General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 03HDC19027)

Parties involved

Mr A	Consumer
Mrs A	Consumer's wife
Dr B	Provider/General Practitioner
Dr C	Medical Director, Medical Centre
Dr D	General Practitioner
Dr E	Psychiatrist

Complaint

On 15 December 2003 the Commissioner received a complaint from Mrs A about services received from Dr B. The following issue was identified for investigation:

The adequacy and appropriateness of Dr B's assessment and treatment of Mr A on 28 November 2003.

An investigation was commenced on 4 March 2004.

Information considered

During the course of my investigation I reviewed information from Mr and Mrs A, Dr B, Dr C, the Medical Centre, and Dr D, general practitioner. Independent expert advice was provided by general practitioner Dr Keith Carey-Smith.

Summary of facts

On 28 November 2003, Mr A presented to the Medical Centre (the Centre) reporting depression and anxiety. Mr A was seen by Dr B.

Dr B informed me that this was the first time he had seen Mr A. His immediate mental picture was of a healthy young man in his mid to late twenties, who appeared alert and lucid. Dr B recalled that Mr A reported "odd, spontaneous episodes of feeling down", feeling anxious and an increased heart rate. The symptoms were of short duration but had been occurring periodically for the past nine years. Mr A reported that he had seen a number of doctors over that time for these symptoms and had received counselling, but no medical problems had been found.

Mr A recalled that he told Dr B that he had woken during the night of 27/28 November with "strange thoughts" which he described as "psychotic delusions". He had had similar symptoms ten years earlier when he had been successfully treated with antidepressants and counselling. Mr A told Dr B that he had a bout of glandular fever in 2002, and had suffered from depression at that time. On this occasion he was treated, short-term, with antidepressants. He questioned whether there was a link between the symptoms and the glandular fever.

Dr B informed me that he questioned Mr A about these events and found that he had used drugs at the time of the other episodes, and had "crashed" emotionally. He had been advised to slow down, stop taking drugs and to rest.

Dr B recorded the consultation. He noted:

> "Hx [history] Episodes of depressions – waves
> Started with drug use at 18 years – has used LSD
> Married 3/12 [three months] ago
> Had a bad car crash 9 years ago – has been seen by doctors – developed glandular fever. Comes out in sweats, tachycardia [rapid heart rate].
> OE [on examination] Clinically well, lucid.
> Normal drugs 6 years.
> Good relationship with parents. Not suicidal – had thoughts in past – years ago.
> Shared Gospel – has been through all counselling etc."

Mr A informed me that his consultation with Dr B took about 15 to 20 minutes and during that time Dr B did not take his blood pressure, pulse or temperature, but told him, "It looks like Satan has got his hooks into you. We are all born with sin and this needs to be gotten rid of." Dr B told him that he should look to God and the Church and gave him two books on religion published by the 'Crusaders of Christ'.

Mr A stated that he had been to see a doctor previously who was a Christian who "never pushed his views onto other people". He said that he was "unconcerned" by the information on the medical centre walls that indicated it was a Christian based practice. Mr A stated that under normal circumstances he would have "stormed out" of the consultation, but because he had such bad depression, he just sat there. He said that Dr B did not offer him counselling or referral to a counsellor or psychiatrist, but asked him whether he had considered spiritual healing.

In contrast, Dr B advised me:

> "[Mr A] said he had no reason socially to have these bouts of anxiety. He also stated that he was happy at work. He was perplexed that he was having such an 'episode' when he was happy.
>
> After gleaning this information, I felt it was important to share what I believe is important for the whole person; the tripod of physical, emotional and spiritual health.

I apply this principle in my practice. … In discussing his physical health, he said that nothing was ever found. (Apart from his glandular fever). As he looked well and healthy, I proceeded to his emotional health.

I suggested that he be referred to either a psychiatrist or a counsellor to help him with any deep emotional issues of his past, his use of drugs etc. I could not address such deep issues in a 15 minute consultation. He told me that he had had a lot of counselling before and in his own words, to my recollection, he said, 'I have been down that path before, and it hasn't helped me'. I thus felt it appropriate, in the sequence of the consultation, to share the spiritual aspect of his health.

If I decide to discuss the spiritual aspect with a patient, I usually tell them a bit about my testimony and that I had started seeking spiritually about 10 years ago. … I also share how I have, since becoming a Christian, seen many people who were heavily involved in drugs and alcohol, be markedly changed by finding their faith in God.

Referring to the quote, 'It sounds like Satan has got his hooks into you. We are all born with sin and this had to be gotten rid of'. It appears that this quote has been taken out of context. The contents of the quote were all discussed within the consultation, but not as a one-liner as stated. This was part of explaining the Gospel over a 10 to 15 minute period.

…

In leaving, I handed [Mr A] a short Gospel book of John and a small tract on who God is, as I felt it might help him better understand what I had said to him. I told him he didn't have to take them; he could throw them away if he felt they were of no help. He readily took the booklets. … I asked [Mr A] if there was anything else he wanted to discuss. He said 'No'. My advice to him on leaving was to see how he went with what we had discussed and to return at any time he wanted.
…

In my clinical judgement, I did not feel that [Mr A] was physically ill or toxic, or that he was more than mildly depressed, in fact in my opinion, I feel that his 'depression' was more anxiety as to why he was getting these unexplained episodes, when he was in essence a happy person. I did not do a Beck Depression questionnaire which I normally use if I think a patient is depressed."

Consultation with Dr D

Mr A was upset when he returned home and Mrs A arranged for him to be seen later that day by Dr D, a general practitioner at another medical practice. Dr D informed me that his assessment of Mr A was that of an "upset young man who was finding it very difficult to cope with life". He performed a screening test to assess whether Mr A was suffering anxiety or depression and found that he was demonstrating a significant mental disturbance. Dr D discovered that Mr A had had blood tests performed earlier by another

general practitioner, checked the results and found that his renal, liver and thyroid functions were normal.
Dr D stated:

> "I felt it very important that he had treatment with medication and an opinion from a psychiatrist. … After some discussion he agreed to trial the medication [Aropax 20mg] as he was a bit diffident because of a previous reaction to some similar medication."

Follow-up
Mrs A and her father went to the Centre approximately an hour and a half after her husband's consultation with Dr B to complain about the service provided to her husband. Mrs A informed me that she and her father spoke with one of the nurses at the medical centre, who did not acknowledge that there was an "ethical issue".

Mrs A stated:

> "[The nurse] proceeded to tell us we were not in the medical profession and that she had seen people cured by accepting God into their lives. She would make no apology for what had gone on and fully agreed with the procedures the doctor had taken. A refund was demanded and given at this time."

Dr C, the Medical Director at the Centre informed me that the practice nurse advised Mrs A to make a complaint on the form the Centre provides for this purpose. On Dr B's instruction, the $45.00 consultation fee was reimbursed. Dr C stated that it was his expectation Mrs A would return the completed complaint form so that the Centre would have the opportunity to try to remedy her complaint, but unfortunately this did not happen.

Dr C advised me:

> "The medical practitioners and other staff at the Centre are practising Christians whose primary aim is to provide high quality medical care to our patients to the best of our ability. We believe we should address physical, emotional and mental needs but, because we believe that there is a spiritual dimension to our patients' lives, we are prepared to discuss this area as one of our treatment options if it is relevant and acceptable to the patient."

Assessment by a psychiatrist
Mr A saw Dr E, psychiatrist, on 22 December 2003. Dr E reported his assessment of Mr A to Dr D in a letter dated 24 December. Dr E noted:

> "Probable diagnosis: Mixed anxiety – depressive disorder with panic.
>
> Thank you for referring this young man whom I interviewed – examined alone on December 22. He was fully alert and coherent, and feeling considerably more settled

> after consulting you about 3 weeks ago, and proceeding with Aropax 20mg each breakfast. I chiefly endorsed and ratified your and his opinions."

Dr E went on to detail his discussion with Mr A about his history and treatment options. Dr E suggested to Dr D that he would be prepared to review Mr A "if any awkwardness recur".

Dr B's apology
Dr B stated:

> "I am truly sorry if I have offended [Mr A], his wife and his father, as my intention as a doctor is always to bring healing to my patients. This was my heart's desire for [Mr A] and I had no other agenda. I believe I treated him safely and to the best of my ability.
>
> I have stopped working as a GP since 31 December 2003 and am no longer practising as a doctor."

Independent advice to Commissioner

The following expert advice was obtained from Dr Keith Carey-Smith, an independent general practitioner:

> "In order to provide an opinion to the Commissioner on case number 03/19027, I have read and agree to follow the Commissioner's Guidelines.
>
> My opinion is based on my training in medicine and general practice, and my experience and ongoing CME as a rural general practitioner in Taranaki for over 30 years. This includes general practice care of patients in three rest homes, including hospital level beds.
>
> My qualifications are FRNZCGP, Dip Obstet (NZ) and DA(UK).
>
> **Purpose**
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> To provide independent advice about whether [Mr A] received an appropriate standard of care from [Dr B], general practitioner.
>
> **Background**
>
> The events surrounding the case are summarised in the Expert Advice notice. The summary relating to the consultation involving [Dr B] are repeated below as relevant.

Complaint /Issues under investigation

- *The adequacy and appropriateness of [Dr B's] assessment and treatment of Mr A on 28 November 2003.*

Documents and records reviewed

Information from:

- Letter of complaint from [Mrs A] to the Commissioner, dated 15 December 2003, marked with an 'A'. (Pages 1 – 7)
- Notes taken during a telephone conversation with [Mrs A] on 25 February 2004, marked with a 'B'. (Page 8)
- Notes taken during a telephone conversation with [Mr A] on 26 March 2003, marked with a 'C'. (Pages 9 & 10)
- Letter of response from [Dr B], dated 21 March 2004, marked with a 'D'. (Pages 11 – 16)
- Letter of response from [Dr C], Medical Director, [the] Medical Centre, with supporting documentation, dated 26 March, marked with an 'E'. (Pages 17 – 21)
- Letter of response from [Dr D], dated 7 April 2004, marked with an 'F'. (Pages 22 & 23)
- Letter of response from [Dr D], dated 27 April 2004, marked with a 'G'. (Pages 24)

Expert advice requested:

To advise the Commissioner whether in your opinion:

- [Dr B] provided [Mr A] with services of an appropriate standard.

In particular:

- Was [Dr B's] assessment and proposed management of [Mr A] symptoms on 28 November appropriate?
- If not, what should he have done?

In addition:

- Are there any other professional, ethical and other relevant standards that apply and, in your opinion, were they complied with?
- Any other comments you consider relevant that may be of assistance?

General comments:

The incident relates to a single episode of care on 28 November 2003, when [Mr A] consulted [Dr B] for the first time, complaining of anxiety and depression, and giving a history of previous depression, anxiety, and drug use. [Dr B] obtained a brief medical and psychiatric history, including enquiry about suicidal ideation, and then proceeded to give advice at a spiritual level. No physical examination was performed and no medication prescribed. [Mr A] later went to another GP who prescribed

antidepressant medication and referred him to a psychiatrist. These facts are agreed by both parties

[Mrs A] ([Mr A's wife]) maintains that
- The spiritual advice ("personal beliefs and opinions"; "preaching to people") without medical treatment was inappropriate
- The spiritual healing was "put like a threat" rather than offered

[Mr A] confirmed that [Dr B] "pushed his views", that he was "lectured" about God and Satan, and also stated that [Dr B] did not ask him if he was suicidal, but that he volunteered the information anyway. However he also stated that [Dr B] "asked him about whether he had considered spiritual healing" before "going on about Satan's hooks". He said that he was not offered referral to a counsellor or psychiatrist, and implied that he had not been offered medication either.

[Dr B's] description of the consultation (supported by his records) confirms the spiritual discussion, and includes the following:
- Discussion about [Mr A's] physical and emotional health
- An enquiry as to whether he had been suicidal
- An offer of referral to a psychiatrist or counsellor, noting that "he told me that he had had a lot of counselling before and in his own words to my recollection he said "I have been down that path before and it hasn't helped me".

He gave a description of his usual approach to discussing spiritual aspects, starting with his own spiritual testimony, and then describing the 3 components of a person – spirit, soul and body. He confirmed using the satanic "fishhook" analogy, as a possible cause of [Mr A's] anxiety attacks, and giving a Christian gospel and tract (telling him he did not have to take them). He says he felt that antidepressants were not indicated. He stated that he asked [Mr A] three times if he was happy with the consultation, and received an affirmative answer, and also gave him the option of ignoring the "spiritual side". He did not feel that [Mr A] was unhappy or ill at ease, but appeared to be taking an interest in the discussion, and to leave appearing happy and expressing thanks.

The … Medical Centre practice has a Christian staff and philosophy, which is evident in the Medical Director's statement that spiritual as well as physical, mental and emotional dimensions are addressed when relevant and acceptable. [Mr A] indicated that there were hints about the Christian philosophy of the practice because of information on the walls.

Specific advice requested:

- *Was [Dr B's] assessment and proposed management of [Mr A] symptoms on 28 November appropriate?*
- *If not, what should he have done?*

Assessment

From the records and information provided I would assess the history taking as comprehensive and appropriate, covering medical, psychiatric and social spheres. [Dr B] clarified the presenting anxiety attack problem, and the history obtained included injuries, medical conditions, previous medical checks, and drug taking. He covered appropriately the social and family context, and ensured the patient was not suicidal. There is no record of enquiry about other symptoms of depression or psychotic symptoms. Although [Dr B] listed the primary diagnosis as "Mild depression" in the notes, he states that he diagnosed anxiety attacks (with no more than mild depression) as the primary problem. This is consistent with the assessment later provided by the psychiatrist [Dr E]. Anxiety and mild depression often coexist, and it is often impossible, and not clinically important, to determine the primary condition.

Physical examination was not performed, but I do not consider this to be a significant omission in a young fit-looking man with primarily psychological symptoms who had been previously medically assessed. It is entirely appropriate in primary care to focus on the presenting problem if there are not markers or risk factors for serious physical disease. He states that he did not feel [Mr A] was physically ill or toxic.

Management

There are a variety of different approaches to management of anxiety and depression, depending on the training and emphasis taken by the practitioner. In this case, [Dr B] chose to offer a spiritual approach in the first instance. This was apparently initially acceptable to [Mr A].

The more common approach would be to commence with general and specific advice, offer referral, and consider medication in more severe cases. Having excluded severe depression, it is a legitimate and acceptable option, and sometimes preferable, not to prescribe anti-depressants as initial management. Most GPs, and many patients, prefer an initial non-pharmacological approach. Failure to respond would then lead to consideration of appropriate medication. I understand that anxiety with panic attacks responds well to a cognitive psychological approach, although it also responds well to medication. The option chosen would depend to a large degree on patient choice and severity of the condition.

Prescribing anti-anxiety drugs, or antidepressants with anti-anxiety effects, should normally be considered only in more disabling or severe cases, and then only alongside general advice, support, and appropriate counselling. Referral to a psychiatrist is seldom necessary, unless the diagnosis is uncertain, the patient fails to improve, or if the patient requests a second opinion. It is quite appropriate to use the initial interview to develop a relationship with the patient, and make some initial suggestions, with later review to determine ongoing management. I would seldom prescribe anti-anxiety or antidepressant drugs at the first interview with a new patient, except for short term relief prior to a follow-up consultation.

In this case it is relevant to compare [Dr B's] management with that of [Dr D]who saw him later the same day. [Dr D] made a similar diagnosis, checked blood pressure, and pulse (and blood tests previously done), prescribed an antidepressant (even though the patient was reluctant), and later referred him to a psychiatrist.

These two approaches illustrate two ends of a spectrum, neither being clearly superior, and both indicating competent practitioners attempting to do their best for their patient. In both cases the practitioner considered his management appropriate, and both approaches are in my view acceptable, though not ideal. With [Dr B], [Mr A] did not indicate disagreement with the direction being taken (apart from possibly declining counselling), whereas with [Dr D], the patient expressed reluctance to take medication but eventually agreed. [Dr B's] approach was clearly unacceptable to [Mr A's] wife and father (an opinion later expressed by [Mr A] himself). The apparent acceptance of [Dr B's] approach by [Mr A] at the time, could have masked an un-expressed disagreement with the spiritual nature of the discussion. His state of anxiety and depression are likely to have made it more difficult to express dissatisfaction with this spiritual management approach. [Dr B] failed to pick this up at the time. An alternative approach would have been to raise and discuss all appropriate management options, and then give the patient the option of commencing one of the options now, or returning later to look further at whichever option was preferred, with a support person if wanted.

In addition there is no evidence that [Dr B] raised or discussed the medication option with [Mr A]. Counselling was however discussed (mentioned also in notes) with the implication that [Mr A] initially declined this option. Follow-up arrangement may not have been clear to [Mr A], and were not recorded in the notes, although [Dr B] stated that he offered a return visit if he wanted further help.

Other issues:

- Are there any other professional, ethical and other relevant standards that apply and, in your opinion, were they complied with?
- Any other comments you consider relevant that may be of assistance?

General practices (or individual practitioners) have varying cultures, emphases, and working philosophies. If the "culture" of the practice impacts on patient management, or departs significantly from the standard or conventional approach, it is important that clients/patients are made aware of this variation, so that they can choose to attend a different practice if preferred. However in my experience, most "Christian" practices take a conventional approach to care of most patients, and only include a spiritual emphasis when this seems appropriate or is raised by the patient. My own practice operates in this way. It would appear that [the] Medical Centre operates similarly. "Low key" waiting room notices or wording of the practice name may be provided as an indicator to Christian patients that spiritual issues can be raised safely in the practice.

However in this situation it is essential for all clinical staff to avoid an overt spiritual approach without taking extra steps to ensure the patient is happy with this approach. This is particularly important when the patient is vulnerable because of emotional or psychological issues. [Dr B] clearly took insufficient care to determine whether the approach he took was fully acceptable, before launching into his discussion. As a Christian myself, I would also take issue with the detail of [Dr B's] spiritual approach when the patient's religious views are not known. His approach might be appropriate for a known devout Christian believer, but not for someone with a secular world-view. It is suggested that [Dr B] upskill in the art of patient-centredness and the ability to discern the patient's agenda. This could be done by appropriately focussed professional development (eg. a peer group with other Christian doctors working in conventional practices). The practice as a whole should clarify, for the benefit of both staff and patients, whether it should remain "conventional", or focus on a purely Christian clientele.

CONCLUSION

It is my opinion that [Dr B] conducted the consultation safely and thoroughly, that his assessment was appropriate, but that his management was weighted too heavily in favour of a spiritual approach, without checking carefully that this was acceptable to [Mr A]. In addition he failed to raise or discuss the option of medication, which, although not always indicated as a first choice, is an effective alternative management option. In other respects, services provided by [Dr B] were of an appropriate standard."

Commissioner's opinion

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.*

RIGHT 5
Right to Effective Communication

1. *Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided.*

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 the receive, including −*

   …

   (b) an explanation of the options available …

No Breach — Dr B

Assessment and treatment
My independent general practitioner advisor, Dr Carey-Smith, commented that although Dr B did not perform a physical examination of Mr A, this was not a significant omission in a fit-looking young man with primarily psychological symptoms who had previously been medically assessed. Dr Carey-Smith stated that there are different approaches to the management of anxiety and depression. The more common approach is to commence with general and specific advice and offer referral, and in more severe cases medication is considered. If the patient is not severely depressed, management with antidepressants is not usually the first option except for short-term relief of symptoms prior to a follow-up consultation. Dr Carey-Smith advised that when the patient is not severely depressed referral to a psychiatrist is seldom necessary unless the diagnosis is uncertain, the patient

fails to improve, or if the patient requests a second opinion. He commented that it was relevant to compare Dr B's management of Mr A with that of Dr D.

Dr Carey-Smith stated:

> "The two approaches illustrate two ends of a spectrum, neither being clearly superior, and both indicating competent practitioners attempting to do their best for their patient. In both cases the practitioner considered his management appropriate, and both approaches are in my view acceptable, though not ideal. With [Dr B], [Mr A] did not indicate disagreement with the direction being taken (apart from possibly declining counselling), whereas with [Dr D], the patient expressed reluctance to take medication but eventually agreed."

Dr Carey-Smith considered that Dr B's history taking was comprehensive and appropriate. He clarified the presenting anxiety attack problems and obtained a history that included social and family factors, previous injuries, medical conditions and assessments, and drug taking. He ensured that Mr A was not a suicide risk. Dr B noted his primary diagnosis for Mr A of "mild depression", which was consistent with the psychiatric assessment three weeks later.

Discussion during consultation
Mr A was disturbed by the nature of the conversation he had with Dr B at the consultation. Mr A had attended the Centre previously and knew that it was a Christian based practice. He was "unconcerned" by the information displayed on the surgery walls indicating their Christian based approach. However, he became concerned about the spiritual emphasis and the content of the discussion with Dr B.

Mr A stated that because of his depressive state, he was unable to convey to Dr B that he considered this approach inappropriate. This may explain why Dr B gained the impression that Mr A was quite at ease during the consultation.

Dr Carey-Smith advised that most Christian medical practices take a conventional approach when treating patients and only include a spiritual emphasis when this seems appropriate or is raised by the patient. He stated that Dr B's management was weighted too heavily in favour of a spiritual approach without carefully checking that Mr A was comfortable with this. Mr A's anxiety and depression would have made it more difficult for him to express dissatisfaction with Dr B's management. Dr Carey-Smith stated that Dr B failed to appreciate this, and that he should have discussed all appropriate management options, including the option of starting medication.

My comments
I have carefully considered Dr Cary-Smith's advice that, although Dr B failed to appreciate that, for Mr A, the inclusion of a holistic/spiritual emphasis to treatment was inappropriate, the consultation was conducted safely and thoroughly. I agree with that advice, and in my opinion, Dr B's medical care was of an appropriate standard, and he did not breach Right 4(1) of the Code.

However, I consider that the practice of offering a spiritual approach to treatment calls for sensitive communication. The doctor needs to check whether the patient is comfortable with a spiritual approach before proceeding – even if there are posters on the walls indicating the faith-based nature of the practice. Patients also need to have all the options for treatment (eg, from a spiritual approach to a medical intervention approach) explained, so they can decide what kind of treatment to opt for. Dr B has raised spiritual matters with Mr A without any prior indication that this would be part of the treatment offered, or that it was what Mr A wanted. Mr A stated that he would not normally have accepted this approach, but because of his depressed state he was unable to indicate this to Dr B. I endorse my expert's view that if the orientation of a practice departs significantly from a standard or conventional approach in a way that impacts on patient management, it is important that patients are informed.

I also think it was quite inappropriate for Dr B, even as a Christian practitioner, to tell Mr A that "it looks like Satan has got his hooks into you".

Follow-up Actions

- A copy of this report will be sent to the Medical Council of New Zealand.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.
- No further action will be taken in light of the fact that Dr B has retired from practice.