inhibitor), doxycycline (a broad-spectrum antibiotic), Naxen (naproxen, a non-steroidal anti-inflammatory drug), Cromolux eye drops, Kenacomb (a corticosteroid), Fucithalmic eye drops, fusidic acid cream, Beta cream, and paracetamol.

Dr B stated that he told Mrs A that he would prescribe medication to help her, on the condition that "she see her own counsellor/psychologists and GP". He said he generally prescribed Aropax 20mg daily, though he increased this to 40mg "when there was a deterioration in the latter stages of [their] relationship".

Dr B stated that he had no hesitation in saying that Mrs A improved while she was taking Aropax. He said that her self-esteem improved "quite dramatically", her rages diminished, and she became more positive in her outlook. He said that "it was evident that her relationship with her children also improved".

Mrs A claims that Dr B prescribed Aropax as a form of controlling her. Dr B denies this allegation and states that at all times he acted in the best interests and welfare of Mrs A. However, Dr B acknowledges that "[i]n hindsight, the need to review my prescribing in these circumstances highlights for me the warning in the Medical Council's statement relating to family care as being neither prudent nor practical due to the lack of objectivity and discontinuity of care".

Lack of records
There are no records of Dr B's treatment of Mrs A. Dr B stated:

> "I readily concede that I have been unwise in the manner of my prescribing of Arapax [sic] to [Mrs A] over the period of some years. I did not keep formal records of my diagnosis of depression and prescribing and did not refer [Mrs A] in a formal way to other practitioners. My monitoring was not recorded, consisting of my observations of her in the context of our relationship".

Involvement of other practitioners
Dr B stated that he "repeatedly encouraged and indeed insisted that [Mrs A] seek independent professional opinion about her condition, a diagnosis and treatment". However, Mrs A said that at no time while Dr B was prescribing Aropax for her did he advise her to see another doctor. She said that when she raised the issue, he reminded her that he was the doctor in the relationship and that his prescribing of Aropax saved her money. Mrs A stated that she did not consult with any other practitioner during the time she lived with Dr B.

Dr B said that, from what he knew at the time, Mrs A did see other practitioners. He "did not enquire into the detail of her exchanges with her medical advisers" because he "respected the sensitive nature and background to these". However, he recalls having general discussions with these practitioners regarding Mrs A's condition, although this contact was "cursory and confined to telephone discussions" and he did not refer Mrs A "in a formal way" to other practitioners. He does not recall the names of those he spoke to or the detail of the discussions except that the diagnosis of depression was confirmed. Dr B cannot recall the name of Mrs A's general practitioner but believes she was registered at "[Medical Centre 2]".

Medical Centre 2 has no record of Mrs A ever attending the practice. Medical Centre 1 confirmed that Mrs A attended the surgery between 1997 and 2002. Medical Centre 1 advised that on 15 September 1999 a prescription for a one-month supply of Cipramil

(an SSRI medication used to treat depression and anxiety) was issued by a general practitioner at that practice without a consultation. However, there are no records of Mrs A's attendance at Medical Centre 1 between 2003 and 2006. Mrs A has no recollection of being prescribed antidepressants by the Medical Centre 1.

Events of 2006

Mrs A said that towards the middle of 2006 she felt she was becoming irrational in her thinking and had developed a "temporary tic" in her left eye. She started "picking holes in [her] head", and having periods of blanking out during conversations and while driving. She said that at this point she was taking up to 80mg Aropax daily on Dr B's advice. Dr B denies ever increasing Mrs A's dosage of Aropax to 80mg a day. Mrs A said that Dr B did not write prescriptions for 80mg Aropax daily but she had "stockpiled" some tablets and took them on Dr B's instruction. In response to my provisional opinion, Mrs A stated that, in April 2006, Dr B facilitated an increase in the dosage of Aropax by writing two scripts for one month's supply of 40mg tablets within 12 days of each other.

Mrs A said that she became worried about her symptoms and, without Dr B's knowledge, referred herself to Dr D (a psychiatric registrar at a Community Mental Health Service).

Dr D advised that Mrs A attended the Community Mental Health Outpatient Clinic for an initial assessment on 19 April 2006, after being referred by the emergency mental health team on 7 April when assessed for "suicidal thinking with the background of low mood and relationship strain". She was then seen for follow-up on 8 May, 12 June and 24 July 2006. Mrs A stated that Dr D immediately weaned her off Aropax over a period of four months. Mrs A's assessment notes record that her Aropax dose was decreased (from 40mg daily), then stopped.

Mrs A told Dr D that she had problems controlling her anger, and would rapidly become angry for no reason. She also reported periods of low mood lasting about two weeks with occasional brief periods of high moods. After her first assessment on 19 April 2006, Dr D recommended long-term psychodynamic psychotherapy and a trial of sodium valproate (an anti-epileptic medication also used to treat mood disorders).

Dr D stated that Mrs A's assessments "did not reveal that she had symptoms of a Major Depressive Disorder" and her symptoms were more in line with "an Adjustment Disorder with depressed and anxious mood". She said that this "implies there was a close association between ongoing stress in her life and the development of her symptoms, most notably the stress of her relationship with her most recent partner". At the time of her last assessment in July 2006, Dr D reported that Mrs A did not meet the criteria for any mental disorder.

While Mrs A waited for an appointment with a psychotherapist, she saw a counsellor, Mrs E. Mrs E confirmed that Mrs A consulted her on 13 June 2006, and described her as being in a "very fragile, fragmented frame of mind". She was "feeling disempowered and debilitated, by the dysfunctional relationship" with Dr B.

The relationship between Mrs A and Dr B ended in May 2006.

Prescription of Paradex
Mrs A said that every time Dr B wrote a prescription for Aropax for her, he included Paradex for his migraine headaches. Prescriptions that Mrs A supplied confirm that Paradex was dispensed on 13 prescriptions Dr B wrote for her, on the following dates: 12 March, 25 June and 21 November 2003; 4 March and 23 June 2004; 1 April, 12 June, 28 July, 24 October, 4 November and 17 December 2005; 6 January and 22 April 2006.

Mrs A claimed that Dr B had Paradex "all over his house, car, office and on his person at any given point in time" and would take the medication three or four at a time. She suggested that he had an addiction problem and questioned whether he was safe to practise. Mrs A stated that Dr B hid the Paradex from her and would only give her one tablet if she needed it. However, she later advised that she cannot take Paradex as her body does not tolerate it.

Dr B stated:

> "On a few occasions, I did write a prescription for Paradex for myself for migraine headaches and I am certain I did not include this on prescriptions for her. On occasion, I did prescribe Paradex for [Mrs A] for back pain, which she suffered from the physical exertions of [her job]. I prescribed this to her on the understanding that she would discuss the matter with her general practitioner."

Mrs A denies that she had a history of back pain or migraines.

Independent advice to Commissioner

The following expert advice was obtained from rural general practitioner Dr Tony Birch:

> "**Purpose**
>
> To provide independent expert advice about whether [Dr B] provided an appropriate standard of care to [Mrs A].

Background

At Christmas 2002 [Mrs A] and [Dr B] entered into a de facto relationship, which ended in 2006. It appears that [Mrs A's] two daughters lived with them for a period of time.

According to [Mrs A] about two weeks after she moved in with [Dr B] he diagnosed her with depression and prescribed Aropax 40mg daily. It appears that by 2005 [Dr B] had increased the dose of Aropax to 80mg daily. [Mrs A] claims that when [Dr B] wrote a prescription for Aropax he also included Paradex for himself.

[Mrs A] said that she had never been diagnosed with depression before she moved in with [Dr B] and had never taken any form of antidepressant medication previously.

[Dr B] has acknowledged that he was imprudent in prescribing antidepressant medication for [Mrs A] but denies that he did not for the reasons she states in her complaint. He said that he urged her to seek professional help and understood that she had done so. At no time did he refer her for professional help.

Complaint

[Mrs A's] complaint is outlined in her letter to the Commissioner but the issues investigated are summarised as follows:

- *The adequacy and appropriateness of [Dr B's] diagnosis and treatment of [Mrs A] for depression between December 2002 and September 2006 while they were living as partners.*

- *The appropriateness of [Dr B] adding the medication Paradex to prescriptions for [Mrs A].*

Supporting Information

- [Mrs A's] complaint to the Commissioner, dated 21 September 2006, marked 'A' (pages 1– 5)
- Notification of investigation to [Dr B], dated 9 October 2006, marked 'B' (pages 6–8)
- [Dr B's] response, dated 31 October 2006, marked 'C' (pages 9–13)
- [Dr B's] response to additional questions, received 20 November 2006, marked 'D' (pages 14–22)

- Report from psychiatric registrar [Dr D], dated 25 October 2006 marked 'E' (pages 23–36)
- Report from counsellor [Mrs E], dated 27 October 2006 marked 'F' (page 37)
- Telephone conversation with [Dr B's] neighbour, dated 7 November 2006 marked 'G' (pages 38–39)
- Telephone conversation with counsellor [Mr C], dated 10 November 2006 marked 'H' (page 40)
- Confirmation of [Mrs A's] mental history marked 'I' (pages 41–42)
- Dispensing information from [Pharmacy 4] marked 'J' (pages 43–46).

Expert Advice Required

1. To advise the Commissioner whether, in your opinion, the medical services [Dr B] provided to [Mrs A] were of an appropriate standard.
2. If not already addressed above please comment on the following:
    a) the failure of [Dr B] to document [Mrs A's] care
    b) the dosage of Aropax [Dr B] prescribed
    c) the side-effects of the medication [Mrs A] exhibited.

If, in answering any of the above questions, you believe that [Dr B] did not provide an appropriate standard of care, please indicate the severity of his departure from that standard.

To assist you on this last point, I note that some experts approach the question by considering whether the provider's peers would view the conduct with mild, moderate, or severe disapproval.

Are there any aspects of the care provided by [Dr B] that you consider warrant additional comment?

Thank you for your letter of 6th March 2007 requesting I provide an opinion to the Commissioner about the services provided by [Dr B] to [Mrs A], as detailed in the documents you supplied. I can confirm that I have no personal or professional conflict in this case. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I understand also that my report is subject to the Official Information Act and that my advice may be requested and disclosed under that Act and that the Commissioner's policy is to name his advisors where any advice is relied upon in making a decision.

I qualified MB, ChB in 1968 from Victoria University of Manchester, UK. I also hold a Diploma in Obstetrics from the Royal College of Obstetricians (1970) and a

Diploma in Health Administration from Massey University (1985). I have been a Member — now Distinguished Fellow of the Royal New Zealand College of General Practitioners since 1980. Prior to working in New Zealand I worked in an isolated area of Fiji for three years. For the past 32 years I have worked as a rural general practitioner in Rawene, Hokianga. This practice involves on call work and the care of patients in a small rural hospital. I was also approved by the Director of Mental Health Services for the Northland District Health Board as clinical leader of the Community Mental Health team for Hokianga. I have recently (February 2006) retired from this post and am now providing consulting and locum services.

I have read the **supporting information** supplied by the Commissioner, viz:

Report

1. In your opinion were the medical services [Dr B] provided to [Mrs A] of an appropriate standard?

   In August 2006 the Medical Council set out in a "Statement" what I would consider to be "normal" practice on providing care to "those close to you":

   > 'It is generally unwise for medical practitioners to treat 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. The Medical Council recognises that there are some situations where treatment of those close to you may occur but maintain that this should only occur when overall management of patient care is being monitored by an independent practitioner.'

   This statement stressed the inappropriateness of prescribing psychotropic medication to family members. In this document there were noted to be a small number of exceptions. **None** of these apply in the case of [Dr B] and [Mrs A].

   [Dr B] states that he tried to persuade [Mrs A] to see her GP but this is disputed by [Mrs A]. Wherever the truth lies in this, [Dr B] showed extreme lack of professional wisdom in first attempting to diagnose a depressive illness in his partner and then in prescribing medication without any support or documentation.

   Depressive illness is a wide spectrum and can be difficult enough to diagnose under ideal conditions in the consulting room. There is often no 'objective' symptom or sign and there is no pathological test to support such a diagnosis.

I have at times had the woman in a relationship seeing me for depression, when, subsequently, it has become clear that it was the man who had the depressive illness. I believe that [Dr B's] peers would view his conduct in not insisting that his partner obtain a proper diagnosis and appropriate medical care with severe disapproval. Prescribing Aropax for such a long period without independent review simply confounds the situation.

2. If not already addressed above, please comment on the following

   a) The failure of [Dr B] to document [Mrs A's] care:
   In the 'statement' referred to above, it also states that when providing care to those close to you, 'The details of the consultation [should be] 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.' We have no evidence that [Dr B] made or kept any notes at all. This would be viewed with moderate disapproval by [Dr B's] peers.

   b) The dosage of Aropax [Dr B] prescribed:
   The 'normal' dose of Aropax prescribed by most GPs is, I believe, 20mg daily. Occasionally one might increase this to 40mg daily to achieve more effective therapeutic benefits. In my experience — as a rural GP and as clinical leader of a community mental health team — I have never prescribed above this level without obtaining specialist psychiatrist assistance. It seems extremely strange, and quite disturbing that [Dr B] would continue to increase the dosage to these levels without insisting on specialist support. I view this with severe disapproval.

   c) The side-effects of the medication [Mrs A] exhibited:
   [Mrs A] describes symptoms of 'becoming irrational in my thought processes', 'a tic in my left eye', 'picking holes in my head' and 'having periods of blanking out'. Although these could be related to other issues in her life at the time, they are symptoms I have seen as side-effects of SSRIs (of which Aropax is one). They did seem to disappear when the drug was discontinued, but this does not mean that they were side-effects. Only restarting and seeing the effects return would give definitive proof.

Further comments:
Quite a lot of the information supplied relates to problems in a relationship break up. There seems to be no 'objective' evidence as to whose version is the 'correct' one. I have tried to remain outside this issue and stick to the issues referred to

above. There is no doubt that [Dr B] has been extremely 'unwise' — which he himself admits. I believe, however, that this behaviour goes beyond this and [Mrs A] has received medical services of a totally inappropriate standard. I view [Dr B's] behaviour as a vocationally registered GP with severe disapproval.

I trust that this report is of assistance to the Commissioner in reaching his judgment. Please do not hesitate to contact me if any further clarification is required."

Responses to provisional opinion

Dr B

Mr Chris Hodson QC provided a response to the provisional opinion on behalf of Dr B. Mr Hodson commented that "the prescribing occurred in a situation unique in Dr B's life which became increasingly and finally terminally unmanageable". He noted:

> "[Dr B] has acknowledged that he should not have prescribed Aropax as he did, and without keeping records. It is to a degree relevant that in fact the prescribing in the early years at the level of 20mg daily was very successful and did bring about the improvements noted in your provisional opinion. However, [Mrs A's] health deteriorated under pressure brought about by the behavioural problems of her two daughters … The problems were very serious and caused much stress in the course of which [Mrs A's] condition deteriorated over time with the eventual catastrophic end of the relationship … [Dr B] advises that he had greatly admired [Mrs A] for her fortitude and felt real compassion for her. His observation that the Aropax worked very well indeed in the early years led to a dulling of the awareness of the extent of the warning signals which multiplied as the relationship deteriorated and moved to its conclusion."

In relation to the proposed referral to the Director of Proceedings, Mr Hodson submitted that "the reasons for not referring the case to the Director of Proceedings outweigh whatever benefit (there do not appear to be any benefits) which might accrue from taking that course". He stated that [Dr B] and [Mrs A] need "to recover from the relationship and to put matters behind them", and that proceedings would be "an experience which is unlikely to be positive for either of them, and which is particularly likely to exacerbate issues which by now are hopefully becoming resolved". Mr Hodson expressed the view that disciplinary charges were not appropriate in this case, as "[Dr B] acted uncharacteristically in unique circumstances" and he has undertaken that he "will never again make any questionable self-prescription".

Mrs A
Mrs A reiterated that, in April 2006, Dr B directed her to increase the dosage of Aropax she was taking from 40mg to 80mg daily. She stated that she "has no recollection of ever being prescribed antidepressants by [Medical Centre 1]" and was "amazed that there is reference to Antidepressants being prescribed" from that practice. Mrs A stated that she did not take the Paradex, Paracetamol, Losec, doxycycline, Naxen or Kenacomb that were prescribed for her by Dr B.

Code of Health and Disability Services Consumers' Rights

The following right in the Code of Health and Disability Services Consumers' Rights is applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Professional standards

The Medical Council of New Zealand's *Statement of Self Care and Family Care* (2001) states:

> "It is generally unwise for medical practitioners to care for themselves or family members in all but minor and emergency health matters. Self care and family care is neither prudent nor practical due to the lack of objectivity and discontinuity of care. The Medical Council recognises that there are some situations where family treatment may occur but maintain[s] that this should only occur when overall management of patient care is being monitored by the family's practitioner.
>
> **Introduction**
>
> 1. All patients are entitled to a good standard of care from a doctor. It is the responsibility of the doctor to provide care that meets the acceptable clinical and ethical standards of the profession. An objective assessment of the patient and the medical condition is necessary for good practice and care. …

Self and family assessment

…

4. The objectivity lacking in self-assessment may also be present when providing care to family members and close friends due to close emotional ties. Family members should have a general practitioner who can provide appropriate care after an objective medical assessment.

5. Council acknowledges that there are some exceptions:

   - When doctors prescribe for themselves and family members for a continuing condition and their general practitioner will monitor the treatment at regular agreed intervals;

   - Doctors' treatment of themselves and family members is acceptable for minor or self-limiting conditions;

   - In an emergency, doctors may provide treatment to themselves, family members and friends until another practitioner is available;

   - If the doctor is employed in a small community where there are family members, there may be additional pressures and doctors should be aware that objectivity may be compromised. Council recommends a low threshold for referring patients to an independent doctor for consultation.

Prescribing

6. A doctor should never sign a prescription for him or herself when the substance is potentially addictive.

Patient records

7. In the interest of patient safety medical consultation and treatment should be documented in the patient's record. This important aspect of medical care is often neglected when doctors care for themselves or family members.

…

Medical care of doctors and their families should be monitored by another practitioner."

Opinion: Breach — Dr B

Introduction
Under Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Dr B had a duty to comply with professional and ethical standards when providing health services. In diagnosing Mrs A with depression, and in treating her by prescribing Aropax, Dr B provided health services to Mrs A. For the reasons given below, in my opinion Dr B failed to provide Mrs A with services that complied with relevant professional and ethical standards, and therefore breached Right 4(2) of the Code.

Diagnosis and treatment of depression
The Medical Council of New Zealand's *Statement of Self Care and Family Care* (2001) provides clear guidance to the profession on the issue of medical practitioners treating people with whom they have a personal relationship. The Statement affirms that "family care is neither prudent nor practical due to the lack of objectivity and discontinuity of care". While the Medical Council recognises that there are some situations where such treatment may occur, "this should only occur when overall management of patient care is being monitored by the family's practitioner". I also note that the Medical Council reaffirmed this position in August 2006 (after the events in this case) in its *Statement on providing care to yourself and those close to you*, which clarifies that medical practitioners should generally not treat people with whom they have close emotional ties.

When a health care provider provides services to someone with whom he or she has a personal relationship, there is a risk that the provider's objectivity and professional judgement is impaired. A romantic and sexual attachment places at risk the clinical detachment necessary for effective diagnosis and treatment. The provider's personal feelings may unduly influence his or her professional medical judgement, and may result in the provider not taking a full medical history, failing to perform the appropriate physical examination, or not discussing relevant but sensitive topics. This influence is evident in this by Dr B's comment that he did not enquire into Mrs A's dealings with other providers because of their "sensitive nature".

Dr B and Mrs A were in a personal relationship and living together when Dr B prescribed Aropax for her. Dr B has acknowledged that it was unwise to write these prescriptions for Mrs A. My expert advisor, Dr Tony Birch, stated that "[Dr B] showed extreme lack of professional wisdom in first attempting to diagnose a depressive illness in his partner and then in prescribing medication without any support or diagnosis".

Dr B explained that he had diagnosed Mrs A with depression based on his knowledge of her previous mental history, his understanding that her psychologist, Mr C, had

diagnosed depression, and his observations of her behaviour (including "periodic rages and her periods of lethargy and inactivity"). Mr C, whom Mrs A consulted during the first half of 2002 and on one occasion in December 2002, said that he was of the view that Mrs A's problems were related to low self-esteem and a lack of confidence, and that she had "relationship problems". Mrs A claimed that Dr B prescribed Aropax as a form of controlling her.

Dr Birch advised:

> "There is no doubt that [Dr B] has been extremely 'unwise' — which he himself admits. I believe, however, that this behaviour goes beyond this and [Mrs A] has received medical services of a totally inappropriate standard. I view [Dr B's] behaviour as a vocationally registered GP with severe disapproval."

Dr B's diagnosis of Mrs A with depression highlights the difficulties associated with doctors diagnosing and treating those close to them. As stated by the Health Practitioners Disciplinary Tribunal in *Re Nuttall* (Med04/03P, 18 April 2005, para 43):

> "It is extremely difficult, if not impossible for a doctor to maintain objectivity and professional judgment if they are engaged in an intimate relationship with their patient. This in turn can lead to seriously deficient treatments for medical and psychological conditions."

The risk that the medical practitioner will not exercise the required objectivity in making a diagnosis of a mental disorder is heightened because of the lack of objective criteria for such conditions. As Dr Birch noted:

> "Depressive illness is a wide spectrum and can be difficult enough to diagnose under ideal conditions in the consulting room. There is often no 'objective' symptom or sign and there is no pathological test to support such a diagnosis."

The Medical Council's *Statement on providing care to yourself and those close to you* (2006) recognises these difficulties, stating that practitioners should avoid prescribing psychotropic medication to those they are close to. The Medical Council's statements acknowledge that there are some exceptions to the general rule that doctors should not provide treatment to those to whom they are close, including prescribing for a continuing condition where a general practitioner will monitor the treatment at regular agreed intervals. However, none of these exceptions applies in the case of Dr B diagnosing and treating Mrs A for depression.

Although Dr B claimed to have had telephone conversations with other practitioners involved in Mrs A's care, he cannot recall who these practitioners were or any detail of these consultations. Mrs A denies ever seeing any other health practitioner during the

period she lived with Dr B. I note that all of the prescriptions dispensed by four chemists over the period Mrs A lived with Dr B were written by Dr B. Mr C stated that he last saw Mrs A on 5 December 2002 around the time Mrs A and Dr B moved in together. Medical Centre 2 and Medical Centre 1 confirmed that Mrs A did not attend these practices during the period Dr B was prescribing Aropax for her. On balance, I accept Mrs A's account that she did not consult with any other health practitioners during the period Dr B prescribed her Aropax.

In any event, even if Mrs A did see other practitioners, it is clear that Dr B did not consult with these practitioners or formally refer Mrs A to another practitioner. In my view, Dr B's diagnosis and treatment of Mrs A for depression was inappropriate and was exacerbated by his failure to ensure she saw another practitioner for independent advice and monitoring.

Dr B also prescribed a number of other medications for Mrs A during the time they lived together, many of which are used to treat skin infections and other minor conditions. However, I note that he also prescribed hormone replacement therapy medication for Mrs A. As with the prescription for Aropax, Dr B should not have prescribed such medication on an ongoing basis without ensuring that Mrs A's treatment was monitored by an independent general practitioner.

In my opinion, by diagnosing and treating Mrs A for depression and other conditions, and not referring her to an independent practitioner for an objective assessment, Dr B did not comply with professional and ethical standards. In these circumstances Dr B breached Right 4(2) of the Code.

Record-keeping

Documentation of services provided is important to ensure quality and continuity of services. Dr B did not keep any records of his clinical assessment and conclusions, treatment plan, effects of the treatment, information he provided about the treatment, or the clinical reasons for increasing or decreasing Mrs A's medication.

The Medical Council's *Statement of Self Care and Family Care* (2001) affirms that "[i]n the interest of patient safety medical consultation and treatment should be documented in the patient's record" and highlights that failure to document care is one of the risks that doctors face when treating family members. Dr Birch advised that Dr B's failure to document the Aropax he prescribed to Mrs A would be viewed with moderate disapproval by his peers.

By not keeping any record of the services he provided to Mrs A, Dr B failed to comply with professional and ethical standards, and therefore breached Right 4(2) of the Code.

Other comments

Dosage of Aropax
Mrs A alleged that towards the end of their relationship she was taking up to 80mg of Aropax daily, on Dr B's recommendation. She said she had stockpiled some Aropax tablets from 2004 and started to use these towards the end of March 2006. She described blanking out, developing a tic in her left eye, and "picking holes in her head", which she attributes to side affects of the high dose of Aropax she was taking. Dr B denies ever advising Mrs A to take 80mg of Aropax daily.

Dr Birch advised that the symptoms Mrs A described could be attributed to Aropax but could also have been caused by other things happening in her life at the time. Medsafe states that the recommended dose of Aropax for treatment of depression is 20mg daily but this may be increased if the patient does not respond, in 10mg/day increments, up to a maximum of 50mg/day. The lists of prescriptions Mrs A provided show that the highest dose of Aropax dispensed was 60 Aropax monthly (that is, 40mg daily). In these circumstances, I am unable to determine whether Dr B advised Mrs A to take 80mg of Aropax daily.

Prescription of Paradex
Mrs A alleged that Dr B included Paradex on her prescriptions and then used it himself for migraine headaches. The prescription lists show that Paradex was dispensed to Mrs A on 13 occasions between 12 March 2003 and 22 April 2006. Dr B acknowledged that he had, on a few occasions, written a prescription for Paradex for himself for migraine headaches. However, he denies including Paradex for himself on Mrs A's prescriptions. He stated that he had at times prescribed Paradex for Mrs A for back pain "on the understanding that she would discuss the matter with her own practitioner". Mrs A stated that Dr B hid the Paradex tablets from her and would only allow her to have one when she needed it.

Given these conflicting accounts, I am unable to determine whether Dr B took the Paradex he prescribed for Mrs A. However, I am concerned by Dr B's admission that he self-prescribed Paradex at times. Paradex contains dextropropoxyphene, which is a mild narcotic analgesic structurally related to methadone. According to the Medsafe website, dextropropoxyphene "when taken in higher-than-recommended doses over long periods of time, can produce medicine dependence characterized by psychic dependence and less frequently, physical dependence and tolerance". The Medical Council's *Statement on providing care to yourself and those close to you* (2006) states that prescribing or administering drugs of dependence to yourself or those close to you is inappropriate and should be avoided. Accordingly, I draw to Dr B's attention that self-prescribing, or adding Paradex to Mrs A's prescriptions with the intention of

taking the medication himself, would constitute a breach of professional and ethical standards.

Follow-up actions

- Dr B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners.
- 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.

Addendum

On 7 November 2007 the Health Practitioners Disciplinary Tribunal upheld a charge of professional misconduct in relation to the diagnosis of depression, prescription of aropax, failure to keep records and his prescription of other medications including paradex (analgaesic), trisequens (hormone replacement) and losec (a treatment for digestive disorders). The Tribunal ordered Dr B to undertake education with regard to professional boundaries, and recommended that the Medical Council of NZ undertake a competence review of his practice with regard to women's health, mental health and record-keeping. Dr B was censured, fined $7,500.00 and ordered to pay $3,000 towards the cost of the investigation and prosecution. He appealed the finding of professional misconduct as well as penalty. The High Court upheld the finding of professional misconduct on all matters except for the prescription of the medications (other than aropax). This conclusion was quashed because the Tribunal had not put to the doctor its conclusions about the seriousness of prescribing paradex at the same time as an anti-depressant, and prescribing Trisequens without clear monitoring had not been put to the practitioner. The Court also reduced the fine to $5000, but upheld the other penalties imposed.