# Dr D

## A Report by the

## Health and Disability Commissioner

## (Case 00/08647)

## Parties involved

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| Mrs A | Complainant, General Manager, A Rest Home and Hospital |
| Mrs B | Consumer |
| Mr C | Consumer's son/welfare guardian |
| Dr D | Provider, general practitioner |
| Dr E | General Practitioner |
| Ms F | Principal Nurse, A Rest Home and Hospital |
| Ms G | Nurse, A Rest Home and Hospital |
| Ms H | Dr E's sister |
| Mr I | Family Court appointed lawyer |
| Dr J | Clinician for a public health service |
| Dr K | Psychiatrist |
| Dr L | Surgeon |
| Dr M | General practitioner |

Expert advice was obtained from an independent general practitioner, Dr Tessa Turnbull.

## Complaint

The Commissioner received a complaint from Mrs A on 24 August 2000 regarding the services provided to Mrs B by Dr D between March and July 2000.

The complaint is summarised as follows:

*Dr D, general practitioner, consulted with Mrs B during March and July 2000 without the permission of her son, Mr C, who holds a Power of Attorney, and without the approval of her regular general practitioner. This resulted in:*

- *Mrs B being advised that she is not a paranoid schizophrenic; and*
- *A change in Mrs B's medication without consultation with her approved general practitioner; and*
- *Mrs B being encouraged to move to [another town] receive treatment there from Dr D.*

The Commissioner commenced an investigation on 11 December 2000.

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

## Information gathered during investigation

*Background*
Mrs B is a woman with a history of paranoid schizophrenia. On 23 July 1998 Mr C, Mrs B's son, was appointed as her welfare guardian for the purpose of making and implementing decisions about where she lives, what medical treatment she receives, and what personal care she requires.

In August 1998 Mrs B was admitted to a rest home and hospital for care, after being placed under a Compulsory Treatment Order under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Mrs A, General Manager of the rest home, stated that she attempted to get Mrs B in touch with her culture's communities when she arrived at the rest home. Mrs B does not speak very good English and can, due to her illness, be suspicious of those who care for her. For this reason it was also considered preferable to obtain a doctor of the same culture to care for her. Dr D was recommended to Mrs A by her sister, Ms H, an active member of this community. Dr D was approached and asked to act as Mrs B's general practitioner. Dr D stated that she had known Mrs B for many years through her involvement in the church. Dr D declined to act as Mrs B's general practitioner, but agreed to assist in developing Mrs B's trust in another general practitioner and in the rest home. Dr E of the medical centre agreed to be Mrs B's general practitioner, and agreed to the assistance of Dr D in establishing a relationship with Mrs B.

Dr D accompanied Dr E on her first visit to Mrs B, to help Dr E gain Mrs B's trust. Dr D stated that she was aware that Dr E was Mrs B's approved general practitioner. Dr D continued to visit Mrs B as a friend several times a year after the initial visit with Dr E.

Mrs A complained that despite her initial refusal to act as Mrs B's general practitioner, Dr D resumed visiting Mrs B in a professional capacity without the express permission of Mr C, Mrs B's son and welfare guardian, or in consultation with Dr E, Mrs B's approved general practitioner, and that this was inappropriate. Mrs A expressed three specific concerns about the relationship between Dr D and Mrs B:

1. Dr D's interference in Mrs B's medical management;
2. Dr D informing Mrs B that she was not schizophrenic; and
3. Dr D encouraging Mrs B to move to [another town] to receive care from her there.

*Alleged interference in medical management*
On 20 July 1999, Dr D visited Mrs B at the rest home, and arranged a high vaginal swab and urine test for Mrs B. Dr D recorded in Mrs B's medical notes, "Seen patient at her request and as previously agreed with Dr E." Dr E advised that she first knew of Dr D's visit to Mrs B on 20 July when she received the results of the swab and urine test, which Dr D had arranged. Dr E advised that she was "cross" about this happening.

On 17 August 1999, Dr D informed Dr E that Mrs B wanted a second opinion with regard to her psychiatric care. Dr E ascertained from Mrs B that she refused to be seen by another psychiatrist at that time. Dr E arranged for another psychiatrist to assess Mrs B in April 2000; however, Mrs B again declined to be assessed.

On 27 March 2000, Dr D visited Mrs B. Dr D stated that on this visit she found Mrs B complaining of a severe headache and that she had a congested face. Dr D stated that for this reason she checked Mrs B's blood pressure. Dr D advised that Mrs B informed both her and the nurse that she had not taken her new hypertension tablet (Inhibace) in the last few days because it made her dizzy and caused her to fall and injure her head. Dr D further stated that it took her and the nurse a long time to convince Mrs B to take her medication. The only compromise they could reach was to split the dose in two, so that Mrs B took the same dose, but half in the morning and half in the afternoon. Dr D then changed Mrs B's Inhibace dosage and wrote in her notes. Dr D asked the nurse on duty, Ms F, to telephone Dr E and inform her of this compromise.

Ms F stated that she had thought that Dr D was visiting Mrs B in the capacity as a friend; however, during the 27 March visit, Dr D told her she was Mrs B's doctor. Ms F stated that she asked Dr D if Mrs B's usual doctor, Dr E, knew about this. Ms F stated that Dr D told her that she was also Mrs B's doctor.

Ms F informed Dr E of Dr D's actions on 27 March. Dr E had concerns about the effectiveness of administering the medication in this manner, and asked Ms F to check with a pharmacist if it was feasible to take the medication as a half dose twice daily. The pharmacist confirmed that it was not feasible to administer the medication in this manner, and that to do so would render it ineffective. For this reason it was necessary to revert back to the original once daily dosage.

Mrs A advised that after this visit Mrs B's behaviour changed, and that from this point there appeared to be a lack of trust in Dr E.

On 26 April 2000, Dr D saw Mrs B again, and took her blood pressure. Dr E advised that after this visit, Dr D suggested to her that she prescribe either Cogentin or Disipal as treatment for Mrs B's tremor.

Dr D advised that over the years Mrs B has informed both her and her sister, who also visited Mrs B, that she was very lonely and depressed at the rest home. Dr D stated that for this reason she tried, as a friend, to be supportive of her, particularly because of their long association. Dr D stated that she never interfered with Mrs B's treatment:

> "It was my understanding at the time I saw [Mrs B] with [Dr E] that [Dr E] agreed I could see [Mrs B], but on the understanding she was her general practitioner. I did not wish to be further involved in [Mrs B's] care, but wished to be able to visit her as a friend."

Dr D advised that subsequent to Dr E becoming involved in the care of Mrs B, she saw Mrs B on two to three occasions. Dr D stated that her only involvement in the care of Mrs

B was when Dr E asked her to see Mrs B jointly with her because Mrs B had vehemently refused to have a Modecate injection. On other occasions when she felt that there were important issues relevant for patient care, she telephoned Dr E.

Dr E advised Dr D, by letter dated 24 October 2000, "Mrs B certainly told me on several occasions that you were her doctor and that she would have nothing to do with me." Dr E stated that she had not asked for further assistance after Dr D had moved. Dr E also stated that it would not be routine, or normally acceptable, for a doctor to be dealing with another doctor's patients without his or her knowledge, and that usually she would not appreciate another doctor interfering in the care of her patients. However, Mrs B was a difficult patient to look after, and although Dr E had found Dr D's interventions slightly irritating, they were "helpful given the specific nature of [Mrs B]".

*Schizophrenia*
Mrs A stated that Dr D indicated strongly to Mrs B that her diagnosis of paranoid schizophrenia was incorrect. Mrs A stated that Ms F advised her that Dr D had a conversation with her, and told her that there was nothing wrong with Mrs B. This, she stated, fuelled Mrs B's paranoia and impeded the ability to manage Mrs B's condition appropriately and to meet her needs, owing to an increased distrust in her nurses, doctor, and legally appointed psychiatrist.

Dr D denied giving Mrs B any advice about her psychiatric care.

*Shift to another town*
Mrs A stated that Dr D actively encouraged Mrs B to move, against the wishes of her son, Mr C, who was appointed welfare guardian for his mother's personal care and welfare, with power "to make and implement decisions as to where she should live". Mrs B has no family in this town and no support. Her son, Mr C, lives in a city, and her granddaughter in another city.

Mrs A stated that Mrs B began ringing the other town to speak to Dr D and this resulted in a decrease of Mrs B's trust for Dr E and the rest home. Mrs A stated that Dr D also tried to contact Mrs B by telephone, but the nurse would not put her through. Mr C noted that at this time he sighted pamphlets from a rest home in that town in his mother's bedroom at the rest home.

Mrs A said that Dr D told her that Mrs B should be in the other town. Ms F confirmed that Mrs B told her that Dr D was going to take her there.

Dr E stated that in July 2000 Mrs B refused to let her examine her. Dr E stated that on this occasion Mrs B was aggressive and expressed a desire to move. Dr E stated that staff at the rest home advised her that Dr D had encouraged Mrs B in this belief. Dr E advised that Mrs B suffered from flights of fancy, and was always saying that she wanted to leave the rest home and go home.

Dr D denied that she ever encouraged Mrs B to move to receive treatment from her. She claimed that she constantly refused to be Mrs B's general practitioner, and tried to

reinforce to Mrs B that Dr E was her general practitioner and to assist, where necessary, in communication between Mrs B and the nurses at the rest home.

Mrs A acknowledged that it may have been Dr D's sister, Ms H, who convinced Mrs B to move.

*Subsequent action taken by Mrs A*
On 21 July 2000, Mrs A telephoned Dr D and explained her concerns. She told Dr D that it was inappropriate for her to visit Mrs B as if she was her patient and that she had no right to change Mrs B's medication. Mrs A pointed out to Dr D that it was inappropriate for her to be talking about moving, and that if she further interfered with Mrs B's treatment she would report her to the Medical Council. Mrs A stated that Dr D hung up on her during the course of the phone call. On 28 July 2000, Mrs A wrote to Dr D to follow up the phone call.

On 26 July 2000, Dr E met with Mrs A and Ms F, who expressed their concern that Dr D had been interfering in Mrs B's care.

Subsequent to the phone conversation on 21 July 2000, Dr D visited Mrs B at approximately 4.45pm on 27 July. Mrs A noted that after this visit from Dr D, Mrs B's behaviour charts indicated a dramatic change in behaviour. She was noted to be talking loudly and accusingly to unknown persons and would not allow anyone to enter her room.

Dr D confirmed that she saw Mrs B in mid-July 2000 briefly for about 10 minutes to give her some clothes and food.

Mrs B's son, Mr C, is unhappy with Dr D's alleged interference with his mother's treatment and management. He confirmed that he had told Mrs A not to let Dr D near his mother.

## Independent advice to the Commissioner

The following expert advice was obtained from Dr Tessa Turnbull, an independent general practitioner:

"**Background:**

*Social history*
[Mrs B] is a widow aged 79 who came to NZ after World War II with her husband. Her only child, a son, lives in a city and visits frequently when he is in [the area] on business. [Mrs B's] husband died about 16 years ago.

*Psychiatric history*
[Mrs B] was first admitted to [a public hospital] in 1963 with 'acute anxiety' and then had numerous further admissions over the next few years with episodes of psychosis. Her diagnosis is paranoid schizophrenia and she is maintained on haloperidol, which causes the side effect of tardive dyskinesia or severe tremor. [Mrs B] was committed to [another public hospital] in 1996 after an incident involving the police and ambulance services.

[Mrs B] is now subject to orders pursuant to the Mental Health Act. This means that from May 1998 she has been required to live at [a rest home] and to receive compulsory treatment for her mental disorder. Her son was appointed by the court as [Mrs B's] property manager and welfare guardian.

[Mr I] was appointed by the Family Court at [a public hospital] to represent [Mrs B] legally. These court appointments are subject to periodic review.

[Dr J] of a public health service assesses her every three months as a requirement of her detention under the Mental Health Act as her responsible Clinician. His assessments have supported the continuation of the compulsory treatment order.

On 2/8/00 [Mr I] suggested that in order to obtain a completely independent reassessment of [Mrs B's] condition an experienced psychiatrist with extensive geriatric involvement be asked to undertake a review. He felt this was necessary as he had received a letter from [Mrs B's] solicitor who had received various letters written by [Ms A] of [the rest home and hospital]. He says 'it suggests there is unseemly squabble over matters relating to [Mrs B].'

[Dr K] reiterated the 'very poor insight' [Mrs B] has into her mental and probably her physical illnesses, as well as her need for treatment.

In November 2000, the Court reappointed [Mr C] as [Mrs B's] Welfare Guardian for another three years.

In summary, it is very clear that [Mrs B] has no or very poor insight into her ongoing and serious psychiatric illness or her need for regular medication to control

this. This is particularly true when she decompensates mentally but is apparent even when she is stable as is evidenced by her reluctance to take medication and to be examined physically by her GP, [Dr E]. [Dr E] visits [Mrs B] monthly. These visits can be cordial and productive or [Mrs B] may be excitable and uncooperative.

*Physical health*
In addition [Mrs B] has a number of other significant medical problems i.e. cancer of the right breast in 1995 treated with surgery, radiotherapy and ongoing tamoxifen. In June 2000 it became apparent there was a local recurrence of her breast cancer and her surgeon, [Dr L], suggested further surgery. [Mrs B] has been adamant that this not be investigated or managed further. She also has significant hypertension, and had a cardiac pacemaker inserted in 1995. She often declines to take her medication or have checks for these problems. In the past she has had gall bladder surgery and treatment for non-Hodgkins lymphoma.

[Mrs B] had previously been looked after in general practice by [Dr M] whom she delusionally came to believe tried to kill her. When this incident came to a head [Mrs B] was admitted to [a public hospital] in a severely psychotic state.

After her admission to [a rest home], [Dr D] was asked by the [rest home] management if she would become [Mrs B's] GP. Dr D declined and [Dr E] agreed to take on this role. [Dr D] accompanied [Dr E] on her first visit to [Mrs B] as an introduction. [Dr D] moved [to another area] shortly after this to a general practice there. Both she and her sister considered themselves friends of [Mrs B] through their common ethnic background and church associations and both visited [Mrs B] at [the rest home] in that role.

[Dr D] visited [Mrs B] on 20/7/99 and took a High Vaginal Swab and arranged a Mid Stream Urine to be tested. She recorded this visit in [Mrs B's] medical notes and annotated this 'seen patient at her request and as previously agreed with [Dr E]'. She spoke to [Dr E] on 17/8/99 and said that [Mrs B] wanted a second opinion with regard to her psychiatric state. When [Dr E] spoke to [Mrs B] about this, she declined another opinion.

On 27/3/2000 [Dr D] checked [Mrs B's] blood pressure and left instructions that she was to have her inhibace cut in half and the half dose given twice daily. Again this is annotated in [Mrs B's] notes.

The nurse at [the rest home] spoke to [Dr E] about this the next day and the instruction was initially left in place, as [Dr E] thought this was the only way to get [Mrs B] to take her medication. However, from a pharmacological point of view this rendered the drug ineffective and the practice was discontinued shortly afterwards.

[Dr D] made another medication suggestion after a visit on 26/4/00 and [Dr E] told [Dr D] that she 'was grateful for that help' and the support of [her sister] in getting [Mrs B] to take her medication.

In April 2000 [Dr E] arranged another psychiatric opinion and [Mrs B] declined this.

In July 2000 [Mrs B] refused any examination from Dr E and expressed ideas of moving. [Mrs B] told [Dr E] and [rest home] staff that she considered [Dr D] to be her GP.

Over this time [Dr D] considered that she could continue to act as a collegial support for [Dr E] with any instructions/suggestions for management being conveyed to [Dr E] directly or indirectly by this being passed on to [Dr E] through the nursing staff or the medical notes.

***Is it usual for a GP to be involved in the care of another GP's patient, without firstly consulting that patient's approved GP? If not, why not?***

It is common practice in New Zealand for people to consult more than one GP and there is no regulation barrier to this. Often it is because the person does not consider they have a regular GP, or wish to consult a GP they perceive to have particular expertise on an area e.g. family planning or sexually transmitted diseases. It may be because they live in one area and work in another.

After hours services are another example where a GP will be involved in the care of a patient 'without first consulting the approved GP'. However most people do register with a single GP and that GP is the guardian of their continuing medical records and chief medical advocate.

Rest Homes are a unique situation and it is usual for patients here to have a single registered GP who visits regularly and unusual for a patient to consult another GP except in an emergency situation. [Mrs B] is subject to orders pursuant to the Mental Health Act. This means that from May 1998 she has been required to live at [the] Rest Home and to receive compulsory treatment for her mental disorder. Her son was appointed by the court as [Mrs B's] property manager and welfare guardian. This means that he has to be consulted with regard to [Mrs B'] general welfare including her mental and physical health. This is an overview role as [Dr J] of [a public health service] assesses her every three months as a requirement of her detention under the Mental Health Act as her responsible clinician.

[Dr E's] position as GP is not a court appointment but she is seen as 'the medical practitioner who usually attended the patient immediately before the patient was required to undergo assessment and treatment'. She has a key role in [Mrs B's] medical management and certainly acts as her chief medical advocate. It is very clear from the background notes that [Mrs B] was not an easy patient to manage from a general practice point of view.

She suffers from relapsing paranoid schizophrenia and has no or poor insight into her ongoing and serious psychiatric and medical illnesses and her need for regular medication to control this. This is particularly true when she decompensates mentally but is apparent even when she is stable as is evidenced by her reluctance

to take medication and to be examined physically at times by [Dr E]. [Dr E's] visits to [Mrs B] can be cordial and productive or [Mrs B] may be excitable and uncooperative.

After [Mrs B's] admission to [the rest home], [Dr D] was asked by the [rest home] management if she would become [Mrs B's] GP. [Dr D] declined and [Dr E] agreed to take on this role. [Dr D] accompanied [Dr E] on her first visit to [Mrs B] as an introduction. [Dr E] says on 19/6/01 'her presence helped me to establish a therapeutic relationship with [Mrs B]'.

In her telephone conversation with [an Investigation Officer from the Health and Disability Commissioner's Office] on 8/10/01, [Dr E] says that she did not expect to have any further contact with [Dr D] after her move. However by [Dr D] writing in the medical notes 'she knew [Dr D] had been and had done things for [Mrs B]'. '[Mrs B] is not a normal person and she was difficult to look after.' And '[Dr D's] interference was slightly irritating but it was helpful given the specific nature of [Mrs B]'. [Mrs B] would have believed that she had the right to use [Dr D] as her GP not understanding the court's role in her care, or her own lack of insight into her medical condition. On the whole, the nursing staff at [the rest home] seemed to cope with this practical difficulty but the management had difficulty with the concept.

In summary, [Dr D] considered that she could continue to act as a collegial support for [Dr E] with any instructions/suggestions for management being conveyed to [Dr E] directly or indirectly by this being passed onto [Dr E] through the nursing staff or the medical notes. She confused her initial and ongoing role in helping [Dr E] establish a therapeutic relationship with [Mrs B] and overstepped the mark a little in the continuing medical management. However, this appears to have been helpful, or at the most irritating, from [Dr E's] point of view.

***Was the change in [Mrs B's] medication by [Dr D] in March 2000 appropriate? Should [Dr D] have consulted with [Dr E] prior to the change in [Mrs B's] medication? If not, why not?***

On 27/3/2000 [Dr D] checked [Mrs B's] blood pressure because she was concerned by her physical state ('severe headache and congested face'). She left instructions, after writing in the medical notes, that [Mrs B] was to have her inhibance cut in the half dose given twice daily. The nurse at [the rest home] spoke to [Dr E] about this the next day and the instruction was initially left in place, as it seemed to be the best way to get [Mrs B] to take her medication. However, from a pharmacological point of view this rendered the drug ineffective and the practice was discontinued shortly afterwards.

The change proposed by [Dr D] was minor i.e. the same dose to be given in a different way. It was not appropriate as the drug was ineffective but [Dr E] says that she appreciated [Dr D's] assistance with this as it was difficult to give [Mrs B] any medication at all: 'for her this was a small matter and had no worries for her'.

***If it is established that [Dr D] did encourage [Mrs B] to move [to another area] to receive treatment from her there, was this appropriate?***
There is nothing in the documentation to support any sense that [Dr D] encouraged [Mrs B] to move. Indeed, she declined the opportunity be [Mrs B's] GP while she was living [there]. Both [Dr D] and her sister considered themselves friends of [Mrs B] through their common ethnic background and church associations and both visited [Mrs B] at [rest home] mainly in that role.

***Any other issues raised by the supporting documentation?***
On 2/8/00 [Mr I] suggested that in order to obtain a completely independent reassessment of [Mrs B's] condition an experienced psychiatrist with extensive geriatric involvement be asked to undertake a review. He felt this was necessary as he had received a letter from [Mrs B's] solicitor who had received various letters written by [Ms A] of [the rest home]. He says 'it suggests there is an unseemly squabble over matters relating to [Mrs B]'. [Dr K] undertook the assessment and his report suggested no change in the arrangements made by the Court for [Mrs B]. [Ms A], the general manager of [the rest home], seems to somewhat inappropriately have been the driving force of this complaint.

***Advise the Commissioner whether [Dr D's] involvement in the care and treatment of [Mrs B] during March and July 2000 complied with professional standards.***
[Dr D] has somewhat confused her role as medical advisor and friend of [Mrs B]. She considered that she could continue to act as a collegial support for [Dr E] directly or indirectly by this being passed on to [Dr E] through the nursing staff or the medical notes. It is not hard to see how this happened because of their common ethnic background and continuing relationship through their church. [Dr E] did not foresee a continuing medical role for [Dr D] but nevertheless found it more helpful than the opposite.

Similar situations happen when GPs look after the families/parents of other doctors. Generally the medical background and interest of both parties is acknowledged and the input valued."

## Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are 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.*

*RIGHT 7*
*Right to Make An Informed Choice and Give Informed Consent*

*(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.*
…

## Opinion: No Breach – Dr D

In my opinion, Dr D did not breach the Code of Health and Disability Services Consumers' Rights for the following reasons:

**Right 4(2)**
Right 4(2) of the Code provides that every consumer has the right to have services that comply with legal, professional, ethical, and other relevant standards. Clause 40 of the New Zealand Medical Association 'Code of Ethics' (1989) states that doctors must:

> "Recognize that an established relationship between a doctor and patient has a value such as to dictate that it should not be disturbed unless there are compelling reasons to do so."

This standard requires that a doctor not interfere with another doctor's established relationship with their patient without compelling reasons to do so.

*Shift to another town*
There is no evidence to support the allegation that Dr D encouraged Mrs B to move. Dr E stated that Mrs B suffered from flights of fancy, and was always saying that she wanted to leave the rest home and to go home. Mrs A acknowledged that it might have been Dr D's sister, Ms H, and not Dr D who encouraged Mrs B in this regard.

*Schizophrenia*
There is nothing in the documentation to support the allegation that Dr D encouraged Mrs B to believe that she was not suffering from schizophrenia.

*Alleged interference in medical management*
Although on several occasions Dr E specifically requested the assistance of Dr D in the care of Mrs B, Dr D attended to Mrs B in a professional capacity on at least two occasions without first informing Dr E of her intention to do so.

I accept that Dr D may have confused her roles as friend to Mrs B, and as the general practitioner who introduced Mrs B to Dr E and tried to help her colleague establish a therapeutic relationship with Mrs B. Dr D's actions were not entirely appropriate, but they resulted from a degree of role confusion. Nevertheless, as recognised by my expert advisor, it is not hard to see how this happened, given the common ethnic background of Mrs B and Dr D, and their shared connection through the church. Mrs B may have believed that she had the right to consult Dr D as her general practitioner and encouraged Dr D to provide her with medical care. This was, perhaps, spurred on by the fact that due to her illness, Mrs B was often suspicious and distrustful of her primary carers. I accept that Dr D did not intend to foster Mrs B's distrust in Dr E or the nurses at the rest home. I also accept that on all occasions, except for the incident involving the vaginal swab and urine test, Dr D ensured that Dr E had prior knowledge of her involvement in Mrs B's care.

Dr E advised me that although she found Dr D's interference in the care of Mrs B slightly irritating, Mrs B was a difficult patient to care for, and Dr D's assistance was, on the whole, helpful.

In summary, I accept that although Dr D's actions resulted from a degree of role confusion, she had Mrs B's best interests at heart. Although it would have been preferable for Dr D to discuss her concerns with Dr E, her actions were helpful, and she kept Dr E informed. Accordingly, in my opinion Dr D did not unreasonably interfere in Dr E's relationship with Mrs B and did not breach Right 4(2) of the Code.

**Right 7(1)**
Services may only be provided to a consumer if that consumer makes an informed choice and gives informed consent. For the purpose of Right 7(1), 'consumer' includes a person entitled to give consent on behalf of that consumer. Mr C, as Mrs B's welfare guardian, was a person entitled to consent to services on behalf of his mother. Mrs A expressed concern that Dr D provided care to Mrs B in a professional capacity without the consent of Mr C. In addition, Mr C was not happy with Dr D's alleged interference with his mother's treatment and management.

In my opinion it was not prudent for Dr D to become involved in the care of Mrs B without consulting Mrs B's welfare guardian, Mr C. However, I note that sections 18(3) and 18(4) of the Protection of Personal and Property Rights Act 1988, under which the welfare guardianship order was made, emphasise the importance of promoting the independence and best interests of the individual. The evidence suggests that Dr D provided care to Mrs B only when acting with Mrs B's full knowledge and concurrence. I acknowledge that Mr

C was the person entitled to consent on his mother's behalf, under sections 18(3) and 18(4) of the Protection of Personal and Property Rights Act 1988. However, given the nature of the interventions and the relationship between Dr D and Mrs B, I do not consider that Dr D's actions constitute a breach of Right 7(1) of the Code. I suggest that, in future, Dr D adopt a more cautious approach to becoming involved in the care of patients in respect of whom a welfare guardianship order is in place.

**Other Comment**
I take this opportunity to remind the complainant, Mrs A, of her obligation to exercise her right to complain in an appropriate manner. In the present case Mrs A made a number of allegations. Some of those allegations were completely unsupported by evidence, and were based on conjecture only. The final aspect of the complaint, involving Dr D's treatment of Mrs B, ignored the fact that Dr D's involvement did not concern Mrs B's existing general practitioner, and in fact was acknowledged to have had some benefit. In the circumstances, Mrs A should have hesitated before laying a formal complaint about Dr D's actions.

## Actions

- A copy of this opinion will be sent to the Medical Council of New Zealand.

- A copy of this opinion, with identifying details removed, will be sent to the New Zealand Medical Association and the Royal New Zealand College of General Practitioners, 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.*