General Practitioner, Dr B

Canterbury District Health Board

A Report by the
Mental Health Commissioner

(Case 16HDC00460)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Ms A had a complex medical history including alcohol and opioid dependence, and chronic knee and back pain following a fracture of her spine. She had been receiving methadone treatment with a service operated by Canterbury District Health Board (CDHB) since 2003.

2. On 24 May 2012, Ms A enrolled as a patient with a medical practice. She was seen by Dr B, who prescribed dihydrocodeine (DHC), which had been provided by doctors previously for Ms A's chronic pain. Dr B said that at the time she was not aware that Ms A was attending the methadone programme. For the remainder of 2012 and 2013, Ms A was seen at the medical practice by both Dr B and Dr C, and she continued to be prescribed DHC for chronic pain.

3. In September 2013, Ms A informed Dr C that she had been on the methadone programme for the past several years. Dr C notified Dr B, who told him that she would discuss the matter with the methadone treatment service to determine the best course of treatment for Ms A.

4. Dr B telephoned the methadone treatment service and asked for "an appropriate person" to contact her to discuss Ms A's ongoing treatment. There is no record that anyone from the methadone treatment service responded to the request.

5. In the absence of contact from the methadone treatment service at that time, the medical practice continued to prescribe DHC for Ms A, although in October 2013 Medicines Control advised the medical practice that a Restriction Notice in the name of [Ms A] had been issued in 2010. Dr B said that Medicines Control asked the medical practice whether it wished to be included as a prescriber on the Restriction Notice in conjunction with the methadone programme.

6. Dr B subsequently contacted a drug and alcohol service[1] for specialist advice regarding prescribing DHC for Ms A and was told that Dr D from the methadone treatment service would contact her. Dr B said that she believed that the medical practice had been included as a prescriber of DHC for Ms A in conjunction with the methadone programme.

7. Dr D documented that she spoke to Dr B and instructed the medical practice to cease prescribing DHC. However, Dr B said that she did not receive a call from Dr D, and Dr D could not confirm that she spoke with Dr B personally. Dr B said that the medical practice had no further contact from the methadone treatment service until March 2014. The methadone treatment service progress notes for December 2013 and February 2014 note that Ms A was receiving DHC from her GP for back pain.

8. In March 2014, a case manager, Registered Nurse (RN) E, discussed Ms A's case with Dr D and documented: "GP to be contacted to discuss ceasing prescribing of codeine." However, Dr B documented that the methadone treatment service had advised that the medical practice was allowed to prescribe DHC, but that it should also consider referring Ms A to a pain clinic. The methadone treatment service progress notes for the same day confirm this discussion.

[1] The service provides a telephone-only service for alcohol and drug issues.

9. The referral to a pain clinic was sent to ACC for approval, but because of a breakdown in communication, the referral was not approved or actioned.

10. On 10 September 2014, Ms A's new case manager, Ms F, documented that Dr D had previously recommended that the DHC prescribing cease and that Ms A be referred to a pain clinic for non-opioid medication. Ms F followed this up with the medical practice, and the medical practice asked that the request to cease prescribing be put in writing. Ms F wrote to the medical practice, and the letter was documented in Ms A's clinical notes, but without any comment or alert.

11. Dr B said that her understanding was that there would be a period of weaning Ms A off DHC, and she attempted to contact the methadone treatment service again about this. At the same time, Ms A told the methadone treatment service that she did not want to stop taking DHC as it was the only drug that helped with her pain.

12. From September 2014 to March 2015, Ms A was seen by the methadone treatment service and the medical practice, and the medical practice continued to prescribe DHC "at the prior dose". On 12 March 2015, Dr B spoke to Ms F about implementing a reduction plan for Ms A, and this was documented in the clinical notes. The methadone treatment service notes also state that the case manager would "discuss with consultant a reduction rate for DHC".

13. On 17 March 2015, Dr B was contacted by the methadone treatment service and instructed to cease prescribing DHC immediately. Dr B was told that there was to be no reduction undertaken by the medical practice, and that it would be managed by the methadone treatment service. The medical practice did not prescribe any further DHC for Ms A from this date onwards.

Findings

14. It was found that the standard of communication by the methadone treatment service with the medical practice was ambiguous and inconsistent. It was also found that, once aware of the dual opioid prescribing for Ms A, the methadone treatment service failed to provide a timely and clear instruction from a senior member of the team to the medical practice for an immediate cessation of prescribing. Criticism was also made about the methadone treatment service's failure to follow up on Ms A's referral to the pain clinic, and that discussions held and decisions made regarding Ms A's care were not well documented or followed up in a timely manner.

15. CDHB is responsible for the operation of the clinical services provided by the methadone treatment service, and the inadequacies identified in the care provided to Ms A are attributable to CDHB. Accordingly, it was found that CDHB breached Right 4(5) of the Code.

16. Adverse comment was made about Dr B, who had a responsibility — once she was aware that Ms A was on the methadone programme — to determine beyond doubt that it was acceptable for the medical practice to continue to prescribe a controlled drug, and to clarify the specifics of any reduction plan in a timely manner. It is accepted that the nature of communications received from the methadone treatment service and Medicines Control were mitigating factors in the ongoing confusion as to whether the medical practice was authorised to do so.

17. Adverse comment was made about Dr C for prescribing a three-month supply of DHC for Ms A when a smaller amount could have been provided while there was uncertainty over the co-prescribing of an opioid to a patient on the methadone programme, and the details of a reduction plan had not been confirmed with the methadone treatment service.

Recommendations

18. It was recommended that CDHB provide a written apology to Ms A. It was also recommended that CDHB conduct a random audit of clients covering the past 12 months to ensure that a copy of the opioid substitution treatment assessment has been sent to the client's GP, and report back on the results of the audit, including any actions taken or planned to address any issues identified.

19. It was also recommended that CDHB, in consultation with the Director of Mental Health and the Ministry of Health Medicines Control, consider the introduction of an alert to GPs on the clinical records system, and report back to HDC on its consideration.

Complaint and investigation

20. The Commissioner received a complaint from Ms A about the services provided to her by Canterbury District Health Board's methadone treatment service. The following issues were identified for investigation:

- *Whether general practitioner (GP) Dr B provided Ms A with an appropriate standard of care between 2013–2015.*
- *Whether Canterbury District Health Board (CDHB) provided Ms A with an appropriate standard of care between 2013–2015.*

21. This report is the opinion of Kevin Allan, Mental Health Commissioner, and is made in accordance with the power delegated to him by the Commissioner.

22. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Dr B	General practitioner (GP)/provider
Dr C	GP/provider
Dr D	Consultant/provider
Canterbury District Health Board (CDHB)	Provider

23. Information was reviewed from:

RN E	Registered nurse/provider
Ms F	Alcohol and drug counsellor/provider

24. Independent expert advice was obtained from in-house clinical advisor Dr David Maplesden (**Appendix A**) and from general physician and addiction specialist Dr Geoffrey Robinson **(Appendix B**).

Information gathered during investigation

Introduction

25. Ms A was aged 37 years at the time of these events. She had a complex medical history including alcohol and opioid dependence, and chronic knee and back pain following a fall that had resulted in a fracture of her spine.

26. In 2003, Ms A began receiving methadone treatment[2] with a service operated by CDHB.

27. Between approximately 2010 and March 2015, Ms A was prescribed dihydrocodeine (DHC) regularly by various doctors for chronic pain relief in relation to her knee and back injury.

28. DHC is a medium-strength opioid that is available in 60mg slow-release tablets with a usual maximum recommended dose of 240mg per 24 hours. It is a Class C controlled drug.[3]

29. On 18 February 2010, the Ministry of Health issued a Restriction Notice[4] in the name of Ms A prohibiting every practitioner (other than the methadone treatment service staff approved in the restriction notice) from prescribing, or any person from supplying her with, controlled drugs, including benzodiazepines.

Consultations, 2012

The medical practice

30. General practitioner Dr B was, at the time of these events, the sole trader and owner of the medical practice. Dr B had seen Ms A previously in 2010 at another medical centre.

31. Dr C was also a general practitioner working as an independent contractor at the medical practice.

32. On 24 May 2012, Ms A enrolled as a new patient at the medical practice. At the first consultation, Ms A was seen by Dr B. The clinical notes for that consultation document a general orthopaedics referral in 2010, and that Ms A had been scheduled to have surgery on her knee, but that it had been deferred. Dr B also documented that Ms A had been taking naproxen and DHC but had stopped some time previously as she said they were not working anymore. At the consultation of 24 May 2012, Dr B prescribed medication, including 90 DHC Continus 60mg tablets[5] for Ms A's pain.

33. Dr B told HDC that as far as she can remember, she was not aware that Ms A was attending the methadone programme.

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[2] Opioid substitution treatment is provided to people with opioid dependence and involves replacing the illegal opioid with a legal, longer acting, but less euphoric opioid, such as methadone. Methadone is also a controlled drug.

[3] The Misuse of Drugs Act 1975 classifies a large number of controlled and illegal drugs according to the level of risk of harm they pose to people misusing them: Class A (very high risk), Class B (high risk), and Class C (moderate risk).

[4] A Notice under Section 25 of the Misuse of Drugs Act 1975.

[5] This is indicated for the treatment of opioid-responsive, chronic severe pain of non-malignant origin, after other conservative methods of analgesia have been tried. It is indicated for use in accordance with the current guidelines on chronic pain management and where there is no psychological contraindication, medicine-seeking behaviour, or history of medicine misuse.

34. Ms A was seen at the medical practice by both Dr B and Dr C for the remainder of the year, and both doctors continued to prescribe DHC for chronic pain. Dr C told HDC that when he saw Ms A on 10 December 2012, he reviewed her MRI report from 2010 and the accompanying note from the orthopaedic surgeon, which indicated significant ligament damage and subsequent arthritis. Dr C stated:

> "At this time there was no reason to suspect any suspicious activity by the patient as she had documented joint damage that was consistent with her pain level and her medication dosage."

Consultations, 2013

35. In February 2013, Dr C prescribed a further 120 DHC Continus 60mg tablets, with instructions for one tablet to be taken in the morning and three tablets to be taken at night. He also noted that this was the "limit of safe daily dose".

36. On 25 September 2013, Ms A was seen by Dr C in relation to an ACC claim issue. At that consultation Ms A asked for a refill of her DHC prescription but also told Dr C that she had been on the methadone programme for the past several years. Dr C notified Dr B, who told him that she would discuss the matter with the methadone treatment service to determine the best course of action for Ms A. There is no record of DHC being prescribed at this consultation.

37. Dr C documented in the clinical notes:

> "No records here stating on Methadone programme and no letters to clinic stating same. Patient states her case worker has sent letters to the GP explaining her being on the Methadone programme, nothing in inbox or in eSCRV[6]."

38. On 27 September 2013, and in light of Ms A's admission that she was on the methadone programme, Dr B contacted the methadone treatment service and left a message for staff to contact her. Dr B documented in Ms A's patient notes that the methadone treatment service registered nurse (RN) E[7] confirmed that Ms A had been on the methadone programme for a lengthy period of time. The notes also state that RN E apologised for Ms A's methadone service clinic reviews having been sent to a previous GP (unspecified), and that RN E faxed the latest review (23 September 2013) to Dr B.

39. Dr B told HDC that following receipt of the September 2013 review there was no further contact from the methadone treatment service until 12 September 2014, when the medical practice received a letter stating that the medical practice should cease prescribing codeine to Ms A. Dr B said that no other progress reports or written communication were received.

40. Dr B told HDC that because she had been prescribing DHC for Ms A since 2012, she asked for "an appropriate person" from the methadone treatment service to call her back to discuss the issue. However, there is no record that anyone from the methadone treatment service contacted the medical practice in response to that telephone message.

[6] HealthOne (Shared Care Record View), formerly known as eSCRV, is a secure record that stores health information including GP records, prescribed medications, and test results.
[7] RN E no longer works for CDHB.

41. On 21 October 2013, Ms A was seen by Dr C, who prescribed her a further 120 DHC Continus 60mg tablets "as per schedule". Dr C said that he did so because the medical practice had had no further advice from the methadone treatment service to do otherwise.

42. On 22 October 2013, Ministry of Health Medicines Control[8] contacted the medical practice after Ms A presented her prescription to a pharmacy that was aware of the 2010 restriction notice. The pharmacy notified Medicines Control that the medical practice was continuing to prescribe DHC for Ms A.

43. Dr B documented the contact from Medicines Control. The clinical notes state:

> "[Ms A] has restrictions regarding scripting on her file since 2010 … [Medicines Control] is going to send us restriction notice and wonders if the GPs in this practice want their names to be added to restriction notice in [liaison] and communication with the methadone programme."

44. On the same day, Medicines Control advised the medical practice that Ms A's case manager at the methadone treatment service could be contacted if the medical practice were considering being included in a restriction notice amendment. A copy of the restriction notice dated 18 February 2010 in the name of Ms A was attached.

45. On 23 October 2013, Dr B documented that she had written to the drug and alcohol service for specialist advice regarding prescribing DHC for Ms A.

46. On 24 October 2013, the drug and alcohol service replied:

> "Thank you for your letter requesting specialist written advice regarding DHC prescribing for [Ms A].
>
> This request has been forwarded to [Dr D] at [another alcohol and drug] service, who will contact you directly regarding this."

47. The methadone treatment service progress notes for Ms A on 24 October 2013 document that a request from Dr B for written advice had been received. Methadone treatment service consultant Dr D documented that Dr B had been prescribing DHC to Ms A, and that the GP practice had been unaware that she was on the methadone programme for opioid dependence. Dr D could not confirm that she spoke to Dr B personally, but the methadone treatment service notes, attributed to Dr D, state:

> "Spoke to GP — advised to cease prescribing of DHC as not clinically appropriate … They are happy with this plan and intend to get a Restriction Notice."

48. When asked if she spoke to Dr B personally, Dr D told HDC that the standard practice is that one of the consultants, or a registrar or medical officer, will contact the GP practice if there have been ongoing issues about prescribing. Dr D said that if the case manager were a registered nurse and the prescribing had only just started, the GP practice would be

[8] Medicines Control is a regulatory team within the Ministry of Health that oversees the local distribution chain of medicines and controlled drugs within New Zealand.

contacted by the case manager in the first instance, after discussion with one of the service's medical staff.

49. Dr B told HDC that she does not recall receiving a telephone call from Dr D, and said that if she had, she would have documented it. Dr B also noted that the recorded time of the progress note is 8.51am, which is earlier than her usual arrival time at work (normally she would not arrive before 9am). Dr B also said that if she had received an unambiguous message from Dr D to cease prescribing DHC, then she would have ceased prescribing immediately.

50. Dr B also said that the entry in the methadone treatment service progress note that "they are happy with this plan and intend to get a restriction notice" does not make sense, as she was "genuinely of the view [that the medical practice] had been included as a prescriber for [Ms A] in collaboration with the Methadone Programme". Dr B said that the medical practice had no further contact from the methadone treatment service until 19 March 2014.

51. On 25 October 2013, a methadone treatment service registered nurse, RN G, noted that she had spoken to Ms A following a positive urine drug screen for DHC. RN G documented that she asked Ms A whether her GP was aware that she was on the methadone programme, and Ms A told her that both her previous and current case managers had spoken with her GP.

52. The methadone treatment service progress notes for 29 October 2013, 1 November 2013, and 8 November 2013 written by RN E refer to Ms A's apparent benzodiazepine use, but do not mention the prescribing of DHC by the medical practice.

53. On 5 December 2013, Ms A was seen at the methadone treatment service by RN E and a medical officer, Dr H. The progress notes state:

> "[Ms A] is stable on 40mg of Methadone and experiencing back pain for which she is having some DHC from her GP."

Consultations, 2014

54. On 16 January 2014, Dr C saw Ms A "for DHC refill" and prescribed a further 120 DHC Continus 60mg tablets "at prior dose".

55. On 27 February 2014, Ms A was seen at the methadone treatment service by RN E and Dr H, and the progress notes document that she "receives codeine from her GP for chronic back pain". The notes also record: "[N]o problems or concerns with her methadone dose at this stage."

56. RN E noted in early March 2014 that Ms A was utilising "as required" codeine every day for chronic back pain, and that this had affected her methadone countdown previously. He documented that Dr D offered to review the case prior to the next pain clinic meeting.

57. Subsequently, RN E discussed Ms A's case with Dr D and documented that the "GP [was] to be contacted to discuss ceasing prescribing of codeine". The progress note plan for 13 March 2014 also included a statement that the "C/M [case manager] [was] to refer [Ms A] to pain clinic for non-opioid management of pain".

58. On 19 March 2014, Dr B documented that RN E had left a message for her to telephone the methadone treatment service. The clinical notes also state:

> "Pain issues — using codeine/counting down on methadone/codeine use goes up/refer to pain clinic/we are allowed to prescribe the DHC for pain/might need to do GP referral for ongoing methadone/[pain clinic][9] would possibly support long term opioid use for chronic pain now but they did not do so in the past."

59. Dr B told HDC that having not had any contact from the methadone treatment service since the previous year, she contacted the methadone treatment service and was told by RN E that the medical practice was allowed to prescribe DHC for Ms A's knee pain, but that the medical practice should also consider referring her to a pain clinic. Dr B also said:

> "I was of the understanding at the time that I could not prescribe to [Ms A] for dependency purposes but that I could prescribe for her knee pain as long as it was done in conjunction with the Methadone Programme (hence my contact with them)."

60. The methadone treatment service progress notes for the same day (19 March 2014) confirm the discussion between RN E and Dr B. The notes state: "[Dr B] reassured prescribing DHC is recommended if best option for pain management."

61. RN E also documented the discussion regarding referring Ms A to a pain clinic, and noted: "[The medical practice] do not have concerns of over use [of DHC] or manipulation of staff and feel prescription appropriate for reported symptoms." RN E noted that he would discuss the conversation with Dr D, but there is no further documentation to indicate that a discussion took place at that time.

62. On 28 March 2014, Ms A saw Dr C for a refill of her DHC prescription. Dr C told HDC that he understood that the instructions from the methadone treatment service were that the medical practice was able to continue to prescribe DHC for Ms A's pain.

63. On the same day, Ms A discussed her options for future pain relief with RN E, who noted that she "ha[d] been utilising prescribed codeine (DHC) for pain management". RN E encouraged Ms A to accept a pain clinic referral and to approach her doctor for a re-referral to "surgery/orthopaedic department for possible surgical options for management of pain".

64. On 31 March 2014, the methadone treatment service referred Ms A to the pain clinic. The methadone treatment service told HDC that because Ms A was an ACC client, the referral was sent to ACC for approval. The methadone treatment service advised that a breakdown in communication occurred, as ACC did not give approval.

65. Ms A was seen by Dr C in April and June 2014 and was prescribed DHC refills "at prior dose". Ms A attended routine methadone treatment service appointments in June and July 2014, but the progress notes do not refer to any evidence of DHC use. At her methadone treatment service appointment on 14 August 2014, it was noted that the urinary drug screen

[9] The pain clinic provides an interdisciplinary approach that is designed to meet the complex needs of individuals with chronic pain. The aim is to restore functional ability and enable individuals to live as independently as possible despite their pain.

test she took that day "will show codeine that she is prescribed for her back pain from a GP".

66. On 9 September 2014, Ms A was discussed by the methadone treatment service clinical team in light of the drug screening showing positive for DHC. The progress notes written by Ms A's new case manager, alcohol and drug counsellor Ms F, document that the DHC prescribing had been reviewed previously by Dr D, with the understanding that the prescribing of DHC should have stopped, and that Ms A would be referred to the pain clinic for non-opioid medication.

67. The following day, Ms F spoke with the medical practice nurse, who confirmed that Dr B was prescribing DHC to Ms A for back and knee pain. The practice nurse asked that the methadone treatment service put in writing the request to cease prescribing DHC and the request for referral to the pain clinic.

68. On 10 September 2014, a letter was sent from the methadone treatment service (written by Ms F) to Dr B, but it was not received by the medical practice until 12 September 2014. The letter states:

> "The consultant [Dr D] after reviewing [Ms A's] file has recommended that you cease all codeine prescribing and recommend a referral to [the pain clinic], for appropriate prescribing considering Methadone treatment.
>
> [W]e advise against the prescription of benzodiazepines or other drugs of dependence … to clients of the [methadone treatment service] and would appreciate you contacting us if requests are made by our clients for the prescription of these drugs."

69. Receipt of the letter is noted in Ms A's clinical notes, but without any further comment or alert. Dr B told HDC that, at the time, her understanding was that there would be a period of weaning Ms A off DHC given her high dose for pain. Dr B said that she attempted to contact the methadone treatment service again about this.

70. On 11 September 2014 (the day before the letter from the methadone treatment service was received), Ms A saw Dr C, who noted that Ms A reported that her back pain was a lot worse and that "the methadone has no effect on her pain so she needs the DHC. Yet is on the methadone for her pain?" Dr C prescribed a further 120 DHC Continus 60mg tablets.

71. On the same day, Ms A talked to Ms F about her ongoing use of DHC. Ms F documented that she told Ms A that the DHC prescribing should have stopped because of the methadone prescribing, and that she explained the rationale for this. Ms F noted that Ms A "wasn't prepared to stop codeine as it is the only drug to help with her pain". Ms F also noted that Ms A felt that there was no point in going to the pain clinic as "they are judgmental towards addicts".

72. The following day, Ms A was again reviewed by the methadone treatment service clinical team, and the letter sent to the medical practice was acknowledged. The progress notes state: "[Ms A] has the option of increasing methadone dose while counting off DHC."

73. On 15 December 2014, Ms A was seen again by Dr C, who documented: "[Ms A] here for refill of DHCs … States [the methadone treatment service] has been weaning her dose and

not concerned with her taking the DHC for pain." Dr C documented that he prescribed DHC "refilled at prior dose".

74. Dr C told HDC that he cannot remember this consultation, but said that he can only assume that he did not see the letter from the methadone treatment service advising against further DHC prescribing. He said that on that day he was the only doctor at the clinic, and that owing to time pressures he may not have checked Ms A's notes prior to her consultation.

Consultations, 2015

75. Ms A had regular appointments with the methadone treatment service between 23 September 2014 and February 2015. The progress notes make no reference to her use of DHC until 27 February 2015, when she requested that the methadone treatment service provide a letter of support for the medical practice to enable it to prescribe her both DHC for pain, as well as methadone. The registered nurse told Ms A that she would refer her request to the case manager.

76. On 12 March 2015, Dr B spoke with Ms F and noted:

> "[T]alked to [Ms F] at methadone clinic — drop the dhc/dose of methadone was increased/… wants to stay on DHC and decrease methadone/… consultant is away, she will let me know how to reduce."

77. The conversation is corroborated in the methadone treatment service progress notes for the same day, in which Ms F noted that Ms A would be reducing her methadone dose, and that Ms F would "discuss with consultant a reduction rate for DHC".

78. On 13 March 2015, Ms A saw Dr B, who prescribed one month's supply of DHC "until we hear from [Dr D]".

79. Dr B told HDC that she believed that an immediate cessation of the high dose of DHC would not be advisable, and therefore she was expecting further contact from the methadone treatment service to expedite a plan to reduce the DHC prescribed for Ms A. Dr B also stated that she found it difficult to get hold of the consultant at the methadone treatment service to discuss setting up such a plan.

80. On 17 March 2015, Dr B was contacted by the methadone treatment service and documented that the methadone treatment service had advised that there was to be no more prescribing of DHC under any circumstance, that it was to stop immediately, and that there would be no reduction by the medical practice. Dr B noted that Dr D instructed that the methadone treatment service would decrease the methadone, and that if Ms A had any withdrawal issues, then the methadone treatment service would manage them. The medical practice did not prescribe any further DHC for Ms A from this date onwards.

Further information

CDHB

81. CDHB told HDC that it acknowledges that it is unclear from Ms A's clinical record whether her review notes were sent to her general practitioner, and that it is unable to confirm whether or not this did occur. CDHB also acknowledges that the advice the methadone treatment service staff provided to Dr B was inconsistent at times.

82. The DHB told HDC that it accepts that communication in 2013 and 2014 between staff, clients, GPs, and other agencies was not as good as it should have been.

83. In October 2013, CDHB instigated an independent review of the methadone programme. The programme was compared against other similar DHB service delivery models and reviewed in comparison with national guidelines for opioid substitution treatment. Finally, recommendations for improvement in the context of the wider CDHB alcohol and other drug treatment services were made. Following the review, clients who had been assessed and accepted onto the opioid substitution programme were required to have a drug screen every three months rather than on a monthly basis. This allowed the medical officer more time to spend on reviewing a client's needs. Clients are reviewed six-monthly and their GP is updated. If any treatment for the client is changed, the GP is notified by telephone or letter. Calls are documented in the client's clinical records.

84. A consultant is required to review all drugs tests, and positive tests are recorded in the multidisciplinary team minutes and then followed up. A clinical manager audits the minutes to ensure that all issues, decisions, or recommendations are acted upon.

85. The methadone treatment service clinical head and a registered nurse now attend the pain clinic monthly liaison meeting to improve the communication with that service and to ensure that there is a more coordinated response to clients' needs in managing their pain.

86. Mental health documents are available to users of Health Connect South (the electronic clinical records system for the five South Island DHBs) and to GPs through the HealthOne module (a shared-care record view). Risk information is available through both Health Connect South and HealthOne. Primarily the risk information is intended for mental health crisis work, but it does have a specific field for alcohol and drug risk.

87. Currently there is no specific alert on the system for restriction notices.

Dr B

88. In regard to the ongoing prescribing, Dr B told HDC:

> "I accept I could have been more proactive in getting clarity around the matter but I say that with the benefit of hindsight … because at the time I was not confused … I was told we could prescribe and then understood a plan to reduce would be forthcoming."

89. Dr B stated that she understood from the communications from the methadone treatment service that Ms A "was withdrawing/had withdrawn from Methadone and her addiction issues were over/soon to be over".

90. Dr B further stated:

> "Had I received clear information to stop prescribing without a weaning period I would have done so.
>
> …
>
> I genuinely thought my authority for prescribing was through my interactions with the Methadone Programme and I was concerned about the clinical implications of sudden

withdrawal of medication, given [Miss A] had been on DHC for years for genuine and clinically indicated pain."

Response to provisional opinion

91. Ms A, Dr B, Dr C, and CDHB were given the opportunity to comment on the relevant parts of the provisional opinion.

92. Ms A stated:

> "[The methadone treatment service] staff need to realise that they prescribe controlled substances for opiate addiction and are not pain relief specialists. If a GP feels that a patient of his/hers needs to be prescribed a controlled drug it should go to [the methadone treatment service] and be discussed on a case by case basis as nothing like what has been done to me should ever happen to another person again."

93. Dr B said that she accepts the findings of the report and does not wish to comment further.

94. Dr C advised that he accepts the findings of the report. He said that he is now much more strict in reviewing previous GP notes before prescribing any controlled medications, to ensure that prescriptions are not provided unnecessarily.

95. CDHB said that it accepts the findings of the report, and that it appreciates the acknowledgement of the improvements made to the service as a result of the recommendations that arose out of its external review.

Opinion: Dr B — adverse comment

Ongoing prescribing of DHC for Ms A

96. On 24 May 2012, Ms A enrolled with the medical practice and was seen by Dr B. Dr B documented a previous consultation with Ms A at another GP practice, where she had been prescribed DHC for chronic pain.

97. Dr B referred Ms A for orthopaedic review and prescribed a further supply of DHC. Dr B told HDC that at this time she was not aware that Ms A was on the methadone programme. My in-house clinical advisor, Dr David Maplesden, said that in these circumstances, the failure of Dr B to check whether Ms A was a Restricted Person prior to prescribing DHC would not be a departure from accepted practice. I accept that advice.

98. In September 2013, Ms A admitted to Dr C that she had been enrolled on the methadone programme for a number of years. Dr B contacted the methadone treatment service to clarify the appropriateness of continuing to prescribe DHC and to discuss a plan to reduce it safely, but did not receive a written response until 12 September 2014. The methadone treatment service acknowledges that it is unclear from Ms A's clinical record whether her review notes were sent to her general practitioner, and the methadone treatment service is unable to confirm whether or not this did occur.

99. After being contacted by Medicines Control in October 2013 regarding the ongoing prescribing of DHC for Ms A, Dr B contacted a drug and alcohol service to seek clarification about the continued prescribing of DHC, and also sought confirmation that the Restriction Notice had been amended to include the medical practice. The drug and alcohol service subsequently advised that her request had been forwarded to Dr D, who would contact the medical practice.

100. The methadone treatment service clinical notes document that the following day (24 October 2013) a call was made to Dr B to request her to cease prescribing DHC as it was not clinically appropriate, and that Dr B intended to get a restriction notice. However, Dr B denies having received a call from Dr D, and said that she was genuinely of the view that the medical practice had been included as a prescriber in collaboration with the methadone treatment service.

101. Dr Maplesden stated that as there was general confusion over extending the restriction notice, Dr B should have been more proactive, particularly while there remained a lack of clarity over the appropriateness of such prescribing.

102. Dr B accepts that she could have been more proactive in getting clarity around the matter, but says that at the time she understood the medical practice to be authorised to prescribe DHC for pain, and that a plan to reduce the prescription would be forthcoming from the methadone treatment service.

103. Dr B said that she understood from the communications from the methadone treatment service that Ms A was in the process of withdrawing from methadone, and that her addiction was no longer an issue. Dr B said that she was concerned about the clinical implications for Ms A if there were a sudden withdrawal of medication, but said that had she received a clear instruction from the methadone treatment service to stop prescribing without a weaning period, she would have done so.

104. Despite this, Dr Maplesden is critical that Dr B did not seek to clarify the specifics of a withdrawal programme with the methadone treatment service. Dr B had been aware of the Restriction Notice since September 2013, and I am concerned that she did not initiate earlier contact with the methadone treatment service for advice on commencing a withdrawal regimen, rather than waiting until a clear instruction was received in March 2015. However, Dr Maplesden has also advised that there were significant mitigating circumstances surrounding the ongoing prescribing, including the doubt over the initial contact received from the methadone treatment service, the contradictory advice from the methadone treatment service, and the lack of specific direction in relation to Ms A's ongoing treatment.

105. On 13 March 2015, Dr B prescribed a further one month's supply of DHC and documented that the methadone treatment service would be calling back within a week to confirm Dr D's plan for DHC withdrawal. I note that Dr Maplesden is mildly critical that a month's worth of DHC was prescribed when a smaller amount would have given Dr B sufficient time to confirm withdrawal arrangements with the methadone treatment service.

106. In my view, while the nature of communication between the methadone treatment service, Medicines Control, and the medical practice contributed to the confusion, Dr B had a responsibility to determine beyond doubt whether it was acceptable for the medical practice

to continue to prescribe a controlled drug to Ms A after September 2013. I appreciate that Dr B genuinely considered that she had authority to continue to prescribe DHC for Ms A, but I am critical that this determination was not undertaken to a satisfactory degree or in a timely manner. Furthermore, I consider that while believing that a reduction plan would be forthcoming from the methadone treatment service, Dr B did not take appropriate steps to clarify the specifics of such a plan. In my opinion, had she done so, the confusion over the ongoing prescribing may have been resolved earlier.

107. Dr Maplesden has advised that the remedial actions undertaken by Dr B since these events are appropriate, and that the changes to the practice's controlled drug prescribing policy appear robust and should minimise the risk of a similar event occurring in the future. I accept that advice.

Opinion: Dr C — adverse comment

108. Ms A did not tell Dr C that she was enrolled on the methadone programme until a subsequent appointment on 25 September 2013. Dr C notified Dr B, who told him that she would discuss the matter with the methadone treatment service to determine the best course of action for Ms A.

109. From October 2013 until December 2014, Dr C continued to prescribe three-month supplies of DHC for Ms A. Dr Maplesden is mildly critical that Dr C did not appear to question the clinical rationale for ongoing prescribing of opioids when he was aware that the patient was undergoing methadone withdrawal treatment.

110. Dr C told HDC that he saw Ms A at appropriate intervals for repeat prescriptions, and that at that time he understood that the instructions from Ms A's case worker were that the medical practice was able to prescribe her DHC for pain relief.

111. Dr C cannot recall his final consultation with Ms A in December 2014 when he prescribed a further three months' supply of DHC. He says that he can only assume that he did not see the electronically filed letter from the methadone treatment service advising against further DHC prescriptions, or that he was still of the understanding that the medical practice was waiting for a reduction plan from the methadone treatment service.

112. Dr C said that his usual practice is to check a patient's notes prior to a consultation, but on that day he was the only doctor in the clinic and he may have omitted to do so owing to time constraints.

113. Dr Maplesden is mildly to moderately critical of Dr C's decision to provide Ms A with a further three-month prescription of DHC at this consultation, given that the issue of co-prescribing of DHC had yet to be resolved. Dr Maplesden considers that such prescribing was clinically unwise when a smaller amount of medication could have been provided while further information was sought from the methadone treatment service.

114. I agree with Dr Maplesden. Given Dr C's awareness of the uncertainty surrounding the management of Ms A's treatment and the limited clinical rationale for ongoing prescribing of DHC to a patient undergoing opioid withdrawal from DHC, it would have been most appropriate to prescribe a small supply of the medication until the treatment plan had been confirmed. I am critical that this did not happen, but accept that there were significant mitigating factors that affected Dr C's decision to continuing to prescribe DHC, including the contradictory advice and lack of specific direction from the methadone treatment service.

Opinion: Canterbury District Health Board — breach

115. District health boards are responsible for the operation of the clinical services they provide, and can be held responsible for any service-level failures.[10] While individual methadone treatment service staff hold a degree of responsibility for the care provided to Ms A, I consider that CDHB holds responsibility at a systems level for ensuring co-operation among providers.

116. The NZ Practice Guidelines for Opioid Substitution Treatment 2014[11] state:

> "Some people with chronic non-malignant pain (CNMP) may have previously exhibited, or may develop, addictive behaviour for opioids. It is most important that clients with CNMP receive an individualised assessment prior to commencement of opioid treatment … Treatment plans for such clients need to be comprehensive … Service providers should review treatment and examination frequently, and carefully supervise prescription and client progress."

Communication with Ms A

117. The methadone treatment service clinical notes for the period October 2013 to March 2015 document that Ms A was being seen on a monthly basis (and more frequently as required). I obtained independent expert advice from a general physician and addiction specialist, Dr Geoffrey Robinson, who said that based on the progress review notes he considers that the methadone treatment service's communication with Ms A covered a wide range of issues and would be considered to be appropriate.

Communication and liaison with the medical practice

118. However, Dr Robinson also advised that while discussions with Ms A were of a good standard during this period, he considers that the inconsistences in the advice regarding DHC prescribing given to the medical practice affected the standard of care provided to Ms A and, consequently, the timeliness of that care was compromised. I agree with that advice.

119. On 27 September 2013, the methadone treatment service telephoned the medical practice to confirm that Ms A was on the methadone programme. Dr B asked the methadone treatment

[10] See 15HDC00563.
[11] 6.6.2 Management of chronic non-malignant pain; Managing people with chronic non-malignant pain who develop prescription opioid dependence.

service to call her back to discuss Ms A's patient status, but there is no record that anyone did so at that time.

120. The methadone treatment service progress notes for Ms A state that on 24 October 2013 a call was made to Dr B advising the medical practice to cease prescribing DHC, because it was not clinically appropriate. However, the methadone treatment service has been unable to confirm which staff member made the call, or to whom the staff member spoke, and Dr B and the medical practice have no record of the call. Accordingly, I am unable to ascertain whether or not the methadone treatment service contacted the medical practice at that time. However, I note that Dr B advised that had she received an unambiguous message from the methadone treatment service to cease prescribing DHC, then she would have ceased the prescribing immediately.

121. The methadone treatment service had no further contact with the medical practice until March 2014, when Dr B was told that "[she] could not prescribe [DHC] for dependency purposes, but that [she] could prescribe for [Ms A's] knee pain", and this is corroborated in the methadone treatment service progress notes for 19 March 2014.

122. Ms A continued to receive dual prescribing of opioids from the methadone treatment service and the medical practice until 15 March 2015, when the methadone treatment service contacted Dr B and instructed that there was to be no further prescribing of DHC under any circumstances, and that if Ms A had any withdrawal issues, these would be managed by the methadone treatment service.

123. Dr Robinson advised that the standard of clinical communication from the methadone treatment service to the medical practice was inadequate to a moderate degree, in that it had been "conflicting, unclear, sporadic and neither timely nor followed through".

124. Dr Robinson further stated that following Dr B's request for specialist written advice on 23 October 2013, and the existence of a Restriction Notice, a methadone treatment service senior medical officer should have provided a response at that time, including a documented treatment plan for Ms A and discussion with Dr B. Dr Robinson also stated that most specialist services routinely write to general practitioners after medical consultations, and I am critical that this did not occur, and that it was another 12 months before any formal correspondence from the methadone treatment service was received by the medical practice.

125. CDHB has acknowledged that "communication in 2013/2014 between staff, clients, GPs and other agencies was not as good as it should have been" and that the advice the methadone treatment service staff provided to Dr B was inconsistent at times.

126. Dr Robinson said that such communication "is important given the complex and at-risk features of many opioid dependent patients", and I consider the failure of the methadone treatment service to send regular updates to the medical practice to have been unsatisfactory. Furthermore, I am critical that a comprehensive treatment plan was not discussed with the medical practice.

127. I note that since the external review (discussed above), a client's clinical reviews are now automatically sent to his or her GP every six months, and any changes made between the

six-monthly reports are communicated to the GP by telephone and letter and documented in the client's clinical file.

Liaison with pain clinic

128. On 31 March 2014, the methadone treatment service referred Ms A to the pain clinic. However, the methadone treatment service stated that because Ms A was an ACC client, the referral would have been sent to ACC for approval, and it appears that this was not granted by ACC or followed up by the methadone treatment service.

129. Dr Robinson stated that pain clinics are not necessarily easy to access, especially for opioid-dependent patients, and advocacy is required. Ms A told her methadone treatment service case manager that there was no point in going to the pain clinic as "they are judgmental towards addicts".

130. Given the difficulty of access to the pain clinic and Ms A's specific concerns, I consider that the failure of the methadone treatment service to follow up on the referral was unsatisfactory. I note that the DHB has acknowledged this failure and has implemented recommendations from the external review, including the methadone treatment service clinical head and a registered nurse attending the pain clinic monthly liaison meeting to improve communication between them and to ensure a more coordinated response to clients' needs in managing their pain.

Documentation

131. The Practice Guidelines[12] state that opioid substitution specialist treatment services must hold a record for each client that includes a comprehensive assessment, treatment plan, progress notes, and review summaries. While Dr Robinson has noted that some aspects of Ms A's care were documented adequately, he also stated that at times the documentation was unclear and did not always acknowledge the issue of the continued DHC prescribing.

132. Thorough, contemporaneous documentation is important, and includes the obligation to record the information provided to other providers involved in the consumer's care. I am critical that at times the standard of documentation was below the expected standard.

Conclusion

133. Ms A had the right to expect co-operation among her providers to ensure quality and continuity of services.

134. Frequently the standard of communication with the medical practice was ambiguous and inconsistent. I am critical of the methadone treatment service's failure to provide the medical practice with regular updates or to discuss a treatment plan for Ms A with Dr B adequately. Furthermore, I am critical that once the methadone treatment service became aware of the dual prescribing, there was not a timely, clear instruction from a senior member of the methadone treatment service team to the medical practice for an immediate cessation of prescribing. I also consider that the methadone treatment service's failure to follow up on Ms A's referral to the pain clinic meant that she was unable to access the care she should have received.

[12] New Zealand Practice Guidelines for Opioid Substitution Treatment, 11.1 Record-keeping.

135. In my view, the discussions held and decisions made regarding Ms A's care were not well documented or followed up in a timely manner, and I consider that this affected the continuity of care provided to Ms A.

136. CDHB is responsible for the operation of the clinical services it provides — in this case the service provided by the methadone treatment service. As outlined above, there were a number of inadequacies in the coordination of Ms A's care, which I consider are attributable to CDHB. Accordingly, I find that CDHB breached Right 4(5) of the Code of Health and Disability Services Consumers' Rights.[13]

137. I accept that the recommendations proposed as a result of the DHB's external review have largely been implemented and continue to be reviewed, with the aim of providing a service that focuses on patient well-being, recovery, and harm minimisation.

Recommendations

138. I note that CDHB has made a number of changes to the methadone treatment service as detailed in paragraphs 83–86 above. In light of those changes, I recommend that CDHB:

1. Provide a written apology to Ms A. The apology should be sent to HDC within three weeks of the date of this report.

2. Undertake the following actions and report back to HDC on each action, within six months of the date of this report:

   a) Conduct a random audit of clients covering the past 12 months to ensure that a copy of the opioid substitution treatment assessment has been sent to the client's GP, along with an update following the three-month and six-month review, and report back on the results of the audit, including any actions taken or planned to address any issues identified by the audit.

   b) Consider, in consultation with the Director of Mental Health and the Ministry of Health Medicines Control, the introduction of an alert to GPs on the clinical records system, as recommended by my experts, Dr David Maplesden and Dr Geoffrey Robinson, and report back on its consideration.

[13] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

Follow-up actions

139. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Canterbury District Health Board, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name in covering correspondence.

140. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Canterbury District Health Board, will be sent to the Ministry of Health for the attention of the Director of Mental Health and Medicines Control, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent GP advice to Commissioner

The following expert advice was obtained from in-house general practitioner Dr David Maplesden:

> "1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms A] about the care provided to her by [the methadone treatment service]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the information on file: complaint from [Ms A]; response from Dr B of [the medical practice]; GP notes from [the medical practice]; response from Canterbury DHB; [the methadone treatment service] clinical documentation.
>
> 2. Ms A's main complaint appears to be her management by [the methadone treatment service], in particular that they abruptly stopped her use of dihydrocodeine (DHC) as analgesia for chronic back and knee pain and instead increased her methadone dose which she feels was both dangerous and ineffective. I have been asked to comment on aspects of the ongoing prescribing of DHC to [Ms A] by her GP providers at [the medical practice] from 2012 to 2015. I note [Ms A] was on a methadone reduction programme under the auspices of [the methadone treatment service] over the period in question (and for some time prior to this). She […] was subject to a Restriction Notice (s25 Misuse of Drugs Act 1975) since 2009 which prohibited the prescribing of controlled drugs including benzodiazepines to her except by medical officers working for [the methadone treatment service].
>
> 3. GP consultation summary[1]

Date	Prov	DHC Rx	Comment
24/5/12	[Dr B]	x 90	First consult. Seen for knee and back pain. Previously under orthopedics. Re-referred and NSAID also prescribed. No old notes available. Patient stated prev medication regime but did not admit to contact with [the methadone treatment service]
6/6/12	[Dr B]	x 20	Awaiting ortho review. Needed increase in DHC to ii BD — top up given
20/6/12	[Dr B]	x 120	Phone request
31/7/12	[Dr B]	x 60(2)	Awaiting ortho review, req referral re back, DHC use decreased to ii daily. Referred physio previously (11 July 2012)
5/10/12	[Dr B]	x 60(2)	Phone request

[1] … DHC Rx refers to number of DHC 60mg tabs prescribed and presumed number of repeats in brackets (not able to be confirmed from clinical notes)

10/12/12	[Dr C]	x 90(2)	Review chronic back and knee pain, DHC increased: i mane, ii nocte. Smoking cessation assistance provided.
25/2/13	[Dr C]	x120(2)	Chronic pelvic pain + headaches. DHC inc to i mane, iii nocte. Bloods and urine ordered.
13/5/13	[Dr C]	x 120(2)	Review […] plus repeat meds
11/7/13	[Dr B]		Seen for back pain, declined trial TCA. No DHC Rx
29/7/13	[Dr B]		Comment in notes: *This pt should not get DHC early and should not get repeats any more*
30/7/13	[Dr B]	x120(2)	Review knee pain + URTI/flu. Ibuprofen also prescribed.
5/8/13	[Dr B]		Contacted ACC to clarify cover for knee injury and notified pt of result
25/9/13	[Dr C]		Seen for ACC […] claim issues. Requested further DHC and pt disclosed she was on methadone programme with [the methadone treatment service] for some years
27/9/13	[Dr B]		Contact with [the methadone treatment service] to clarify pt status. Reports had been sent to prev GP. Latest report faxed (23/9/13) which included pt drug history and current methadone regime. No reference to concurrent DHC use.
27/9/13	[Dr B]		Call back to [the methadone treatment service] from [Dr B] noting she had been prescribing pt DHC since 2012. Requested call-back but no return call received.
21/10/13	[Dr C]	x 120(2)	Review of back pain + […].
22/10/13	[Dr B]		Call from Medicines Control noting pt has a restriction order and wondering if practice should be included as prescribers. Restriction notice received on 23/10/13 identifying [the methadone treatment service] as only approved prescriber of controlled drugs including benzodiazepines
29/10/13	[Dr B]		Letter received from [drug and alcohol service] acknowledging [Dr B] query regarding prescribing of DHC for pt and that enquiry had been referred to the medical officer who will contact [Dr B] directly. No further contact from [drug and alcohol service] and assumption by [Dr B] that the restriction order now included [the medical practice] as prescribers and there was no issue with prescribing DHC for pain
16/1/14	[Dr C]	x120(2)	Reviewed for repeat DHC and smoking cessation
19/3/14	[Dr B]		Contact with [the methadone treatment service]: *Pain issues, using codeine, counting down on methadone, codeine use goes up, refer to pain clinic, we are allowed to prescribe the DHC*

			for pain, might need to do GP referral for ongoing methadone
27/3/14	[Dr C]	x 120(2)	Requesting […], rpt of DHC, to swap to GP prescribing of methadone and requested sleeping pills. […] and methadone requests declined, DHC + zopiclone x10 tabs prescribed
16/4/14	[Dr B]		Appears to be contact from pt not wanting to be on two opiates, wanting increased dosed of methadone — outcome of conversation unclear
18/4/14			Presentation at after-hours clinic stating […] recent DHC script stolen. Unclear from notes of further tabs provided at that visit
22/4/14	[Dr C]	x 120	Reported meds stolen (as above). Dispensing records checked and police report […] requested. Once supplied and determined no dispensing since 17/4/14 further one month DHC supplied and discussed weekly dispensing
9/6/14	[Dr C]	x 120(2)	[…] review and repeat usual meds. No comment re ongoing pain.
10/9/14			Contact from [the methadone treatment service] noting pt has positive urine screen for DHC. Recommended pain clinic referral if pain is an issue. Asked to send advice in writing. Letter received 12/9/15 recommending DHC prescribing cease and referral to be made to pain clinic if pain remains an issue despite methadone. Letter includes: *Please note that we advise against the prescription of benzodiazepines or other drugs of dependence (including zopiclone) to clients of* [the methadone treatment service] *and would appreciate you contacting us if requests are made by our clients for the prescription of these drugs.*
11/9/14	[Dr C]	x 120(2)	Noted back pain worse, not sleeping. DHC repeated plus amitrip 10mg x 90. Notes include: *Also mentions that methadone has no effect on her pain so she needs the DHC…*NB letter from [the methadone treatment service] not available at this time
15/12/14	[Dr C]	x 120(2)	Notes include *States the [methadone treatment service] has been weaning her dose and not concerned with her taking the DHC for pain.* Repeat script provided for DHC and amitrip
13/3/15	[Dr B]	x 120	*Has tried codeine and tramadol for pain, methadone worked initially for pain, DHC works the best, would like to come off methadone…*one month of DHC provided while awaiting further advice from [the methadone treatment service]
17/3/15	[Dr B]		Advice received from [the methadone treatment service] medical officer to stop all DHC immediately, no further prescribing and [the methadone treatment service] will manage patient's withdrawal and methadone dosing.

4. [The methadone treatment service] notes review

(i) It is unclear whether [the methadone treatment service] review notes were automatically sent to the patient's GP. There is no GP address on most of the notes examined. Where there is evidence of contact with the GP (GP address or evidence from the content of the documentation) this will be noted. Available documentation starts October 2013.

(ii) Progress note 24 October 2013 made by consultant [Dr D]: *Received request for written advice from GP [Dr B]. They have been prescribing [Ms A] DHC and she had not disclosed to them she was on the Methadone programme for opioid dependence. According to their documentation she has a history of chronic back and knee pain […] Spoke to GP — advised to cease prescribing of DHC as not clinically appropriate, and also positive [drug screen] for benzodiazepines. They are happy with this plan and intend to get a Restriction Notice.* I note that [Dr B] implies in her response that she did not have telephone contact with [Dr D]. I note also that [Ms A] was already under a Restriction Notice at the time [Dr D's] note was written and I presume she is referring to [Dr B] applying to become listed as an approved prescriber under that notice although the rationale for this is not clear under the circumstances.

(ii) Progress note 25 October 2013 made by [the methadone treatment service] [RN G] on discussing with [Ms A] her recent positive urine drug testing: *I enquired if her GP was aware that she was on the [methadone programme] and [Ms A] advised that her GP was aware, further stating that both [previous and current case managers] have spoken with her GP.* Subsequent progress notes in November 2013 discuss [Ms A's] intermittent use of benzodiazepines which she had obtained from various non-medical sources.

(iii) Progress note 6 December 2013 made by MO [Dr H] includes: *she is stable on 40mg of methadone and experiencing back pain for which she is having some DHC from her GP.* There is no other reference to use of DHC or additional concern expressed about this ongoing co-prescribing despite the previous progress notes referring to the inappropriateness of this prescribing.

(iv) Progress note 31 January 2014 by case manager [RN E] indicates there was discussion around [Ms A's] ongoing use of codeine and withdrawal options discussed without any firm conclusion. At clinic review on 28 February 2014 ([RN E] + MO [Dr H]) it is noted [Ms A] continues to receive GP prescriptions for codeine for back pain. No concern at this co-prescribing is expressed in the clinic note.

(v) [The methadone treatment service] MDT meeting 11 March 2014 — concern expressed by case manager at effect [Ms A's] ongoing codeine use might be having on her methadone withdrawal. Review note 12 March 2014: includes reference to [Ms A] taking DHC (although inaccurate dose and formulation recorded) as *it appears [Ms A] takes codeine most days for relief of back pain, mostly the full PRN dose of 3 x 30mg codeine daily.* Referral to pain clinic discussed (formal referral sent 31 March 2013) and [Ms A] made aware that *codeine also undermines receptor readaptation when reducing off methadone.* Dispensing records audited 13 March 2014 (no evidence of 'doctor shopping'). File review note 13 March 2013: *Discussion with [Dr D]. GP to be contacted to discuss ceasing prescribing of codeine. [Ms A] to be informed and may*

need methadone adjusting through clinic. [Ms A] phoned by the case manager the same day and advised regarding cessation of codeine. She expresses her concern — that codeine is more effective for her pain than methadone, and she does not want to increase her methadone dose. Case manager plan recorded as: *[Ms A] will attempt reducing and stopping codeine and assess pain levels. Clinic available for [Ms A] to adjust methadone dose. C/M to explore tablet [methadone] prescribing option through [the methadone treatment service] policy. C/M to refer to pain clinic for non-opioid management of pain.*

(vi) 19 March 2014 (and see corresponding note in GP consultation table) refers to case manager [RN E] speaking with [Dr B]: *Able to discuss concerns with DHC prescribing affecting [Ms A's] methadone countdown. [Dr B] also concerned she was prescribing DHC when unaware [Ms A] on OST — however reassured prescribing DHC is recommended if best option for pain management … D/W [Dr B] a pain clinic referral for advice on management of pain, [Dr B] wanting this. The surgery do not have concerns of over-use or manipulation of staff and feel prescription appropriate for reported symptoms.* [RN E] referred [Ms A] to pain clinic on 31 March 2014 (unclear what outcome was of this referral).

(vii) Progress notes dated 20 June 2014 (MO review), 17 July 2014 (telephone call RN) and 15 August 2014 (MO review) note [Ms A] was making good progress with her methadone reduction and appeared well. There is no reference to her use of DHC. On 9 September 2014 MDT meeting notes (per AD counsellor [Ms F]) refer to [Ms A] returning a positive drug test for DHC (implying staff were not aware of her ongoing use) *which she said was prescribed by her GP … To discuss with [her GP] prescribing of DHC, it has been reviewed by [Dr D] in the past with the understanding that DHC were to stop and refer to pain clinic for non-opioid medication.* It is not clear whether [Ms A] gave the GP name in error or if she was receiving DHC from more than one source at this stage.

(viii) 10 September 2014: contact between [Ms F] and [Dr B's] practice nurse: *… confirmed that [Ms A] was registered with their practice and that the doctor is prescribing DHC 60mg mane and three tabs nocte, for knee and back pain. Said there was a note from previous case manager regarding a referral to pain clinic, said we would put in writing regarding ceasing prescribing of DHC, and referral to pain clinic so that other doctors are privy to that information.* On the same day, letter sent from [Ms F] to [Dr B] which includes *The consultant [Dr D] after reviewing [Ms A's] file has recommended that you cease all codeine prescribing and recommend a referral to the [pain clinic], for appropriate prescribing considering methadone treatment* (and see corresponding GP reference in table above).

(ix) [Ms A] had contact with [the methadone treatment service] regularly until March 2015. There is no reference to DHC intake until a file note dated 27 February 2015 when [Ms A] rang to request *a letter of support from this service for her GP to be able to prescribe her DHC as well as methadone. [Ms A] reports the DHC is prescribed for pain from her arthritis.* On 12 March 2015 [Ms F] spoke with [Ms A] regarding her ongoing use of DHC with [Ms A] stating she would rather continue this medication (as it is effective for her pain) and stop her methadone. Later that day [Ms F] spoke with [Dr B]: *reaffirmed letter sent that she needs to be reduced off DHC, that she is*

reducing her methadone dose but has only recently started this. Said I would discuss with consultant a reduction rate for DHC. On 17 March 2015 [Ms A] was discussed at a MDT meeting with the conclusion that [Ms F] was to *confirm to GP that DHC prescription is to cease, that any withdrawal symptoms will be managed by our service … a restriction notice will be forwarded to Medicine Control, restricted to this service.* DHC prescribing ceased from this point.

5. Comments

(i) [Dr B] states that at all times [Ms A] was being prescribed DHC for the purposes of pain relief and not to treat dependency. [Dr B] was continuing a regime which was evidently effective for [Ms A's] pain, and which had been started by her previous GP. [Dr B] was not aware that [Ms A] was being treated at [the methadone treatment service], or that she was subject to a Restriction Notice until late September 2013. While there was some variation in the dose of DHC required by [Ms A] between May and September 2013, the pattern of consumption did not raise particular suspicion that [Ms A] was dependent on the drug or that she was abusing the drug. [Dr B] attempted to expedite orthopaedic review for [Ms A's] various musculoskeletal complaints. I think, under the circumstances, the prescribing of DHC (with an NSAID) to [Ms A] to this point was not a departure from expected standards of care. However, I note the MCNZ recommendation[2]: *When you prescribe drugs which have the potential for abuse you must ensure that the person you are writing the prescription for is not: dependent upon such drugs, seeking such drugs to supply to other individuals,* [or is] *a restricted person*. The same publication states: *Make the care of patients your first concern. It is unethical to provide any treatment that is illegal or detrimental to the health of the patient.* The list of Restricted Persons is made available to GPs in hard copy approximately twice a year. In my experience this list might be accessed if the provider has a suspicion the patient is abusing a controlled drug rather than being consulted on every occasion a patient is prescribed a controlled drug and I would not regard the failure by [Dr B] to check whether [Ms A] was a Restricted Person prior to her prescribing of DHC to be, under the circumstances, a departure from common or accepted practice.

(ii) In September 2013 [Dr B] attempted to clarify the appropriateness of her DHC prescribing with [the methadone treatment service] staff but evidently did not receive the information she requested. Before this issue was resolved, [Dr C] reviewed [Ms A] and provided a three-month prescription of DHC. Given [Dr C] was aware [Ms A] was on the methadone programme and the issue of co-prescribing of DHC was yet to be resolved, I think such prescribing was clinically unwise when one month of medication could have been provided while further information was sought from [the methadone treatment service]. It is also difficult to determine why, from this point on, either GP thought there was clinical rationale for [Ms A] being on two opioid medications simultaneously (methadone and DHC) despite there being different indications for the treatments (opioid dependency and pain). While [Ms A] was attempting to overcome her opioid dependency by partaking in a methadone step-down programme (which by

[2] https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Prescribing-drugs-of-abuse.pdf Accessed 5 June 2016

now both GPs were aware of) the co-prescribing of another opioid medication would inevitably defeat this purpose.

(iii) In October 2013 [Dr B] became aware [Ms A] was a Restricted Person. [The methadone treatment service] notes suggest [Dr D] spoke directly with [Dr B] around 24 October 2013 (see 4(ii)) but [Dr B] does not recall this contact. There is general confusion over extending the restriction notice and it is unclear why the notice would be extended (in terms of approved prescribers) if [Dr D] was advising cessation of DHC prescribing, and a restriction notice covering all controlled drugs (which includes DHC) was already in place. I have had personal contact with Medicines Control and confirmed that [Ms A's] restriction notice prohibited prescribing of controlled drugs for any purpose (including pain relief) other than by the prescribers approved in the restriction notice ([the methadone treatment service] staff). Restriction notices are commonly invoked because there is a history of abuse of controlled drugs. [Dr B] was aware that [Ms A] had been less than candid about her involvement with [the methadone treatment service] from the outset of their professional relationship. I am therefore critical that the prescribing of DHC continued while there remained a lack of clarity over the appropriateness of such prescribing, including the legality of the prescribing (regarding the restriction notice). The communication from [the methadone treatment service] to [Dr B] may have contributed to the level of confusion if the call from [Dr D] did not take place as described. However, [Dr B] had a responsibility to determine beyond doubt that it was acceptable to [the methadone treatment service] and to Medicines Control that it was reasonable for her to continue prescribing DHC to [Ms A] and I do not feel this determination was undertaken to a satisfactory degree.

(iii) Subsequently there was an inconsistent response from [the methadone treatment service] to the awareness (when there was awareness) that [Ms A] continued to receive prescriptions for DHC. There was no apparent concern from the [methadone treatment service] MO reviewing [Ms A] in December 2013. In March 2014 concern was again raised but GP and [the methadone treatment service] documentation suggests the phone contact between [the methadone treatment service] staff and [Dr B] on 19 March 2014 included ambiguous advice which could be interpreted as a mandate to continue prescribing of DHC. I am mildly to moderately critical of the standard of communication from [the methadone treatment service] to the GP on this occasion, and that there was not another phone call ([the methadone treatment service] clinician to GP) following the call in October 2013 (if this call took place) as soon it as was evident that [Ms A] continued to receive prescriptions for DHC.

(iv) In September 2014 the issue of [Ms A] taking DHC came to the fore after a positive urine drug screen and [Dr B's] practice was contacted by [the methadone treatment service] staff with a recommendation that all DHC prescribing cease and [Ms A] be referred to pain clinic. This plan was not explicitly described in the practice nurse note (10 September 2014) but I feel it was quite clear in the letter provided to [Dr B] (dated 10 September 2014 and received 12 September 2014). I note also that [the methadone treatment service] had already referred [Ms A] to pain clinic in March 2014 but there is no reference to this in the letter. At this point [Dr B] was aware [Ms A] was subject to a restriction notice and there was now clear advice from [the methadone treatment service] that the DHC prescribing should cease. I feel if [Dr B] was unclear how the DHC was to be stopped she might have contacted [the methadone treatment

service] for explicit advice. Conversely, direct contact between [Dr B] and a MO from [the methadone treatment service] at this point might have helped clarify the rationale for ceasing DHC and what ongoing management was going to entail. I note there was no attempt made to initiate a DHC withdrawal regime between September 2014 and March 2015, or any obvious attempt made to seek further advice on how to initiate the withdrawal. Under the circumstances, … to 'wait for advice from [the methadone treatment service]' was not a reasonable therapeutic strategy and I am critical that [Dr B] and [Dr C] continued to prescribe [Ms A] DHC.

(vi) Over the period September 2014 to March 2015 a majority of prescriptions for DHC were provided by [Dr C] who should be asked to provide a response before I make final comments on the degree of departure from expected standards of care. [Dr B] may also like to provide comment on the implication (from [the methadone treatment service] notes) that [Dr D] spoke with her directly on 24 October 2013.

Supplementary advice:

Thank you for the request that I provide further clinical advice on this case. This advice should be read in conjunction with my original advice dated 4 July 2016. I have reviewed a response from [Dr C] dated 28 July 2016 and a further response from [Dr B] dated 4 August 2016.

(i) [Dr C] notes that for a majority of the time he prescribed [Ms A] her codeine he was under the impression such prescribing had been sanctioned by the [methadone treatment service]. In relation to the consultation of 15 December 2014, [Dr C] noted the following in his response (29 June 2016):

I cannot remember the consultation on 15 December 2014 but from my notes, I see the patient presented to me for her regular refill of DHC. I can only assume I did not see the electronically filed letter from [the methadone treatment service] advising against further DHC prescriptions or I had spoken to [Dr B] at some stage and understood we were still prescribing while awaiting a plan for reduction. While I normally attempt to review all new information in each patient's electronic record prior to seeing them, I obviously did not do so on that occasion or I was aware of it but at some stage had discussed it with [Dr B] and was of the impression we could continue to prescribe pending a reduction plan.

(ii) Regarding [Dr C's] prescribing of DHC to [Ms A] up to and including the consultation of 11 September 2014, I am mildly critical of the fact that [Dr C] evidently did not question the clinical rationale for ongoing prescribing of opioids to a patient undergoing methadone withdrawal (and he was aware from September 2013 that [Ms A] was receiving methadone withdrawal treatment under the auspices of [the methadone treatment service]). The criticism is mild because of the circumstances noted in my initial advice — some doubt regarding whether or not a clear direction to stop the co-prescribing was ever received from [the methadone treatment service] prior to September 2014; documentary evidence of 'mixed messages' received from a [methadone treatment service] case worker regarding the co-prescribing over the period in question (prior to September 2014); [Dr C] not the patient's registered provider; no alert on the patient's notes following receipt of letter from [the methadone treatment service] on 12 September 2014 (filed by [Dr B]) to cease codeine prescribing; no

reference to directive to cease codeine co-prescribing in the practice nurse record of [the methadone treatment service] contact on 10 September 2014.

(iii) I am mildly to moderately critical of [Dr C's] decision to provide [Ms A] with a three month prescription for DHC (60mg mane and 180mg nocte) on 15 December 2014, evidently on the basis of the patient's reassurance that [the methadone treatment service] approved such prescribing. The letter from [the methadone treatment service] was apparent in the clinical file as a recent Inbox entry (12 September 2014 — *Ibx: methadone prog letter*) although the content of the letter was not obvious without opening the file. [Dr C] has acknowledged his oversight in not referring to this letter. Given his apparent awareness (as per his response) that there had been some discussion with [Dr B] regarding weaning [Ms A] off her DHC, and the fact there was limited clinical rationale for ongoing prescribing of DHC to a patient undergoing structured opioid withdrawal through the methadone programme, I think it was important for [Dr C] to clarify as far as possible the advice from [the methadone treatment service] regarding [Ms A's] withdrawal from DHC (starting with review of the September [methadone treatment service] letter) before ongoing prescribing. If he was unable to establish the recommended programme at the time of the consultation on 15 December 2014, it would have been most appropriate to prescribe a small supply of the medication (certainly not three months' worth) while taking further steps to confirm [Ms A's] management plan with [Dr B] and/or [the methadone treatment service]. As noted previously, I acknowledge [Dr C] was not [Ms A's] registered provider and most of the direct contact between [the methadone treatment service] (and Medicines Control) and the practice had been through [Dr B]. [Dr B] has provided a further response. She is unable to recollect a call from [Dr D] ([the methadone treatment service]) on 24 October 2013 and is sure that if she had been instructed to stop prescribing codeine at this time she would have recorded this and followed the instruction. She notes that with the benefit of hindsight it appears the situation regarding whether or not she was regarded as an 'approved' prescriber (with respect to [Ms A's] restriction notice) might have been clarified further at the time, but [Dr B] felt confident that her name (and that of [Dr C]) had been included as approved prescribers and no information was received from Medicines Control to the contrary. I remain critical of the fact that [Dr B] continued to prescribe [Ms A] codeine after receiving written advice from [the methadone treatment service] on 12 September 2014 for the prescribing to stop and that she did not seek to clarify the specifics of a withdrawal programme with [the methadone treatment service] after this time when no such advice was forthcoming ie the approach of continuing to prescribe codeine between September 2014 and March 2015 without attempting to obtain advice regarding withdrawal or to actually commence a withdrawal programme was not clinically appropriate or sufficiently proactive under the circumstances. I am mildly to moderately critical of this situation and of [Dr B's] overall management of [Ms A's] prescribing and I would be more critical if not for the significant mitigating circumstances. These circumstances include: doubt over the initial contact received from [the methadone treatment service] in October 2013; 'mixed messages' and lack of specific direction from [the methadone treatment service], even though they continued to be aware of the co-prescribing, between October 2013 and September 2014; inadequate input from Medicines Control who must have been aware after October 2013 that [Drs B and C] were non-approved prescribers continuing to prescribe a controlled drug for a restricted person (which is

against the law); failure by [the methadone treatment service] to contact [Dr B] again (until March 2015) after September 2014 regarding her ongoing prescribing of codeine to [Ms A].

Supplementary advice (12 March 2018):

[Regarding] the issue of [Dr B's] prescribing on 17 March 2015, I would be mildly critical that a month's worth of DHC was prescribed when a smaller amount would have given sufficient time for [Dr B] to confirm withdrawal arrangements with [the methadone treatment service], an action that should have been done in September 2014 (and the delay in this action is the more critical omission)."

Appendix B: Independent drug and alcohol advice to Commissioner

The following expert advice was obtained from Dr Geoffrey Robinson:

"**Re 16HDC00460**

Thank you for seeking my advice to assist this investigation. I have read the documents you provided namely:

1. Letter of complaint dated 23 March 2016
2. Correspondence from Canterbury DHB/[the methadone treatment service]
3. Clinical records from Canterbury DHB covering the period 2003–2016.
4. [The medical practice] responses.
5. New Zealand Practice Guidelines for Opioid Substitution Treatment 2014.
6. External review of [the DHB's methadone] programme.

My name is Geoffrey Robinson and I am a registered medical practitioner. I worked in the Alcohol and Drug service at Capital and Coast DHB from 1980 until last year when I retired. I continue to participate in Peer Review Group meetings.

I am a fellow of the Royal Australasian College of Physicians (FRACP).

I am a fellow of the Australasian Chapter of Addiction Medicine (FAChAM), and was a member of the foundation committee.

I was also the Chief Medical Officer at CCDHB from 2005 to 2016.

I trained in Addiction Medicine by completing a residency programme in this in Canada in 1978–1980.

Introductory comments:

I note that [Ms A] is a medically complex patient with opioid dependence […] and chronic pain (right knee osteoarthritis and back pain from a fractured lumbar vertebrae). Such patients are not uncommon in opioid services. In addition […] which may relate to difficulties tracking her previous medical records by General Practitioners (GPs). She may well be adroit in negotiating medical systems.

Of interest, I note the restriction notice sent (for unknown reasons) to the [medical practice] 22/10/13 for [Ms A] … was dated 18/2/10 and is explicit about controlled drugs being only prescribed by the [methadone treatment service]. […] I note in the case records of [the methadone treatment service] 17/3/14 that a restriction notice (application I presume) would be forwarded to Medicines Control suggesting that [the methadone treatment service] were unaware of the previous notice of 2010.

DHC, Dihydrocodeine, is a medium strength opioid which is available in 60mg slow release tablets with a usual maximum recommended dose of 240mg per 24 hours. It is a Class C controlled drug. It has a known misuse liability relating to the shorter-acting preparation in other countries. I am not aware of clinical or pharmacological evidence

that it would be more effective for chronic pain, than more potent opioids such as methadone ([Ms A] had maintained that DHC was more effective than lower dose methadone).

When [the methadone treatment service] eventually stopped the GPs' prescribing of DHC, then I believe that most drug clinics would have taken the approach that [the methadone treatment service] adopted of stopping the DHC and increasing the Methadone, even though this was not the preference of [Ms A].

[Ms A] appears to have a slower clearance of methadone by the liver which resulted in higher levels than would be usually anticipated. In addition there is comment on methadone-induced QT interval on an ECG, but no detail on the degree of this change. [The methadone treatment service] took the appropriate action of reducing the methadone in the interest of safety. This started in October 2015 within a few weeks of the levels having being done.

It is noted in [Ms A's] letter of complaint that she states her methadone went from 25mg to 120mg when the clinic ceased the DHC. In fact the dose went from 65mg up to 120mg.

[Ms A] also alludes to a delay in getting the blood methadone levels and ECG done after being on the 120mg dose. I feel this time period was acceptable and within the spirit of the guidelines for ECGs and blood methadone levels.

Thus, for the issues covered above I believe these were at a reasonable standard of accepted practice.

You have also sought comment on:

1. *The adequacy and appropriateness of the communication between:*

   a. *[The methadone treatment service] staff and [Ms A]*

On review of the progress notes of [the methadone treatment service] it would appear it was probably adequate communications over a wide range of issues. The disquiet from [the methadone treatment service] about the DHC prescribing is discussed in (3) to follow.

   b. *[The methadone treatment service] staff and the GPs at [the medical practice]*.

There are at least 2 separate issues here. Firstly, around the communications over the dual prescribing of opioids, I would expect a Drug Clinic to be concerned to learn of GP prescribing of another opioid to a patient on methadone. As already mentioned, Drug Clinics would attempt to take over the GP prescribing and use one opioid usually by increasing methadone dosage.

There may have been a difference of views or lack of knowledge by clinicians at [the methadone treatment service] over the DHC, and certainly some case notes including those of [Dr H] did not express concern, and just noted the prescribing of DHC without further comment.

I suspect the advice from [the methadone treatment service] to [the medical practice] had been conflicting, unclear, sporadic and neither timely or properly followed through.

In particular the arrival at [the medical practice] of the restriction notice should have prompted a plan. I note [Dr B] sent through a formal referral seeking specialist written advice on the 23/10/13. There should have been a response at this time which would usually be undertaken by a Senior Medical Officer at the clinic by discussing this with the GP and documenting the plan in writing. In passing, I note the Restriction Notice is a formal document and prohibits the prescribing of Controlled drugs, and does not specify pain or dependency indications. It appears from the documentation that it was not until a year later that formal correspondence from the clinic occurred (from the Case-Manager).

I would regard this communication and administration processes as being below the usual standards of practice to a moderate degree in this situation.

I also refer to the [methadone treatment service] Clinical Review document of 12/3/14 which notes the codeine (DHC) issue but does not have any clear plan to address the GP prescribing or the restriction notice issue. The Clinical Review document does not name the GP on it which leads to the second issue of clinical communication to the General Practice. It appears, as acknowledged in [CDHB's] letter 15/8/16 that it is unclear what regular information or clinical reviews were sent to the GPs, and the system set up following the review of [the methadone treatment service] may have failed in this case ([the medical practice] could advise on what Clinical Review and updates had been received during 2013–2015).

It is interesting to reflect that most specialist services in most DHBs routinely write to GPs after medical consultations but there seem to be different standards in [the methadone treatment service], and possibly other mental health services which may reflect multidisciplinary patient management. Nevertheless I note the [methadone treatment service] aim to communicate six-monthly to GPs. Such communication is important given the complex and at-risk features of many opioid dependent patients.

If [the methadone treatment service] did not send updates then I would regard this clinical communication as unsatisfactory and below the usual standard of practice to a moderate degree.

2. *The Co-ordination of care between [the methadone treatment service] and other agencies including but not limited to the [pain clinic]*.

This patient, and her GPs and [the methadone treatment service] staff would have benefited from [the pain clinic] advice that could have helped generate a more co-ordinated treatment plan.

It seems that at earlier points in time there was an expectation that the GP might make such a referral but subsequently referrals were done by [the methadone treatment service] ([RN E] after the Case Review 31/3/14 and [Ms F] 8/5/15) neither of these referrals were copied to the GPs for their information and may have been deficient in their medicines reconciliations. For example, the patient was on amitriptyline according to the GP's case notes 13/3/15. (Incidentally this drug is specifically mentioned with

regard to QTc prolongation in the protocol, and I wonder if [the methadone treatment service] knew she was prescribed it.)

I do not find any information acknowledging the referrals or acceptance of them by [the pain clinic]. Pain Clinics are not necessarily easy to access especially for opioid dependent patients and advocacy is required. It is pleasing to see that the [methadone treatment service] Clinical Head attends [the pain clinic] monthly 'to ensure a coordinated response' ([DHB response]). This was specifically stated in the Case Review 3/14. It is unclear of the response from these referrals in the [methadone treatment service] case notes, or follow-up of this matter by them. (HDC may need to seek the [pain clinic] records to determine the outcomes.)

I note in the progress notes 21/7/15 ([Ms F/Dr D]) comment that the patient had changed GP … and will approach him for a referral to the Pain Clinic. This is odd given that [Ms F] had made a referral two months earlier to [the pain clinic]. Thus, [the methadone treatment service] made two referrals to [the pain clinic] plus intended [the methadone treatment service] consultant advocacy. However there is no record of an outcome, which would have been important for the patient and there is no clear follow up of the outcome of the referrals. I cannot see any reference to the patient's pain issues in the treatment plan of 9/11/15.

I thus have concern that after the referral to [the pain clinic] there was a loss of follow up of the pain issue which given the situation, and the patient's concerns, seems below the accepted standard of care to at least a mild degree.

Regarding other service coordination issues I would say there was a reasonably holistic approach […]

[…]

3. 'The adequacy and appropriateness of the documentation of the discussions held with [Ms A] including but not limited to the reduction of her use of DHC.'

This is difficult to judge given the extended period from October 2013 when [Dr D] first broached with the GP to cease DHC. In the remaining months of 2013 most concern at [the methadone treatment service] was about benzodiazepines in the urine. On 5/12/13 a Clinical Medical Review notes the DHC prescribing but no other comment was referenced. The [methadone treatment service] consultation 31/1/14 with [RN E] does very adequately address the DHC issue with [Ms A] including various treatment options. However, in February 2014 it was again noted that she was continued to be prescribed 'Codeine' (DHC), and the patient may have felt the DHC was acceptable to the clinic at that time. DHC was again addressed on 13/3/14 by [RN E] and various options discussed adequately.

On 28/3/14 the case notes record [Ms A's] views so they appear to have been heard by [the methadone treatment service], at least by [RN E], and the Pain Clinic referral was also discussed. However, following this discussion the DHC issue appeared to go into abeyance and was not mentioned in the case notes until 9/9/14 when clearly [Ms A's] views and the clinic were not in alignment (telephone call). [Ms A] did not arrive for 2 appointments in October 2014 and her partner was reported to have suicided.

Possibly because of this, the DHC was not addressed again in 11/14 and 2/15 consultations. DHC cessation was again raised in 12/3/15 with [Ms F] (Case Manager) and the patient's distress was well documented including her comment that the DHC prescribing had now been going on for 3 years with the [methadone treatment service's] knowledge.

There was further difficult discussion documented in 8/4/15, including the [methadone treatment service's] plan to increase methadone to compensate for the DHC cessation. Detoxification alternatives were also offered but were probably unrealistic to the patient as DHC would not have been prescribed after detoxification at the … Unit. This is a point when the Pain Clinic opinion would have been most helpful.

In summary one could take the view that [Ms A] had quite a number of advisory warnings that the DHC prescribing was to cease, was against [the methadone treatment service] policy and was possibly illegal given the restriction notice (of which the patient should have been aware). I feel that there were acceptable discussions about this and various treatment options at least discussed by [RN E]. The difficulties were compounded by inconsistent follow up on the resolution of the clinic for DHC to either be stopped or reduced. There were periods when certain clinicians did not address the DHC issues already documented in the case notes, and such procrastination, or ambivalence, would have been noted by [Ms A] who was resolved in her desire to stay on DHC.

Overall I think some of the discussions were of good standard around the [methadone treatment service] and patient options during this period. However, because of inconsistencies on following through the DHC prescribing issue I believe the standard of care for more rapid action and a consistent clinician approach was below what would normally be expected to a mild to moderate degree.

I note in CDHB['s] letter … to … HDC commentary that communications were suboptimal about reducing DHC, but I think it would have been unlikely that [Ms A] would have complied with such requests and more definitive action would have been needed.

Otherwise the case notes record discussions around a variety of other issues e.g. urine drug screening results, driving, […] blood levels which appear adequate.

4. The adequacy of policy and procedures now in place at [the methadone treatment service] as a result of the 2013 external review of the [methadone treatment service]

This is difficult as I have mostly seen the review and recommendations as opposed to policies and procedures that have been forthcoming from the external review. I have seen [the DHB's] letter reporting progress.

However comments arising from this case include:

a. A continuing emphasis on urinary drug screening results 'treatment by urinary drug screen' (Review page 5) which at times seemed to distract from the overall treatment plan for this patient which should have importantly included GP communication, pain management issues, and DHC prescribing.

b. Medical Consultations at [the methadone treatment service] Review Services Practice Recommendations, p.10).

It appears from this case that this recommendation is yet to be achieved. I found no evidence of dictated letters to GPs after each Medical Review. The medical role seems unclear as nurses and case managers seem to mostly undertake referrals e.g. Pain Clinic, or calls to GPs. I was concerned to find no documented evidence of physical examination of this patient e.g. pulse, blood pressure when the high blood levels of methadone were found, no comment on […] (except in the Case Review), and no evidence of examination for needle marks if for example this patient was injecting takeaway methadone or other drugs. Clinic Medical Officers did work with the methadone toxicity issues however.

I note [the DHB's] letter to the Director of Mental Health 7/12/15 stating that this medical communication role is being achieved (with other patients).

c. Harm minimisation/flexibility/Suboxone

In the absence of responses from the Pain Clinic and with the issue of a 120mg methadone dose causes potential toxicity and the subsequent reduction to a current dose of 62mg (due to [Ms A's] failure to repeat serum levels) which the patient says is less effective for her pain; then team meeting MDT could have considered alternative approaches for this patient, for example, [the methadone treatment service] could have considered a switch/trial of Suboxone (buprenorphine/naloxone). (This option was mentioned in the treatment plan 31/1/14 by [RN E].)

d. Pain Clinic Liaison

I see this was an improvement arising from the [methadone treatment service] External Review. I would be interested whether this patient's referral from [the methadone treatment service] to [the pain clinic] was discussed and to what effect given the important issues that have arisen with this case.

5. Any other matters in this case that warrant comment

I am unsure of the interconnectivity of computerised Medical Records between [the DHB], and General Practice systems. In some DHBs this has been well achieved and allows hospital clinicians to view GP prescribing, allergies, diagnoses and laboratory results. Similarly in some DHBs, GPs can view hospital medical records.

This is of significant assistance especially in [the] area of medicines reconciliation across both domains. It would be excellent if there could be agreement to post alerts on [the] system such as 'patient on opioid substitution' or 'Ministry of Health prescribing restriction order'.

Such measures may assist and prevent GPs from prescribing controlled drugs to patients who nominate/request them.

Also, I believe the system of restriction notices via the Ministry of Health need review as I believe it has not changed significantly in 40 years. The list of restricted persons is paper-based and seems less frequently distributed and is possibly less well resourced.

Restriction notices are helpful in managing drug seekers but the system is only as good as its visibility and awareness to prescribers.

Recommendations

General:

1. The status of MoH prescribing restriction notices should be recognised and acted on with alacrity by agencies/clinics/GPs concerned.

2. As electronic record systems develop interconnectivity then alerts around restriction orders/opioid substitution should be considered.

[The methadone treatment service] (based on this case review)

1. See 1. Above

2. Ensure all clinicians attending a patient are aware of priority issues (e.g. pain management, GP opioid prescribing, in this case); and that these are followed through in a timely manner.

3. Medical clinical communications to GPs are enhanced in line with the 2013 [methadone treatment service] External Review.

4. The roles of various clinical staff may need to be better defined e.g. nurses, counsellors, case-managers, doctors and specialists.

G. M. Robinson FRACP, FAChAM"