Dr C

Medical Centre Company

A Report by the

Health and Disability Commissioner

(Case 20HDC00126)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

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Executive summary

1. This report relates to the care provided to an elderly woman with dementia when she and her partner presented to a doctor to complete a medical certificate certifying the woman's mental capacity to appoint an EPOA. The report highlights the importance of doctors being familiar with the process and requirements of certifying capacity and completing the relevant documentation in these circumstances.

2. The doctor saw the woman in February 2018, and presumed that what was required was a letter to certify the woman's lack of mental capacity to make decisions regarding her financial and medical well-being. The doctor completed a medical certificate stating the same. However, prior to completing the certificate, the doctor did not undertake a formal assessment of the woman's mental capacity or her ability to understand, retain, and reason through the information required to make a decision to appoint an EPOA.

3. Subsequently, the woman's partner returned to the medical centre and told the doctor that the certificate provided was not what his solicitor required. He asked the doctor to issue a letter stating whether or not she deemed the woman to have the mental capacity to appoint him as her EPOA. The doctor contacted the solicitor for clarification, and concluded that what was required was a certificate stating that the woman had the mental capacity to appoint her partner as her EPOA. The doctor completed a medical certificate stating this, despite her acknowledged opinion that the woman lacked that capacity.

Findings

4. The Commissioner found that by failing to perform a formal assessment of mental capacity to appoint an EPOA, and certifying the woman's mental capacity to appoint an EPOA contrary to her own opinion, the doctor failed to provide services to the woman that complied with legal and professional standards. Accordingly, the Commissioner found that the doctor breached Right 4(2) of the Code.

5. The Commissioner noted that whilst medical centres have a responsibility to facilitate and assist their staff to provide services in accordance with the Code, she considered that the doctor's conduct amounted to an individual failure, and did not indicate broader systems or organisational issues at the medical centre. She found that the medical centre company did not breach the Code.

Recommendations

6. In accordance with the recommendations proposed in the Commissioner's provisional opinion, the doctor provided HDC with evidence of attendance at three seminars/courses on the topic of completing mental capacity documentation, and provided HDC with a written apology to the woman's family for her breach of the Code.

7. The Commissioner recommended that in addition, the doctor arrange for a peer review of the next three mental capacity documents she signs, to ensure that these have been completed appropriately and in accordance with the relevant guidelines.

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8. The Commissioner recommended that the medical centre provide HDC with evidence of training provided to its staff on capacity assessments, and develop an educational booklet on mental capacity assessment and the EPOA process.

9. The Commissioner also recommended that the district health board consider creating and implementing an educational booklet for GPs in the area, to assist with capacity assessments.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided to her mother, Mrs A, by Dr C at the medical centre. The following issues were identified for investigation:

- *Whether Dr C provided Mrs A with an appropriate standard of care in February 2018.*
- *Whether the medical centre company provided Mrs A with an appropriate standard of care in February 2018.*

11. The parties directly involved in the investigation were:

Mrs B	Complainant/consumer's daughter
Dr C	Doctor/provider
Medical centre	Provider

12. In-house clinical advice was obtained from General Practitioner (GP) Dr David Maplesden (Appendix A).

Information gathered during investigation

Background

13. Mrs A, aged in her seventies at the time of events, had a medical history that included asthma, glaucoma,[1] hypertension,[2] and dementia.[3] Mrs A required full assistance with all activities of daily living owing to her dementia, and her partner, Mr A, was her main carer.

[1] A group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of the eye.
[2] High blood pressure.
[3] A group of conditions characterised by impairment of at least two brain functions, such as memory loss and judgement. Symptoms include forgetfulness, limited social skills, and thinking abilities so impaired that it interferes with daily functioning.

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At this time, Dr C[4] at the medical centre had been Mrs A's main doctor for just over two years.

14. This report concerns the care provided to Mrs A, specifically in relation to Dr C's completion of Enduring Power of Attorney[5] (EPOA) documentation in February 2018.

Discussion about future cares in early February 2018

15. On 2 February 2018, Mrs A presented to Dr C at the medical centre, accompanied by her partner, Mr A, and her daughter to discuss appropriate cares for Mrs A going forward. Dr C documented the appointment in Mrs A's clinical records as follows:

> "[Elderly] patient with dementia. Healthy except with recalcitrant GERD.[6] [Here] with [daughter] and her partner [Mr A]. Discussion regarding her health and care going forward in light of [Mr A's] severe arthritis and hip and knee pain."

16. Dr C stated that at this appointment, Mrs A's daughter expressed her concerns about Mr A's continued ability to care for Mrs A given his own physical conditions. Dr C told HDC:

> "I did agree that additional support would be of benefit to both of them and made a referral for a Needs Assessment through [the] District Health Board's Needs Assessment and Service Coordination service (NASC).[7]"

17. Dr C told HDC that at this appointment, there was no discussion about the need for an EPOA.

Montreal Cognitive Assessment and NASC referral

18. An assessment of Mrs A's mental/cognitive capacity was required for the NASC referral, and a Montreal Cognitive Assessment[8] was carried out on 8 February 2018 by another health practitioner at the medical centre, and then forwarded to NASC by Dr C.

19. Mrs A scored 7 out of 30 points on the Montreal Cognitive Assessment, indicating severe[9] cognitive impairment.

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[4] Dr C is an overseas qualified doctor, and received general scope registration in New Zealand in 2016. She is not a vocationally registered general practitioner.

[5] A legal document in which a person (the donor) appoints another person (the attorney) to make decisions on the donor's behalf if the donor becomes incompetent.

[6] Gastroesophageal reflux disease (GERD) occurs when stomach acid frequently flows back into the tube connecting the mouth and stomach.

[7] Organisations contracted by the Ministry of Health to work with disabled people and their family, whānau, aiga, or carers, to identify their strengths and support needs, outline what disability support services are available, and determine their eligibility for Ministry-funded support services.

[8] A cognitive screening tool for many illnesses, including Alzheimer's disease and dementia.

[9] The scoring for the assessment is as follows: a score of over 26 is considered to be indicative of having no cognitive impairment, a score of 18–25 indicates mild cognitive impairment, a score of 10–17 indicates moderate cognitive impairment, and a score of less than 10 indicates severe cognitive impairment.

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Discussion about EPOA between family members

20. On 12 February 2018, Mrs B emailed Mr A on behalf of her siblings and herself, as they felt that their mother's health was declining and that an EPOA needed to be put in place. Mrs B stated that their suggestion was that her brother should be a joint EPOA with Mr A.

21. Mrs B told HDC:

> "By this stage we were genuinely concerned about our mother. She was wandering off and had almost been run down on [the main road] as she crossed the road. Mum's partner [Mr A] is physically impaired, he needed a new hip and both knees need replacing. He could not go after her if she wandered off …"

22. Mrs B said that at the time of these events, her mother did not know who she or her other siblings were, and Mrs B considered that her mother was not mentally competent.

Completion of certificate of mental capacity for appointment of EPOA

23. On 15 February 2018, Mr and Mrs A attended an appointment with Dr C, as Mr A thought that he needed a certificate in respect of Mrs A's mental capacity for appointment of an EPOA. Dr C stated:

> "On 15 February 2018, [Mrs A] and [Mr A] were seen in consultation for a medical certificate relating to [Mrs A's] mental capacity. This had been requested by their solicitor. [Mrs A] did not have the capacity to make decisions regarding her own health and wellness nor for management of her personal property and finances."

24. Dr C told HDC:

> "After some discussion and trying to ascertain what was required of me, I presumed what was required was a letter to state [Mrs A's] lack of mental capacity to make decisions regarding her financial and medical wellbeing. So I used an existing template in our Medtech outbox designed to activate an EPOA."

First certificate — mental incapacity to manage property

25. Dr C completed a "Health Practitioner's certificate of mental incapacity for enduring power of attorney in relation to property",[10] which stated:

> "I, [Dr C] … a heath practitioner, certify that—
>
> …
>
> 2. My scope of practice includes the assessment of a person's mental capacity.
> 3. On 15/02/2018 I examined/assessed [Mrs A] ([DOB]), the donor of the enduring power of attorney in relation to property to ascertain her mental capacity.

[10] This is a certificate that is used to activate an EPOA, where one has already been appointed.

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4. In my opinion, the donor is mentally incapable because she is not wholly competent to manage her own affairs in relation to her property.
5. The reasons for my opinion are based on personal knowledge of [Mrs A] as a patient, and review of medical documentation on file."

Second certificate — mental incapacity to make decisions

26. Later that same day, Mr A re-presented to the medical centre and told Dr C that the certificate she had provided was not the certificate that his solicitor required. Dr C then drafted a medical certificate to indicate that Mrs A did not have the mental capacity to make decisions for her medical care. The certificate stated:

> "The above patient was seen and examined by me today. In my opinion she does not have mental capacity to make decisions for her medical care. I have known [Mrs A] and [Mr A] for more than 2 years and she has always been comfortable with [Mr A] making decisions for her."

27. On 16 February 2018, Mr A returned to see Dr C again, as she had still not completed the correct certificate that the solicitor required. Dr C stated that Mr A requested that she issue a letter stating whether or not she deemed Mrs A as having the mental capacity to appoint him as her EPOA.

Third certificate — mentally capable of appointing EPOA

28. Dr C told HDC that she then undertook some preliminary investigation into what was required, and around this time she spoke with Mr A's solicitor by telephone. She cannot recall what transpired following the call, but said that she must have concluded that a certificate stating that Mrs A had the mental capacity to appoint an EPOA was required, and she typed up a document for this.

29. The document titled "Health Practitioner's certificate of mental incapacity for EPOA" stated:

"I, [Dr C] … a heath practitioner, certify that—

…

2. My scope of practice includes the assessment of a person's mental capacity.
3. On 15/02/2018 I examined/assessed [Mrs A] ([DOB]), the donor of the enduring power of attorney.
4. In my opinion, the donor is mentally capable to make a decision regarding appointment of an enduring power of attorney.
5. The reasons for my opinion are based on personal knowledge of [Mrs A] as a patient, and review of medical documentation on file."

30. Dr C did not assess Mrs A's understanding of appointing someone to make decisions for her, but recalls asking Mrs A if she wanted Mr A to continue looking after her, and she agreed. Dr C stated that Mrs A was able to communicate and, when she did, it seemed appropriate, for example, Dr C could ask her medical questions and she would answer appropriately

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much of the time. However, Dr C stated that she does not consider that in February 2018 Mrs A would have been able to understand, retain, and reason through the information required to make a decision to appoint an EPOA.

31. No formal assessment of Mrs A's capacity in relation to decision-making for EPOA appointment or decisions regarding personal care and welfare was undertaken by Dr C before she completed any of the above documentation.

32. Dr C stated that at this time, she was "confused as to what was required" of her, and she felt that it was in Mrs A's best interests to have Mr A continue to care for her, so she issued him a certificate that stated that Mrs A had the mental capacity to appoint an EPOA. Dr C told HDC:

> "Although I did not understand at that time there were specific items that needed to be elicited with a mental capacity assessment, I believed that [Mrs A] would have wanted [Mr A] to fulfil this role as he had been doing it for many years. [Mr A] had clearly always taken good care of her and had always had her best interests at heart. I was not aware of family discontent. I assumed it was a formality in order for [Mr A] to be able to get something done for [Mrs A]."

Subsequent events

33. On 16 February 2018, Mrs A signed an EPOA naming Mr A as her sole attorney to act on her behalf for all her personal care and welfare matters.

34. In a letter to Mrs B's lawyers (dated 1 June 2018, in response to queries about the EPOA), Mr A's solicitor stated:

> "I confirm that I did powers of attorney from [Mrs A] to her partner only and that the circumstances were that I was asked to do the powers of attorney but had my doubts and advised the parties that I could not do so without a certificate of mental capacity. The certificate was then presented to me on 16 February 2018 with the request that I do the powers of attorney on the spot which I did after speaking to [Dr C]. You will see that the certificate is headed of mental incapacity and the Doctor confirmed that she was 'not clear on the certificates' but what she meant was that [Mrs A] had the capacity to appoint an attorney and needed to do so because of her deteriorating health … I only prepared and witnessed the powers of attorney in reliance on the certificate from [Dr C] and after discussing it with her …"

35. Mrs B told HDC that after the EPOA was activated (in March 2019), Mr A moved Mrs A to a rest home, against her and her siblings' wishes, and then subsequently moved her to a rest home further away from them, again without advising or consulting with Mrs B or her siblings.

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Further information

Dr C

36. Dr C stated:

> "I accept and understand that my actions were not appropriate. I deeply regret this and have no reservation about apologising to [Mrs A's] family for the sequence of subsequent events and my role in it … At the time, I felt pressured and uncomfortable at what was being asked and recognised that I lacked knowledge in this area. I was unaware of how to perform a mental capacity assessment and the documentation required."

37. Dr C said that she has since undertaken steps to educate herself on these requirements, and has provided appropriate capacity assessments for other patients. She told HDC that she is now familiar with her professional obligations around medical certification and will not allow herself to be put in a similar situation again.

Medical centre

38. At the time of events, the medical centre did not have any specific policies, procedures, or guidelines in place relating to patient assessment for mental capacity to appoint an EPOA. Dr C told HDC that this is not something a practice would have routinely, as they would have followed the national and DHB guidelines.

39. The medical centre stated that electronic guidelines and pathways are available for its GPs to access through the patient management system, and that this includes the Montreal Cognitive Assessment tool for capacity assessment, as well as the Mini-Addenbrooke's Cognitive Examination form.[11] In addition, the medical centre stated that collegial support is available from the Medical Director and any of its other GPs. The medical centre told HDC: "We expect that our General Practitioners will access the necessary tools and support available if they are uncertain in any area of delivery of medical care."

40. As a result of this case, the medical centre underwent a peer review discussion with doctors from the wider area. The medical centre told HDC that almost none of these doctors had ever received formal instruction with regard to EPOA forms or filling out capacity assessments, despite having been in practice for many years. It stated that the peer review highlighted the need for all health practitioners in the area to receive further education on the completion of capacity assessments and associated documentation.

41. In response to these events, the medical centre stated that training will be provided at the next peer review, so that all health practitioners in the area can improve their knowledge around the EPOA process. Education on capacity assessments and the relevant obligations will be provided in each of its three clinic site meetings.

[11] A brief and sensitive cognitive screening tool for mild cognitive impairment and dementia. It is the recommended cognitive test for use by New Zealand primary care and general secondary care services as part of a dementia assessment.

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42. The medical centre also stated that it has advised its practitioners that it supports them with the right to defer or refuse to complete any assessment or documentation if they do not feel confident to do so, and to refer the patient elsewhere.

43. In response to the provisional opinion, Dr C advised that in addition, the medical centre now requires a written request from the patient's lawyer stating what specific information is required and why, prior to performing a capacity assessment.

Responses to provisional opinion

Mrs B

44. Mrs B was provided with an opportunity to comment on the "information gathered" section of the provisional opinion. She stated that she does not believe it was Dr C's job to decide who should have been taking care of her mother. Mrs B said that she appreciates Dr C's admission that her actions were not appropriate.

Dr C

45. Dr C was provided with an opportunity to comment on relevant sections of the provisional opinion, and stated:

> "The course of events in this case, the complaint and commencement of a formal investigation by your office has been a salutary lesson for me and one I have taken very seriously. There was no malicious intent in my actions … I accept my action of stating that I had performed a capacity assessment when I had not and that [Mrs A] had capacity to appoint an EPOA was wrong … I deeply regret this and have no hesitation apologising to [Mrs A's] family."

Medical centre

46. The medical centre was provided with an opportunity to comment on the provisional opinion, and had nothing further to add.

Relevant standards

47. Chapter 16 of *Coles Medical Practice in New Zealand 2017* — "Mental Capacity" outlines:

> "Assessing capacity is an essential skill for doctors. Any doctor seeking consent for investigation or treatment needs to be able to assess the patient's capacity to give or refuse consent. Doctors may also be asked to assess a patient's capacity to decide about their care and living arrangements, to make a will, to make or activate an enduring power of attorney or to make financial decisions. Although assessing any particular capacity does not require detailed legal knowledge, a doctor must understand in broad terms the relevant legal tests or thresholds for capacity."

48. The Medical Council of New Zealand's "Statement on Medical Certification" (September 2013) states:

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"3. Certificates are legal documents. Any statement you certify should be completed promptly, honestly, accurately, objectively and based on clear and relevant evidence.

4. Your obligation is to the patient and to the law. Issues like the type of certificate being completed or who initiated, or pays, for the consultation must not influence your assessment and findings.

…

6. You must be aware that completing a certificate has implications for the patient, yourself, and the agency receiving the certificate.

…

10. Certificates must meet the standards outlined in relevant legislation and be written legibly, and in such a way that it is understandable to a lay person.

11. The information disclosed should be accurate and based upon clinical observation, with patient comment clearly distinguished from clinical observation."

Opinion: Dr C — breach

49. Ordinarily, a person has a right to make decisions about matters that affect them. However, a constraint upon that right is if a person lacks the mental capacity to make a decision. If a person is incompetent, someone else can override their decisions or make decisions for them. Accordingly, care should be taken when deciding issues of competence, to ensure a balance between allowing patients to make their own decisions, and protecting patients from the harmful consequences of incompetently made decisions. This case concerns the lack of care taken by Dr C when deciding Mrs A's competence.

50. At the time of events, Dr C had been Mrs A's doctor for over two years. As her doctor, Dr C was responsible for ensuring that Mrs A was provided with services that complied with the Code of Health and Disability Services Consumers' Rights (the Code) and, in particular, services that complied with legal and professional standards.

51. In February 2018, Mr A sought to arrange Mrs A's appointment of an EPOA. Mr A's solicitor reportedly had doubts about Mrs A's capacity to do so, and requested that her doctor provide a certificate of mental capacity. On 15 February 2018, Mrs A and Mr A presented to Dr C to obtain documentation regarding Mrs A's mental capacity to appoint an EPOA.

52. An EPOA is a legal document executed in accordance with the requirements of the Protection of Personal and Property Rights Act 1988 (the PPPR Act). A person giving power

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of attorney (the donor) can sign the document only while still competent to do so.[12] The EPOA can be used if the donor later becomes incompetent to make their own decisions.

53. If there is doubt about the donor's mental capacity to give an EPOA, the donor may seek to have their capacity assessed by a doctor, and obtain a doctor's certificate of their capacity before signing the EPOA. A doctor assessing capacity must understand in broad terms the relevant legal tests or thresholds for capacity.[13]

54. The PPPR Act sets out the legal test for mental incapacity once an EPOA has already been given (which, if met, will "activate" the EPOA).[14] However, it does not set out a legal test for capacity to give an EPOA in the first place. The common law test for competence is that a person must be able to understand the nature of decisions and foresee the consequences of those decisions, and communicate them.[15]

55. Accordingly, when Mrs A presented to Dr C, Dr C needed to be satisfied that Mrs A understood the meaning of an EPOA, and how much authority she was giving to Mr A.[16]

56. It is not for me to determine whether at the time of events Mrs A had the mental capacity to make decisions regarding her personal care and welfare, or to appoint an EPOA. However, Dr C stated her opinion that in February 2018 Mrs A would not have been able to understand, retain, and reason through the information required to make a decision to appoint an EPOA. I note also that Dr C was aware of the recently completed Montreal Cognitive Assessment, which indicated severe cognitive impairment.

57. Despite this, within a short timeframe of two days, Dr C completed three forms related to Mrs A's mental capacity. Two stated that Mrs A did not have the mental capacity to make decisions regarding her property and health care, and the final document declared Mrs A to have the mental capacity to make decisions regarding the appointment of an EPOA, despite Dr C's acknowledged opinion that Mrs A lacked that capacity. This final document was also completed using the incorrect form entitled "Health Practitioner's certificate of mental *incapacity* of EPOA".

58. There was no reference to a formal assessment of Mrs A's mental capacity specifically in relation to her decision-making regarding an EPOA appointment or decisions regarding personal care and welfare. Dr C told HDC that she did not assess Mrs A's understanding of appointing someone to make decisions for her, but recalls asking Mrs A if she wanted Mr A to continue looking after her, and she agreed.

59. This final document, which certified Mrs A's capacity to appoint an EPOA, was presented to Mr A's solicitor, and accordingly documentation was completed and signed by Mrs A, appointing Mr A as her EPOA for personal care and welfare. The EPOA was activated shortly

[12] If a donor lacks the requisite capacity, they cannot make an EPOA, but there are other means of appointing substitute decision-makers through the Family Court.
[13] See para 47 above — Chapter 16 of *Coles Medical Practice in New Zealand 2017*.
[14] See section 94 of the PPPR Act.
[15] *X v Y (Mental Health: Sterilisation)* [2004] 23 FRNZ 475 at [51].
[16] See https://www.hdc.org.nz/news-resources/search-resources/articles/enduring-power-of-attorney/

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afterwards by a certificate from another doctor, on the basis of Mrs A being deemed incompetent. Mr A began to make decisions on Mrs A's behalf.

60. Dr C told HDC that she was "confused as to what was required" of her, and she felt that it was in Mrs A's best interests to have Mr A continue to care for her, so she issued him a certificate that stated that Mrs A had the mental capacity to appoint an EPOA.

61. It is clear that Dr C did not understand what was required of her, and lacked knowledge around the capacity assessment process. My in-house advisor, Dr David Maplesden, stated:

> "I would expect a GP who is prepared to sign a certificate regarding capacity of a patient:
>
> - to be aware of the appropriate assessment and documentation process
> - to adequately document the assessment process undertaken and the reasons for the final decision regarding capacity
> - to present the practitioner's opinion accurately in the signed documentation.
>
> It does not appear Dr C satisfied these criteria and I believe her failure to do so represents at least a moderate departure from accepted practice."

62. I agree. If Dr C was confused about what was required of her, and felt uncomfortable and pressured to complete the documentation requested, I consider that she should have familiarised herself with the relevant requirements, or referred Mrs A to an appropriate third party for the assessment. Dr C also had access to collegial support at the medical centre. The medical centre told HDC that collegial support was and is available from the Medical Director and any of its other GPs, and that it "expect[s] that [its] General Practitioners will access the necessary tools and support available if they are uncertain in any area of delivery of medical care".

63. The Medical Council of New Zealand's "Statement on Medical Certification" (September 2013) clearly states that certificates are legal documents, and should be completed promptly, honestly, accurately, and objectively, based on clear and relevant evidence. In my view, Dr C completed the documentation inappropriately and at odds with the Medical Council statement, by declaring that Mrs A had mental capacity when Dr C herself did not think this was the case. She did so because she considered that it was in Mrs A's best interest for Mr A to be appointed as Mrs A's EPOA. As a result, Mrs A later signed EPOA documentation appointing Mr A as her EPOA for personal care and welfare, despite evidence that she lacked capacity to do so.

64. I am concerned that Dr C completed important documentation regarding Mrs A's capacity without first assessing Mrs A's competence adequately and satisfying herself that she was familiar with the process and requirements of certifying capacity in these circumstances. Furthermore, Dr C's certification of Mrs A's capacity to appoint an EPOA did not reflect her actual clinical opinion.

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65. By failing to perform a formal assessment of mental capacity to appoint an EPOA, and certifying Mrs A's mental capacity to appoint an EPOA contrary to her own opinion, Dr C failed to provide services to Mrs A that complied with legal and professional standards. Accordingly, I find that Dr C breached Right 4(2)[17] of the Code.

Opinion: Medical centre company — no breach

66. As a healthcare provider, the medical centre company is responsible for providing services in accordance with the Code. Mrs A and her partner presented to the medical centre to see Dr C in February 2018, in order to obtain a certificate declaring Mrs A capable to make a decision regarding appointment of an EPOA. As outlined above, Dr C failed to satisfy herself that she was familiar with the mental capacity and EPOA documentation process, and accordingly did not complete the documentation as per the relevant legal and professional guidelines.

67. The medical centre stated that electronic guidelines and pathways are available for its GPs to access through the patient management system, and that this includes capacity assessment tools. In addition, the medical centre stated that collegial support is available from the Medical Director and any of its other GPs, and it expects that its GPs will access the necessary tools and support available if they are uncertain in any area of delivery of medical care.

68. Dr Maplesden advised:

> "All medical practitioners have a responsibility to identify weaknesses in their clinical knowledge and to address these weaknesses as part of professional development. I believe identification of weaknesses is generally an individual's responsibility, while an organisation such as [the medical centre] has a role in facilitating addressing of the issues (eg through education).
>
> In this case, [the medical centre] was not aware of the apparent organisation-wide uncertainty over processes for capacity assessment and certification and nor would I expect it to be unless there had been prior complaints related to this process."

69. I accept Dr Maplesden's advice. Whilst medical centres have a responsibility to facilitate and assist their staff to provide services in accordance with the Code, I consider that Dr C's conduct amounted to an individual failure, and did not indicate broader systems or organisational issues at the medical centre. Therefore, I find that the medical centre company did not breach the Code.

[17] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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Recommendations

70. I acknowledge that Dr C has since undertaken steps to educate herself on the requirements for completing mental capacity documentation. In addition, I recommend that Dr C arrange for a peer review of the next three mental capacity documents she signs, to ensure that these have been completed appropriately and in accordance with the relevant guidelines. An update of the peer assessment is to be sent to HDC within 12 months of the date of this report.

71. In response to the recommendations made in the provisional opinion, Dr C provided HDC with a written apology to Mrs A's family for her breach of the Code, and provided evidence of her attendance at three seminars/courses on the topic of completing mental capacity documentation. I therefore consider these recommendations to have been met.

72. I recommend that the medical centre:

    a) Provide HDC with evidence of the training outlined in paragraph 41, within four months of the date of this report.

    b) Develop an educational booklet on mental capacity assessment and the EPOA process, to be placed on its patient management system for access by GPs in all the medical centre facilities. Evidence that this has been completed is to be sent to HDC within six months of the date of this report.

73. I recommend that the district health board consider creating and implementing an educational booklet for GPs in the area, to assist with capacity assessments.

Follow-up actions

74. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr C's name.

75. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Royal New Zealand College of General Practitioners, the Ministry of Health, and the district health board, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: In-house clinical advice to the Commissioner

The following expert advice was obtained from GP Dr David Maplesden:

"1. I have reviewed the information on file in this case. [Dr C] completed a medical certificate on 16 February 2018 confirming her patient, [Mrs A], had capacity to sign Enduring Power of Attorney (EPA) documentation in relation to [Mrs A's] personal care and welfare, and property. However, she states in her response that at the time of this certification she felt [Mrs A] actually lacked capacity to make decisions regarding personal care and welfare and her reason for signing the capacity certificate was to facilitate [Mrs A's] partner being appointed the EPA as she felt sure this would be [Mrs A's] wish based on her experience of the couple's interactions over some years. [Dr C] has acknowledged her reasoning was flawed and provision of a certificate stating [Mrs A] had capacity for the decision making in question was inappropriate. She outlines factors contributing to her error as a lack of knowledge in the area of capacity assessment and certification, and a perceived degree of pressure to facilitate appointing of [Mrs A's] partner as EPA. Since the events in question she has undertaken further education on capacity assessment and documentation using the local and national resources cited in the response.

2. Clinical notes dated 15 February 2018 are*: Here for medical certification of [Mrs A's] mental capacity. Has been to see a lawyer who recommended getting letter from GP regarding [Mrs A's] mental capacity.* There is no reference to formal assessment of [Mrs A's] capacity being undertaken on that date. On 2 February 2018 [Dr C] had referred [Mrs A] for a NASC assessment citing *dementia and decline in function* as the reason for the referral. In that referral there is reference to a Mini Mental 23/30 on 24 July 2013. The referral was re-sent on 9 February 2018 following current MOCA with the note *MOCA attached 7/30* (undertaken on 8 February 2018). On review of clinical notes from February 2017 to February 2018 I could find no reference to a formal assessment of capacity specifically in relation to decision making for EPA appointment or decisions regarding personal care and welfare.

3. A copy of the certificate completed by [Dr C] is represented below:

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Health practitioner's certificate of mental incapacity for EPOA

I, a health practitioner, certify that-

1 I am a health practitioner registered, with New Zealand Medical Council is a practitioner of general practice.

2 My scope of practice includes the assessment of a person's mental capacity.

3 On 15/02/2018 I examined/assessed the donor of the enduring power of attorney.

4 In my opinion, the donor is mentally capable to make a decision regarding appointment of an enduring power of attorney.

5 The reasons for my opinion are based on personal knowledge of as a patient, and review of medical documentation on file.

Date: 16 Feb 2018

4. On 12 March 2018 [a doctor] certified [Mrs A] lacked capacity to make decisions, or understand the nature of decisions, in regard to her personal care and welfare. I am unable to comment on the nature and extent of the assessment undertaken on this date.

5. Coles Medical Practice in New Zealand 2017 includes the comment: *Assessing capacity is an essential skill for doctors. Any doctor seeking consent for investigation or treatment needs to be able to assess the patient's capacity to give or refuse consent. Doctors may also be asked to assess a patient's capacity to decide about their care and living arrangements, to make a will, to make or activate an enduring power of attorney or to make financial decisions. Although assessing any particular capacity does not require detailed legal knowledge, a doctor must understand in broad terms the relevant legal tests or thresholds for capacity.* Comprehensive resources are available for supporting the clinician's role in assessing capacity including a capacity assessment toolkit published in 2016, which [Dr C] has accessed following the events in question. The Medical Council of New Zealand lists professional obligations required when completing medical certification including:

- *Certificates are legal documents. Any statement you certify should be completed promptly, honestly, accurately, objectively and based on clear and relevant evidence.*
- *Your obligation is to the patient and to the law. Issues like the type of certificate being completed or who initiated, or pays, for the consultation must not influence your assessment and findings.*

6. While I am unable to comment on whether or not [Mrs A] had or lacked capacity to make decisions regarding her personal care and welfare in February and March 2019, it appears [Dr C] was of the opinion [Mrs A] lacked such capacity yet she signed a certificate to the effect [Mrs A] retained such capacity. The primary reason for this action appears to be a deficiency of knowledge surrounding the capacity assessment

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process. I would expect a GP who is prepared to sign a certificate regarding capacity of a patient:

- to be aware of the appropriate assessment and documentation process
- to adequately document the assessment process undertaken and the reasons for the final decision regarding capacity
- to present the practitioner's opinion accurately in the signed documentation

7. It does not appear [Dr C] satisfied these criteria and I believe her failure to do so represents at least a **moderate** departure from accepted practice. If [Dr C] did not feel comfortable making the assessment in question or completing the certification, it would have been appropriate to defer the assessment until she familiarised herself with the requirements of the process or for [Mrs A] to be referred to an appropriate third party for the assessment. I note [Dr C] has now familiarised herself with the assessment and certification process and she has apologised to the family of [Mrs A] for any distress caused by her actions. I think these are appropriate remedial actions."

The following further advice was received from Dr Maplesden:

"This advice should be read in conjunction with my original advice dated 19 May 2020. I have reviewed additional information provided by [Dr C] and [the medical centre]. There is no new information provided by [Dr C] which alters my initial comments.

[Medical centre] response

1. The topic of capacity assessment was discussed at a peer group meeting with findings that almost none of the participants had ever received formal instruction in capacity assessments or completing an EPA form, the local standard was a variety of ad hoc processes, and none of the participants were aware of the publication 'A Toolkit for Assessing Capacity' cited in my initial advice. The response suggests my statement regarding accepted practice with respect to assessment and documentation of capacity did not accurately represent actual practice. My statement read:

I would expect a GP who is prepared to sign a certificate regarding capacity of a patient:

- *to be aware of the appropriate assessment and documentation process*
- *to adequately document the assessment process undertaken and the reasons for the final decision regarding capacity*
- *to present the practitioner's opinion accurately in the signed documentation*

2. Local research published in 2018 supports [the medical centre's] impression of GP knowledge regarding assessment of capacity. Extracts include:

- *In general, the respondents' knowledge about the principles of capacity assessment was adequate and there was some evidence of better knowledge among those who had had training in capacity assessment. However, the majority of doctors were*

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either not confident or confident only for straightforward cases, in being able to do capacity assessments to a medico-legally acceptable standard, that is, to a standard high enough to have their opinion presented in a court.

- *The majority of respondents did not use a structured method of assessment. These findings suggest the respondents were aware of a need to improve their capacity assessments and that any teaching should focus on providing a structure for doing so.*
- *It is of some concern that one-third of responding hospital doctors and over half of responding GPs did not appear to know that a capacity assessment applies to a specific decision. Many respondents incorrectly believed that a patient's next of kin, without having an enduring power of attorney (EPOA), could give legal consent on the patient's behalf.*
- *A significant number of respondents (HDs: 30%; GPs: 24%) did not consider capacity assessment to be within their scope of practice. This response is surprising considering the assessment of a patient's capacity is integral to obtaining informed consent. The Medical Council of New Zealand has advised that all doctors should be able to assess capacity.*
- *This research suggests that many of the doctors surveyed had deficiencies in their clinical and legal knowledge on assessing capacity, and lacked confidence in their opinion. Efforts to educate doctors on the importance of, and how to perform, a capacity assessment would be beneficial and well-received.*

3. On the other hand, assessment of capacity has been raised as an issue by MPS in several articles since 2012 and constitutes a chapter in the current 'Coles Medical Practice in New Zealand' since 2017. The Goodfellow Unit has had an on-line training module available since 2018 and has undertaken other education sessions on the topic since at least 2017 (including a Webinar on 6 October 2020). The Medical Council of New Zealand notes, in its 2016 publication 'Good Medical Practice':

You must be competent in each professional role you hold. You must follow relevant guidance, including the guidance published by the Council, and continue to develop your knowledge and skills. This applies to all doctors, and to all aspects of your medical practice including management, research and teaching ... Recognise and work within the limits of your competence … Keep your knowledge and skills up to date throughout your working life:

- *familiarise yourself with relevant guidelines and developments that affect your work*
- *take part regularly in professional development activities that maintain and further develop your competence and performance*
- *adhere to and keep up to date with all laws and codes of practice relevant to your work.*

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4. I believe the main issue [the medical centre] are alluding to in their response is the distinction between accepted practice (which I believe is accurately represented in the statement referred to in section 1) and what might be regarded as common practice. It may be that it is common practice for assessment of capacity to be undertaken by some (and perhaps a majority) of GPs in an unstructured fashion without adequate knowledge of the appropriate process, but such an approach would be hardly regarded as acceptable with respect to other aspects of healthcare. I cannot predict what other GPs might have done when faced by the situation presented to [Dr C] but there are some actions specific to this case which have influenced my advice: [Dr C] acknowledged she was unclear about the process she was undertaking but continued to sign a legal document despite this uncertainty; within a very short time frame [Dr C] twice documented the patient as lacking capacity to make decisions regarding her personal health and then assessed her as having capacity to make a decision regarding EPA although she states she did not actually believe this to be the case; the assessment process and rationale for the final decision was not documented. In light of these specific factors I remain of the view that [Dr C's] actions represent a moderate departure from accepted practice and an educational approach to this issue is most appropriate. I acknowledge the research showing assessment of capacity is often performed poorly in primary care, although an increasing number of educational resources are available to address this issue. All medical practitioners have a responsibility to identify weaknesses in their clinical knowledge and to address these weaknesses as part of professional development. I believe identification of weaknesses is generally an individual's responsibility, while an organisation such as [the medical centre] has a role in facilitating addressing of the issues (eg through education). In this case, [the medical centre] was not aware of the apparent organisation-wide uncertainty over processes for capacity assessment and certification and nor would I expect it to be unless there had been prior complaints related to this process. I believe [the medical centre] and [Dr C] have undertaken appropriate actions since identifying the deficiency in capacity assessment knowledge and I have no further recommendations for remedial actions."

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