General Practitioner, Dr B

A Medical Centre

A Report by the

Health and Disability Commissioner

(Case 13HDC00059)

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Executive summary

1. In 1999 Mrs A (aged 22 years) transferred to a medical centre. From November 2007, Mrs A usually consulted general practitioner Dr B.

2. Mrs A remained under the care of Dr B until 7 February 2013. During that time, Mrs A presented on numerous occasions to Dr B with various concerns including an eating disorder, anxiety, and obsessive-compulsive disorder.

3. Dr B discussed "self pleasure" with Mrs A, indicating that it would be a useful treatment for her eating disorder.

4. Dr B made comments about Mrs A's body, and Mrs A said that Dr B told her that he liked seeing her and thought of her after work hours.

5. Dr B recommended therapeutic use of sexual behaviours, low pressure water enemas, and deep abdominal massage as treatment for Mrs A. Dr B prescribed Mrs A with glycerol suppositories, despite her known risk factors including a history of laxative abuse, her eating disorder, weight loss, and her apparent fixation on purging. When Mrs A complained of constipation, Dr B did not conduct an abdominal or per rectum examination.

6. Dr B prescribed zopiclone for Mrs A from 2007 until 2013. He continued to do so after 8 February 2010, when Mrs A took an apparently accidental overdose of the medication. Between March 2010 and March 2011 Mrs A was prescribed zopiclone in significant amounts with no review over the 12-month period.

7. In 2010 Dr B wrote a referral letter to psychologist Dr C, but the letter was not received by Dr C. Dr B did not follow up the referral. Mrs A self-referred to Dr C in 2012.

8. In February 2013 Mrs A transferred to a new general practitioner at another medical centre.

Decision summary

9. Dr B's repeated discussion of masturbation and his inappropriate comments to Mrs A were a breach of sexual boundaries. As a medical professional it was Dr B's responsibility to recognise and maintain professional boundaries between himself and his patient. Dr B did not do so, and therefore breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

10. Dr B's treatment of Mrs A was clinically inappropriate in that he recommended the therapeutic use of sexual behaviours, low pressure water enemas and deep abdominal massage, and prescribed glycerol suppositories and large amounts of zopiclone with inadequate review. Dr B failed to follow up the referral of Mrs A to Dr C. Dr B failed to provide services to Mrs A with reasonable care and skill and therefore breached Right 4(1) of the Code.

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11. Adverse comment was made about the medical centre not having put in place a reminder system for following up specialist referrals.

Complaint and investigation

12. The Commissioner received a complaint from Mrs A about the services provided by Dr B. The following issues were identified for investigation:

- *Whether Dr B provided an appropriate standard of care to Mrs A between 2007 and 2013.*
- *Whether the medical centre provided an appropriate standard of care to Mrs A between 2007 and 2013.*

13. An investigation was commenced on 7 October 2013.

14. The parties directly involved in the investigation were:

Mrs A	Consumer/complainant
Dr B	General practitioner
Dr C	psychologist
The medical centre	Provider
Dr D	General practitioner

Also mentioned in this report:

Dr E	Gastroenterologist
Dr F	Endocrinologist
Ms G	Psychologist

15. Expert clinical advice was obtained from Dr David Maplesden, a vocationally registered general practitioner (GP) (**Appendix A**).

Information gathered during investigation

Effects of bulimia nervosa

16. Bulimia nervosa is an eating disorder characterised by episodes of binge eating followed by purging, either through self-induced vomiting or the excessive use of laxatives. Electrolytes are lost through chronic vomiting and diarrhoea. To prevent electrolyte imbalances, such as low potassium, the lost electrolytes must be replenished, either through oral ingestion of electrolyte solutions or intravenous administration. People with bulimia nervosa vomit or defecate several times

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throughout the day. Because of this, lost potassium is not replaced and low potassium blood levels can develop.[1]

17. Potassium plays an integral role in fluid balance, muscle contraction, nervous system function, blood pressure, heart health and bone health. In addition to being characterised as a mineral, potassium is also an electrolyte. Electrolytes carry either a positive or negative charge, maintain fluid balance, and keep the pH of the blood normal, which ensures that the acid–base balance in the body is maintained.

Mrs A — background

18. From 1995 to 1998 Mrs A had symptoms suggestive of an eating disorder and had received treatment for this while she was overseas.

19. In 1999, at age 22 years, Mrs A transferred to a medical centre back in New Zealand. Initially Mrs A was seen usually by Dr D. In 2000, Dr D prescribed Mrs A fluoxetine,[2] and this was continued until she became pregnant towards the end of 2003.

20. In 2002 Mrs A shifted to another region. In September and October 2002 Mrs A had contact with the local DHB eating disorders team until she shifted back to her home town. Mrs A was noted to have chronically low potassium levels associated with frequent bingeing and purging. On 11 June 2003 Dr D referred Mrs A to the DHB community mental health services. On 29 September 2004 Dr D recorded: "Stopped the prozac 3–4 weeks ago after weaning down. The bulimia is no longer a problem. Feeling good." In 2005, Mrs A took up [a sport]. Dr D noted in March 2007 that this was an "[i]deal discipline as has to eat and exercise and not allowed to lose [weight]".

21. From November 2007, Mrs A was usually treated at the medical centre by Dr B, a vocationally registered GP. Mrs A remained under the care of Dr B until 7 February 2013. During that time, Mrs A presented to Dr B on numerous occasions with concerns of a sensitive nature, particularly her eating disorder, anxiety, and obsessive-compulsive disorder (OCD).[3] Mrs A told HDC that she saw Dr B once a month or every two months for regular blood tests, weigh-ins and measurements.

Inappropriate comments and masturbation advice

22. Mrs A said that Dr B repeatedly made inappropriate comments to her during her consultations with him. In particular Mrs A said that, despite her never asking Dr B about any sexual health issue, he made a comment of a sexual nature either every time or every second time she saw him. Mrs A stated that Dr B used sexually suggestive words and would "most always" lead the conversation to masturbation, and said she "should be doing [it] often, for self-pleasure". She said he did not discuss

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[1] See Mehler, PS, "Medical Complications of Bulimia Nervosa and Their Treatments", *International Journal of Eating Disorders* 44(2) 95–104 (2011).

[2] A selective serotonin re-uptake inhibitor (SSRI) used to treat depression or obsessive-compulsive disorder in adults.

[3] Obsessive-compulsive disorder (OCD) is an anxiety disorder characterised by intrusive thoughts that produce uneasiness, apprehension, fear, or worry; by repetitive behaviours aimed at reducing the associated anxiety; or by a combination of such obsessions and compulsions.

HDC

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masturbation in the context of treatment for an eating disorder, but suggested it as a way to "make [her] smile ... make [her] more happy or in a more pleasant state". She said that when she saw Dr B for a cold or similar matter he would discuss masturbation or issues of a sexual nature with her, which was "completely out of context to the treatment [she was] seeking". The clinical records do not generally record the specific content of Dr B's conversations with Mrs A, except as detailed below.

23. Mrs A also stated that Dr B told her that "he would like to lock [her] in a closest [sic] with something pleasurable".

24. Mrs A stated that, in addition to his comments to her about masturbation, Dr B made inappropriate or poorly chosen comments about her body, and "he said if he could examine every inch of [her] body he would be able to locate every organ, every bone etc". She stated that he flirted inappropriately and would often say that he liked seeing her and thought of her after work hours. She was adamant that she had not misinterpreted anything that Dr B said to her.

2007

25. On 29 November 2007, Mrs A presented to Dr B complaining of being "[t]ired, washed out and no energy". Dr B noted: "I am not keen to add to the bulima [sic] energy. Discussed [Mrs A's involvement in sport]." Dr B referred Mrs A for counselling and re-commenced fluoxetine 20mg 1 capsule once daily.

26. On 19 December 2007, Mrs A requested "more sleeping pills", and on 20 December Dr B prescribed dothiepin[4] and zopiclone.[5] (See **Appendix B** for a table of the prescribing of zopiclone.)

27. With regard to prescribing Mrs A with zopiclone, Dr B advised HDC:

> "I always advise that zopiclone is best used in its lowest effective dose for the shortest possible time. I explain that there can be a risk of dependency … and that it should be used with caution … my usual practice is to instil in my patients a respect for and awareness of the risks involved in long term use [of zopiclone]… On the occasions I prescribed a repeat of [z]oplicone [to Mrs A] I would have likely followed my usual practice …"

28. Dr B advised HDC that he monitored Mrs A's use of zopiclone at every consultation and discussed the risks and benefits of ongoing use of zopiclone. In contrast, Mrs A

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[4] Dothiepin is a serotonin-norepinephrine reuptake inhibitor. It is an atricyclic antidepressant used for the treatment of major depressive disorder. The Medsafe Data Sheet (8 January 2013) states that it "is associated with high mortality in overdose. There is a low margin of safety between the (maximum) therapeutic dose and potentially fatal doses. A limited number of tablets should be prescribed to reduce the risk from overdose for all patients and especially for patients at risk of suicide. A maximum prescription equivalent to two weeks supply of 75 mg/day should be considered in patients with increased risk factors for suicide at initiation of treatment, during any dosage adjustment and until improvement occurs."

[5] Zopiclone is used to treat people with sleep disorders and insomnia. All prescriptions for zopiclone were for 7.5mg tablets.

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advised HDC that when Dr B first prescribed zopiclone to her in 2007, he did not discuss the potential side effects or how long she might be on the medication. Mrs A recalls that after Dr B had been prescribing zopiclone to her for approximately a year, he did mention the potential for becoming "reliant" on or "addicted" to zopiclone.

29. There is no evidence in Dr B's clinical notes that he had any discussions with Mrs A regarding the effects of zopiclone.

2008

30. On 22 April 2008, Dr B noted: "Weight appears to have increase [sic] — appears normal no [sic] discussed and not measured. Still on the fluox and pleased with it. [N]o side effects. Good progress."

31. On 21 September 2008, Dr B referred Mrs A to a gastroenterologist, Dr E, because of a suspected upper gastrointestinal (GI) bleed, GI pain and reflux.[6] Mrs A's eating disorder history was noted in the referral documentation, together with the comment: "She has come through her difficulties and is now very secure, happy and healthy." A gastroscopy[7] conducted in October 2008 identified a gastric ulcer.

32. In September 2008, Dr B also referred Mrs A to hospital following an episode of loss of consciousness. Dr B noted Mrs A's eating disorder history on the referral form. On admission to hospital, Mrs A had very low potassium levels at 2.4mEq/L.[8] She had an EEG,[9] which suggested a partial seizure disorder. On 16 October Dr B saw Mrs A and noted that he was monitoring her potassium levels.

2009

33. In late 2009 Dr B referred Mrs A to Dr E several times because of her abdominal pain. Dr E investigated her symptoms with a repeat gastroscopy, ultrasound and various blood tests. In November 2009 Mrs A saw an endocrinologist, Dr F, with regard to her chronic hypokalaemia.[10] Dr F's report includes the statement: "Mrs A has a history of bulimia in the past, from which she has improved without ongoing evidence of symptoms …" Mrs A also underwent various tests to investigate her "chronic diarrhoea".

2010

34. On 22 January 2010 Dr B prescribed 60 zopiclone and 100 potassium tablets to Mrs A.

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[6] Stomach acid coming up from the stomach into the oesophagus.
[7] Gastroscopy is an examination of the inside of the gullet, stomach and duodenum. It is performed by using a thin, flexible fibre-optic instrument that is passed through the mouth and allows the doctor to see whether there is any damage to the lining of the oesophagus (gullet) or stomach, and whether there are any ulcers in the stomach or duodenum.
[8] Normal potassium levels are defined as 3.6–4.8mEq/L of blood. Low potassium levels are defined as anything under 3.6mEq/L. A dangerously low potassium level is defined as less than 2.5mEq/L.
[9] An electroencephalogram (EEG) is a test to measure the electrical activity of the brain.
[10] Low potassium in the blood.

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35. On 8 February 2010 Mrs A and her husband Mr A attended a consultation with Dr B after Mrs A overdosed on a bottle of zopiclone. Mrs A told Dr B that she had mistaken a bottle of zopiclone for a bottle of laxatives. Dr B documented:

> "[Mrs A] 'accidentally' [took] a bottle full of zopiclone … Insistent there was no intention to self harm … This episode gets the use of purgatives out into the open. Is in the habit … not very often of taking a small bottle full of dulcolax[11] (OTC) to purge the bowel becase [sic] of symptomatic bloating. Is not doing the bulemia [sic]/vomiting any more … Discussed management of OCD and needing to replace this with a better ritual. Will do without sleeping pills — penance? ... [Dr C] for help with the OCD …"

36. There is no record of any prescription of medication on 8 February 2010. Mrs A stated that at that appointment, which her husband attended with her, Dr B suggested that she use glycerol suppositories when she and her husband were having sex. She stated that they "were both quite shocked" by this advice. Mr A was not willing to provide evidence in this matter.

Referral to Dr C

37. On 17 February 2010 Dr B prepared a referral letter to clinical psychologist Dr C.[12] Dr B recorded in the clinical notes "… fax referral". In the referral letter, Dr B noted that Mrs A was "able to manage without sleeping pills" and stated:

> "I have done my best to seed the idea that [Mrs A] needs to build less destructive rituals. There has to be a safer way of achieving the same end. I think she is clever enough to do this … There are less dangerous ways of emptying the bowel — low pressure water enemas used to be very popular. Deep abdominal massage to the L [left] lower abdomen is part of traditional Maori massage and has been very successful in our local rest home. I think it is important to recognize the underlying drivers of the behaviour and I think [Mrs A] needs to include sexual behaviour with her ritual. I am fairly sure about this but feel a little out of my depth as I have not helped people build cleansing rituals before."

38. Mrs A said that when Dr B discussed cleansing rituals with her, this was a spiritual exercise and was not of a sexual nature.

39. Dr C advised HDC that she never received the referral letter from Dr B, and that Mrs A self-referred to her in 2012. Mrs A recalls that Dr B mentioned Dr C's name in about 2010, but that no referral was made and she did not consult Dr C at that stage.

40. Dr B advised HDC that he did not discuss Mrs A's treatment with Dr C at any stage, but that he did ask Mrs A "how her counselling was going and relied on her report … that it was going well". There is no record that Dr B had such a conversation with Mrs A prior to her self-referral to Dr C in 2012. He further advised that his usual practice

[11] Dulcolax is a laxative used to treat constipation.

[12] The medical centre advised HDC that "The MedTech audit log verifies that this letter was written 17/02/10 at 2:28:42pm. There have been no subsequent changes or alterations to this document." A copy of the MedTech audit log was provided to HDC, but it is difficult to read.

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is to "advise patients being referred that they will hear from the specialist concerned within a certain time frame … [and] to let [Dr B] know if they have not received an appointment within the expected time". However, there is no record in the clinical notes that Dr B had such discussions with Mrs A.

41. The medical centre stated that its computerised patient management system, Medtech (which was in place in 2010), allows all doctors to track progress of referrals or of urgent pending results. Doctors can select reminders through a task manager or an inbox message to check on patient follow-up or set a recall task. In February 2010 the medical centre did not have a formal written policy regarding the tracking of follow-up of referrals. The medical centre stated that it was the responsibility of the doctor who saw the patient and initiated the referral to elect whether or not to activate a follow-up reminder system, and that follow-up on patients after they had been seen by a specialist service was variable dependent on the nature of the referral and the referral outcome.

42. There are no reporting letters from Dr C to Dr B in the records.

Further reviews in 2010

43. On 20 March 2010 Mrs A had a seizure. On 22 March she was reviewed by Dr B. Her potassium levels were recorded as being normal, but her sodium levels were slightly reduced.

44. Dr B prescribed zopiclone in amounts of 60 tablets at a time on 28 June, 24 August, 11 October and 9 December 2010 (see **Appendix B**).

2011

45. On 28 January 2011, Dr B prescribed 60 zopiclone tablets and noted: "MUST be seen for next script." However, on 17 March a further 30 zopiclone tablets were prescribed without Dr B having seen Mrs A. On 22 March 2011, Dr B reviewed Mrs A regarding her ongoing abdominal pain. Her weight at that time was 43.9kg.

46. On 15 April 2011, Dr B noted a drop in Mrs A's potassium levels to 2.6mEq/L. He noted that he discussed the level with a medical registrar at the hospital, who confirmed that Mrs A "really needs cardiac monitoring at this level". Dr B referred Mrs A to hospital for acute cardiac monitoring.

47. On 18 April Dr B noted an improvement in Mrs A's potassium levels to 3.3mEq/L.

48. On 24 May Dr B prescribed Mrs A 90 zopiclone tablets and 100 potassium tablets, prior to her travelling overseas for seven weeks. On 26 July, 22 September and 25 November Dr B provided further prescriptions for 30 zopiclone tablets.

49. On 12 December the clinical notes state: "[The] pharmacy phoned to make us aware [Mrs A] hsa [sic] been buying a lot of dulcolax from them."

50. There is no reference in Dr B's notes in 2011 to discussions about specific eating disorder management strategies.

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2012

51. On 14 March 2012, Mrs A rang the medical centre for repeat medications and was advised by a staff member that she needed to be reviewed by a GP. The clinical notes for this phone call state: "[M]ed request however hasn't had a medication review for ages also previous hypokalaemia and using a lot of laxatives lately. Plan needs U+E[13] GP review please after this."

52. On 31 May Mrs A's most recent laboratory results were given to Dr B. They showed that her potassium level was 2.5mEq/L.

53. On 1 June, Dr B reviewed Mrs A and recorded:

> "Here about the low K [potassium] discussed. This is from laxative use and a phobia of becoming clogged up with feces [sic] and a need to purge. Discussed the physiology. Discussed ways of cleaning out the rectum without causing all the difficulties of purging … better to address the tail end rather than risk her life. Is having counselling for her phobias …"

54. At this consultation, Dr B prescribed 30 zopiclone tablets and 40 glycerol suppositories[14] to be used "as required". Both prescriptions were repeated on 10 August 2012. There is no record of Dr B having performed an abdominal examination or per rectum (PR) examination at the time he prescribed the suppositories. On 22 August Mrs A commenced therapy with a psychologist, Ms G.

55. On 27 August Dr B prescribed 100 potassium tablets. He noted that Mrs A had reduced her use of laxatives and that he had discussed her anxiety with her. On 3 September Mrs A's potassium levels had improved.

56. Dr C advised that she saw Mrs A (who had self-referred) for 10 sessions between 31 August 2012 and 14 March 2013. Mrs A said she told Dr C some of the things Dr B had said to her, including that he had suggested that she should masturbate. Mrs A said that Dr C, who had worked with Dr B in the past, "was very clinical and did not assist [her] with the issues regarding Dr B".

57. On 11 September Dr B prescribed 30 zopiclone tablets and 30 quetiapine tablets.[15] On 17 September Dr B reviewed Mrs A, noting: "Seems a little desperate … has been seeing [Dr C] … discussed drug options and what to take. Will try the Quetiapine … See in two weeks." Also in September Mrs A underwent further gastroscopy and gastric biopsies by Dr E with nothing of note found.

58. On 18 September 2012 Dr B noted that Mrs A's potassium levels were "low again. Will start bananas again and K supplement." Dr B continued to monitor Mrs A's potassium levels throughout 2012.

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[13] Urea and electrolytes — a blood chemistry test used to detect, for example, kidney failure and dehydration.

[14] Used to treat constipation.

[15] An antipsychotic approved for the treatment of schizophrenia, bipolar disorder and, along with an antidepressant, to treat major depressive disorder. All prescriptions for quetiapine were for 25mg tablets.

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59. On 1 October Dr B noted: "I am worried that [Mrs A] really needs to be distracted from her own self preoccupation …" He again prescribed quetiapine and potassium, which was increased to six tablets per day. He monitored Mrs A's weight (40.5kg) and potassium levels (2.6mEq/L).

60. Mrs A told HDC that in 2012 she was seeing psychologist Ms G at the same time as she was seeing Dr C. Ms G assisted her with relaxation techniques and breathing. Mrs A said that neither Dr C nor Ms G discussed cleansing rituals with her.

61. On 18 October Mrs A attended an appointment with Ms G. Mrs A's clinical notes from that appointment state: "Discussed speaking to her Dr. [C]lient became agitated and asked me not to contact him. Client was not able to give a reason upon questioning and became defensive."

62. On 6 November Dr B prescribed Mrs A 100 potassium tablets to be taken twice daily. On 7 November Mrs A's weight was recorded as 40.8kg.

63. On 29 November Mrs A attended a further appointment with Ms G. Mrs A said she told Ms G some of the things that Dr B had said, including telling her about a movie he had been watching in which a lot of people were masturbating, and that Dr B had suggested to her that "this is how people got their pleasure".

64. The clinical notes from that appointment state:

> "Client reports that her GP has made inappropriate comments with sexual overtones. 'Locking her in a cupboard with pleasurable things' and 'masturbating to a movie'. Client reports feeling 'icky' about the comments …"

65. Dr B advised HDC that he does not know of "any movie of this nature and certainly would not make such a remark to a patient, nor anyone else for that matter".

66. Dr B further advised:

> "I did not have any discussions [regarding my personal life] that I recall and it is my usual practice not to discuss my personal life or anything outside of work with patients."

67. On 3 December Dr B prescribed 100 potassium tablets, to be taken twice daily, 30 quetiapine tablets, and 30 zopiclone tablets. By 3 December Mrs A's weight was 38.8kg, a drop from her weight recorded in November. On 11 December Dr B noted that Mrs A's weight had increased to 40.3kg and recorded: "[H]as been a good week … discussed self pleasure." Mrs A's potassium level was 2.0mEq/L. On 14 December Dr B advised Mrs A to increase her "slow K" to six tablets daily.

68. On 21 December 2012 Dr C accompanied Mrs A when she attended an appointment with Dr E to discuss the clinical investigations carried out in the previous weeks. Dr E referred Mrs A back to Dr B and reported that "the abnormality in her case rests with the abnormal connection between the oesophagus and the brain". Dr E stated that the problem may have developed as a result of bulimia and purging. Dr E suggested to Dr

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B that Mrs A be changed to an SSRI[16] in the hope that her pain could be reduced. He noted: "There is a protocol for changing [Mrs A] from Dopress [dothiepin] to an SSRI which I would need to investigate or I would be happy for you to supervise if it is something you are familiar with."

69. Dr C stated that following the appointment on 21 December 2012 she discussed with Mrs A the process for a referral to a psychiatrist. Dr C stated:

> "In that discussion I had included [Dr B] in that proposal. I recall [Mrs A] telling me that she was somewhat unhappy with [Dr B] and was uncomfortable with the way he had responded to her more recently. I do not recall any specific criticisms of [Dr B]."

2013

70. On 8 January Mrs A's weight is recorded as 42.3kg and her potassium as 2.5mEq/L. On 9 January the notes state: "Phoned in for K+ level. Delighted it has increased."

71. On 21 January 2013 Dr B prescribed Mrs A melatonin tablets,[17] quetiapine, 180 dothiepin[18] 25mg caps, 30 zopiclone and 100 potassium tablets. Dr B advised that he prescribed dothiepin to Mrs A rather than an SSRI at Mrs A's request. He advised that Mrs A had been taking dothiepin regularly since 2007. Mrs A had tried an SSRI (fluoxetine) from 2000 to 2003, and again from 2007 to 2008. Dr B advised that Mrs A was not willing to try an SSRI again and "clearly wished to continue using the dothiepin rather than … to switch to an SSRI".

72. Mrs A advised HDC that she does not specifically recall the above conversation with Dr B. However, she confirms that Dr B discussed prescribing her with fluoxetine on a number of occasions, and that she was not willing to try it again.

73. On 7 February 2013, Mrs A transferred to another medical centre.

Dr B's response

74. Dr B told HDC that Mrs A had a serious eating disorder and an obsessive-compulsive personality. He stated that Mrs A "purges herself to the extent that she is cachexic"[19] and that her body salts are so severely affected as to make the risk of sudden death by cardiac arrhythmia[20] "a real possibility". Dr B stated that his method of treating Mrs A was to avoid focusing on food or purging, as she was already too focused on these things.

75. Dr B stated that Mrs A's situation was "difficult to manage medically". He stated that he tried talking to her about "building different habits in her life, even to the extent of ritualising them in order to replace her current self-destructive behaviours". He noted that he mentioned to Mrs A that he had seen other patients with self-destructive habits

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[16] Selective serotonin re-uptake inhibitors (SSRIs) are a class of compounds typically used as antidepressants in the treatment of depression, anxiety disorders, and some personality disorders.
[17] Used for sleep disorders.
[18] See footnote 4.
[19] The loss of body mass that cannot be reversed nutritionally.
[20] An irregular heartbeat.

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replace these with alternative habits, and that "[t]his did include reference to other forms of self-pleasure, sexual or otherwise". Dr B told HDC that he encouraged a range of alternative habits, including "music, singing or dancing", exercise, and religion, although these latter suggestions are not recorded in the clinical notes.

76. Dr B advised HDC that he cannot recall the number of times he discussed self-pleasure with Mrs A. However, he stated that "based on [his] clinical notes [he] would say it was [two to three] times". Dr B noted that the advice was also documented in his referral letter to Dr C.

77. Dr B advised HDC that he did not "specifically" discuss masturbation when Mrs A consulted him for reasons other than her eating disorder. He advised that as Mrs A's GP he did "make a habit" of enquiring as to her progress with ritual building, "because it was [his] overriding concern for [Mrs A's] health".

78. Dr B told HDC that he did not at any time suggest that glycerine suppositories had any "sexual purpose".

79. Dr B denied that he was "sexually suggestive or otherwise inappropriate" towards Mrs A. He denied ever making a comment regarding wanting to lock Mrs A in a closet. He stated that it is likely Mrs A misunderstood a comment about his being worried for her personal safety with regard to her critically low potassium levels as meaning that he was thinking of her outside work hours. Dr B said that he did not intend to engage in inappropriate flirting. He started: "At no time did I countenance any personal interest in [Mrs A]."

80. Dr B acknowledged that he commented about being able to locate Mrs A's abdominal organs. He stated that Mrs A's physical condition is such that abdominal organs would be easy to find on examination. "I was suggesting that this is uncommon. I did not intend to infer that I had any personal interest in doing so."

81. Dr B stated that his genuine concern for Mrs A is corroborated by the fact that he referred Mrs A for other health professional assistance. He stated: "Please refer to my letter dated 17 February 2010 to [Dr C, psychologist]."[21] Dr B noted that after Mrs A "had been seeing" Dr C, he made a habit of asking Mrs A how she was getting on with "building an alternative ritual". He stated that he tried to talk to her about the positive things in her life and building up the things she enjoyed. In his first response to HDC he stated: "I did encourage her to find and concentrate on anything hedonistic. Including masturbation." Dr B later told HDC:

> "[W]ith the benefit of hindsight … I agree that my suggestions to assist [Mrs A] were naïve and not well judged. There was never any intent or purpose for my suggestions and I am sorry that [Mrs A] has interpreted my suggestions in a sexual manner, that was never my intent."

82. With regard to the clinical basis for his suggestions, Dr B stated:

[21] As stated, Dr C said that Dr B did not refer Mrs A to her, rather Mrs A self-referred in August 2012. Dr C has no record of the letter to which Dr B refers.

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> "My idea was to re-focus [Mrs A's] destructive obsession … during the discussion regarding alternative rituals I had also suggested exercise, religion and other rituals, anything that would take her mind away from those things that were destructive to her health.
>
> I cannot recall where I heard or read about taking people's minds off what they are obsessing over but it was, at the time, my genuine belief that if I could get [Mrs A] focused on something other than her eating and obsessive fixation, that perhaps she would be helped."

The medical centre

83. The medical centre advised HDC that its directors do not condone suggesting "alternate behaviour therapy" for patients with complex medical presentations. However, the medical centre considers that Dr B's referral of Mrs A to Dr C was "good practice in the circumstances".[22]

84. HDC asked the medical centre for its policies with regard to the follow-up of referrals. The medical centre advised HDC that in February 2010 it "did not have a formal written policy regarding the tracking of follow-up referrals". The medical centre advised that it is now a fully computerised practice, and that "the management system Medtech allows for doctors to track progress of referrals" of patients.

85. The medical centre stated that it is the responsibility of the doctor who initiated the referral to elect whether to activate a follow-up reminder in the system. The medical centre stated, however, that it would be usual practice for doctors to activate a reminder, and that further follow-up by the doctor is dependent on the findings and recommendations of the specialist in each case.

86. The medical centre advised that it had a "verbal" or "unwritten" policy with regard to repeat prescribing of medications until November 2012, at which time a written policy was developed. The policy states:

> "Please be aware that your professional judgement, discretion and common sense are your most valuable tools … High risk conditions, high risk patients, high risk medications all need close monitoring."

87. Dr B stated that in April 2013 the medical centre underwent Cornerstone accreditation,[23] which included a review of the repeat medications policy, and that there is a "much more rigorous system in place now". In July 2013 the medical centre gained Cornerstone accreditation.

Subsequent events

88. Dr B stated that the medical centre has a practice based peer review meeting every fortnight to discuss clinical issues, and he attends an external peer group on a monthly basis.

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[22] The medical centre was not aware at that time that the referral had not been received by Dr C.
[23] Cornerstone is an accreditation programme specifically designed by the Royal New Zealand College of General Practitioners for general practices in New Zealand.

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89. Dr B said that he now refers patients with eating disorders to a specialist, or suggests that they see a GP with particular knowledge and expertise in dealing with such disorders.

90. Dr B advised HDC that the DHB does not provide a multidisciplinary team service to treat patients with eating disorders.

Responses to provisional opinion

Dr B

91. Dr B submitted that his concern was always for Mrs A's health and his discussions with her were never for any sexual gratification or associated purpose.

92. Dr B said he has improved his practices regarding prescribing and referrals and attended education on the management of eating disorders.

The medical centre

93. The medical centre stated that it has developed guidelines regarding the tracking of results and are extending the guidelines to include the tracking of specialist referrals.

Standards

94. The Medical Council of New Zealand publication *Sexual Boundaries in the Doctor–Patient Relationship — a resource for doctors* (October 2009) provides:

> "5. A breach of sexual boundaries comprises any words, behaviour or actions designed or intended to arouse or gratify sexual desires. It is not limited to genital or physical behaviour. It incorporates any words, actions or behaviour that could reasonably be interpreted as sexually inappropriate or unprofessional.
>
> …
>
> 8. Sexual impropriety means any behaviours, such as gestures or expressions, that are sexually demeaning to a patient, or that demonstrate a lack of respect for the patient's privacy. Such behaviours include, but not exclusively:
>
> …
>
> - making inappropriate comments about, or to, the patient, such as making sexual comments about a patient's body or underclothing
> - making sexualised or sexually-demeaning comments to a patient
> - making comments about sexual performance during an examination or consultation (except where pertinent to professional issues of sexual function or dysfunction)
>
> …
>
> 15. The successful doctor–patient relationship may not depend solely on you, as you are only one half of the relationship, however, as the professional, it is your responsibility to maintain clear sexual boundaries.

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…

23. As the professional, the onus is always on you to behave in a professional manner. You must ensure that every interaction with a patient is conducted in an appropriate professional manner.

…

28. Your actions and how you communicate them to the patient influence the patient's perceptions about what you do and the treatment he or she receives. What may be an acceptable form of physical examination may appear suspicious behaviour to a patient if he or she does not understand what is happening and why it is necessary.

Explain why you are asking questions or why the physical examination is necessary and what will happen in the examination. Remember that it may be obvious to you why these questions or examinations are necessary but it may not be obvious to the patient."

95. The Medical Council of New Zealand publication *Good prescribing practice* (April 2010) provides:

"1.You should only prescribe medicines or treatment when you have adequately assessed the patient's condition, and/or have adequate knowledge of the patient's needs and are therefore satisfied that the medicines or treatment are in the patient's best interests

…

Be familiar with the indications, side effects contraindications, major drug interactions, appropriate dosages, effectiveness and cost-effectiveness of the medicines that you prescribe.

…

Never prescribe indiscriminately, excessively or recklessly.

Prescribe in accordance with accepted practice and any relevant best practice guidelines. Prescribing outside of accepted norms should only occur in special circumstances with the patient's informed consent. In such circumstances, it might be useful to discuss the proposed treatment with a senior colleague before completing the prescription.

Periodically review the effectiveness of the treatment and any new information about the patient's condition and health if you are prescribing for an extended period of time. Continuation or modification of treatment should depend on your evaluation of progress towards the objectives outlined in a treatment plan."

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Opinion: Dr B

Introduction

96. This opinion relates to Dr B’s conduct during his consultations with Mrs A, and the clinical appropriateness of the treatment and advice provided to her. The events occurred during consultations over a period of approximately five years. Dr B was aware of Mrs A’s medical history and that she was a vulnerable patient with issues regarding anxiety, OCD and an eating disorder.

97. I am concerned about a number of aspects of Dr B’s treatment of Mrs A. Trust is especially important in the doctor–patient relationship. Patients look to their doctor as a person in whom they can place trust and impart confidences. In my view, Dr B behaved in an inappropriate and unacceptable manner and, in doing so, breached his relationship of trust with Mrs A. I also consider that aspects of Dr B’s treatment of Mrs A were not clinically appropriate.

Alternative rituals – Masturbation: Breach

Factual findings

98. There are a number of references in the clinical records to Dr B recommending the development of alternative rituals, including “self-pleasure”, as treatment for Mrs A’s eating disorder.

99. Dr B stated that Mrs A’s condition was difficult to manage medically, and that his treatment method in relation to Mrs A’s eating disorder was to avoid focusing on food or purging, as she was already too focused on these things. Rather, Dr B stated that he talked to Mrs A about “building different habits in her life, even to the extent of ritualising them in order to replace her current self-destructive behaviours”. He noted that he mentioned to Mrs A that he had seen other patients with self-destructive habits replace these with alternative habits, and that “[t]his did include reference to other forms of self-pleasure, sexual or otherwise”. Dr B told HDC that he encouraged a range of alternative habits, including “music, singing or dancing”, exercise, and religion. However, there is no record of Dr B discussing these suggestions with Mrs A.

100. Dr B has not denied that he discussed masturbation with Mrs A, and he recorded in the clinical records and in his referral letter addressed to Dr C dated 17 February 2010 (which is in Mrs A’s clinical records but was not received by Dr C) that he provided such advice to Mrs A. In that letter, Dr B stated: “I think she needs to include sexual behaviour with her ritual. I am fairly sure about this but feel a little out of my depth as I have not helped people build cleansing rituals before …” Dr B told HDC that, after that date, he “[made] a habit” of asking Mrs A how she was getting on with “building an alternative ritual”.

101. Mrs A stated that Dr B would “most always” lead the conversation to masturbation. She said she saw Dr B once a month or every two months for regular blood tests, weigh-ins and measurements and never asked Dr B about anything sexual. However, she recalls that he made a comment of a sexual nature either every time or every

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second time she saw him. She said that he did not discuss masturbation in the context of treatment for an eating disorder.

102. Dr B advised HDC that he did not "specifically" discuss masturbation when Mrs A consulted him for reasons other than her eating disorder. He said he cannot recall the number of times he discussed self-pleasure with Mrs A. However, he stated that "based on [his] clinical notes [he] would say it was [two to three] times".

103. I note that the records do not generally record the specific content of Dr B's conversations with Mrs A, but do record discussions regarding "self-pleasure". In addition, I note that Mrs A's psychologists, Dr C and Ms G, both recall Mrs A raising concerns about Dr B with them at the time. Ms G recorded Mrs A's concerns in the clinical notes.

104. Based on Dr B's own evidence, it is clear that Dr B raised the subject of masturbation with Mrs A multiple times, and that he indicated that masturbation would be a useful treatment for her eating disorder. It is clear from Mrs A's evidence that this advice made her uncomfortable.

Clinical appropriateness

105. Published literature suggests that cognitive-behavioural therapy (CBT) is indicated as first-line treatment for outpatients with bulimia nervosa. As part of CBT, patients are encouraged to develop alternative habits. This approach focuses upon the clinical features that maintain bingeing and purging; the core psychopathology involves problems with self-evaluation and self-esteem, such that patients judge themselves primarily in terms of body weight and shape and the ability to control these. Patients should develop alternative behaviours for responding to acute cues or craving for bulimic behaviours, as well as high-risk times (eg, weekends and evenings) and situations that are associated with bulimic behaviours. The literature suggests that activities that are incompatible with binge-eating, such as calling someone, going on a brisk walk, or taking a shower, are especially useful.[24]

106. My expert advisor, GP Dr Maplesden, advised:

> "I could not find any reference, on review of the medical literature, which refers to masturbation or other sexually oriented sensate focussing as a validated strategy for treatment of eating disorders … In my view masturbation is not a clinically appropriate treatment for eating disorders …"

107. In my view, the recommendations of therapeutic use of sexual behaviours as treatment for Mrs A were clinically inappropriate and not supported by medical literature.

<u>Sexual boundaries</u>

108. Dr B stated that he had no inappropriate intentions when giving his advice about masturbation. As I have stated previously, with reference to the Medical Council of

[24] See Michell, JE, "Bulimia nervosa in adults: Cognitive-behavioral therapy (CBT)" UptoDate, last updated 3 March 2013.

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New Zealand publication *Sexual Boundaries in the Doctor–Patient Relationship — a resource for doctors*:[25]

> "A doctor breaches sexual boundaries not only through physical behaviour, but also through any behaviour, including discussions, that has as its purpose some form of sexual gratification, or that might reasonably be interpreted as having that purpose"

109. Dr Maplesden advised:

> "[Mrs A] states she found [Dr B's] comments inappropriate. The comments, which were introduced into the consultations by [Dr B] and which do not appear to have any basis as an accepted treatment strategy for eating disorders, could be readily perceived as sexual impropriety … Certainly, the comments were inappropriate from a clinical and professional perspective ... I consider that [Dr B's] repeated references to masturbation could reasonably be interpreted as unprofessional conduct, and thus a breach of sexual boundaries, irrespective of whether he had prurient or salacious motives."

110. I agree with this advice and find that, irrespective of his motives, Dr B's repeated discussion of masturbation was not clinically justified and was a breach of sexual boundaries, in that the discussions could reasonably be interpreted as being for the purpose of Dr B's own sexual gratification. Dr B's repeated discussion of masturbation was a breach of sexual boundaries. As a medical professional it was Dr B's responsibility to recognise and maintain professional boundaries between himself and his patient. Dr B did not do so, and therefore breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code).[26]

Personal comments: Adverse comment

Factual findings

111. Mrs A stated that, in addition to his advice about masturbation, Dr B made other inappropriate comments to her.

112. She stated that Dr B "said if he could examine every inch of [her] body he would be able to locate every organ, every bone etc." Dr B acknowledged that he commented about being able to locate Mrs A's abdominal organs. He said Mrs A's physical condition is such that abdominal organs would be easy to find on examination and stated: "I was suggesting that this is uncommon. I did not intend to infer that I had any personal interest in doing so."

113. Mrs A also stated that Dr B told her "he would like to lock [her] in a closest (sic) with something pleasurable". Dr B denied ever making a comment regarding wanting to lock Mrs A in a closet.

[25] See 11HDC00237, 26 March 2013.

[26] 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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114. Mrs A further stated that Dr B flirted inappropriately with her. Dr B denied that he was "sexually suggestive or otherwise inappropriate" towards Mrs A. Dr B said that he did not intend to engage in inappropriate flirting and stated: "At no time did I countenance any personal interest in [Mrs A]".

115. Mrs A alleged that Dr B would often say that he liked seeing her and thought of her after work hours. Dr B stated that he considers it is likely Mrs A misunderstood a comment about his being worried for her personal safety with regard to her critically low potassium levels as meaning that he was thinking of her outside work hours. Mrs A also stated that Dr B discussed an inappropriate movie with her, which Dr B denies. Mrs A was adamant that she had not misinterpreted anything that Dr B said to her.

116. I find it is more likely than not that Dr B made comments to Mrs A about her body, as noted above, and indicated that he enjoyed seeing her and thought of her outside of work hours. I am not able to make any finding as to whether Dr B flirted with Mrs A, discussed an inappropriate movie with her, or made a comment about locking her in a cupboard.

Conclusion

117. In my view Dr B's comments to and about Mrs A were ill-judged and were communicated in such a way that left Mrs A feeling uncomfortable. I suggest that Dr B reflect on his communication with Mrs A in this respect and on how it could have been improved.

Alternative rituals ─ Bowel cleansing: Breach

Factual findings

118. In the letter dated 17 February 2010, addressed to Dr C but not received by her, Dr B noted Mrs A's recent overdose of zopiclone (recorded as having been an accidental overdose when Mrs A mistook zopiclone for laxative tablets), her past history of eating disorder and hypokalaemia, and her recent admission to frequent purging. Dr B noted:

> "I have done my best to seed the idea that [Mrs A] needs to build less destructive rituals. There has to be a safer way of achieving the same end. I think she is clever enough to do this … There are less damaging ways of emptying the bowel — low pressure water enemas used to be very popular. Deep abdominal massage to the L [left] lower abdomen is part of traditional Maori massage and has been very successful in our local rest home. I think it is important to recognise the underlying drivers of the behaviour and I think she needs to include sexual behaviour with her ritual. I am fairly sure about this but feel a little out of my depth as I have not helped people build cleansing rituals before …"

119. On 1 June 2012, Dr B reviewed Mrs A and recorded:

> "Here about the low K discussed. This is from laxative use and a phobia of becoming clogged up with feces [sic] and a need to purge. Discussed the physiology. Discussed ways of cleaning out the rectum without causing all the difficulties of purging … better to address the tail end rather than risk her life. Is having counselling for her phobias …"

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Clinical appropriateness

120. Dr Maplesden advised me that he was unable to find any reference in the medical literature that cleansing rituals such as low pressure water enemas and deep abdominal massage were of use in the management of eating disorders. Dr Maplesden advised that the focus on bowel cleansing did not appear to be consistent with the general psychotherapeutic approach of trying to remove the patient's obsessive focus on intake and excretion and, in fact, might reinforce that obsession.

121. In my view, the recommendations of low pressure water enemas and deep abdominal massage as treatment for Mrs A were clinically inappropriate and not supported by medical literature. Accordingly, Dr B failed to provide services to Mrs A with reasonable care and skill and therefore breached Right 4(1) of the Code.[27]

Prescribing: Breach

Prescribing suppositories

122. Despite recognising the risks of purging, from June 2012 Dr B prescribed glycerol suppositories to Mrs A to be used "as required". Dr B continued to prescribe Mrs A with glycerol suppositories, despite her known risk factors including a history of laxative abuse, her eating disorder, weight loss and her apparent fixation on purging.

123. In addition, when suppositories were prescribed, there is no documentation of abdominal examinations or a per rectum examination being performed by Dr B.

124. Mrs A stated that Dr B suggested that she should use the suppositories at a time when she and her husband were having sex. She stated that she and her husband "were both quite shocked" by this advice. Mr A has not been willing to comment about this account. Dr B advised that he "did not at any time suggest that glycerine suppositories had any sexual purpose". As there are conflicting accounts provided by Mrs A and Dr B with regard to this matter, I am unable to make a finding as to whether such a conversation occurred.

125. Dr Maplesden advised:

> "The clinical rationale for prescribing the suppositories in large amounts as an alternative to Dulcolax appears somewhat flawed as there was still a focus on [Mrs A] emptying her bowel by 'artificial' methods rather than a focus on 'normal' bowel movement through use of adequate fluids and dietary fibre."

126. In my view, the prescribing of glycerol suppositories was inappropriate given that Dr B knew Mrs A had an eating disorder and had been abusing oral laxatives. The failure to examine Mrs A was also suboptimal, as she was complaining of abdominal symptoms.

[27] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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Prescribing zopiclone

127. In 1998 Medsafe issued a statement "*Dependence with Zopiclone*"[28] which states:

> "It is important … to follow the advice in the data sheet for zopiclone, and to limit the treatment duration to no more than 4 weeks. If a longer duration is required, it may be necessary to taper the dose in withdrawal or even gain the assistance of those who have experience in assisting withdrawal from minor tranquillisers to minimise the disruption to the life of the patient."

128. The Medsafe Data Sheet "Apo-zopiclone Zopiclone 7.5mg Tablets" (2011)[29] states that treatment with zopiclone should be as short as possible and should not exceed four weeks, including the period of tapering off. Extension beyond the maximum treatment period should not take place without re-evaluation of the patient's status. The Data Sheet states that long-term treatment should be considered only after consultation with a specialist.

129. The Data Sheet states that clinical experience to date with zopiclone suggests that the risk of dependence is minimal when the duration of treatment is limited to four weeks or less. However, patients with marked personality disorders are included in the group at risk of dependence.

130. Dr B prescribed zopiclone for Mrs A from 2007 until 2013. He continued to do so after 8 February 2010, despite Mrs A having taken an overdose of the medication. Dr Maplesden advised:

> "The ongoing prescribing of large amounts of zopiclone (up to 90 tablets at a time) following [Mrs A's] overdose of the medication, even though there was no voiced intention to self harm, was not a clinically wise strategy. Between March 2010 and March 2011 [Mrs A] was prescribed zopiclone in significant amounts on several occasions with no review over that 12 month period. In a patient with a known psychiatric disorder (eating disorder) and recent overdose (albeit unintentional) I think this management strategy would meet with moderate disapproval by my peers."

131. In my view, the ongoing prescribing with extended periods without review by Dr B was unsafe, poor practice, and put Mrs A at risk of harm. Furthermore, Dr B should have referred Mrs A for specialist review of her long-term use of zopiclone. Dr B's treatment of Mrs A was clinically inappropriate in that he prescribed glycerol suppositories and large amounts of zopiclone inappropriately. Dr B failed to provide services to Mrs A with reasonable care and skill and therefore breached Right 4(1) of the Code.

Referrals: Breach

132. Dr B regularly monitored Mrs A's weight, blood pressure and potassium levels, and appropriately referred her to a number of specialists including an endocrinologist, Dr

[28] Website: July 1998 Prescriber Update No.16:20–22.
[29] Available at: http://www.medsafe.govt.nz/profs/datasheet/a/Apozopiclonetab.pdf.

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F, and a gastroenterologist, Dr E. In September 2008, Dr B referred Mrs A to hospital following an episode of loss of consciousness.

133. Dr Maplesden advised that patients with eating disorders are best cared for by a multidisciplinary team consisting of a mental health clinician, a dietitian, and a general medical clinician. Dr Maplesden notes that, although physicians and a psychologist were involved in Mrs A's care while she was seeing Dr B, this was not as a dedicated multidisciplinary team. However, Dr B advised HDC that the DHB does not provide a multidisciplinary team service for the treatment of eating disorders.

134. In my view, Dr B's monitoring of Mrs A and his referrals of her to specialists were appropriate and generally in accord with expected standards, although I note that Dr B did not refer Mrs A to the DHB's community mental health services at any point.

135. However, it is of concern that Dr B said that he referred Mrs A to Dr C in February 2010 and recorded "fax referral" in his notes when no referral was received by Dr C. I do not consider it necessary to make a finding whether Dr B intended to send the letter but failed to do so due to an oversight, or whether the letter was sent but not received. In either event, I am satisfied that the letter was not received by Dr C. I consider that the lack of reporting correspondence from Dr C should have alerted Dr B to the fact that the referral had not been received. In my view, it was Dr B's responsibility to follow up the referrals he made. In addition, although Dr B told HDC that he asked Mrs A how she was progressing with counselling following his referral, there is no record of such a conversation in the clinical records until after Mrs A self-referred to Dr C in 2012. As I have previously stated:[30]

> "Medical providers need to have robust systems in place to ensure mistakes and omissions are identified at an early stage to prevent harm being caused to the patient. One simple precaution providers can take to ensure referrals are being actioned in a timely manner is to allow for automatic alerts to appear on their computer screen at a nominated interval after a referral letter has been generated, alerting them to follow up if they have not heard back from the clinician by that time …
>
> Another precaution providers can take is to ask the patient to contact the clinician to whom they have been referred, directly, if they have not heard from them within a certain time frame. A provider who explains to the patient the purpose of the referral and its importance not only ensures that the patient is adequately informed, but also encourages the patient to be vigilant in following up if the referral appointment is not received."

136. Dr B's failure to put in place any precautionary measures to ensure that he would be alerted if the referral was not actioned, was an inadequate standard of care. Mrs A recalls that Dr B mentioned Dr C in 2010 but does not recall a referral having been made. Dr B's omissions meant that Mrs A was not given the opportunity to have her condition assessed and treated by a psychologist in a timely manner. By his failure to

[30] See 10HDC00974 (15 June 2012) at page 15.

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follow up on his purported referral to Dr C, Dr B failed to provide services to Mrs A with reasonable care and skill and therefore breached Right 4(1) of the Code.

Summary

137. I accept that Mrs A's presentation was complex. Dr B acknowledged in the letter he wrote to Dr C (which she did not receive) that he was out of his depth. Given the complexity of treating Mrs A, Dr B showed a lack of judgement by recommending strategies that were beyond his expertise. He should have referred Mrs A to a specialist in treating eating disorders, and to community mental health services, and suggested that she see a GP with knowledge and expertise in dealing with such disorders. Eventually, in 2012, Mrs A self-referred to psychologists.

138. Dr B's repeated discussion of masturbation was a breach of sexual boundaries. As a medical professional it was Dr B's responsibility to recognise and maintain professional boundaries between himself and his patient. Dr B did not do so, and therefore breached Right 4(2) of the Code.

139. Dr B's treatment of Mrs A was clinically inappropriate in that he recommended the therapeutic use of sexual behaviours, low pressure water enemas and deep abdominal massage, and prescribed glycerol suppositories and large amounts of zopiclone inappropriately. In addition, Dr B failed to follow up on his purported referral to Dr C. In each of these respects, Dr B failed to provide services to Mrs A with reasonable care and skill and therefore breached Right 4(1) of the Code.

Opinion: Adverse comment — The medical centre

140. Under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), employers are responsible for ensuring that their employees comply with the Code. Pursuant to section 72(5) of the Act, it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the acts or omissions leading to an employee's breach of the Code.

141. Until November 2012 the medical centre had only a "verbal" or "unwritten" policy with regard to repeat prescribing of medications. At that time a written policy was developed. However, the Medical Council of New Zealand provides professional standards (as above), and it would be reasonable for the medical centre to expect practitioners to comply with their professional obligations.

142. The medical centre advised HDC that its directors do not condone suggesting "alternate" behaviour therapy for patients with complex medical presentations. the medical centre stated that Dr B's referral to Dr C was "good practice in the circumstances".

143. The medical centre advised HDC that at February 2010 it "did not have a formal written policy regarding the tracking of follow-up referrals". The medical centre advised that it is now a fully computerised practice, and that "the management system

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Medtech allows for doctors to track progress of referrals" of patients. The medical centre stated that it is the responsibility of the doctor who initiated the referral to elect whether to activate a follow-up reminder in the system.

144. In my view, more care should have been taken by the medical centre to put in place a reminder system for following up specialist referrals that was not subject to individual error. The medical centre's poor systems contributed to the unsatisfactory care provided to Mrs A. As I have stated in a previous opinion:[31]

> "Had [the medical centre] required its doctors to use the automatic reminder system for its referral letters, [Dr B] should have been alerted to the fact that [Mrs A's] colonoscopy referral was not being actioned. It is likely that this would have led to the realisation that the letter had never been sent, and the appropriate remedial action could then have been taken in a timely manner. I consider that the establishment of an effective alert system is a reasonable precautionary action for a medical practice to take to ensure referrals are not lost or forgotten."

145. The same principles, in my view, apply to this case, and the medical centre should reflect on the adequacy of their systems for ensuring follow-up of specialist referrals.

146. In regards to Dr B's breaches of professional boundaries, I consider that these were individual failings. I have not been provided with any evidence to suggest that the medical centre was on notice of Dr B having previously failed to adhere to appropriate professional boundaries. I therefore do not consider that the medical centre is vicariously liable for Dr B's actions in this respect.

Recommendations

147. Dr B has provided HDC with a written apology to Mrs A, for forwarding to her.

148. I recommend that Dr B:

- Arrange a competency review by the Medical Council of New Zealand by three months from the date of this report.
- Remain in a mentoring relationship with the two senior GPs (including at least three face-to-face meetings with each mentor each year) until **31 December 2015**, and that both mentors provide written confirmation to the Royal New Zealand College of General Practitioners that the mentoring has occurred and that Dr B appears to be continuing to maintain appropriate professional boundaries with patients.

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[31] 10HDC00974, available at www.hdc.org.nz.

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Follow-up actions

149.

- 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 the Royal New Zealand College of General Practitioners, and they will be advised of Dr B's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the District Health Board, and it will be advised of Dr B's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A — Independent General Practitioner advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden, a vocationally registered GP:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs A] about the care provided by her by [Dr B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have reviewed the information on file: complaint from [Mrs A]; responses from [Dr B]; GP notes. The complaint and responses have been comprehensively detailed in the HDC memorandum on file and will not be reiterated in detail here. In essence, [Mrs A] complains that [Dr B] has, on several occasions over the past five years, suggested to [Mrs A] that she masturbate as treatment for her eating disorder. His constant revisiting of this advice has made her feel uncomfortable and has led to the complaint.

2. In his response dated 15 February 2013, [Dr B] states *I did suggest she find some avenue of self pleasure, sexual or otherwise to replace her current habit or ritual of purging ... I had no intention of causing offence or making improper suggestion ... After* [Mrs A] *had been seeing* [a clinical psychologist] *I did make a habit of enquiring how she was getting on with building an alternate ritual. I also tried to talk to her about the positive things in her life and building up the things she enjoyed. I did encourage her to find and concentrate on anything hedonistic. Including masturbation. My letter of referral to* [the clinical psychologist] *puts my thinking in perspective and I would ask you to refer to that.*

3. Brief clinical synopsis from information on file:

(i) [Mrs A] had symptoms suggestive of an eating disorder since 1995 having had treatment while [overseas] until 1998. In 1999, her GP ([Dr D]) had referred her to community mental health services and also engaged her with a counsellor at her practice in [the town]. Fluoxitene was prescribed in 2000 and maintained for several years except when [Mrs A] was pregnant. In 2002 [Mrs A] shifted to [another region] and was involved with the local DHB Eating Disorders Team in September/October 2002 until her shift back to [her home town] (she was noted to have frequent bingeing and purging associated with chronically low potassium levels). On 11 June 2003 [Dr D] referred [Mrs A] back to [the DHB's] community mental health services. On 29 September 2004 GP [Dr D] has recorded *Stopped the prozac 3–4 weeks ago after weaning down. The bulimia is no longer a problem. Feeling good.* In 2005 [Mrs A] took up [a sport] and in March 2007 was noted to be *still doing the website counselling for eating disorders* (this may refer to counselling training rather than counselling as treatment).

(ii) On 29 November 2007 [Mrs A] saw [Dr B] presented with symptoms of *tired and washed out and no energy.* Referred for counselling, bloods ordered and fluoxitene recommenced. Imovane was prescribed for sedation and changed to prothiaden 25mg nocte on 19 December 2007 when [Mrs A] requested more

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sedatives. Subsequently it appears both Prothiaden and Imovane were prescribed. Losec was being prescribed for control of GORD symptoms. On 22 April 2008 [Dr B] recorded *Lots better ... weight appears to have increased — appears normal not discussed and not measured. Still on the fluox and pleased with it. No side effects. Good progress ...*

(iii) August 2008 [Mrs A] saw gastroenterologist [Dr E] on referral from [Dr B]. [Mrs A] had had a recent possible GI bleed and a history of persistent gastro-oesophageal reflux (GORD) symptoms was noted together with the chronic hypokalaemia. The history of eating disorder was noted in the referral letter but not in [Dr E's] response. Gastroscopy on 13 October 2010 revealed gastric ulceration and pantaprozole was prescribed.

(iv) On 22 September 2008 [Mrs A] was admitted to [hospital] following an episode of loss of consciousness the previous evening. Eating disorder history was noted on the referral form. She had several investigations following this (EEG, MRI). On 16 October 2008 [Dr B] has recorded *Appears well, denies purging. Things are good at home ...* Potassium levels were monitored. On 4 December 2008 [Dr B] prescribed propranolol for [Mrs A's] anxiety symptoms with good response. Through the latter part of 2009 there were consultations for abdominal pain and [Mrs A] was referred back to [Dr E] who investigated her further with repeat gastrosocpy, ultrasound and various blood tests. A high dose of pantoprazole was prescribed for chronic gastritis. In November 2009 [Mrs A] was seen by endocrinologist [Dr F] with respect to her chronic hypokalaemia. His report includes the statement *[Mrs A] has a history of bulimia in the past, from which she has improved without ongoing evidence of symptoms ...* various tests were ordered to investigate [Mrs A's] 'chronic diarrhoea'. Repeat gastroscopy in March 2012 showed healing of the previously observed ulcerated areas.

(v) To this point I could find nothing in the consultation notes referring specifically or indirectly to [Mrs A's] complaint. On 8 February 2010 [Dr B] has extensively documented a consultation with [Mrs A] and her partner in which he establishes [Mrs A] *had 'accidentally' taken a bottle full of zopiclone ... insistent there was no intention to self harm ... this episode gets the use of purgatives out into the open. Is in the habit (not very often) of taking a small bottle full of Dulcolax (OTC) to purge the bowel because of symptomatic bloating. Is not doing the bulimia/vomiting any more ... discussed management of OCD and needing to replace this with a better ritual. Will do without sleeping pills — penance? Will attend praxis ?[Dr C] for help with OCD ...*

(vi) On 17 February 2010 [Dr B] referred [Mrs A] to clinical psychologist [Dr C]. The referral letter noted [Mrs A's] recent overdose of sedatives (recorded as 'accidental' when they were mistaken for laxative tablets), her past history of eating disorder and hypokalaemia and her recent admission to frequent purging. [Dr B] notes *I have done my best to seed the idea that [Mrs A] needs to build less destructive rituals. There has to be a safer way of achieving the same end. I think she is clever enough to do this ... There are less damaging ways of emptying the bowel — low pressure water enemas used to be very popular. Deep abdominal*

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massage to the L lower abdomen is part of traditional Maori massage and has been very successful in our local rest home. I think it is important to recognise the underlying drivers of the behaviour and I think she needs to include sexual behaviour with her ritual. I am fairly sure about this but feel a little out of my depth as I have not helped people build cleansing rituals before … There is no progress letter from [Dr C] on file although later correspondence (see below) suggests therapy may be ongoing.

(vii) On 22 March 2010 [Mrs A] had a seizure and was reviewed by [Dr B]. Potassium was normal at the time but sodium levels slightly reduced. Last prescription for fluoxitene was January 2010 with note made 11 October 2010 *no longer taking Fluox or propranolol.* It does not appear she was reviewed again in 2010 although zopiclone (Imovane) was prescribed in amounts of 60 tablets at a time on 28 June, 24 August, 11 October and 9 December 2010, and again on 28 January and 17 March 2011 (30 tablets only on the last occasion). The next consultation was 22 March 2011 regarding [Mrs A's] ongoing abdominal pain. Weight was measured at 43.9kg. She was advised to contact [Dr E] (reviewed and managed with repeat gastroscopy April 2011). There was ongoing monitoring of potassium levels with referral made for acute cardiac monitoring when levels dropped to 2.6 mmol/L on 15 April 2011. On 24 May 2011 [Dr B] prescribed [Mrs A] 90 zopiclone tablets prior to seven weeks overseas travel. A further 30 zopiclone were prescribed on 26 July, 22 September and 25 November 2011. There is no reference to discussion about specific eating disorder management strategies in 2011.

(viii) On 14 March 2012 [Mrs A] rang for repeat medications and was advised she needed GP review. Thirty zopiclone tabs were prescribed and blood tests ordered prior to review undertaken on 1 June 2012. At that appointment [Dr B] has recorded *Here about the low K, discussed. This is from laxative use and a phobia of becoming clogged up with faeces and a need to purge. Discussed the physiology. Discussed ways of cleaning out the rectum without causing all the difficulties of purging … Is having counselling for her phobias …* Three month supply of dothiepin and potassium replacement prescribed, together with 30 zopiclone and 40 glycerol suppositories (presumably prescribed in case of rebound constipation following cessation of purgatives). Both zopiclone and glycerol suppository scripts were repeated on 10 August 2012 (suggesting daily use of glycerol suppositories). Potassium was monitored.

(ix) On 27 August 2012 [Mrs A] saw [health care provider] with difficulty swallowing. This was felt to be anxiety related and it was noted she was already attending a psychologist. On 3 September 2012 [Mrs A] was reviewed by [Dr B] who discussed her recent symptoms but currently improved potassium levels. On 17 September 2012 [Dr B] reviewed [Mrs A] who *seems a little desperate … has been seeing [Dr C] … discussed drug options and what to take, will try quetiapine … see in two weeks.* Quetiapine prescribed at 25mg nocte. Also in September 2012 — further gastroscopy and gastric biopsies performed by [Dr E] — 'lax oesophagus' but nil else of note found. pH study in December 2012 suggested a 'hypersensitive oesophagus'. [Dr E] wrote to [Dr B] following this study (cc

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Liaison Psychiatrist) and described having reviewed [Mrs A] with her psychologist and recommended her commencing an SSRI as treatment for her oesophageal problems.

(x) Review by [Dr B] 1 October 2012 — *I am worried that [Mrs A] really needs to be distracted from her own self preoccupation* ... repeats of quetiapine and potassium prescribed. Weight and potassium levels monitored. Review by [Dr B] 3 December 2012 — weight dropping — oral contraceptive pill changed and quetiapine continued (further 30 zopiclone prescribed). 11 December 2012 — weight increased and *has been a good week ... discussed self pleasure.* On 21 January 2012 [Mrs A] requested repeats of her usual medications and on 7 February 2013 a request for transfer of notes was received.

4. A review article on current recommendations for management of eating disorders[1] includes the following comments:

- *Patients with eating disorders should be monitored for medical complications.* [Dr B] did monitor [Mrs A's] potassium levels and blood pressure, and made appropriate referrals for her GI symptoms and following her loss of consciousness].
- *Patients with eating disorders are best cared for by an interdisciplinary team consisting of a mental health clinician, dietitian, and general medical clinician.* [Mrs A] had received care from a variety of sources over the years since her diagnosis, including a dedicated Eating Disorders Team [in another region] in 2002. Physicians and a psychologist were involved in her care while she was seeing [Dr B], but this was not as a dedicated MDT approach. However, it is not clear that [the] DHB had such a resource available to referrers during the period in question, or whether [Mrs A's] symptoms were sufficiently severe to satisfy criteria for referral to such a team].
- *The treatment of anorexia nervosa generally involves nutritional rehabilitation and psychotherapy. Nutritional rehabilitation for patients with anorexia nervosa includes prescribing and supervising meals, and proscribing binge eating and purging; hospitalization may be necessary for treatment resistant patients. Refeeding that is too rapid or aggressive can lead to the potentially fatal refeeding syndrome. Psychotherapy options for anorexia nervosa include family therapy, cognitive-behavioral therapy (CBT), specialist supportive clinical management, and motivational interviewing. In addition, adolescent patients may benefit from family therapy. Adjunctive pharmacotherapy is indicated for acutely ill patients who do not gain weight despite initial treatment with nutritional rehabilitation and psychotherapy.* [See comments in section 5]
- *Patients not gaining weight despite standard treatment are candidates for adjunctive pharmacotherapy, including patients with anticipatory anxiety when confronting a meal. Low weight patients treated with pharmacotherapy are at increased risk for side effects and should initially receive a small dose.*

[1] Forman S. Eating disorders: Overview of treatment. Uptodate. Last updated July 2013. www.uptodate.com

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Bupropion should not be used because it is associated with a higher incidence of seizures in patients with eating disorders. Medical complications of anorexia nervosa should also be considered. As an example, drugs that impact cardiac function, such as antipsychotics and antidepressants (especially tricyclic agents), should be used cautiously in malnourished patients. [See comments in section 5]

- *Standard treatment for bulimia nervosa includes nutritional rehabilitation, psychotherapy, and pharmacotherapy. Cognitive-behavioral therapy is the psychotherapy of choice. The treatment of binge eating disorder generally involves psychotherapy; however, pharmacotherapy is a reasonable alternative. For overweight or obese patients with binge eating disorder, behavioral weight loss therapy may be beneficial.*

5. From the MCNZ publication 'Sexual Boundaries in the Doctor–Patient Relationship[2]':

(i) *A breach of sexual boundaries comprises any words, behaviour or actions designed or intended to arouse or gratify sexual desires. It is not limited to genital or physical behaviour. It incorporates any words, actions or behaviour that could reasonably be interpreted as sexually inappropriate or unprofessional.*

(ii) *Sexual impropriety means any behaviours, such as gestures or expressions, that are sexually demeaning to a patient, or that demonstrate a lack of respect for the patient's privacy. Such behaviours include, but not exclusively:*

… making inappropriate comments about, or to, the patient, such as making sexual comments about a patient's body or underclothing

… making sexualised or sexually-demeaning comments to a patient

(iii) *As the professional, the onus is always on you to behave in a professional manner. You must ensure that every interaction with a patient is conducted in an appropriate professional manner.*

5. Non-pharmacological treatment of [Mrs A's] eating disorder

(i) [Dr B] states he did, as part of his strategy to assist [Mrs A] with her eating disorder, suggest she masturbate as distraction or alternative focus away from her eating disorder. He enquired after her progress with this strategy on a number of occasions. I could not find any reference, on review of the medical literature, which refers to masturbation or other sexually oriented sensate focussing as a validated strategy for treatment of eating disorders. [Mrs A] states she found [Dr B's] comments inappropriate. The comments, which were introduced into the consultations by [Dr B] and which do not appear to have any basis as an accepted treatment strategy for eating disorders, could be readily perceived as sexual impropriety. It is not possible for me to determine whether the comments have been made naively without any intent of impropriety (as stated by [Dr B]) or

[2] Available at: Sexual Boundaries in the Doctor–Patient Relationship. www.mcnz.org.nz

HDC

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whether there was other intent. Certainly, the comments were inappropriate from a clinical and professional perspective and if they were made naively one must wonder at [Dr B's] competency in discerning appropriate from inappropriate clinical behaviour.

(ii) [Dr B] describes some of the 'cleansing rituals' he discussed with [Mrs A] in his referral letter to psychologist [Dr C] (see 3(vi) and (viii)). I could find no reference in the medical literature that such strategies were of use in the management of eating disorders, and their focus on bowel cleansing (albeit using measures other than abuse of laxatives) do not appear to be consistent with the general psychotherapeutic approach of trying to remove the patient's obsessive focus on intake and excretion but in fact might reinforce this obsession.

(iii) I acknowledge [Dr B] did refer [Mrs A] for psychological intervention in 2010 and she evidently continued to access the psychologist over the next two years. I could not find any progress report from the psychologist in the documentation examined.

6. [Mrs A's] pharmacological management

(i) With reference to section 4, tricyclic medications (in this case Prothiaden) should be used with caution in patients with eating disorders (particularly when there is associated electrolyte disturbance) with manufacturer recommendations noting hypokalaemia should be corrected before use[3]. It is not clear this factor was considered in the ongoing prescribing of Prothiaden to [Mrs A], even when her potassium levels were very low. However, I note other physicians were involved in her care over this period and there does not appear to have been any recommendation to review the use of Prothiaden.

(ii) The ongoing prescribing of large amounts of zopiclone (up to 90 tablets at a time) following [Mrs A's] overdose of the medication, even though there was no voiced intention to self harm, was not a clinically wise strategy. Between March 2010 and March 2011 [Mrs A] was prescribed zopiclone in significant amounts on several occasions with no review over that 12 month period. In a patient with a known psychiatric disorder (eating disorder) and recent overdose (albeit unintentional) I think this management strategy would meet with moderate disapproval by my peers.

(iii) In June and August 2012 [Mrs A], having admitted to regular purging with dulcolax, was prescribed 40 glycerine suppositories which medication records suggest were used daily to the time a repeat prescription of 40 was supplied. The clinical rationale for prescribing the suppositories in large amounts as an alternative to Dulcolax appears somewhat flawed as there was still a focus on [Mrs A] emptying her bowel by 'artificial' methods rather than a focus on 'normal' bowel movement through use of adequate fluids and dietary fibre.

[3] See http://www.medsafe.govt.nz/profs/datasheet/d/Dopresscap.pdf

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7. Taking into account the factors discussed above, I feel aspects of [Dr B's] non-pharmacological management of [Mrs A], particularly those relating to his suggestion she masturbate regularly and his enquiry after her progress in this regard, represent a moderate departure from expected standards. If there was an intent by [Dr B] to gain some personal pleasure from these discussions and this was the reason they were introduced and revisited, this would be a severe departure from expected standards. However, the fact [Dr B] has referred in his clinical documentation and referral letters to the discussions leads me to feel they were more likely made in a context of naivety and poor judgement in which case referral to the Medical Council of New Zealand might be appropriate. There were aspects of [Dr B's] pharmacological management of [Mrs A] which departed from expected standards to a moderate degree."

Further advice

On 28 January 2014 Dr Maplesden provided the following further advice:

"1. You have provided me with additional information received since provision of my original advice on 16 September 2013:

(i) The referral letter from [Dr B] to psychologist [Dr C] referred to in section 3 (vi) of my original advice was never received by [Dr C]. [Mrs A] began seeing [Dr C] after she self-referred in August 2012, and was also seen by psychologist [Ms G] from this time. This means my assumption [Mrs A] was receiving psychological counselling between 2010 and 2012, during which time she was experiencing problems with chronic hypokalaemia secondary to purging, was incorrect. It appears [Dr B] was under the impression [Mrs A] was receiving regular counselling somewhat earlier in 2012 (see 3(viii) and 5(iii) of my original advice), the grounds for this assumption being unclear as there were no psychologist reports in the clinical notes for the period in question

(ii) [Dr B] has noted he continued to prescribe [Mrs A] dothiepin (as recently as January 2013) at her request and because she was reluctant to trial an SSRI, and had used dothiepin previously without problems (refer section 6(i) of my original advice). However, he notes also in one of his responses to HDC that [Mrs A's] habitual purging and secondary hypokalaemia made the risk of sudden death by cardiac arrhythmia *a real possibility.*

(iii) [Dr B] has denied he was ever *sexually suggestive or otherwise inappropriate* in his interactions with [Mrs A] … *At no time did I countenance any personal interest in [Mrs A] ...* He feels some comments he made regarding [Mrs A's] abdominal organs being easy to palpate, and to attempting to ensure her personal safety, were misperceived by [Mrs A] as having possible inappropriate overtones.

(iv) The medical centre has advised on its referral follow-up and repeat prescribing processes. Although no relevant formal policies were in place for these processes at the time of the events in question, current policies described appear to be consistent with expected practice and the practice received Cornerstone accreditation in July 2013.

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(v) [Dr B] has described his participation in relevant peer groups, and now refers patients with eating disorders to providers with expertise in this area. He states his DHB does not offer a MDT service for patients with eating disorders.

2. Based on the additional information received I make the following comments:

(i) The additional information received since provision of my original advice does not alter my impression that aspects [Dr B's] management of [Mrs A] departed from expected standards to a moderate degree with respect to his pharmacological and non-pharmacological management of [Mrs A's] eating disorder and associated conditions. His subsequent responses have reassured me that those comments he made to [Mrs A] which were perceived as being sexually inappropriate were made in a context of naivety and poor judgement rather than with any intent to gain personal pleasure.

(ii) The additional information received with respect to non-receipt of the referral letter to [Dr C] in 2010 does raise some concerns at the failure by [Dr B] to follow-up the referral although current referral process at the medical centre now appear appropriate. I think it was a moderate departure from expected standards for [Dr B] not to follow up the referral when he had not received any feedback from [Dr C] within a reasonable time frame, unless he was given the impression by [Mrs A] that she was attending the psychologist over the period in question (and this appears a possibility from [Dr B's] responses). Had he never intended to make the formal referral to [Dr C], this is reflected in my comments on his overall management of [Mrs A's] eating disorder ie still a moderate departure from expected standards.

(iii) In providing this advice I have acknowledged the fact [Mrs A] had previously received specialised help for her eating disorder and have noted the difficulties encountered in managing patients with such disorders and the (at best) modest success both pharmacological and non-pharmacological methods have in achieving permanent control of the condition. Eating disorders are commonly associated with patient behavioural characteristics that make accurate assessment and effective management of the disorder particularly difficult.

(iv) I remain of the view that aspects of [Dr B's] prescribing as discussed in my original advice, and his comments made regarding [Mrs A] establishing 'self pleasuring' rituals as part of her eating disorder treatment, do warrant consideration of referral to the Medical Council of New Zealand."

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Appendix B — Table of prescribing zopiclone/quetiapine/Glycerol Suppositories

Date of prescription	Prescribing Practitioner	Who saw/assessed [Mrs A]	What was prescribed
20/12/2007	Dr B	Dr B	30 Zopiclone (Imovane) 7.5mg
15/01/2008	Dr at medical centre	Dr at medical centre	30 Zopiclone (Imovane) 7.5mg
22/04/2012	Dr B	Dr B	20 Zopiclone (Imovane) 7.5mg
18/03/2009	Dr B	Dr B	20 Zopiclone 7.5mg
13/05/2009	Dr B		20 Zopiclone 7.5mg
24/06/2009	Dr B		20 Zopiclone 7.5mg
10/07/2009	Dr at medical centre		20 Zopiclone 7.5mg
21/08/2009	Dr B	Dr B	20 Zopiclone 7.5mg
07/09/2009	Dr B	Dr B	20 Zopiclone 7.5mg
25/09/2009	Dr B	Dr B	20 Zopiclone 7.5mg
13/10/2009	Dr B	Dr B	60 Zopiclone 7.5mg
18/11/2009	Dr B		60 Zopiclone 7.5mg
11/12/2009	Dr B		60 Zopiclone 7.5mg
22/01/2010	Dr B		60 Zopiclone 7.5mg
28/06/2010	Dr B		60 Zopiclone 7.5mg
24/08/2010	Dr B		60 Zopiclone 7.5mg
11/10/2010	Dr B		60 Zopiclone 7.5mg
09/12/2010	Dr B		60 Zopiclone 7.5mg
28/01/2010	Dr B		60 Zopiclone 7.5mg
17/03/2011	Dr B		30 Zopiclone 7.5mg
24/05/2011	Dr B	Dr B	90 Zopiclone 7.5mg
26/07/2011	Dr B	Dr B	30 Zopiclone 7.5mg
22/09/2011	Dr B		30 Zopiclone 7.5mg
25/11/2011	Dr at medical centre	Dr at medical centre	30 Zopiclone 7.5mg
14/03/2012	Dr at medical centre		30 Zopiclone 7.5mg
01/06/2012	Dr B	Dr B	30 Zopiclone 7.5mg 40 Glycerol suppositories 3.6g
10/08/2012	Dr B		30 Zopiclone 7.5mg 40 Glycerol suppositories 3.6g
11/09/2012	Dr B		30 Zopiclone 7.5mg
17/09/2012	Dr B	Dr B	30 Quetiapine 25mg
01/10/2012	Dr B	Dr B	30 Quetiapine 25mg
03/12/2012	Dr B	Dr B	30 Zopiclone 7.5mg 30 Quetiapine 25mg
21/01/2013	Dr B		30 Zopiclone 7.5mg 30 Quetiapine 25mg

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