Psychiatrist / Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC7464

Complaint

The Medical Council of New Zealand forwarded a complaint from the consumer about the treatment she received from the first psychiatrist, a consultant psychiatrist employed by a Crown Health Enterprise. The complaint was that:

- *The first psychiatrist prescribed Tegretol to the consumer in early July 1996. He did not explain, in any conversation prior to early September 1996, how important it was for the consumer to monitor her mood in the initial stages of taking this drug.*
- *The first psychiatrist did not tell the consumer that the Tegretol dose she was on could be increased if she showed signs of instability and that there was a certain level of medication to work towards.*
- *The first psychiatrist did not inform the consumer of the possibility that she could suffer withdrawal symptoms when coming off Lithium Carbonate.*
- *The first psychiatrist was remiss in not scheduling two weekly appointments with the consumer in July 1996 and did not explain why this was imperative for the monitoring of her medication.*
- *The first psychiatrist was remiss in not scheduling appointments at two weekly intervals thereafter until the consumer was stabilised. This action would have saved her weeks of suffering.*
- *The first psychiatrist forgot to give the consumer blood test forms at her appointments with him.*
- *The first psychiatrist blamed the consumer in early September and told her she should remember to collect the forms from him, "otherwise we wouldn't get paid".*
- *The first psychiatrist did not contact the consumer's general practitioner with an update of the medication that he had prescribed her.*
- *In mid-July 1996 the second psychiatrist advised the consumer to continue taking 800mgs of Tegretol by phone without checking the consumer's prescription beforehand.*

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Report on Opinion – Case 97HDC7464, continued

Investigation Process

The complaint was received on 22 July 1997 and an investigation was commenced. The Commissioner referred the matter to an advocacy service on 22 September 1997. Resolution between the parties was not achieved. The investigation was extended to include the second psychiatrist on 25 September 1998. Information was obtained from:

The Consumer	
The First Consultant Psychiatrist	Provider at the Crown Health Enterprise ("CHE")
The Second Consultant Psychiatrist	Provider at the CHE
A Legal Advisor from the CHE	

Relevant clinical records were obtained and viewed. The Commissioner obtained advice from an independent consultant psychiatrist.

Information Gathered During Investigation

The consumer was referred to the first psychiatrist in July 1995 with a diagnosis of bipolar affective disorder with significant relationship problems.

The first psychiatrist advised the Commissioner that, at the time, the consumer was receiving a mood stabilising drug, (*lithium carbonate*, 1000mg at night), an antipsychotic drug (*trifluoperazine*, 10mg at night) and an antidepressant drug (*imipramine*, 125mg at night).

The first psychiatrist diagnosed major depression with a significant delusional component. He advised the Commissioner that the nature of the consumer's illness was thoroughly explained to her and she was offered community support. The consumer's treatment was reviewed and the *imipramine* was replaced with *doxepin* at a starting dose of l00mg at night. The first psychiatrist advised that *imipramine* was replaced with *doxepin* because it had a better sedative profile and that the reasons for the change were fully explained to the consumer.

A community mental health nurse visited the consumer at home, at the first psychiatrist's request. In her report dated early August 1995, the nurse recorded that the consumer had been "*doing well*" following the change in medication and that her sleep had improved. The nurse also noted that the consumer had requested information about *doxepin*.

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Report on Opinion - Case 97HDC7464, continued

Information Gathered During Investigation, *continued*

The first psychiatrist advised the Commissioner that the consumer's mental state remained stable until March 1996 when she began to exhibit mild features of depression in the form of poor energy, poor motivation and a broken sleep pattern. Her treatment was reviewed in late March 1996 and her antidepressant medication (*doxepin*) was increased to 150mg at night.

In mid-June 1996 the consumer was reviewed by the first psychiatrist in the outpatient clinic. The first psychiatrist's clinical notes recorded that the consumer appeared stable but that she was experiencing infrequent involuntary myoclonic jerks (muscle spasms) during the day. The first psychiatrist said he concluded that the jerks were a side effect of her treatment (the antipsychotic and/or the antidepressant) and that these drugs are known to lower the seizure threshold. The first psychiatrist decided to keep the consumer on the antipsychotic and antidepressant medication because of his concerns about inducing a relapse if either of these drugs were stopped. He decided, instead, to replace the *lithium carbonate* with *tegretol*, another mood stabiliser.

The first psychiatrist's clinical notes recorded:

> *"...Because* [the consumer's] *mental state has been stable on such combination we decided to reduce the Lithium Carbonate by 250 mgs weekly before stopping it completely and replacing it with Carbamazapine 200 mgs mane* [morning] *and nocte* [evening] *for its mood stabilising effect and its effect in increasing the seizure threshold. Liver function test, full blood picture and serum Tegretol level will be done in a few weeks' time. I will review* [the consumer's] *mental state briefly next week and a thorough review in eight weeks time.*

The first psychiatrist advised the Commissioner that the consumer was informed about the possible risk of relapse and the occurrence of withdrawal symptoms following the discontinuation of *lithium carbonate*. He said she was also informed about the side effects involved with the *tegretol* treatment. In his letter to the Commissioner, dated mid-December 1997 the first psychiatrist noted:

> *"She was mainly informed about the effect of the Tegretol on the bone marrow and the liver and was informed that regular full blood counts and liver function tests would be required.*

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Report on Opinion – Case 97HDC7464, continued

Information Gathered During Investigation, *continued*

She was fully informed also about the need to start the Tegretol with a small dose and to increase it gradually being guided by her clinical response and her tolerance to the drug."

The first psychiatrist advised that following this meeting, the consumer was commenced on *tegretol* 200mg morning and night while her dosage of *lithium carbonate* was reduced by 250mg/week.

The first psychiatrist was on annual leave from early July until late July 1996. In early July 1997, and in the first psychiatrist's absence, the consumer was given a repeat supply of *tegretol* 200mg morning and night, as well as a supply of *trifluoperazine* and *doxepin* by a third consultant psychiatrist.

The consumer wrote to the first psychiatrist in mid-July 1996. She reported that all the side effects and *"trials and tribulations"* of being on a mixture of *lithium* and *doxepin* had disappeared and *"my family and I are pleased with the end result after these months of working on the drugs".*

The first psychiatrist advised the Commissioner that the results of the consumer's blood test in mid-July 1996 indicated *"a normal blood picture and normal liver function".* He indicated that her serum *tegretol* level (18 u.mol/L) was *"just below the lower end of the therapeutic range"* (20-40 u.mol/L) and that this was noted by the third consultant psychiatrist in mid July 1996. The first psychiatrist said no action was taken because the consumer's letter later in July 1996 indicated that she was well, and his approach in initiating patients on *tegretol* was to "*start low and go slow*". The first psychiatrist advised the Commissioner:

"It has also been shown that there is no close relation between serum levels of Tegretol and its stabilising antimonic or antidepressant properties and, therefore, gradual increase of the drug guided by the clinical efficacy is the best way to go."

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Report on Opinion – Case 97HDC7464, continued

Information Gathered During Investigation, *continued*

The Second Psychiatrist

The consumer telephoned the community mental health service in mid-July 1996 and was put through to the second psychiatrist, who was also a consultant psychiatrist. The second psychiatrist advised the Commissioner that, to the best of her recollection, she was in the middle of a clinic session at the time. The second psychiatrist said the consumer described side effects which reportedly followed the ingestion of an 800mg *tegretol* dose the night before. She was advised to skip one dose of *tegretol* and to recommence the following day on 400mg twice a day.

The second psychiatrist's clinical note recorded:

> "*Advice over phone in absence of* [the first psychiatrist]. *After Carbamazapine 800mg nocte last night feeling dizzy and unsteady this morning Advised to take 800mg in 2 divided doses. No dosage this morning, if dizziness subsides 400mg tonight, then continue Carbamazapine 400 bd."*

The manager: adult mental health, in his memorandum to the CHE legal advisor dated early June 1998, noted that the consumer was not the second psychiatrist's patient but that the second psychiatrist was providing back-up consultant coverage during the first psychiatrist's absence. He said that the second psychiatrist assumed the consumer's concerns were genuine and had no reason to doubt the validity of the information the consumer provided her with over the telephone. He said the second psychiatrist did not have immediate access to the file, that the second psychiatrist assumed the consumer was prescribed *tegretol* 800mg at night and had consequently advised her to take that in divided doses. When the second psychiatrist noted this conversation in the file she had no reason to suspect the consumer had not told her the dosage accurately and so did not cross-check the previous notes. He acknowledged that this was an oversight but said the consumer knew the correct dose to take (*tegretol* 200mg morning and night). He said that the second and third psychiatrists were endeavouring to provide cover for the first psychiatrist's caseload as well as managing their own and that the level of the cover was intended to deal only with pressing or urgent circumstances. He said that this practice is consistent across the country.

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Report on Opinion – Case 97HDC7464, continued

Information Gathered During Investigation, *continued*

The consumer commented on the second psychiatrist's clinical notes, in her letter dated mid-May 1997 to the community mental health service, at a second public hospital. She indicated:

> *"It says I was given advice over the phone to take 800mgs in 2 divided doses, 400mgs (or was it 200mgs???? Why was this changed) morning and 400mgs at night, again changed to 200mgs. I cannot remember speaking to* [the second psychiatrist]*, whether this person is a male or female, I have no idea. I have absolutely no recollection of being told to increase my dose to 800 mgs. I received no prescription for this amount and have no extra Tegretol tablets to suggest I was given these tablets by whoever ... If you actually work out the dates you will find that my blood level collected on the* […] *July could not possibly have been in* [the third psychiatrist's] *office by the* […] *????? or* […] *July for another 800mgs script to be given to me by the* […] *July for me to complain about my dizziness on the morning of the* […] *July. I will say again most vehemently I was not told at any time to increase my tablets of Tegretol to 800mgs at any time, - till this happened by* [the first psychiatrist]*, at an absurdly much later date... what I'm suggesting to you, is that there has been incompetence also on 2 other Psychiatrists part, in the initial stages of me being put on Tegretol. The blood level of 18umol/L was sighted by* [the third psychiatrist] *on or about the* […] *July 1996, but nothing actually constructive was done about this, which everyone now knows should have been, and* [the third psychiatrist] *and* [the second psychiatrist] *of course knew this around that time."*

The first psychiatrist advised the Commissioner that when he resumed his duties in August 1996 he was not able to establish how the *tegretol* dose was increased from 400mg to 800mg. He said:

> *"I presumed that* [the consumer] *decided to double up her dose without seeking her psychiatrist's opinion. The side effects reported at that time were dizziness and unsteadiness. These were in keeping with tegretol's known adverse effects."*

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Report on Opinion – Case 97HDC7464, continued

Information Gathered During Investigation, *continued*

The first psychiatrist advised the Commissioner that in August 1996 he received a handwritten note from the consumer which indicated she was well. She requested her appointment, scheduled for mid-August, be deferred until early September 1996. The first psychiatrist said he telephoned the consumer at home to enquire about her mental health and to check whether she was still experiencing any side effects of her treatment. He said the consumer indicated that she was well and that she planned to see him in early September.

The first psychiatrist advised the Commissioner that, during their consultation in early September, the consumer expressed anger towards her parents. The first psychiatrist said he offered suggestions as a starting point for communication with her mother and offered her community support.

The consumer was visited by the community mental health nurse. The nurse reported that the consumer had a lot of negative feelings that were felt to be emerging from the ongoing dynamics of her relationship with her parents. It was suggested at the time that she undergo psychotherapy and she was subsequently referred to a clinical psychologist in the team.

An entry made by the nurse in the consumer's clinical notes, dated early September 1996 recorded, *"Phone contact. Tegretol levels* ↓ [the first psychiatrist] *advises to increase Tegretol to 1 mane* [morning] *and 2 nocte* [night]*."*

Serum *tegretol* levels, from blood collected in mid-September 1996, indicated a level of 23 u.mol/L.

The consumer wrote to the first psychiatrist in late September 1996. She said:

> *"Thank you for putting me on the extra Tegretol tablet on the* […] *September. I must say my poor mental and physical state over the period of about seven weeks was telling us the medication I was on was not doing the job. Initially for about a week I seemed to be doing well so I don't quite know what went wrong. Anyway now, some time later on the extra 200mg tablet I am in better shape. The painful anger swings and lengthy and strong repetitive thoughts have disappeared. I am actually coping again with problems and feel that overall my mood is stabilised."*

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Report on Opinion – Case 97HDC7464, continued

Information Gathered During Investigation, *continued*

The consumer arrived at her early October 1996 appointment with her husband. The first psychiatrist said she handed him a letter which stated that she had been poorly managed by him and that her recent surges in negative feelings were the result of the low *tegretol* serum level. The consumer felt she was left to suffer because her *lithium* was withdrawn and the *tegretol* dose was kept low. The first psychiatrist attempted to explain to the consumer that her negative feelings were not new and that her psychiatric record always referred to relationship difficulties between her and her parents. He said she was also informed that a serum *tegretol* level of 18 u.mol/L was acceptable as long as her illness was under control. The first psychiatrist advised that the consumer was informed that, when the *tegretol* level was increased, in July 1996, she experienced side effects and *"there was no harm in going slow in building up the dose".*

The first psychiatrist's clinical notes recorded:

> *"…She reported a significant improvement in her mood. She reported that her worries about the relationship with her mother have markedly diminished. However* [the consumer] *presented me with a letter of complaint stating that her management over the past two months has been far from satisfactory. She felt that the deterioration in her mental state was due to the inadequate dose of Tegretol she was placed on. She stated that she was left to suffer unnecessarily. I have explained to* [the consumer] *that the Tegretol was introduced because she was having some myoclonic jerk while receiving the combination of Lithium Carbonate, Stelazine and Doxepin. She was aware that she was fully informed about the treatment and also the risks of relapse following the discontinuation of Lithium Carbonate. Despite the gradual reduction of the Lithium Carbonate and the introduction of the Tegretol she maintained a serum level of 18 umol/L. The myclonic jerks were reported to have subsided during the first week of the Tegretol therapy.*
>
> *I believe that the mild relapse that* [the consumer] *experienced was due to the withdrawal of the Lithium therapy. I am more than satisfied that her management was of a high standard and she was involved in every decision to review her treatment.* [The consumer] *requested to see another psychiatrist in the future which will be arranged as soon as possible.*

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Information Gathered During Investigation, *continued*

Her treatment was reviewed today and the Tegretol was increased to 400mgs mane and nocte, to be given in sustained release form… I have not made any arrangement to see her again and I will request one of my colleagues to take over her future care and follow up."

The first psychiatrist advised the Commissioner that the consumer was not in a position to accept any of his explanations and was only interested in a written apology from him. He said he informed her he was unable to apologise for something he had not done. He said he offered to transfer the consumer's care to one of his colleagues as she expressed that a written apology was a condition for any future attendance at his outpatient follow up clinic.

The consumer wrote the following in a letter dated mid-May 1997 addressed to a representative of the community mental health service.

> *"Regardless of what the New Ethicals catalogue says I know I got better on the increased dose of Tegretol given on the* […] *September 1996…* [The first psychiatrist] *said in that September appointment, that I probably had withdrawal symptoms from Lithium, and immediately increased by Tegretol, so can you also see that as wrong???? I know from my suffering that this increase should have happened weeks earlier. Of course in the initial stages of taking Tegretol a patient's blood level should be tested, at least every two weeks, until that patient's Tegretol dose and mental health is stabilised… If as you say in your letter to me when initiating Tegretol, the positive effects experienced by the individual should dictate the dose rather than the therapeutic range, why did not* [the first psychiatrist] *listen to my phone call to him, when not only did I tell him I was feeling mentally so unwell, but also that I was on 400mgs, and I had noticed on the Tegretol packet carrying my medication, that this could be given up to as high as 800mgs to l200mgs."*

The consumer's *tegretol* dose was increased to 800mg in October 1996. The first psychiatrist advised the Commissioner that this resulted in a better serum *tegretol* level. He said that, to his knowledge, *"her anger remained but this time her anger was directed at me. I was seen as the cause of all her suffering".*

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Report on Opinion – Case 97HDC7464, continued

Information Gathered During Investigation, *continued*

The consumer, in a letter dated mid-May 1997 to the community mental health service at the second Hospital, complaint of the first psychiatrist's:

> *"*[L]*ack of attention toward me on our first conversation, after his return from leave, and up until I was finally put on 600mgs of Tegretol weeks later … I know he did* <u>not</u> *explain to me how blood levels concerning Tegretol can play such a vital role in the wellbeing of a sufferer of Bi-polar Disorder… He has been very sloppy in his whole approach to the illness I felt (because of the changeover from Lithium to Tegretol and afterwards the stabilisation on Tegretol). When I told him of my continued mental ill health … he did nothing till too much later."*

The first psychiatrist said he believed he had offered the consumer the best psychiatric service he could at the time. He said she was always involved in all decisions that were taken to review her treatment.

Communication with the Consumer's General Practitioner

The consumer complained that the first psychiatrist did not contact her general practitioner with an update of the medication he had prescribed her. The first psychiatrist advised the Commissioner that, from his first contact with the consumer, she made it clear that she did not want the reports of her assessments being sent to her general practitioner. The first psychiatrist said he fully respected the consumer's request.

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Report on Opinion – Case 97HDC7464, continued

Independent Advice to Commissioner

The Commissioner sought advice from an independent consultant psychiatrist who commented:

> *"The decision to change* [the consumer's] *medication from lithium to carbamazepine is stated to have been on the basis of myoclonic jerks arising as a result of the combination of trifluoperazine and doxepin 150 mg. I agree that this is a likely explanation, especially as this emerged after an increase in dose of the doxepin. I note that the dose of lithium had been stable over this period and was at a therapeutic level.*
>
> *While there are a number of strategies which might have been used to address this situation, in my opinion a change from lithium to carbamazepine was a reasonable clinical decision.*
> *Abrupt discontinuation of lithium is associated with a very high risk of relapse in bipolar affective disorder. Therefore gradual discontinuation is recommended. The rate of discontinuation is still a matter of debate.* [The first psychiatrist's] *practice appears similar to many others in reducing this over 3-4 weeks. …*
>
> *It is general practice to increase the dose of this slowly to reduce the incidence of side effects and indeed some would have increased the dose even more slowly than* [the first psychiatrist].
>
> *The relationship between plasma levels of lithium and therapeutic benefit for patients is generally close. In contrast, the blood levels of carbamazepine are a less certain predictor of therapeutic benefit, although they are certainly of some use as a guide and allow higher levels, associated with the toxic effects of excessive doses, to be avoided. Therefore the dose of carbamazepine needs to be adjusted on the basis of clinical response rather than by always following rather the uncertain therapeutic range. This range was originally established in relation to treatment of epilepsy, not bipolar disorder.*

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Report on Opinion – Case 97HDC7464, continued

Independent Advice to Commissioner, *continued*

In general, clinical good practice would be to maintain close review of mood during a transition in medication of this nature. This might mean fortnightly reviews, but would need to be guided by the extent to which the patient was able to recognise changes in their mood state and seek help, and the rate of becoming unwell in the past. A planned review in 8 weeks in the absence of monitoring would appear long. …

I consider that it would be conventional to check carbamazepine levels approximately one to two weeks after a change in dose and weekly or fortnightly until they reached therapeutic effectiveness and somewhere close to or within the conventional therapeutic range. Subsequently they could be monitored much less frequently, unless other medication was introduced which might interact necessitating a dose adjustment. However, I stress the need to monitor clinical response as the principal guide to changes in dose. …

The position that [the second psychiatrist] *found herself in was difficult, but is not uncommon. Her advice, based on her perception of the patient's drug regime, was appropriate, in my view. It would have been desirable to confirm that this was in fact the dose prescribed, but* [the second psychiatrist] *did not appear to have any reason to doubt the patient's word, and many colleagues would act similarly. It is not always possible to obtain a patient's note immediately, and in some cases not within 24 hours. Therefore advice may have to be given on the basis of the information available… A dose of 800 mg nocte is not outside the ordinary therapeutic range, although such a single night time dose is a little unusual. It is more commonly given twice a day, unless the patient had trouble remembering twice daily doses. Therefore I do not consider that there were matters which would have alerted* [the second psychiatrist] *to check the dose at the time of the phone call or to have raised enough concern to ensure that the notes were called for as a matter of urgency. The advice she gave was, in my opinion, appropriate given the information she believed she had been given."*

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Report on Opinion – Case 97HDC7464, continued

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

...

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

...

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 his or her condition; and

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option.

...

Psychiatrist / Psychiatrist / Crown Health Enterprise

Report on Opinion – Case 97HDC7464, continued

Opinion: Breach The First Psychiatrist

In my opinion the first psychiatrist breached Rights 4(2) and 4(5) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(2)

The first psychiatrist arranged to review the consumer one week after the *tegretol* was commenced in mid-June 1996 and then again after eight weeks. I accept my independent psychiatrist's advice that it is conventional to check *tegretol* levels approximately one to two weeks after a change in dose and weekly or fortnightly until therapeutic effectiveness has been reached and that monitoring clinical response by way of interview is the principal guide to therapeutic effectiveness. The plasma level of mid-July 1996, which was just below the lower end of the therapeutic range, together with the consumer's letter of mid-July 1996, would not have required a change in dose at that stage if the consumer's mood had been in the normal range when clinically reviewed. I note the consumer's advice that when she wrote to the first psychiatrist in late July 1996 she had been on *tegretol* for four weeks and it was not until late July 1996 that she felt unwell.

The first psychiatrist had an obligation to ensure the consumer was reviewed at regular intervals until the therapeutic effectiveness of *tegretol* was achieved. By not doing so, in my opinion the first psychiatrist breached Right 4(2) of the Code.

Right 4(5)

In early April 1995 a social worker from the community mental health service wrote to the consumer's general practitioner informing him that the service had again become involved with the consumer and that he would be informed of any medication changes that were necessary. It was recorded that this was the only information the consumer requested be passed on and the letter concluded "*we will endeavour to keep you up-to-date with how our involvement is progressing*".

While I accept the first psychiatrist's explanation that the consumer did not want reports of her assessments to be submitted to her general practitioner, the consumer had requested that changes in medication be communicated and the first psychiatrist should have noted any discussions to the contrary in the clinical record. In my opinion by not informing the consumer's general practitioner of her current medications the first psychiatrist breached Right 4(5) of the Code.

Psychiatrist / Psychiatrist / Crown Health Enterprise

Report on Opinion – Case 97HDC7464, continued

Opinion: No Breach The First Psychiatrist

In my opinion the first psychiatrist did not breach Rights 4(2) and 6(1) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(2)

The consumer complained that the first psychiatrist forgot to give her blood test forms at her appointments with him and that he told her in September 1996 that she should remember to collect the forms from him "*otherwise we wouldn't get paid*". The investigation showed that the consumer had blood tests performed in May, July, September (twice), October, November and December 1996. In my opinion, there is insufficient evidence to support the consumer's complaint that blood test forms were not supplied to her by the first psychiatrist.

Right 6(1)

The Code sets out the information a consumer can expect to receive without having to ask. The consumer complained that prior to early September 1996 she was not told that it was important for her to monitor her mood in the initial stages of taking *tegretol* or that she could suffer withdrawal symptoms when coming off *lithium carbonate*. The investigation showed that *tegretol* was commenced in mid-June 1996. As the events of which the consumer complained occurred prior to the commencement of the Code on 1 July 1996 I am unable to form an opinion on this aspect of the complaint. However I note that it was a professional duty to keep consumers informed prior to 1 July and after that date the first psychiatrist had a legal obligation to do so.

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Report on Opinion – Case 97HDC7464, continued

Opinion: No Breach The Second Psychiatrist

In my opinion the second psychiatrist did not breach Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

The second psychiatrist was in a difficult position as she was with another consumer when she received the consumer's telephone call. I accept that the advice the second psychiatrist gave to the consumer was appropriate in the circumstances. While it would have been desirable to confirm that an 800mg night-time dose had been prescribed, it is not outside the normal therapeutic range and the second psychiatrist did not have any reason to doubt the information given to her in the telephone conversation with the consumer.

In the circumstances the second psychiatrist gave appropriate advice on the basis of information available and in my opinion did not breach the Code.

Opinion: No Breach The CHE

In my opinion, the CHE did not breach the Code. Its policies and procedures were appropriate. However I am concerned regarding coverage for psychiatrists on leave and have recommended this be reviewed.

Psychiatrist / Psychiatrist / Crown Health Enterprise

Report on Opinion – Case 97HDC7464, continued

Actions: The First Psychiatrist

I recommend that the first psychiatrist takes the following actions:

- Provides a written apology to the consumer for breaching the Code. The apology is to be sent to the Commissioner and will be forwarded to the consumer.
- Reads the Code of Health and Disability Services Consumers' Rights.
- Undertakes to clinically review consumers commencing *tegretol* at regular intervals until therapeutic effectiveness is achieved.
- Ensures his patients are fully informed of the medication given including risks and side effects.

Actions: The CHE

The CHE is requested to review the availability of medical records for mental health staff and its policies to ensure appropriate team cover is available when its staff are absent on leave. In this regard a copy of the opinion will be sent to the Health Funding Authority for its information.

Other Actions

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