General Practitioners, Dr B / Dr C / Dr D

A Report by the

Health and Disability Commissioner

(Case 00HDC11568)

Complaint

The Commissioner received a complaint from Mr A about the standard of care he received from Drs B, C and D at a Medical Centre.

The complaint against Dr B was that:

- *Dr B did not tell Mr A about the different types of anti-depressants and their associated side effects.*
- *Dr B did not tell Mr A that he could become addicted to Ativan within a four week period.*
- *Dr B did not tell Mr A that Aropax can increase anxiety levels in the first two weeks of taking it.*
- *Dr B prescribed Aropax and Ativan but did not arrange follow-up appointments or suggest/recommend referral to a counsellor, psychiatrist or psychologist for further assessment of Mr A's anxiety and depressive symptoms.*
- *Dr B was contacted by Psychiatric Services on 11 November 1999. Despite this Dr B made no arrangement to contact Mr A or to arrange an appointment for him.*
- *Mr A would like Dr B to refund the consultation fees and prescription charges.*

The complaint against Dr C was that:

- *Dr C prescribed a further two week supply of Ativan without assessing in detail the potential risk of addiction.*
- *Dr C made no attempt to refer Mr A for specialised help.*
- *Dr C made no arrangement for a follow-up appointment to check progress.*
- *On 11 November 1999 Dr C prescribed a further supply of Ativan despite a recommendation from Psychiatric Services that Mr A receive no further sedatives.*
- *Mr A would like Dr C to refund the consultation fees and prescription charges.*

The complaint against Dr D was that:

- *Dr D did not read Mr A's notes in detail and did not take Mr A's benzodiazepine addiction seriously.*
- *Mr A would like Dr D to refund his consultation fees.*

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Investigation process

The complaint was received on 6 November 2000 and an investigation was commenced on 30 January 2001. Information was obtained from:

Mr A	Consumer
Dr B	Provider / General Practitioner
Dr C	Provider / General Practitioner
Dr D	Provider / General Practitioner

Relevant clinical records were obtained and viewed. Expert advice was obtained from Dr Chris Kalderimis, an independent general practitioner.

Information gathered during investigation

Drs B, C and D are independent general practitioners working at the Medical Centre. Dr B advised:

> "[The] Medical Centre is an address out of which five independent practitioners work. The associate agreement has been in place for some years now, prior to me joining the centre in late 1996 as an associate. We encourage patients to see their own practitioner, thus helping with continuity of care. However, we will 'cover' for each other in emergencies and when someone is unavailable especially on a Saturday morning when we are rostered on a one in five basis to allow urgent service to be available with a familiar practitioner. At other unstaffed times [two other medical centres] cover care."

Mr A had been experiencing anxiety and depression due to long work hours and high levels of stress. On 5 October 1999 he consulted Dr B at the Medical Centre.

Dr B advised:

> "The initial consultation lasted close to one hour with my hearing from [Mr A] about the trigger for his episode of depression. I discussed with him lifestyle factors that were contributing to his depression along with positive ways to make changes. I was concerned on his behalf to note that he was very low. This was exhibited in a number of ways including loss of appetite and an inability to sleep. When patients get this low they can get caught in a vicious cycle. They are depressed so they don't sleep or eat. The lack of sleep and lack of appetite compounds depression leading to isolation from friends and other social contacts. The depression thus can worsen leading to more sleep loss and so on and the downward spiral sinks even deeper.
>
> As a result of this long consultation it was my opinion that this ordinarily well functioning individual, who I had known since the early 1990s when he attended me

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as a locum GP, needed help to get out of this cycle of depression that had become entrenched.

It was my opinion that the most important issues to address in this long consultation were to reach a correct diagnosis and counselling Mr A as to that diagnosis in a way to give him hope for future improvement.

To get [Mr A] over the present hump I chose to offer him one of the newer antidepressants with one of the lowest side effect profiles, ie a selective serotonin reuptake inhibitor as well as one that, considering his age and sex, is the safest when it comes to avoid self harm, ie overdose.

I prescribed him Aropax [an antidepressant] starting at only half a tablet daily. It is my routine to start with half a tablet, which is less than the therapeutic dose. This is done as a trial precisely to look for the rare cases of the onset of side effects. I am a prescriber for the Regional Alcohol and Drug Services and am a frequent attendee at their medical education updates. I am a low prescriber of benzodiazepines. I take care to avoid prescribing in a way that triggers their potential for addiction.

[Mr A's] state of depression was such that I focussed on being positive and encouraging during the consultation which in my view was therapeutically justified. This was balanced by telling him about the medication I recommended, why I recommended it and the risks associated with its use. When explaining the risks I did so in a way to avoid adding to his overwhelming depression but nonetheless emphasised those common problems he should be aware of. I told him to tell us if he had any side effects such as tremor, drowsiness, dizziness or gastrointestinal upset especially during the first four days. I asked him to return in one month by which time the Aropax should be having its effect, or sooner if he had any concerns. He was concurrently prescribed Imovane [a sedative] for his extreme sleep disturbance. …"

Dr B's clinical note recorded:

"Depressive episode follows stress through long hours/house building/no leave/no recreation. Poor sleep. Loss of appetite. Tired. Gym 1/52 [one week] only. See 1/12 [one month]. ? [query] increase dose.
Rx [treatment]: Aropax 20mg tab, Imovane 7.5mg tab."

Mr A consulted Dr B on 15 October 1999. His depression had subsided but his anxiety was still "at a high level". Mr A stated:

"I was not taking Aropax as after conducting my own research I discovered that it can increase the anxiety level in the first two weeks of taking it. This information was at no stage conveyed to me by [Dr B].

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> I advised that for the past two weeks I had been self medicating with alcohol. Despite this, [Dr B] failed to provide me with adequate warning of the risk of combining alcohol with benzodiazepines [tranquillisers].
>
> [Dr B] prescribed Ativan (Lorazepam) [a benzodiazepine] (1mg) Qty: 30 (two week dosage).
>
> He advised that this was an addictive drug, however I would not become addicted to it within a two week period. He made no arrangement for a follow up appointment to check progress.
>
> I had no knowledge of benzodiazepines and their highly addictive nature."

Dr B advised that, when he saw Mr A on 15 October 1999:

> "[I] felt he [Mr A] was extremely agitated. He told me he had not been taking the SSRI (Aropax). I therefore concluded that the Aropax was not the cause for the anxiety. I was aware of the potential for short term anxiety with Aropax and as mentioned had prescribed Imovane at our previous appointment.
>
> [Mr A] did not want to take Aropax despite my strong recommendation that he do so. Aropax was my preferred treatment for him given its low side effect profile and its documented as well as self observed success rate in other patients with anxiety and depression. [Mr A] wanted a sedative. His degree of anxiety, continued lack of sleep and obvious need for something to help him at this time resulted in me agreeing to prescribe a benzodiazepine at this time. It is my policy not to give more than two supply weeks knowing of the potential for dependence in some personalities if taken for a longer period. Having only prescribed for two weeks I did not expect a problem with addiction to arise and therefore did not warn [Mr A] of this possibility. Similarly I did not tell [Mr A] of the possibility of anxiety being caused by Aropax having discussed with him the most likely side effects at the earlier meeting, having addressed this potential by the prescription of Imovane and this not being relevant given that he had not taken the prescribed Aropax. At the time I prescribed Ativan, I did so stressing to him that I wanted him to take the Aropax, and that I was prescribing the Ativan to get over the anxiety and sleep disturbance that he was suffering and the prescription was for a short period of time only."

Dr B's clinical note recorded:

> "Didn't take Aropax, feels improved. Imovane helped sleep. Wants Sedative.
> Rx [treatment]: Ativan 1mg tab."

Mr A next attended the Medical Centre on 30 October 1999. He saw Dr C, general practitioner. Mr A told Dr C that Ativan had helped to reduce his anxiety levels. Dr C prescribed a further two week supply.

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Dr C advised:

> "… [Mr A] visited me on 30 October in [Dr B's] absence. His main concern that day was of a poor sleep pattern. His medication was discussed. In particular he described the relief that he had obtained by use of Ativan. My conclusion was since that he had been helped by the Ativan and as he had confirmed to me that he was to be seen in two weeks' time by Dr B for review, I would continue his medication of Ativan.
>
> With the benefit of hindsight I keenly wish that I had explored with him the possibility of specialist service referral on that occasion. This occurred to me at the time but I deferred to [Dr B], his main care provider, thus allowing him to continue his treatment to hold him until he could be seen by the doctor most familiar with his care. My notes made reference to the use of Ativan as a short term anti-anxiety medication. Before prescribing this medication I checked specifically with him about his past history and present history. There was nothing in his history to suggest that he had addictive problems. My notes clearly state 'To see later (ie follow up with [Dr B] in two weeks) re the response to Aropax'."

Dr C's clinical note recorded:

> "Still poor sleep. Advised to continue short term with Ativan tab. See later re response to the Aropax.
> Rx: Ativan 1mg tab."

Mr A took his last dose of Ativan at 9.00am on 9 November 1999. By 5.00pm the next day he had developed "a high level of panic/anxiety/stiff joints". Mr A was not aware that he was experiencing benzodiazepine withdrawal: "I had been advised by both [Dr B] and [Dr C] that the addiction period was substantially longer than a month."

By 11.00pm on 10 November 1999 Mr A's withdrawal symptoms had worsened: "I was experiencing an extreme level of fear/panic/desperation, my jaw was locking up, my neck/shoulder muscles were stiff." He did not know he was experiencing withdrawal symptoms and took 12-15 Panadol tablets in an attempt to reduce his joint and muscle stiffness.

Mr A attended a public hospital's Emergency Department at 5.00am on 11 November 1999. He explained that he had taken 12-15 Panadol tablets but did not know what had caused the symptoms. Mr A was advised that there was no risk of a paracetamol overdose. A meeting was arranged with the hospital's Psychiatric Services later that morning.

Mr A was seen by Psychiatric Services at 9.20am on 11 November 1999. The impression was of an impulsive non-lethal overdose, with no intent to die. Mr A was discharged home.

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Psychiatric Services contacted Dr B. Clinical notes at 10.15am recorded:

> "Phone call to [Dr B] – [the] Medical Centre. [Mr A] first seen 5.10.99, prescribed Aropax and 7x Imovane for ↓ sleep/appetite. Seen 10/7 [10 days] later. [Mr A] had not started the Aropax, taken Imovane – wanted more. Still complaining of long working hours, ↓ sleep, no relaxation.
> [Mr A] now sitting in waiting room waiting to see another doctor in practice even though [Dr B] has free appointment at the moment.
> [Dr B] suspects [Mr A] still angling for sedatives rather than following other options of anti-dep/counselling.
> He will ensure [Mr A] gets appropriate treatment and refer on to [the Community Mental Health Centre] or counselling PRN [as required]."

Dr B advised:

> "The next contact I had was when the Psychiatric Services rang me at approximately 9.30am on 11 November 1999 regarding a paracetamol overdose on the preceding night as per the enclosed clinical notes. I understood [Mr A] was with them and via the registrar calling booked an appointment for him with me at 10.30 that morning as per the enclosed appointment schedule for that day.
>
> Prior to this unfortunate episode [Mr A] had received 15 more days of Ativan by the Saturday doctor on duty. This was unbeknown to me until the conversation with the Psychiatric Services. …"

Dr B's clinical note recorded:

> "OD'd panadol 15 in night s/b [seen by] psych services advise see GP this am. ADVISED BY PSYCH SERVICES NO SEDATIVES AS REQUESTED, told them not genuine suicide attempt. They felt referral to [the Community Mental Health Centre] most appropriate."

Mr A attended the Medical Centre on 11 November 1999 for an appointment with Dr B at 10.30am. He saw Dr C. Mr A advised:

> "I was now fully aware that I had a severe addiction to Ativan and was absolutely desperate to obtain a further dose to ease the withdrawals – this was my only objective in the short term, I was not concerned with the long term objective of detoxification. …"

Dr C advised:

> "… This consultation was both comprehensive and prolonged. An appointment was made for [Mr A] to see [Dr B] that morning but for some reason he was seen by me. My written clinical notes confirm:
>
> 1. I made him fully aware of the statement and recommendations that had been made by the psychiatric services.

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2. He denies he required any assistance and had no further thoughts of suicide.
3. He was thinking of returning to work the following week.
4. A comprehensive discussion re the signs of depression which were clearly apparent from his history and presentation. He was specifically advised to make contact with the [Community Mental Health Centre], who at that time were able to provide immediate contact with any referred patient. He was given a letter of referral and their telephone number. As my notes state 'he will contact them'.
5. My notes go on to advise him re the use of sedatives and again my notes show that he 'fully understood'. This means that not only did I give him the information but I was careful to check that he had heard and understood what I had said.
6. He was then advised to seek medical attention in two days' time to see his response to his problem.
7. I went on to advise him further that he had access to the Crisis Team based at [the public hospital] at any time, ensuring he knew how to access them as had occurred the previous night.
8. My final note states that he continued to deny that he required any assistance.

I conclude that in the circumstances of this consultation I discharged my duty providing medical care to him under the circumstances at that time. As a result of the consultation he was prescribed six Imovane tablets and six Ativan to continue with rather than to suddenly stop until he had made contact with specialist care as advised."

Dr C's clinical note dated 11 November 1999 recorded:

"Advised re the call from [the Community Mental Health Centre]. Denies any problems now re suicide but still tense and anxiety. Going to return to work next week. Discussed signs of depression. Denies all of them. Advised must still make contact with mental health given letter and telephone. Says he will contact them. Advised re use of sedatives. Fully understands advised to see response to situation in 2 days. Advised re crisis team based at [the public hospital] and need to call sos. Continues to deny needs any assistance.
Rx: Imovane 7.5mg tab, Ativan 0.5mg tab."

Dr B advised:

"On 11 November while I was with the preceding patient [Mr A] then chose to see [Dr C] and had departed by the time I was due to see him. I viewed the notes and saw all aspects of care had been covered by [Dr C] on that day and I was not privy to this. Thus, follow up through [the Community Mental Health Centre] had all been arranged. Somehow despite my note in capital letters [Mr A] managed to be prescribed a short course of benzodiazepines until his appointment with [the Community Mental Health Centre] was available five days later. A clinical decision to give these medications was made by [Dr C] looking at all aspects on that day."

Mr A took all the Ativan tablets prescribed by Dr C on 11 November 1999. By the next day, 12 November 1999, he was "experiencing severe withdrawal symptoms again".

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Mr A consulted Dr B on 12 November 1999. Mr A said Dr B was concerned as "he was aware that I had developed a benzodiazepine addiction".

Dr B advised:

> "I found [Mr A] pacing and anxious in the waiting room. [Mr A] told me he had taken all six Ativan from the preceding consultation. I rang [the Community Mental Health Centre] immediately concerned at his state. They advised me to give five more days to help until they could see him. I was anxious to help and explained to [Mr A] that continuity of prescribing was paramount in his present condition."

Dr B's clinical notes dated 12 November 1999 recorded:

> "Pacing anxious ++. No sleep. No appetite. Social isolation. Rung [the Mental Health Centre] appointment 3/7 [three days] or sooner prn [as required] for benzo's over weekend .5mg not doing enough, [the Community Mental Health Centre] unaware of overdose.
> Rx: Ativan 1mg tab."

The Community Mental Health Centre clinical notes dated 12 November 1999 recorded:

> "Phone call from GP – [Dr B]. Concerned re [Mr A]. Anxiously pacing, can't stay still, ↓ sleep – 2 hours/night, ↓ appetite, social isolation. Mixed anxiety, depressive symptoms. OD Wednesday night – 15 panadol – seen at [the public hospital].
> Received referral from GP.
> Plan: CTT [Community Treatment Team] to h/v [home visit] and assess.
> Crisis appointment 16/11/99 1400."

A second entry in the Community Mental Health Centre's clinical notes dated 12 November 1999 recorded:

> "Phone call to [Mr A] at 2130 [9.30pm]. Took meds an hour ago, now feeling drowsy. About to go to bed – would prefer visit in the morning. Happy to attend doctor's appointment on Tuesday and to be engaged in our service. Nil safety concerns – states he will call after hours number if feeling unsafe. Has partner home with him tonight.
> Plan: Home visit morning. Phone call first."

Despite repeated attempts by staff at the Community Mental Health Centre to contact Mr A over successive days, he was not available, and was not seen until 16 November 1999.

Mr A next attended the Medical Centre on Saturday, 13 November 1999. He saw Dr D. Mr A advised:

> "I was now again experiencing severe withdrawal symptoms. I was in an extremely desperate and panic stricken state.

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[Dr D] prescribed Melleril and advised that I should cease taking Aropax which I had started taking two weeks earlier in desperation as it can worsen the anxiety level.

He also prescribed another anti-depressant. He did not prescribe Ativan as he advised that it would worsen the addiction.

An appointment had still not been made by [Dr B] with [the Community Mental Health Centre]."

Dr D advised:

"… When [Mr A] came to me at that Saturday urgent surgery when I was covering for the medical centre he was very anxious and agitated and requested more Ativan. I fully perused the previous relevant records and was concerned that he had been on Ativan for some weeks and discussed in depth why he was reporting to me for more Ativan when he had had a script for Ativan on 12 November 1999. He said they had all been used. I can remember discussing at length with [Mr A] the dangers of benzodiazepines and their addictive nature; that I was concerned at his request for a further supply. We discussed my alternatives for his anxiety – ie Melleril 10mg 2 to 3 four times a day or Serenace 0.5mg – both antipsychotics but anxyiolitics in small dose and non addictive. I asked him to try Melleril and prescribed some 10mg tablets to be used as above. The anxiety was marked and having seen people on Aropax develop quite severe anxiety suggested a change may be appropriate and suggested that Aropax be stopped and after two days to try Allegron 25mg 2 at night which I prescribed.

After this in depth discussion [Mr A] was most unhappy and wanted more Ativan and as it was Saturday and he was due to be seen at [the Community Mental Health Centre] next week and knowing that with benzopdiazepine reliance one cannot stop the supply suddenly I also gave him 10 1mg Ativan only to be used if really necessary; to use the Melleril regularly and to be reviewed by [Dr B] on Monday or [the Community Mental Health Centre] on Tuesday 16.11.99.

My involvement in this complaint was limited to the extent that I was covering my associates for the weekend. I did peruse the medical records; I was concerned and I did discuss the problem in depth. I was well aware of [Mr A's] growing reliance on Ativan and only complied to breach a two day gap in an acute situation until [Mr A] could revisit [Dr B] on the Monday and being aware that sudden complete withdrawal of Ativan could have been dangerous considering the previous suicidal thoughts expressed."

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Dr D's clinical notes dated 13 November 1999 recorded:

> "Anxiety; pulse 100; on Ativan; sees [the Community Mental Health Centre] Tuesday; being seen today. Stop Aropax – nil 2 days; may = anxiety; add Allegron; try and cope with anxiety with Melleril; 10 Ativan only sos.
> Rx: Ativan 1mg tab, Melleril 10mg tab, Allegron 25mg tab."

Mr A was seen at the Community Mental Health Centre on 16 November 1999. Clinical notes recorded that he was pleasant and co-operative and that he had symptoms of anxiety and depression. He was started on Melleril and Aropax.

Mr A attended the Medical Centre on 17 November 1999. He saw Dr B. Dr B's clinical notes recorded:

> "Seen by [the Community Mental Health Centre] yesterday, on Aropax 20 daily not started yet. Melleril 80 daily plan = review daily through phone call team, wants Ativan. Advised take meds as prescribed thru psych, must stick with one prescriber ie [the Community Mental Health Centre], seeing them next week. Advise liaise re increasing Melleril dose."

The Community Mental Health Centre notes on 17 November 1999 recorded:

> "Received phone call from [Dr B]. He is aware that [Mr A] has been 'shopping around' to various doctors for Ativan. He has an appointment with another of the doctors in Dr B's practice this afternoon. Dr B was given information (as requested) re [Mr A's] medication regime.
> Plan: pm phone call."

Mr A was contacted by the Community Mental Health Centre later that day. They discussed the issue of obtaining and using benzodiazepines, and concerns about the dangers of on-going benzodiazepine use. Mr A was recorded to be "somewhat surprised re our knowledge of his visits to doctors to get these". The role and effectiveness of Melleril was discussed. An appointment was arranged for 2.30pm on 24 November 1999.

Mrs F, Mr A's mother, contacted the Community Mental Health Centre on 18 November 1999. She advised that Mr A had consumed a bottle of wine and taken "more Melleril than prescribed". Mrs F was invited to attend the appointment on 24 November 1999. Clinical notes also recorded:

> "Phoned [Mr A], he said that he was 'fine', sounded intoxicated. Admitted he had been drinking. Plan: discuss with … – consider pm home visit to remove meds, either provide medication for daily dispense or pm home visits with meds in interim. [Mrs F] would like to be kept informed.
> [Mrs F] is particularly anxious because her own mother died from an OD of alcohol and prescription drugs. She will phone CADs [Community Alcohol and Drug Service] for advice on getting [Mr A] committed under the Drug and Alcohol Act – he is driving while intoxicated."

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Mr A contacted the Community Mental Health Centre on 19 November 1999. Clinical notes recorded:

> "Call from [Mr A] – requesting doctor's appointment today as has run out of Ativan.
> Informed doctor's appointment not available for same.
> Revisited long term concerns of benzodiazepine use.
> Encouraged to continue with charted meds. Suggested pm home visit tonight. [Mr A] may be out – phone call first."

Mr A attended the Medical Centre on 19 November 1999. He saw Dr B. Mr A advised:

> "The withdrawal symptoms had reached an unmanageable level and I was desperate for a further dose of Ativan. Consultation with [Dr B]. He was now very concerned about benzo addiction. He contacted [the Community Mental Health Centre] whom advised that I should be prescribed Diazepam [a tranquilliser] on the basis of withdrawing off Ativan and [the Community Mental Health Centre] Crisis team will visit daily to administer meds and take over the Detox Program."

Dr B advised:

> "[Mrs F] contacted me on 19 November regarding her worry over substance abuse, ie alcohol and driving. The situation was once again discussed with Mental Health Services who could not see him for another five days. We queried benzodiazepine withdrawal and stressed continuity of prescriber. The consultation ended angrily when I informed [Mr A] that to comply with this a prescribing restriction order would be applied for stopping potential abuse. …"

Dr B's clinical notes dated 19 November 1999 recorded:

> "Rang mental health services says they can't see for 5.7 [five days] say GP should prescribe benzo on basis going through ? [query] withdrawal. I advised if benzo should be diazepam in view easier to withdraw from due to longer half life. Phone call from mum re worry re etoh [alcohol] intake, driving. Discussed with [the Community Mental Health Centre]. They will visit daily through crisis team and remove all meds so they administer daily.
> Rx: Diazepam 5mg tab."

The Community Mental Health Centre clinical notes dated 19 November 1999 recorded:

> "Phone call from GP as received phone call from mother who's concerned about [Mr A] driving company vehicle around whilst under the influence of alcohol and benzos. Was seen by him and partner three times this week complaining of feeling very anxious and requesting Ativan. Saw [Mr A] today and gave him Diazepam 5mg (7 tabs). Wants CATT [Community Assessment and Treatment Team] to be aware of [Mr A] having Diazepam as may not disclose this.
> Plan: Home visit this pm and remove meds. Advised GP to circularise benzos."

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A second entry in the Community Mental Health Centre notes dated 19 November 1999 recorded:

> "Phoned [Mr A] 1800 hrs [6.00pm], prior to home visit to uplift meds. Not at home. 1900 [7.00pm] not at home. 2015 [8.15pm] Received page from [Dr G], GP at [a suburb]. [Mr A] was in his surgery seeking Ativan – said he had a habit and was suffering withdrawal symptoms. Seemed agitated. Informed [Dr G] of [Mr A's] drug seeking behaviour. He will refuse his request and tell [Mr A] to contact us upon his return home. [Mr A] smelled of alcohol. Received phone call from [Mrs F] saying that [Mr A] had just contacted her asking for sleeping pills. [Mr A] was said to be home. CATT set out to home visit, en route received phone call from [Dr H] (forensic psychiatrist) personal friend of [Mrs F], demanding that we have [Mr A] committed under Drug and Alcohol Act. Did not seem interested that drug addiction/abuse was not our raison d'etre. Home visited [Mr A] – he was not there. Phoned [Mrs F] with suggestion she seek medical detox for [Mr A] if he resurfaced in a 'desperate state' during the night.
> Plan: am phone call ? follow up."

Mrs F contacted the Community Mental Health Centre later on 19 November 1999 to advise that Mr A had returned home. She planned to take him to the emergency department and to request a medical detoxification. The Community Mental Health Centre staff contacted the emergency department to inform them of Mr A's recent history. The plan was to phone Mrs F in the morning and to await information from the emergency department.

Mr A attended the emergency department at the public hospital with his parents at 1.30am on 20 November 1999. His case was discussed with a member of the Psychiatric Liaison team, who reviewed him. The public hospital's psychiatric unit was informed and notes were faxed so that arrangements could be made for the crisis team to review him in the morning. Mr A was discharged home to his parents. He was given an immediate dose of chlorpromazine (an antipsychotic).

Mr A advised that, by 20 November 1999, he had taken the diazepam prescribed by Dr B the previous day and was again experiencing severe withdrawal symptoms. The Community Mental Health Centre Crisis Team visited him late that evening and prescribed Ativan to "see [him] through" until the diazepam detox programme commenced. Clinical notes recorded:

> "Seen at home with Crisis Team. Six week history of depressive symptoms plus <u>severe</u> anxiety/panic attacks.
>
> Presented to [the Community Mental Health Centre] last week. Paroxetine [Aropax] restarted. Lorazepam [Ativan] tapered/stopped. Thioridazine [Melleril] started with little benefit re anxiety.
> Has <u>severe</u> anxiety (partly rebound) since Lorazepam stopped. No suicidal ideation, but distressed ++ by anxiety.
> Plan: Agree to re-commencing the Lorazepam to treat anxiety.
> Reduce ? stop Melleril

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Continue Paroxetine
Contact crisis team PRN if unsafe.
Review medically this week.
Advised to stop etoh [alcohol] (self-medicating) and not to drive."

Mrs F contacted the Community Mental Health Centre on 22 November 1999. She was confused by "mixed messages" regarding Ativan and the general diagnosis. A home visit was arranged, which took place at 7.00pm that evening. Clinical notes recorded:

"PM home visit at 1900 hours [7.00pm].
[Mr A] just leaving to go out – agreed to five minutes with CATT.
Appearing unsteady on feet, smelling of alcohol, speech slurred.
Given clear message re our intent to remove Ativan. Had script filled Saturday night for 27 tabs 1mg. Up to 4x daily. 13 tablets had been taken.
[Mr A] saying repeatedly that we were in conflict with [Dr I] (who had prescribed meds) and that we were just looking for work.
Concerns reiterated re Ativan in combination with alcohol – CADS rediscussed. [Mr A] dismissive of same. Had no recollection re previous discussions with CATT.
Plan: PM home visit Tuesday – administer meds through to appointment Wednesday.
Any charting of meds requires daily pick up.
Indications for CADS involvement continue to increase."

The Community Mental Health Centre clinical notes dated 23 November 1999 recorded:

"PM home visit – met with [Mr A] and girlfriend [Ms J].
[Mr A] not intoxicated tonight, speech not slurred.
Feeling very positive re events of today. Had taken Ativan tab 1mg x 1 only. Much more realistic re issues of dependence.
Has been taking Ativan for 5 weeks, using it in much higher doses than prescribed. Recognised it was becoming a problem and stopped altogether. Was fine for 2/7 then began experiencing ↑ anxiety, physical symptoms, sweaty palms, ↑ heart rate and panic feelings → panic attack. Resumed Ativan, using same in combination with alcohol.
[Ms J] describes [Mr A] as having an addictive personality and both recognise need for anxiety management strategies and clear limits/availability of prescribed meds.
Little change in mood state since starting Aropax (possibly complicated by benzo and ETOH use).
Plan: Doctor's review Wednesday, appears short withdrawal regime may be indicated and/or ? ↑ Melleril to manage anxiety.
Suggest sessions re anxiety management. ? referral CADS. Liaison with GP also required. Review anti-depressants."

Mr A subsequently underwent a detoxification with the Community Mental Health Centre. He was discharged on 1 February 2000.

Mr A and his mother met with Drs B, C and D on 26 October 2000 to discuss their management of him. The doctors agreed to refund the consultation costs and

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prescription charges. Mr A received a written statement subsequent to this meeting. He was not satisfied with its contents and, after "careful consideration", complained to the Commissioner instead.

Dr B advised:

> "I am happy to refund the money as requested as a gesture of good will. I strive hard to do the best for my patients and if they are not happy for whatever reason then I would not want them to be out of pocket as a result of unhappiness. In saying this I feel I would not have changed my management of [Mr A] even with the knowledge I have now. Specialist therapy has revolved round the same antidepressant/anxiolytic ie Aropax that I originally prescribed and [Mr A] chose not to take. I see how [Mr A] came by a supply of benzodiazepines to create this unfortunate dependence and I very much regret this. I, however, was not in control of the prescribing of a second course by a colleague and have done my best through appropriate agencies in advising an appropriate detoxification programme. Just as [Mr A] chose to see [Dr C] instead of me he has now chosen to sever contact with me. The severance arose as I would not give him the medication requested by him following the request that I substitute diazepam for Ativan by [the Community Mental Health Centre]."

Dr C advised:

> "I am most distressed by the outcome of this management as are my colleagues. As you are aware a meeting with [Mr A] took place to discuss these issues which were fully canvassed. As a result of this meeting we felt we had resolved his concerns and questions. We further moved to ensure that this problem of several doctors being involved in one patient's care did not occur again. This means that the continuity of care with a difficult and sensitive medical problem will always be managed by that patient's own doctor within our practice. If they choose to see someone else then this will alert us to be particularly vigilant and seek an explanation as to why it is that a change is sought.
>
> This, I believe, has been a valuable lesson learnt by all of us. The sharing of [Mr A's] health on this particular occasion allowed him to slip through the cracks. I am truly sorry for the distress it has caused him."

Dr D advised:

> "I am sorry that this episode has been so distressing and protracted for [Mr A]. I was well aware of his previous medical records and spent some time expressing my concern re his Ativan reliance and trying to find and prescribe more suitable alternatives. As mentioned previously I have no hesitation in offering to refund [Mr A] his fee for this Saturday consultation but it was carried out with care, concern and in depth discussion."

Independent advice to Commissioner

The following expert advice was obtained from Dr Chris Kalderimis, an independent general practitioner:

> "This is a complaint made by [Mr A] regarding the standard of care that he received from [Drs B, C and D].
>
> As you have detailed in the background advice to me [Mr A], who had been a patient of [Dr B's] at [the Medical Centre] for some years, presented to [Dr B] on 5 October 1999. It appeared that he had become anxious and depressed and a diagnosis was made by [Dr B] at that time of anxiety and depression. He was prescribed Aropax and Imovane. Aropax is a serotonin uptake inhibiting drug and is a safe and generally effective anti-depressant medication. Imovane is an anxiolytic drug but it is primarily used to help sleep. It has a short half life and, although it is not strictly like benzodiazepine, it does have addictive properties.
>
> On 15 October, some ten days later, [Mr A] saw [Dr B] again and informed him that he had not taken the Aropax, but because of the anxiety he was feeling he was prescribed Ativan. Ativan is an anxiolytic and has addictive properties.
>
> Some 15 days later [Mr A] returned to [the Medical Centre] and unfortunately was not seen by his own GP ([Dr B]) but was seen by [Dr C]. A further course of Ativan was prescribed by [Dr C] and subsequent to this, some 11 days later, [Mr A] was seen at [the public hospital's] Accident & Emergency Department because of an overdose of paracetamol tablets. The Psychiatric Services that saw him after referred from A&E suggested to [Dr B] that further medication should not be prescribed and instead [the Community Mental Health Centre] Team should see [Mr A].
>
> On that same day [Mr A] was seen once again by [Dr C] who prescribed Ativan again. The next day [Mr A] was seen by [Dr B] who, after being advised by [the Community Mental Health Centre], prescribed further Ativan tablets. The next day [Mr A] was seen by [Dr D] who prescribed Ativan, Melleril and Allegron. [Mr A] was seen once again by [Dr B] on 17 and again on 19 November but no medication was prescribed on these occasions.
>
> In response to the specific questions that you have raised regarding this somewhat complex situation:
>
> 1. What are the specific standards that apply and were they followed?
>
> The specific standards that apply are that the correct diagnosis is needed to be made by the attending general practitioners and that appropriate therapy be instituted once a diagnosis is made. As well the patient needs to be informed of the potential side effects and pitfalls of the treatment.

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It appears to me that the standards were not entirely followed inasmuch as [Mr A] was not notified of the potential pitfalls of using Aropax and also the potential pitfalls of using a benzodiazepine type drug as a sedative.

2. Was [Dr B's] choice of Aropax, and its dosage, on 5 October 1999 reasonable in the circumstances?

Yes, I believe that [Dr B's] choice of Aropax was reasonable. Aropax has an indication to be used for depression that has a component of anxiety and ironically, even though it may exacerbate anxiety for the first two weeks or so of its use, it nevertheless can treat that condition very well indeed.

3. What should a person taking Aropax for the first time be told about it?

The person who takes Aropax for the first time needs to be informed that it is an anti-depressant, that it is not addictive and the patient needs to be informed that it takes some four to six weeks to have an effect. He or she needs to be informed that it needs to be taken on a regular daily basis and taking it sporadically is not at all effective. He or she also needs to be told that heightened anxiety is not at all unusual for the first two weeks or so of taking it.

4. What short term changes, if any, can occur in anxiety levels when first starting Aropax?

As mentioned above, anxiety is the short term change that may often occur when starting Aropax.

5. Was [Dr B's] decision not to tell [Mr A] that Aropax might increase anxiety, because he had addressed this potential by prescribing Imovane, reasonable in the circumstances?

No, I believe [Dr B] should have told [Mr A] that Aropax might well increase anxiety.

6. What is the addiction period for Ativan?

This is unclear. For some individuals it is obviously shorter than for others, but something like two to four weeks is not at all uncommon. It also depends on the dosage used.

7. What are the symptoms of addiction?

The symptoms are that an increased dose will often be needed to produce the level of anxiety suppression that had been previously achieved and that when the Ativan is no longer taken, extreme anxiety and agitation as well as insomnia can take place.

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8. What should a person taking Ativan for the first time be told about it?

The principal thing that he or she needs to be told about it is that this is an addictive drug. The patient needs to be clearly informed that if taken for a period of time, more than just a few days, there is a risk to it. He or she needs to be told that it is generally a safe drug and it would be hard to overdose on it or produce life-threatening consequences through taking a large dose of it.

9. Was [Dr B's] decision to prescribe Ativan on 15 October 1999 reasonable in the circumstances?

I think this was reasonable and I have seen a number of psychiatrists prescribe a benzodiazepine to suppress anxiety when first starting with a drug such as Aropax. However, if it is to be used, I believe the individual taking the medication needs to be warned of the potential pitfalls of Ativan.

10. Was [Dr B's] decision not to warn [Mr A] about the possibility of addiction to Ativan reasonable in the circumstances?

No, it was not reasonable and in retrospect I believe that [Dr B] himself would feel that he should have warned [Mr A] about the possibility of addiction.

11. Was [Dr B's] failure to discuss specialist service referral with [Mr A] on either 5 or 15 October 1999 reasonable in the circumstances?

Yes, I believe it was reasonable as the very great bulk of patients treated for anxiety and depression in a general practice setting will not require specialist referral. There is only a very small percentage that do not respond to medication that require such ongoing referral. A referral is often made after a drug such as Aropax has been used for in excess of six weeks with no significant success.

12. Was [Dr C's] decision to prescribe a second two week supply of Ativan on 30 October 1999 reasonable in the circumstances?

This is a hard question to answer. Not being present at that consultation, and not knowing how actually it proceeded, makes it difficult to provide an answer. Perhaps in retrospect, given the difficulties that [Mr A] went on to encounter with his addiction to Ativan, then perhaps a second two week supply of Ativan was not a wise decision, but once again, it is sometimes easier to make judgement in retrospect than it was at the time.

13. Was [Dr C's] decision not to discuss specialist service referral with [Mr A] on 30 October 1999 reasonable in the circumstances?

Again, I think this was reasonable because of the fact that [Mr A] had not been taking Aropax for the length of time it would take for it to work. Thus he had not been treated for a length of time that would necessitate a specialist consultation.

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14. Was [Dr C's] decision, on 30 October 1999, not to make a follow up appointment, but to allow [Mr A] to see [Dr B] in two weeks' time, reasonable in the circumstances?

Yes, I think following the lines of the answer in the previous question I believe that this was a reasonable course of action.

15. Was it reasonable for [Dr C] to have seen [Mr A] on 11 November 1999?

It was reasonable for [Dr C] to have seen him although in the usual circumstances it is much more appropriate for the actual GP that the person is registered with to see the patient in this sort of complex situation. This sort of situation, seeing a different doctor every time, is not a very successful modus operandi.

16. Was [Dr C's] advice to [Mr A] on 11 November 1999 reasonable in the circumstances?

I believe that the advice that [Mr A] make contact with a specialist mental health service at [the Community Mental Health Centre] was certainly very appropriate at that time because things were not going well, especially with the extensive use of benzopdiazepine. However, given that [Dr C] had written a letter of referral and given [Mr A] the appropriate contact number, the only significant point of contention about the consultation was that, despite [Dr B's] feeling that no further sedatives should be prescribed, a further short course of benzodiazepine was prescribed until an appointment with [the Community Mental Health Centre] was available five days later.

Again, it demonstrated the problem of a patient being seen by a number of doctors rather than just by one, so a degree of consistency is often not maintained.

17. Was [Dr C's] prescription of Ativan and Imovane on 11 November 1999 reasonable in the circumstances?

With the benefit of hindsight I do not think this was reasonable but I can see why this was done. By this time [Mr A] was clearly in a difficult situation and the prescribing of the medication was understandable if not especially wise.

18. Was [Dr B's] prescription of Ativan on 12 November 1999 reasonable in the circumstances?

Given that [Dr B] was advised by [the Community Mental Health Centre] team to prescribe five more days of Ativan on 12 November, then I feel that this is extremely reasonable. [Dr B] simply took the advice the specialist team gave him.

19. Was [Dr D's] prescription of Melleril, Allegron and Ativan on 13 November 1999 reasonable in the circumstances?

[Dr D] saw [Mr A] on 13 November in the Saturday morning clinic that was run by [the Medical Centre]. [Dr D] was in a very difficult situation by this stage. It was

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clear to [Dr D] that [Mr A] had developed a benzodiazepine addiction and it was also quite clear that he was going to be seen by the [Community Mental Health Centre] specialist medical centre in a few days' time. [Dr D] realised that he could not stop the benzodiazepine at short notice and thus he really had no great choice but to continue with the prescription until such time as the [Community Mental Health Centre] team could treat the addiction. Thus the prescription that [Dr D] dispensed of Melleril, Allegron and Ativan was probably reasonable in the circumstances.

20. Was [Dr B's] subsequent treatment of [Mr A] reasonable in the circumstances?

It would probably have been wise and prudent for [Dr B] to have kept in touch with [Mr A] subsequent to the [Community Mental Health Centre's] specialist team starting treatment for his addiction. However, it is probably somewhat understandable why this did not happen as oftentimes the general practitioner concerned may feel that there is undue pressure upon him/her to continue the prescribing of a benzodiazepine.

It is of interest that the [Community Mental Health Centre] team did in fact restart Aropax as initially prescribed and which [Mr A] chose not to take initially.

21. Are there any other matters you consider relevant in relation to the standard of care provided to [Mr A]?

I believe [Mr A] was, for the most part, treated appropriately and I think it is extremely unfortunate that he was seen by a number of general practitioners, and in particular by [Dr C], rather than by [Dr B]. This is a case where often judgement is made much more lucidly in retrospect but, at the time of the consultation, I believe there was thorough care taken. However, I do believe that [Mr A] should have been informed both of the increased anxiety that Aropax could have caused him and also of the high dangers of addiction to benzodiazepines if they are used for any significant period of time. Unfortunately [Mr A] developed a severe addiction in a very short order and he not unreasonably feels aggrieved about this.

I believe that [Mr A] was treated with the very best of intentions by all three practitioners concerned and, although an unfortunate situation ensued from the treatment, I do not believe that significant blame needs to be apportioned to the treating general practitioners."

Response to Provisional Opinion

Ms K, barrister, responded to my provisional opinion on behalf of Dr B as follows:

"I act for [Dr B] who is in receipt of your provisional opinion. On his behalf I submit the finding of a breach is not justified.

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[Mr A] belongs to a group of patients which, as you will be aware, are among the most litigious – if not the most litigious – of all categories of patients. This group is also one of the most fiscally unrewarding for practitioners to treat. It is submitted that to find [Dr B] (and the other doctors who are quite properly described as conscientious and attentive) in breach and therefore subject to the stigma of such a finding is, in all the circumstances, inappropriate.

1. It is respectfully submitted that the threshold for the finding of a breach is not met in [Dr B's] case.

2. It is further submitted that in addition there are policy reasons why a breach should not be found in this particular case.

3. Threshold

3.1 It is accepted and abundantly clear from the correspondence that [Dr B] acted with attention to detail, thoroughness, empathy and sympathy towards his patient. His only motivation was [Mr A's] best interests.

3.2 It is also clear that there is a significant amount of trust on [Dr B's] part (as is important in a therapeutic relationship) that the patient was being truthful and frank.

3.3 It is clear that [Dr B] was willing to continue to assist this patient, even when it became clear that the trust and frankness expected of the relationship was not being honoured, with this being particularly clear when [Mr A] chose not to keep his appointment with [Dr B].

3.4 In a lengthy and thorough consultation of close to an hour in length (for which [Dr B] only received the standard $39 fee, less than half the amount a junior solicitor receives on legal aid), he took a thorough history, examined the patient and discussed a recommended course of treatment.

3.5 There is no suggestion that [Dr B] was motivated by anything other than achieving what was in the patient's best interests. The issue is: was it reasonable for [Dr B] not to inform [Mr A] of the possibility of anxiety with Aropax and the possibility of addiction from Ativan?

3.6 Your expert – whose basis for claiming expertise in this area as well as in GP obstetric care is not disclosed – has provided one opinion that does not refer to a number of matters. Significantly there is no reference to the objective and subjective test that applies.

3.7 It is submitted that objectively it is doubtful whether the potential for increased anxiety on Aropax is something that [Mr A] should have been advised of. Information on the drug (copy enclosed) describes

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the drug as improving associated symptoms of anxiety. Other information (also enclosed) does not set out this risk as a common or frequent factor. Indeed it is notable that anxiety occurred in 5% of cases where Aropax was used but was also found to occur in 3% of cases where patients took a placebo. The percentage of occurrence being markedly less than the occurrence of the other risk factors [Dr B] has reported discussing with [Mr A]. [Dr B's] letter shows that Imovane was given concurrently to assist with sleep. Thus, if anxiety had been experienced as a side effect it would in any event have been helped with the Imovane. It is therefore submitted that objectively one cannot say that it is reasonable to impose a duty that such information be given.

3.8 In addition, it is submitted that your expert has not fully looked at the following circumstances:

3.8.1 a very low risk of causing anxiety,

3.8.2 an already anxious patient,

3.8.3 a medication combination that, while treating sleeplessness also avoided the risk of anxiety,

3.8.4 that [Dr B's] decision was made without the benefit of hindsight, and

3.8.5 the perceived needs of the patient, namely that reassurance was a high priority in communication.

It is thus further submitted that this decision was reasonable.

3.9 It is also submitted that the blanket statement made by your expert at page 16 of your opinion does not adequately allow for the importance of what is said to the patient being tailored to meet the patient's needs.

3.10 We then look at the issue of whether subjectively it was appropriate to give this information to [Mr A]. While it could be said that because he chose not to take the medication after searching the internet in order to avoid anxiety this meant he should have been informed of the risk. It is respectfully suggested that this may be a somewhat naïve explanation. When one reads the provisional opinion afresh, it is entirely possible that this was someone who from the beginning wanted benzodiazepines. Enclosed is a letter from [Dr L], general practitioner and consultant physician to the Regional Alcohol and Drug Services. (Unfortunately this facsimile is a little indistinct. For assistance a transcript is also attached.) Whether this is a fair comment or not, [Mr A] placed [Dr B] in a situation whereby he wouldn't follow his recommended safe drug prescription of Aropax

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and, against his better judgement, [Dr B] then gave in to a specific request for benzodiazepines. All indications from [Mr A] to [Dr B] were that he wanted alleviation not increase of his anxiety. The enclosed study found that "*In general, improvement in patients starts after one week but does not become superior to placebo until the second week of therapy.*" The importance of reassurance rather than fear of increased anxiety cannot be under estimated.

4. Further dispute is taken with your expert's advice that it would take four to six weeks for the drug to have effect. You are referred to the above quote.

5. Policy Reasons

5.1 This complaint was initiated only after a severance in the patient/doctor relationship between [Dr B] and [Mr A]. The relationship ended as a result of [Dr B] taking what was by no means an easy decision, that decision being to inform [Mr A] that a restriction order would be applied for. There is an obvious inference to draw that had [Dr B] complied with [Mr A's] strong wishes he would have avoided the ordeal of the complaints process and the risk of an adverse finding. It is submitted that as a matter of policy care should be taken before reaching a decision that acts as a deterrent to doctors making the hard decisions despite the risk of a complaint as made in this case.

5.2 You will be aware that the Government is currently trying to place increased obligations on general practitioners to treat patients rather than refer them to specialists for reasons of lengthy waiting lists and limited availability of such specialists. As [Mr A] belongs to a particularly risky group of patients he was the very type of patient where a doctor practising defensively would have immediately chosen to refer him to a specialist rather than acting as the Government seeks to advocate by managing [Mr A's] treatment himself.

5.3 To find doctors' conduct (particularly in [Dr B's] case) to be significant enough to warrant a finding of breach rather than just acknowledging shortcomings without the attendant stigma is contrary to the obligations which the Government wishes to impose on general practitioners.

5.4 The finding of a breach will significantly impact should [Dr B] wish to obtain a certificate of good standing and has other long term consequences.

5.5 It is submitted that in this instance –

- where there are no issues of clinical incompetence,

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- where [Dr B] has shown insight and – within his practice – looked at ways to avoid recurrence,
- where there has been an appropriate response and offer following the complaint,
- where there is no doubt that [Dr B] at all times acted with the patient's best interests uppermost in his mind, and
- where there is no dispute that [Dr B] acted attentively and conscientiously,

– this is not a case where the shortcomings are sufficient to meet the threshold that justifies a finding of a breach.

[Dr B] is more than happy to refund the sum recommended. As noted, he has already apologised."

Dr C responded to my provisional opinion as follows:

"I have had the opportunity to read your provisional opinion and note that it finds me to be in breach of Right 4(1) for prescribing Ativan and Imovane at the consultation with [Mr A] on 11 November 1999.

On that date I was faced with the following situation:

1. A patient who needed assistance in managing his withdrawal from Ativan but was not able to access the […] Community Mental Health Centre at that time.

2. A patient who would clearly suffer physical and mental adverse consequences if he was not given some medication to tide him over until he could be seen by specialist services.

3. A choice of meeting his clear, obvious and justifiable need for something to tide him over until he could be seen, noting that ideally he should be able to be seen by specialist services immediately but the earliest appointment they could offer him was five days away.

Thus, there was no option other than five days of unmanaged withdrawal or five days of medication to tide him over. Following a full discussion of the risks, I offered the latter course which I felt was the most humanitarian under the circumstances.

I note that despite the blanket directive from [the Community Mental Health Centre] on 11 November, when Dr B rang them on the 12th to advise that Mr A had taken all the tablets I had prescribed, their advice was that he should be given five more days to help him until he could be seen. Thus the course that I followed on the day was

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no different from that which [the Community Mental Health Centre] advised the following day.

My regret over what has happened is sincere and deep. The apology that I have already made to Mr A cannot truly express how sorry I am over the situation he is in. I am more than happy to refund the sum of $19.50 to him but ask that you reconsider the finding of a breach that has been made against me."

Further independent advice to Commissioner

In light of the response to my provisional opinion submitted on behalf of Dr B, the following advice was obtained from Dr Antonio Fernando, an independent consultant psychiatrist and expert in psychopharmacology:

"You asked me to comment on several issues:

1. my views on what information a general practitioner should provide to a patient when prescribing Aropax and Ativan (ie the professional standard for information disclosure) and

2. my views on what a reasonable patient in [Mr A's] situation would expect to be told by his general practitioner

3. duration of response for Aropax to take effect.

Regarding the first issue, any practitioner prescribing any medication must discuss with the patient the most common side effects and or side effects that the practitioner believes have a relatively high chance of occurring given a particular patient. Discussing serious (potentially life threatening) side effects and side effects which might affect the patient's compliance should also be discussed. Aside from side effects, a general practitioner should explain the rationale for the use of a particular medication, potential interactions, duration and cost of treatment and alternatives to the proposed treatment.

For Aropax, anxiety as a side effect is not commonly observed. In fact, anxiety disorders are commonly treated with Aropax. I do not expect general practitioners to advise their patients of anxiety as a side effect from Aropax. A reasonable general practitioner should advise patients on Aropax about nausea or stomach upset and sexual dysfunction. Aside from these, it is up to the practitioner what else he/she wants to discuss as side effects.

In [Dr B's] case, his standard of care in providing information on Aropax was adequate.

For Ativan, patients should be advised by a reasonable practitioner on its potential for a) physical and or psychological dependence as well as b) drowsiness and its

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consequences (ie operating heavy machinery, driving a vehicle). Though short term use (less than 2 weeks) generally does not cause physical dependence, psychological dependence can develop easily in vulnerable individuals of certain personality types. Even if the risks for dependence is generally low for a 2 week prescription of Ativan, many patients will refuse a prescription of Ativan once they hear of that risk. Because of this, I expect a reasonable practitioner to advise their patient of the risk for dependence.

Regarding the second issue, a reasonable patient would expect to be told by his general practitioner of the following: a) possible diagnosis b) treatment options c) pertinent side effects (pertinent based on frequency and clinical variables; also refers to potentially life threatening side effects) d) duration of treatment e) costs. Since the general practitioner or any practitioner for that matter [does] not have time to discuss all the side effects and possibilities with a particular medication, a reasonable practitioner should advise the patient that he should report any untoward reaction. A reasonable patient is then expected to contact his practitioner for any adverse reaction or concern. Regarding prescribing Ativan, a reasonable patient is expected to be told the risk of dependence on Ativan even if the risks are low for a two week prescription. It is not uncommon for patients to ask clinicians if what they are about to take is 'addicting'. A significant number of patients refuse to take 'addictive' medications even if the risks are quite low.

Regarding the third issue, clinical studies as well as experience have shown that antidepressants like Aropax generally start to cause effect or improvement within the first 2 weeks of treatment. Effect or improvement is different from remission. It takes about 4-8 weeks to judge whether treatment with an antidepressant is successful or not. Between 4-8 weeks, the practitioner has to decide whether to continue to modify/change the treatment."

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Code of Health and Disability Services Consumers' Rights

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

RIGHT 4

Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

   …

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

RIGHT 6

Right to be Fully Informed

1) *Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –*

   …

   a) *An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …*

Opinion: Breach – Dr B

In my opinion Dr B breached Right 6(1)(b) of the Code.

Right 6(1)(b)

Ativan

Dr B prescribed Ativan, an anxiolytic benzodiazepine, when Mr A returned on 15 October 1999. This decision was taken because Mr A refused to take Aropax, and because he was experiencing a high degree of anxiety and sleeplessness. Mr A recalled being advised that Ativan was addictive, but not within a two week period. However, Dr B said that he did not tell Mr A that he could become addicted to Ativan within a four week period because the prescription was for a two week supply and he did not expect a problem with addiction to arise within that time.

I accept the advice of my independent general practitioner that Dr B's decision to prescribe Ativan was a reasonable one. However, I note the comment:

> "… If it is to be used, I believe the individual taking the medication needs to be warned of the potential pitfalls …."

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These pitfalls include the possibility of addiction. Mr A was entitled to know that if Ativan is taken for a period of time "more than just a few days", there are potential risks. My advisor commented:

> "… I believe Dr B himself would feel that he should have warned Mr A about the possibility of addiction."

I asked my expert in psychopharmacology to advise me what information, in his view, a general practitioner should provide a patient when prescribing Ativan. Dr M stated:

> "For Ativan, patients should be advised by a reasonable practitioner on its potential for a) physical and or psychological dependence as well as b) drowsiness and its consequences (ie operating heavy machinery, driving a vehicle). Though short term use (less than 2 weeks) generally does not cause physical dependence, psychological dependence can develop easily in vulnerable individuals of certain personality types. Even if the risks for dependence is generally low for a 2 week prescription of Ativan, many patients will refuse a prescription of Ativan once they hear of that risk. Because of this, I expect a reasonable practitioner to advise their patient of the risk for dependence."

Dr M also noted that a reasonable patient would be expected to be informed of the risk of dependence on Ativan, including the low risk associated with a two week prescription. Accordingly, in my opinion Dr B's failure to advise Mr A of the possibility of addiction to Ativan in the short term was a breach of Right 6(1)(b) of the Code.

Opinion: No breach – Dr B

In my opinion Dr B did not breach Right 4(1) or Right 6(1)(b) of the Code.

Right 4(1)

Types of anti-depressant

Mr A was concerned that Dr B did not tell him about the different types of anti-depressant and their associated side effects.

Dr B prescribed Aropax when Mr A saw him on 5 October 1999. Mr A had been experiencing anxiety and depression and Dr B considered that Aropax, "one of the newer antidepressants with one of the lowest side effect profiles", was appropriate, in light of Mr A's age and sex. I accept the advice of my independent general practitioner that it was reasonable for Dr B to prescribe Aropax. I do not consider it was necessary in the circumstances for Dr B to present Mr A with a list of possible anti-depressants and ask him for his preference.

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I am satisfied that it was reasonable for Dr B to prescribe Aropax on 5 October 1999. In the circumstances I conclude that he provided clinical services with reasonable care and skill and did not breach Right 4(1) of the Code.

Further assessment
Mr A was concerned that Dr B prescribed Aropax and Ativan but did not arrange follow-up appointments or suggest referral to a counsellor, psychiatrist or psychologist for further assessment of his anxiety and depressive symptoms.

As already noted, Dr B prescribed Aropax on 5 October 1999 and Ativan on 15 October 1999. He had the opportunity on both occasions to discuss onward referral. However, I note the advice of my independent general practitioner:

> "… The great bulk of patients treated for anxiety and depression in a general practice setting will not require specialist referral. There is only a very small percentage that do not respond to medication that require such ongoing referral. A referral is often made after a drug such as Aropax has been used for in excess of six weeks with no significant success."

In light of this advice I accept that, when he first prescribed the drugs, it was reasonable for Dr B not to refer Mr A for further assessment. I conclude that Dr B provided clinical services with reasonable care and skill and did not breach Right 4(1) of the Code.

Psychiatric Services
Mr A was concerned that, although Psychiatric Services made contact with Dr B on 11 November 1999, Dr B did not contact him or arrange an appointment.

Dr B received a phone call from Psychiatric Services advising that Mr A had taken a paracetamol overdose the previous evening. I accept that Mr A was with Psychiatric Services at the time, that an appointment was made for him to see Dr B at 10.30am that day, and that Mr A was aware of this. I note that Mr A attended the Medical Centre on the morning of 11 November 1999 but chose to see Dr C instead of Dr B.

In my opinion Dr B made appropriate arrangements to see Mr A on an urgent basis. In the circumstances I conclude that he provided clinical services with reasonable care and skill and did not breach Right 4(1) of the Code.

Right 6(1)(b)

Aropax
Dr B prescribed Aropax on 5 October 1999 without telling Mr A that it can increase anxiety levels in the first two weeks of taking it. Instead, he addressed that possibility by also prescribing Imovane, which is a sedative.

Aropax can be used to treat depression and Dr B prescribed it because of its lower side effect profile and safety in the event of an overdose. I accept the advice of my independent general practitioner that it was reasonable for him to do so.

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My independent general practitioner advised:

> "The person who takes Aropax for the first time needs to be informed that it is an anti-depressant, that it is not addictive and the patient needs to be informed that it takes some four to six weeks to have an effect. He or she needs to be informed that it needs to be taken on a regular daily basis and taking it sporadically is not at all effective. He or she also needs to be told that heightened anxiety is not at all unusual for the first two weeks or so of taking it."

Ms K, the barrister acting for Dr B, disputed that increased anxiety is a common risk factor of Aropax and that it takes four to six weeks for the drug to have effect. She also queried whether my general practitioner advisor was suitably qualified to advise on this issue. Accordingly, I asked an independent consultant psychiatrist, and expert in psychopharmacology, Dr Antonio Fernando, to advise me whether it was reasonable for Dr B not to inform Mr A of the possibility of increased anxiety to Aropax. Dr Fernando stated:

> "For Aropax, anxiety as a side effect is not commonly observed. In fact anxiety disorders are commonly treated with Aropax."

I accept Dr M's advice that general practitioners should not be expected to advise their patients that anxiety is side effect associated with Aropax. I also accept that Aropax generally starts to have an effect within the first two weeks of treatment, but that it may be four to eight weeks before it can be determined whether the treatment has been successful.

In all the circumstances I conclude that Dr B had no obligation to advise Mr A of any risk of increased anxiety when starting Aropax and did not breach Right 6(1)(b) of the Code.

Opinion: Breach – Dr C

In my opinion Dr C breached Right 4(1) of the Code.

Right 4(1)

Ativan

Mr A was concerned that on 11 November 1999 Dr C prescribed a further supply of Ativan despite a recommendation from Psychiatric Services that he receive no further sedatives.

I note the advice of my independent expert:

> "With the benefit of hindsight I don't think [it] was reasonable [for Dr C to prescribe Ativan and Imovane] but I can see why this was done. By this time [Mr A]

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> was clearly in a difficult situation and the prescribing of the medication was understandable if not especially wise."

Dr C was aware that Psychiatric Services had made contact that morning and of its recommendations. Dr C's actions included writing a letter referring Mr A to the Community Mental Health Centre and providing a contact telephone number, advising Mr A on the use of sedatives and requesting that he seek medical attention in two days' time, and informing him about the Crisis Team at the public hospital and how to access it. He also noted that Mr A continued to deny that he required assistance.

Dr C nonetheless prescribed six Ativan and six Imovane tablets to tide Mr A over, until he was able to make contact with specialist care. This was contrary to the recommendation of Psychiatric Services, and despite Dr B's note in the clinical records, that no sedatives should be prescribed.

Dr C stated that "there was no option other than five days of unmanaged withdrawal or five days of medication to tide him over". He also noted: "[D]espite the blanket directive from the Community Mental Health Centre on 11 November, when Dr B rang them on the 12th to advise that Mr A had taken all the tablets I had prescribed, their advice was that he should be given five more days to help him until he could be seen. Thus the course that I followed on that day was no different from that which the Community Mental Health Centre advised the following day."

In my opinion, although Dr C's action was understandable, he should not have prescribed Ativan and Imovane on 11 November 1999. It was clearly noted in the clinical record that Psychiatric Services had advised that no sedatives be prescribed. It was also noted that a referral to the Community Mental Health Centre was considered the most appropriate option. If Dr C had had any doubts about prescribing sedatives when he saw Mr A on 11 November 1999, he could have telephoned Psychiatric Services and/or the Community Mental Health Centre for specialist advice. Dr B did not issue the new prescription on 12 November 1999 until he had telephoned the Community Mental Health Centre and received advice to do so. I am conscious of the benefit of hindsight. However, I have concluded that, in prescribing Ativan and Imovane on 11 November 1999, Dr C did not provide clinical services with reasonable care and skill and breached Right 4(1) of the Code.

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Opinion: No breach – Dr C

In my opinion Dr C did not breach Right 4(1) of the Code with regard to the following:

Right 4(1)

Ativan
Dr C prescribed a second two week supply of Ativan on 30 October 1999. Mr A was concerned that he did this without assessing in detail the potential risk of addiction.

In response to my question whether it was reasonable in the circumstances for Dr C to have prescribed Ativan, my independent expert commented:

> "This is a hard question to answer. Not being present at that consultation, and not knowing how actually it proceeded, makes it difficult to provide an answer. Perhaps in retrospect, given the difficulties that [Mr A] went on to encounter with his addiction to Ativan, then perhaps a second two week supply of Ativan was not a wise decision, but once again, it is sometimes easier to make judgement in retrospect than it was at the time."

I accept that Dr C did not have the benefit of hindsight. His decision to prescribe a second course of Ativan was based on Mr A's reported relief, his confirmation that he would be reviewed by Dr B in two weeks' time, and a determination that there was nothing in his history to suggest that he had addiction problems.

In the circumstances I am not satisfied that Dr C inappropriately prescribed a second two week supply of Ativan. In my opinion he provided clinical services with reasonable care and skill and did not breach Right 4(1) of the Code.

Specialist referral
Mr A was concerned that, on 30 October 1999, Dr C made no attempt to refer him for specialised help.

I accept the advice of my independent general practitioner:

> "I think this was reasonable because of the fact that [Mr A] had not been taking Aropax for the length of time it would take for it to work. Thus he had not been treated for a length of time that would necessitate a specialist consultation."

In my opinion Dr C provided clinical services with reasonable care and skill and did not breach Right 4(1) of the Code.

Follow-up appointment
Mr A was concerned that, on 30 October 1999, Dr C made no arrangement for a follow-up appointment to check progress. I accept my independent expert's advice that this was reasonable in the circumstances. Mr A had been taking Ativan for only two weeks, which was not long enough for this action to be warranted. Furthermore, Dr C was aware that Mr A had an appointment to see Dr B in two weeks' time.

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In my opinion Dr C provided clinical services with reasonable care and skill and did not breach Right 4(1) of the Code.

Opinion: No breach – Dr D

In my opinion Dr D did not breach Right 4(1) of the Code.

Right 4(1)

Mr A was concerned that Dr D did not read his notes in detail and did not take his benzodiazepine addiction seriously.

When Mr A went to the Medical Centre on Saturday 13 November 1999, he was experiencing withdrawal symptoms and described himself as "extremely desperate and panic stricken". I accept that Dr D read the relevant clinical notes and discussed Mr A's condition with him. He established that a prescription for Ativan had been dispensed the previous day. He queried why Mr A was reporting for more. He discussed alternative, non-addictive, treatments for Mr A's anxiety (such as Melleril or Serenace). Mr A wanted more Ativan and Dr D prescribed Melleril and Allegron (to be used instead of the Aropax that Mr A had started taking), as well as 10 Ativan tablets, to be taken "if really necessary". He did so because of the risk of stopping a benzodiazepine suddenly.

I note the advice of my independent general practitioner:

> "[Dr D] realised that he could not stop the benzodiazepine at short notice and thus he really had no great choice but to continue with the prescription until such time as the [Community Mental Health Centre] team could treat the addiction. Thus the prescription that [Dr D] dispensed of Melleril, Allegron and Ativan was probably reasonable in the circumstances."

There is no evidence that Dr D did not read Mr A's notes in detail. Nor is there evidence that he did not take Mr A's benzodiazepine addiction seriously. In my opinion Dr D provided clinical services with reasonable care and skill and did not breach Right 4(1) of the Code.

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Action

I note that Drs B and C have apologised to Mr A for any shortcomings in their care. Furthermore, they (and Dr D) offered to refund $216.60, being Mr A's total general practitioner and pharmacy expenses from 15 October to 19 November 1999. I do not believe that this is warranted. Instead, I recommend that:

- Dr B refund $39.00 to Mr A, being half the cost of his consultations on 5 and 15 October 1999.
- Dr C refund $19.50 to Mr A, being half of the cost of his consultation on 11 November 1999.

Other action

- A copy of this opinion will be sent to the Medical Council of New Zealand and to Medsafe, Ministry of Health.
- A copy of this opinion with identifying features removed will be sent to the Royal New Zealand College of General Practitioners, and the Royal Australasian College of Psychiatrists, for educational purposes.

Other comments

Continuity of care
Right 4(5) of the Code states that every consumer has "the right to co-operation among providers to ensure quality and continuity of services". In a medical centre such as the Medical Centre, each of the doctors is an individual provider. Effective co-operation between the doctors means shared management of a patient, and consistency of approach. I note my advisor's comment that this case "demonstrated the problem of a patient being seen by a number of doctors rather than just by one, so a degree of consistency is often not maintained". I agree. I am pleased to read Dr C's advice that the Medical Centre had taken action "to ensure that this problem of several doctors being involved in one patient's care [does] not occur again". Continuity of care of a patient with the difficult and sensitive problems with which Mr A presented is especially important. It is preferable for such a patient to be seen by his usual doctor, so far as reasonably practicable. If the patient wishes to see another doctor, this should alert staff at the medical centre to ask for an explanation of why the change is sought and, if possible, to consult with the patient's usual doctor about the situation.

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Patient responsibility

Mr A was a troubled young man when he presented at the Medical Centre in October and November 1999. He was experiencing anxiety and depression, loss of appetite, and inability to sleep. Drs B, C and D conscientiously attempted to treat Mr A's symptoms, and to help him work his way out of his state of anxiety and depression. In the course of treating him, Drs B and C erred in some respects. However, their motivation and attentiveness to caring for him is not in doubt.

Mr A must accept some responsibility for his failure to take his medication as prescribed, his abuse of alcohol, and his drug-seeking behaviours. These problems cannot all be laid at the door of the doctors who treated him at the Medical Centre.

Mr A has chosen to pursue this complaint even after Drs B, C and D met him and his mother on 26 October 2000 to address his concerns, and offered to refund $216.60 as full reimbursement of his medical and pharmacy expenses for the period 15 October to 19 November 1999. Although his complaint has in part been upheld, I have taken Mr A's conduct into account in my recommendations above.