# Psychiatrist, Dr E
# District Health Board

## A Report by the
## Deputy Health and Disability Commissioner

**(Case 18HDC01890)**

**(Case 19HDC00558)**

**(Case 19HDC01179)**

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

## Contents

## Executive summary

1. This report relates to three complaints primarily about the tone and manner of communication of a psychiatrist working at a district health board (the DHB). Broadly, all of the complaints raise concerns about the language and tone used by the psychiatrist in both in-person assessments and in written communication.

2. In this report, the Deputy Commissioner notes that the three consumers, despite having varied backgrounds and life circumstances, were similar in that they were all grappling with significant mental health and/or addiction issues. This meant that they were particularly vulnerable. The Deputy Commissioner emphasised the importance of such consumers being treated with respect, and of clinicians involved in their care working to develop therapeutic and supportive relationships. The importance of DHBs supporting their staff to communicate appropriately was also highlighted.

**Findings**

*Psychiatrist*

3. The Deputy Commissioner found that the language used by the psychiatrist in his written communication was inappropriately derogatory, reflected his personal views about Consumer A, and was very unlikely to promote a trusting relationship with the consumer.

4. The Deputy Commissioner found that in his oral and written communication, the psychiatrist used inappropriate, non-therapeutic, and disrespectful language towards and about Consumer B. The psychiatrist also allowed his personal views to affect his interactions with the consumer inappropriately.

5. The Deputy Commissioner found that the psychiatrist failed to recognise the distress from both Consumer C and his mother, and to listen to and be receptive to their concerns in an empathetic and respectful way, and used disparaging and inappropriate language in his written communication.

6. In all three cases, the Deputy Commissioner considered that the tone and manner of the psychiatrist's oral and/or written communication amounted to failures to treat the consumers with respect, and to comply with professional standards. The psychiatrist was therefore found in breach of Rights 1(1) and 4(2) of the Code in respect of all three consumers.

7. The Deputy Commissioner also found the psychiatrist in breach of Right 4(1) of the Code for a number of issues relating to the psychiatrist's management of Consumer A's medication regimen.

*DHB*

8. The Deputy Commissioner found that the DHB did not take such steps as were reasonably practicable to prevent or address issues with respect to the psychiatrist's communication, and therefore that the DHB was vicariously liable for the psychiatrist's breaches of Rights

1(1) and 4(2) of the Code with respect to each of the three consumers. The DHB was also found to have directly breached Right 4(1) for several issues in Consumer A's clinical care.

**Recommendations**

*Psychiatrist*

9. The Deputy Commissioner recommended that the psychiatrist a) attend further training, provided by people with lived experience of mental distress, on therapeutic communication, establishing trust and rapport with mental health consumers, treatment of BPD, and how to manage the risk of countertransference; b) provide a reflective statement to HDC about these cases; and c) provide formal separate written apologies to each of the consumers/their whānau.

10. The Deputy Commissioner also recommended that the Medical Council of New Zealand consider whether a review of the psychiatrist's competence or conduct is necessary.

*DHB*

11. The Deputy Commissioner recommended that the DHB a) audit a random selection of 20 pieces of clinical documentation written by the psychiatrist to assess the appropriateness and standard of the content; b) provide HDC with details of the feedback given by DHB staff who observed the psychiatrist in three consultations, and details of any further training or support for the psychiatrist identified as necessary; c) consider adopting a new guideline for the monitoring of consumers on antipsychotic medications; d) consider adopting a new form, to be incorporated into multidisciplinary team meeting notes, to prompt staff when repeat tests or reviews are due; e) consider adopting a form to request and reply to applications for a second opinion for consumers who are subject to the Mental Health (Compulsory Assessment and Treatment) Act 1992; and f) provide formal separate written apologies to each of the consumers/their whānau.

## Complaint and investigation

12. The Health and Disability Commissioner (HDC) received three complaints about the services provided by the DHB and by psychiatrist Dr E to three consumers: Consumer A (deceased), Consumer B, and Consumer C. The following issues were identified for investigation:

- *Whether Dr E provided Consumer A with an appropriate standard of care between 2015 and 2018 (inclusive).*
- *Whether the DHB provided Consumer A with an appropriate standard of care between 2015 and 2018 (inclusive).*
- *Whether Dr E provided Consumer B with an appropriate standard of care on 7 October 2016 and on 15 March 2019 to 18 March 2019 (inclusive).*

- *Whether the DHB provided Consumer B with an appropriate standard of care in relation to the acute mental health assessments carried out by Dr E on 7 October 2016 and on 15 March 2019.*
- *Whether Dr E provided Consumer C with an appropriate standard of care on 27–28 March 2019 (inclusive).*
- *Whether the DHB provided Consumer C with an appropriate standard of care in January 2019 to March 2019 (inclusive).*

13. This report is the opinion of Deputy Health and Disability Commissioner Dr Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner. The opinion is further to a provisional opinion from previous Deputy Commissioner Kevin Allan.

14. The report considers the care provided to each individual consumer by Dr E and the DHB, and makes recommendations and follow-up actions relevant to all cases. The "Information gathered" section relating to Dr E is relevant to each individual case. The report addresses the facts of each case and the care provided to each consumer separately.

**Parties involved**

*Consumer A*

15. The parties directly involved in this investigation (18HDC01890) were:

| | |
|---|---|
| Mrs D | Complainant/consumer's mother |
| Mr D | Complainant/consumer's father |
| Dr E | Consultant psychiatrist/provider |
| DHB | Provider |

16. Further information was received from:

| | |
|---|---|
| Dr F | Psychiatrist |
| Registered Nurse (RN) RN G | Registered nurse |
| Medical centre | |
| Supported accommodation | Mental health support service |
| The Office of the Coroner | |

17. Also mentioned in this report:

| | |
|---|---|
| Dr J | Psychiatrist |
| Dr K | Consultant psychiatrist |

*Consumer B*

18. The parties directly involved in this investigation (19HDC00558) were:

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|---|---|
| Consumer B | Consumer |
| Dr E | Consultant psychiatrist/provider |
| DHB | Provider |

19. Further information was received from:

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|---|---|
| RN H | Registered nurse |
| RN I | Registered nurse |

20. Also mentioned in this report:

| | |
|---|---|
| Mr L | Psychologist |
| RN M | Mental Health Emergency Team (MHET) nurse |

*Consumer C*

21. The parties directly involved in this investigation (19HDC01179) were:

| | |
|---|---|
| Consumer C | Consumer |
| Mrs N | Complainant/consumer's mother |
| Dr E | Consultant psychiatrist/provider |
| DHB | Provider |

22. Further information was received from:

| | |
|---|---|
| Mr O | Alcohol and other drug counsellor |
| Medical centre | |

**Independent advice**

23. Independent expert advice was obtained from psychiatrist Dr Rosemary Edwards with respect to each consumer (Appendices A (advice about Consumer A), B (advice about Consumer B), and C (advice about Consumer C)).

## Information gathered during investigation

**Dr E**

24. Dr E is a consultant psychiatrist at the DHB. He commenced his employment in this role at the DHB in 2005. He was educated overseas, where he worked as a psychiatrist for over 30 years.

*Induction and training provided by DHB*

25. The DHB provided HDC with a copy of its induction and education information for Dr E. It showed that Dr E completed orientation and induction to the service, and attended a number of education sessions between 2010 and 2014, including on topics such as stigma and discrimination, pharmacology and mental health, values and attitudes, eating disorders, psychosis, and seclusion. No education information was provided for the years 2014 to 2018. In 2019, Dr E attended training on psychological therapies.

## Consumer A

### Factual background

*Introduction*

26. Consumer A had been involved with mental health services since his mid-20s. Consumer A's medical history included long-standing schizoaffective disorder (a mental health disorder that involves symptoms of both schizophrenia and a mood disorder (such as major depression or bipolar disorder)), cannabis dependence, and severe chronic obstructive pulmonary disease (COPD).[1]

27. Sadly, Consumer A died aged in his forties. A post mortem was completed, and the cause of his death was determined to be cardiac arrhythmia (irregularity of the heartbeat).

28. This section of the opinion focusses on Dr E's tone of written communication when he provided care to Consumer A between 2015 and 2018. It also discusses the management of Consumer A's medication regimen, including in relation to the side effects of Consumer A's medications.

*Background — Consumer A's inpatient mental health admission Month1*

29. On 14 Month1,[2] Consumer A was admitted to the DHB's inpatient mental health unit (the MHU), his fourth MHU admission in 2014. Consumer A was admitted because he had experienced a psychotic and manic relapse, apparently because he had stopped taking his medications[3] shortly after he was discharged from a recent MHU admission.

30. At the time of his admission, Consumer A was under a Compulsory Treatment Order (CTO) pursuant to section 30 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA).[4] Consultant psychiatrist Dr J was responsible for Consumer A's care at the time. However, on 12 Month2 Dr E took over as Consumer A's responsible clinician.

31. Consumer A remained an MHU inpatient for nearly a year, before being discharged on 5 Month13. He was discharged to supported accommodation. Dr E continued to be Consumer A's responsible psychiatrist, and managed his care following his discharge. Consumer A remained under a CTO (section 29 of the MHA), having his treatment provided in the community rather than as an inpatient.

[1] Pulmonary disease (as emphysema or chronic bronchitis) that is characterised by chronic typically irreversible airways obstruction resulting in a slowed rate of exhalation.
[2] Relevant months in Consumer A's case are referred to as Months 1–47 to protect privacy.
[3] Clozapine (a medication used to treat schizophrenia) and lithium (a medication used to stabilise mood).
[4] The MHA provides a legal framework for people experiencing a mental illness who require compulsory psychiatric assessment and treatment. Compulsory treatment orders under the MHA are court orders stating that a consumer who is assessed as having a mental disorder will have to receive treatment, and can be given treatment even if the consumer does not consent to that treatment. A compulsory treatment order can be extended for an indefinite period if necessary, but the clinician responsible for the consumer's care must review the order regularly.

*Clinical care — medication regimen and monitoring of side effects*

Paliperidone palmitate

32. In a discharge summary letter (written in Month13),[5] Dr E summarised the history of Consumer A's medication regimen while he was an inpatient from Month1 onwards. Dr E noted that because Consumer A continued to decline oral antipsychotic medication, it was decided that he would receive an injection of 150mg paliperidone palmitate (an antipsychotic medication used for the treatment of schizophrenia) every four weeks.[6] Dr E noted that while Consumer A's psychotic symptoms improved, Consumer A tended to deteriorate on the fourth week following the injection. Dr E wrote: "It was then decided to go through the protocol for off label use,[7] and the injection was made 3 weekly, with corresponding improvement."

33. Dr E also noted on the discharge summary: "[A]t long last we are on the same page." He told HDC that he documented this because Consumer A's father agreed to the proposed treatment. However, in response to the provisional opinion, Consumer A's father told HDC that he said this in relation to Dr E stating that he would be putting firm boundaries around Consumer A's behaviour, not in relation to the treatment. Consumer A's parents added that they understood that Dr E was changing Consumer A to a three-weekly paliperidone dose and that Dr E would need to write to the Ethics Committee, but he did not explain what that meant or seek consent from their son or from them for the change.

34. The Medsafe data sheet (2010) for paliperidone palmitate states that the recommended maintenance dose is 75mg a month, although the recommended range spans from 25 to 150mg. The data sheet states: "It is recommended that responding patients be continued on treatment at the lowest dose needed." The data sheet also notes that paliperidone causes a "modest" change in the heart's electrical rhythms.[8] Other side effects associated with paliperidone include tardive dyskinesia (a neurological disorder characterised by involuntary uncontrollable movements), metabolic effects such as hyperglycaemia (excess blood sugar level), diabetes, and weight gain, and, in rare cases,[9] sexual dysfunction.

35. The discharge documentation also indicates that on 18 Month3, Consumer A was first prescribed "150mg [intramuscular] x every 3 weeks" of paliperidone by Dr E. However, the medication charts appended to the regular multidisciplinary team (MDT) meetings (from Month2 onwards) provided to HDC by the DHB indicate that Consumer A was first prescribed a monthly 150mg paliperidone injection on 20 Month4. In response to the provisional opinion, Dr E told HDC that this apparent discrepancy was an error in the

[5] Other aspects of this letter are set out in further detail in paragraphs 71–72 below.

[6] Mr A's medication regimen also included lithium carbonate (lithium), at a dose of 1,500mg once daily. Mr A remained on this dose of lithium until his death.

[7] This means that the medicine's use, dose, age range, or route has not been assessed by the manufacturer for this particular regimen. Off-label use is common and accepted in New Zealand provided certain conditions are met.

[8] Specifically, it states that paliperidone causes a "modest increase" in the corrected QT (QTc) interval. The QT interval indicates the time taken from when the cardiac ventricles begin contracting to when the ventricles finish relaxing. QTc is corrected for the heart rate.

[9] Less than 2% of participants in trials experienced this side effect.

medication chart documentation, and that Consumer A continued on three-weekly paliperidone injections after that plan was agreed in late 2014.

36. On 9 Month5, a consultant forensic psychiatrist at the DHB wrote a detailed assessment of Consumer A and opinion on the management of his risk to others. The forensic psychiatrist noted that Consumer A's regular medication included a three-weekly 150mg paliperidone injection (increased from the initial four-weekly injections). She also noted that staff reported that when Consumer A was receiving four-weekly injections, his levels of irritability, arousal, and elation increased in the week prior to the injection being due and, as a result, the frequency was increased. The forensic psychiatrist wrote that she agreed with the MDT's decision to change Consumer A's medication from an oral antipsychotic to depot (slow-release injection, i.e. the paliperidone), and noted: "I strongly advise that this is continued in the longer term."

37. Section 59 of the MHA outlines the process by which treatment can be given to a patient under a CTO. After the first month of compulsory treatment, further treatment cannot be provided unless either the patient consents in writing or a psychiatric second opinion is obtained that concludes that the treatment is in the patient's interests. Section 59(4) also states that a clinician will, wherever practicable, seek to obtain the patient's consent to treatment even if the treatment is authorised without the patient's consent under the MHA.

38. On 10 Month5, it was noted in the MDT notes that Consumer A was refusing "to sign consent re depot paliperidone 150 mg [intramuscular]". The medication chart appended to the MDT notes records that Consumer A had been charted paliperidone injection, 150mg, to be administered three-weekly.

39. Following an MDT meeting on 17 Month5, the frequency of the paliperidone injection was changed back to four-weekly. The MDT notes do not record a reason for the change.

40. On 3 Month6, consultant psychiatrist Dr K reviewed Consumer A for a second opinion under section 59 of the MHA because Consumer A was refusing to sign the consent for treatment form. Dr K's opinion was set out in a letter, addressed to Dr E, and concluded: "In my opinion, [Consumer A] is clearly unwell and has no insight into his illness. He requires an ongoing treatment and I agree with the current regime of his treating Psychiatrist." Dr K's letter did not specifically refer to or detail Consumer A's medication regimen. Dr E said that he was sufficiently clear what treatment regimen was being supported by Dr K (reiterating that Consumer A remained on three-weekly injections from late 2014, despite the documentation indicating otherwise). Dr E added that second opinions do not expire and "repeat second opinions are neither sought nor required".

41. In response to the provisional opinion, Dr E said that the "off-label" use of paliperidone (the three-weekly dose) was also discussed at the consultants' weekly peer-review meeting, and this change was endorsed by the meeting. He also said that the long-term management plan was reviewed at the complex case conference on 6 Month8. The notes from this meeting, to the extent that they refer to Consumer A's medication regimen, state: "Currently [Consumer A] is on [paliperidone] and lithium, lithium is essential."

42. The frequency of the paliperidone injection was again changed to three-weekly on 7 Month7 (and remained the same until Consumer A's discharge). The medication chart records that the change was as per Dr E's instructions, but not the reason for the change.

43. Neither Dr E nor the DHB provided HDC with any written documentation or other contemporaneous evidence that the clinical benefits and side effects of the increased dose of paliperidone were discussed with Consumer A at the time. In response to the provisional opinion, Dr E said that the rationale for the treatment, along with other medication-related issues, were explained to Consumer A. Dr E said that Consumer A was also provided with printed information sheets about lithium and paliperidone, as was customary with all patients. He said that the rationale for changing the paliperidone dose to three-weekly was also explained verbally to Consumer A. However, none of this was documented.

44. The DHB provided a copy of its Informed Consent form in place at the time of events. It includes spaces to record the information verbally provided to the consumer about the treatment, the consumer's consent to the treatment, and, if relevant, for a specialist second opinion agreeing or not agreeing to the treatment. The Informed Consent form specifically notes that it may be used to obtain consent from a consumer who is subject to the MHA. However, the DHB did not provide HDC with evidence that this form was completed for Consumer A at any time during his admission or thereafter. However, a copy of the form from Consumer A's file provided to HDC includes the handwritten note: "Explained it to him. Refused to sign 3 [Month6]." The clinical records provided to HDC contain no further documented attempts to obtain Consumer A's written consent to his treatment.

45. Dr E reviewed Consumer A on 10 Month28 and documented that Consumer A had requested that his paliperidone injection be changed to four-weekly. Dr E wrote that he agreed to this, and recorded at the end of the notes that Consumer A's prescription was to be "[Injection] paliperidone palm[itate] 150mg [intramuscular] x 4 weekly". Dr E also informed Consumer A's general practitioner (GP) that the frequency of Consumer A's paliperidone injections had been reduced to four-weekly.

46. However, this change was not initiated, and Dr E's clinical notes written on 18 Month32 note that Consumer A was receiving three-weekly paliperidone injections. Dr E's notes do not document a reason for the dose change agreed to in Month28 not being initiated (or any other discussion about the paliperidone dose). There is no evidence that Consumer A was informed that the change had not been made. In response to the provisional opinion, Dr E said that, given the time that has elapsed, he cannot explain the documented change in medication in Month28 but he thinks it was an inadvertent error in the documentation.

*Side effects of medication*

47. Mr and Mrs D told HDC that their son "reported side effects many times to the Mental Health Team … — weight gain, dry mouth, sexual dysfunction, tiredness, sleepiness, lack of interest, acne and tremor". In addition, Mrs D told HDC that prior to her son's death, she had been concerned about the involuntary jerking of his hands.

48. In a letter to Consumer A's GP dated 23 Month18, Dr E wrote:

> "[Consumer A's] long standing, ill-conceived and misinformed narrative regarding the 'adverse effects' of his current medication persists, despite attempts at Psychoeducation. He has been advised to consult you regarding his acne."

49. The clinical notes provided by the DHB show that on 3 October 2016, Consumer A reported to Dr E that he "[b]elieve[d] his medication [was] 'poisoning' him". Dr E advised Consumer A to discuss this with his parents, and arranged for another review, with Consumer A's parents present, in three months' time. In Month32 and Month38, and again in Month41, it was documented in Dr E's letters to Consumer A's GP that Consumer A reported feeling that his medication was "poisoning" him. Also in Month41, Dr E documented that Consumer A expressed concern about the impact the medication was having on his romantic life. No further action was taken by Dr E in relation to these concerns.

50. Dr E said that the rationale for, and appropriateness and side effects of, the three-weekly paliperidone injections were discussed routinely at the weekly peer-review and multidisciplinary team meetings. Dr E said that these conversations were "more than once [discussed] with [Consumer A] and his parents during various discharge planning meetings and routine consultations which the family were always welcome to attend". However, Dr E's clinical notes from the regular three-monthly reviews with Consumer A do not record Dr E having had any discussions about the rationale, appropriateness, and/or side effects of the three-weekly paliperidone dose specifically.

51. Dr E told HDC that Consumer A's belief that his medication was "poisoning" him pre-dated his transition to paliperidone injections, and even before Dr E started providing care to him. Dr E also told HDC that, in his view, given Consumer A's "generic antipathy, rooted in poor insight and persistent denial of the reality of this severe mental health disorder, rendered any meaningful interaction with him difficult if not impossible".

52. In response to the provisional opinion, Dr E added that Consumer A had been reporting side effects with different medications, rather than any specific drug, over the preceding decade. Dr E referred to a statement from RN G (Consumer A's key worker from Month35 until Month47), in which RN G noted that Consumer A had reported side effects, such as the feeling that his medication was poisoning him, since 2009. Dr E reiterated that the repeated reporting of side effects, regardless of what medication Consumer A was on, reflected Consumer A's antipathy towards medication in general and his unwillingness to take any at all.

*Clinical reviews between 2015 and 2018*

53. Following Consumer A's discharge from the MHU in Month13, clinical reviews with Dr E were held regularly, approximately every three months.[10] Dr E documented these reviews

[10] On 21 Month15 (also attended by a DHB staff member and a representative from Consumer A's supported accommodation); 23 Month18 (also attended by a DHB staff member); 7 Month22 (also attended by a DHB staff member and a representative from Consumer A's supported accommodation); 3 Month25 (also attended by a DHB staff member and a medical student); 10 Month28 (also attended by Consumer A's father, a DHB

in Consumer A's progress notes, and sent a letter to Consumer A's GP (these letters are discussed in more detail below). The DHB provided HDC with evidence that an MDT review form was completed once between 2015 and 2018. This review form was filled out on 16 Month35 by RN G, and the notes state: "Please refer to [Dr E's] clinical note of 16 [Month35]." The attendees of this review were Consumer A, Dr E, and RN G, but no other clinicians were present.

*Consumer A's physical well-being*

Metabolic monitoring[11] and weight

54. The DHB's Metabolic Monitoring Guidelines (2014) (as set out in Appendix D) state that while a consumer is receiving antipsychotic medication, the following measurements must be taken yearly: weight; height; waist circumference; blood pressure (BP); fasting cholesterol and LDL (low-density lipoprotein — a type of cholesterol); and fasting glucose (blood sugar). The guidelines do not require any regular testing of prolactin (a hormone — raised levels of prolactin (called hyperprolactinaemia) in men can cause erectile dysfunction, as well as decreased energy, sex drive, muscle mass and strength, and blood count).

55. In response to the provisional opinion, the DHB noted that the UK's National Institute for Health Care and Excellence's 2014 guideline "Psychosis and schizophrenia in adults: prevention and management" (the NICE Guideline) does not recommend routine prolactin monitoring. However, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) 2016 clinical practice guideline for the management of schizophrenia and related disorders (the RANZCP Schizophrenia Guideline) recommends yearly testing[12] of prolactin levels for people taking antipsychotic medication. The RANZCP Schizophrenia Guideline also notes that hyperprolactinaemia is a frequent side effect of paliperidone.

56. While Consumer A was an MHU inpatient (from Month1 to Month13), a Lifestyle and Metabolic Monitoring Datasheet (the Metabolic Monitoring Sheet) was completed regularly. It showed that Consumer A's weight increased from 76.2kg (Month3) to 85.8kg (Month8). However, following Consumer A's discharge from MHU in Month13, the Metabolic Monitoring Sheet was filled out only once (by RN G, in Month35). It shows that his weight was 89.5 kilograms, his waist circumference was 100 centimetres, and his blood pressure (BP) was 132/78mmHg (slightly elevated). His BMI[13] was not calculated, but, had it been, it would have been approximately 26.7 (overweight).

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staff member, and a representative from Consumer A's supported accommodation); 10 Month29; 18 Month32 (also attended by a supported accommodation representative and a medical student); 16 Month35; 15 Month38; 12 Month41 (also attended Consumer A's father and a supported accommodation representative); 27 Month42 (also attended by Consumer A's supported accommodation representatives); 17 Month43 (also attended by Consumer A's parents and a supported accommodation representative); and 21 Month47 (at which point, Consumer A's psychiatrist had changed to Dr F).

[11] Consumers with serious mental illnesses including schizophrenia have increased rates of metabolic disturbances such as obesity and diabetes, and are at increased risk of medical illness, particularly cardiovascular disease. Treatment with antipsychotic medication can cause or aggravate these disorders. See: bpac[nz], "Monitoring for metabolic disorders: In patients taking antipsychotic drugs", *Best Practice NZ* (2007).

[12] As well as baseline and 24-week tests.

[13] Body mass index — a measure used to determine whether a person's weight is healthy.

57. In response to the provisional opinion, Dr E said that, as noted by RN G in his statement, Consumer A being overweight was not alarming, and he was not classified as obese. In addition, Dr E said that Consumer A being overweight was attributable to unhealthy eating habits rather than the psychiatric medications. In support of this, Dr E referenced a statement from RN G that noted that Consumer A drank excessive amounts of energy drinks.

58. Blood sugar levels and fasting cholesterol were not recorded following Consumer A's discharge. However, lipid tests in Month35 show that Consumer A had increased triglycerides[14] (a type of fat).

59. Dr E told HDC:

> "The patients' key-workers are responsible for metabolic monitoring, with any concerns being shared with the psychiatrist/nurse practitioner concerned. In [Consumer A's] case, his key-worker, [RN G] had been performing this role."

60. RN G told HDC that he works in the Community Mental Health Team, and this service provides assessment, treatment, and support for people aged 18 years and over who have been diagnosed with a significant mental illness. He said that he visited Consumer A every three weeks at his residence, and "the purpose of these visits was for the administration of prescribed Paliperidone 150mg …, an assessment of [Consumer A's] mental state, and more general support and advice to support his recovery".

Blood tests

61. The DHB provided HDC with evidence that renal function tests were performed in Month15, Month18, Month22, Month23, Month35, Month41 and Month44. Liver and thyroid function tests, and others, were completed in Month35 and were normal.

ECGs

62. An electrocardiogram (ECG — a measure of the electrical activity of the heart at rest) was recorded on 16 Month7, and showed no abnormalities. The DHB did not provide HDC with evidence of further ECGs being completed for Consumer A after Month7.

63. The DHB's "Physical Health Guidelines" (2016) (as set out in Appendix D) state that baseline assessments of a consumer's physical health are to be completed within 24 hours of a consumer's entry into inpatient mental health services. Such assessments include "[o]ther assessments as indicated such as ECG, blood sugar level, blood tests, peak flow". There was no requirement for ECGs to be repeated.

64. Dr E and the DHB both told HDC that none of the Medsafe Datasheet for paliperidone, the prescribing information, the US FDA[15] data sheets, and/or the UK National Health Service's

[14] 1.7mmol/L.

[15] The United States Food and Drug Administration.

(NHS's) April 2018[16] "Guidance on the Use of Antipsychotics" (the NHS Guidance) require ECGs to be done yearly. The NHS Guidance states that for antipsychotic medications, ECGs are "[r]ecommended pre-treatment and at dose increase for [typical antipsychotics — paliperidone is an atypical antipsychotic], high dose antipsychotic treatment and combination treatment with more than one antipsychotic or another drug at risk of causing QT prolongation". In response to the provisional opinion, Consumer A's parents commented that the Medsafe Datasheet for paliperidone has been written assuming that the recommended dose is used, and in their view this meant that more careful monitoring was needed.

65. In response to the provisional opinion, Dr E submitted that the Maudsley Guidelines[17] do not require yearly ECGs. He noted that the Maudsley Guidelines stipulate: "ECG — Baseline and when target dose is reached (ECG changes rare in practice) on admission to hospital and before discharge if drug regimen changed." However, in the same section referred to by Dr E, the Maudsley Guidelines also state: "Ideally, all patients should be offered an ECG at least yearly."[18] In addition, the Maudsley Guidelines note that where a patient is receiving high-dose[19] antipsychotic medication, they should have regular ECGs (including baseline ECGs and ECGs every 6–12 months). The Maudsley Guidelines state: "ECG monitoring is essential for all patients prescribed antipsychotics. An estimate of QTC interval should be made on admission to in-patient units … and yearly thereafter." Dr E commented that "instituting annual ECGs, with little evidence to support the same, for the very large number of patients on antipsychotic medication … would overload already stretched resources".

66. Similarly, in response to the provisional opinion, the DHB submitted that annual ECGs was not the expected standard of care at the time. The DHB noted that the Maudsley Guidelines referenced above (and by HDC's clinical advisor, Dr Rosemary Edwards) were not published until late in the period covered by this report (as it relates to Consumer A).

67. However, earlier editions[20] of the Maudsley Guidelines also included the guidance that ideally all patients on antipsychotic medication should be offered an ECG at least yearly, and that those receiving high-dose antipsychotics should have ECGs performed every 6–12 months. In addition, the RANZCP Schizophrenia Guideline also recommends yearly ECGs for people taking antipsychotic medication.

[16] Available at https://www.sussexpartnership.nhs.uk/sites/default/files/documents/antipsychotic_guidelines_v4_-_apr_2018_-_final_3_1.pdf

[17] *The Maudsley Prescribing Guidelines in Psychiatry*, 13th edition (2018).

[18] Maudsley Guidelines Table 1.7, "Monitoring of physical parameters for patients receiving antipsychotic medications".

[19] Which the Maudsley Guidelines state can result from the prescription of either a single antipsychotic medication at a dose above the recommended maximum, or two or more antipsychotic medications concurrently that, when expressed as a percentage of their respective maximum recommended doses and added together, result in a cumulative dose of more than 100%.

[20] Including the 12th edition (2015) and 10th edition (2009).

Dental check-ups

68. In Month37, Consumer A was seen in the DHB Respiratory Clinic for review of his COPD. A respiratory physician noted that Consumer A had "just lost a tooth" and that "the rest of his teeth look[ed] to be at risk". Shortly before[21] his death, Consumer A was seen at the DHB ED for treatment of an oral infection (a periodontal abscess). The ED doctor noted that Consumer A had "very poor oral hygiene", and an X-ray completed in ED noted five missing teeth and tooth decay affecting at least 19 teeth. Also in Month46, just prior to Consumer A's death, his GP sent a referral to the DHB for a review of Consumer A's "neglected rotten broken teeth".

69. The DHB told HDC: "The [mental health] service's understanding is that dental treatment was suggested to [Consumer A] …" In response to the provisional opinion, the DHB also noted that it runs an emergency dental clinic at the public hospital, which can provide urgent care to qualifying unwaged people. The DHB added that it does not usually offer a routine dental care service, but can provide emergency treatment in certain circumstances if the patient is willing to receive it.

*Sudden Death Review*

70. Following Consumer A's death on 29 Month47, the DHB undertook a Sudden Death Review.[22] The DHB provided HDC with the single page of notes from the review. The notes included the following:

> "[Consumer A] was suffering from a chest infection when he passed away from medical causes.
>
> … It should be documented that [Consumer A's] treating team had continued to encourage smoking cessation over a long period, however unfortunately this had not happened for [Consumer A] and he continued to smoke cigarettes up until his death. It was felt that the fact that [Consumer A] had survived the medical conditions that he had until his death were a testament to the care he had received from living at [supported accommodation]. There were no admissions since [Consumer A] had lived at [supported accommodation], compared to several admissions prior to him living there.
>
> … [The Clinical Lead of the DHB's Mental Health Services] commented that everything possible appeared to have been done by both Mental Health Services and [supported accommodation] in this case for [Consumer A]."

*Dr E's written communication*

71. As noted above, on Consumer A's discharge from the MHU in Month13, Dr E wrote a discharge summary letter (extracts of which are set out in paragraph 72 below). Dr E also

[21] In Month46.

[22] Present at this review were Dr E, RN G, and psychiatrist Dr F (who had recently taken over from Dr E as Mr A's responsible clinician), as well as the Clinical Lead of the DHB's Mental Health Services, the Team Leader of the DHB's Integrated Community Mental Health Teams, and two representatives from supported accommodation.

continued to see Consumer A for regular reviews, roughly every three months, between 2015 and 2018. Following these reviews, Dr E would send letters to a number of people involved in Consumer A's care. Extracts from some of the letters are also set out below.

Month13 discharge summary

72. Dr E's discharge summary letter was sent to Consumer A's GP, and Consumer A's parents told HDC that Consumer A also received a copy of this letter. Under the heading "Clinical Information", Dr E began the letter with the following:

> "[Consumer A], a long standing patient of schizoaffective disorder with alcohol & substance misuse, dysfunctional lifestyle and innumerable relapse[s], as well as forensic involvement ('10–12 charges of domestic violence'[23]) over nearly the past two decades, has become used to routinely breaching boundaries and getting away with grossly offensive and often abusive/assaultive behaviour by using intimidation as a tool, an art which he has practised to perfection. In my first meeting with him on taking over as his responsible clinician on 12 [Month2], he tried the same stunt, but when firmly told to cut this crap out, he shut up, but not before making a final attempt at physical intimidation by suddenly moving towards me and sitting down on the chair next to mine. However, when this tactic was treated with the contempt which it deserved, his bravado instantly deflated. At no point did I feel physically threatened. I have been told he had allegedly accosted [Dr J] on the street and threatened to kill him and his children. Responding to such pathetic attempts only serves to give him a sense of power and reinforces this pattern of behaviour. While dealing with him, any expression of fear will embolden him further and probably result in actual physical assault. This formulation is based on a large body of published research on victimology. …
>
> His respiratory function is severely compromised and if he continues to smoke, he will die within the next one year … The question is not if but when. Since we cannot allow him to commit chronic latent suicide, no leave (which he will utilise to consume alcohol and/or illicit substances) or smoking breaks will be allowed [while he is an inpatient]."

2015–2016 reviews

73. Dr E saw Consumer A in Month15, and in Month18, Month22, and Month25. Dr E's letters from these reviews were unremarkable and have not been included in this report.

18 Month32 letter

74. Dr E saw Consumer A along with his key worker, RN G, a person from Consumer A's supported accommodation, and a medical student. Dr E's subsequent letter was addressed to the GP, and copies were sent to Consumer A, RN G, and the person from Consumer A's supported accommodation. Dr E wrote: "[Consumer A] was paranoid, excitable, accusative and even more unpleasant than he usually is."

[23] Mr A's parents told HDC that they believe that this point is incorrect. They consider that their son had never had a conviction for domestic violence, although he did have two dysfunctional relationships, and protection orders had been taken against him.

16 Month38 letter

75. Dr E saw Consumer A along with RN G. Dr E's subsequent letter was addressed to the GP, and copies were sent to Consumer A and RN G. Dr E wrote:

> "While [Consumer A] feels '*well*' and seems quite content with the status quo, his lung condition continues to deteriorate due to smoking … Unfortunately, however, he remains in denial, contemptuous and dismissive of medication advice, becoming really unpleasant and obnoxious if the point is pressed further, alleging that the psychiatric medications are '*poisoning'* him. … I have little more to offer, even as [Consumer A] continues down the path of self-destruction."

13 Month41 letter

76. Dr E saw Consumer A along with his father, RN G, and a person from Consumer A's supported accommodation. Dr E's subsequent letter was addressed to the GP, and copies were sent to Consumer A, RN G, other mental health staff from the DHB, and the supported accommodation representative. Dr E wrote:

> "[Consumer A] was even more hostile, combative and accusative than is his wont. He continues to assert that he has *no mental health disorder,* that he was '*unjustly*' placed under the [MHA], that he is being '*poisoned*' by the medications which have, allegedly, ruined his love life to the extent that '*no girl would look*' at him. In this rather regressive narrative he had the tacit support of his father who believes that the current medications are *harming* his son in *'every way'*. This has been a recurring theme."

13 Month43 letter

77. Dr E saw Consumer A along with his parents, RN G, and a person from supported accommodation. Dr E's subsequent letter was addressed to the GP, and copies were sent to Consumer A, his mother, RN G, other mental health staff from the DHB, and two people from supported accommodation. Dr E wrote:

> "**Heavy Smoking in the Context of [Consumer A's] Severe COPD**
> This constitutes a serious medical risk [and] has probably contributed to the reported *erectile dysfunction*. While his parents believe that he is making efforts in this regard, I have seen little evidence of the same and he continues to have a strong odour of stale tobacco around him.
>
> At some point during this discourse, [Consumer A] started yelling, making the usual allegations peppered with the foulest abuses/4-letter words, and then stormed out. His parents followed suit later, alleging that they were not being listened to. It was again suggested that they might like to make a formal complaint if they felt aggrieved …"

*Comment from Consumer A's parents*

78. Mr and Mrs D told HDC:

> "Personally [Dr E] enraged us with his comments toward our son, showing no empathy and no concern for his overall wellbeing. I feel constantly dumbfounded that [Dr E] was

> able to make his dislike for [Consumer A] so obvious and yet no health professional questioned it."

79. They also told HDC:

> "When [Consumer A] was well he was a loving son, dad, brother and friend. He was kind and thoughtful and [had various pastimes], he loved working with … and enjoyed being employed in the various jobs he had. We believed his mental health did not define him. I could find no positive comments about [Consumer A] in [Dr E's] correspondence or any acknowledgement of who [Consumer A] was as a person."

*Comment from Dr E*

80. Dr E told HDC:

> "I am conscious of the fact that, attributable perhaps to the over 3 decades [in my previous employment] … my *general tone and manner* might sound curt, rather abrupt and forthright to the point of being blunt, and may offend some.
>
> … I am sorry if anything I have written has been a cause of upset for [Consumer A] or his family and I extend my sympathies for their loss." (Emphasis in original.)

*Comment from RN G*

81. RN G told HDC:

> "[Dr E] is passionate about the health of his clientele (mentally and physically) and tailors his communication style to the client, always with an improvement in their health as the objective. Occasionally, when a client has no insight into their illness and they are subject to compulsory legislation, a more prescriptive approach is the therapeutic option. [Dr E] will use language challenging the client's actions and clients (and their family) can find this confronting. [Dr E] will not 'shy away' from this …"

**Responses to provisional opinion**

82. Consumer A's parents, Dr E, and the DHB were all given the opportunity to respond to relevant sections of the provisional opinion. Where appropriate, their responses have been incorporated into this report. In addition, I note the following comments.

*Dr E*

Communication style

83. Dr E told HDC that it is important that the care he provided to Consumer A be considered in the complex, high-risk context in which Consumer A's care was transferred to him in Month1. Dr E said that Consumer A's care was assigned to him while he was on annual leave, and he understands that this is because none of the other consultants were inclined to accept the responsibility. Dr E stated that it was against this background that he outlined his proposed strategy for treating Consumer A in an email in Month2 to those involved in Consumer A's care, and he pointed out that the treating team did not raise any concerns about the proposed strategy or approach while Consumer A was under their care.

84. Dr E also referred to the 2015 forensic opinion from the forensic psychiatrist. Dr E said that the forensic psychiatrist's opinion provides "vital insights" into Consumer A's severe mental health disorder and associated risks, as well as other behaviour patterns which, in Dr E's opinion, rendered "a positive therapeutic alliance virtually impossible to establish or maintain".

85. Dr E also noted that as a result of the "factual, firm and assertive" approach in respect of the care the team provided, Consumer A did not have a single relapse or readmission after coming under Dr E's care. Dr E commented that psychotic relapses have a devastating impact that contribute to poor quality of life and eventually to treatment resistance. He stated:

> "I have no hesitation in admitting that my robust style of communication … may have caused un-intended upset to the late [Consumer A] and his parents. This is deeply regretted, and I have been making continuing efforts to modify my approach, with full support from [the DHB]."

Metabolic monitoring

86. Dr E told HDC that he believes that the level of care provided in respect of metabolic and other monitoring of Consumer A's physical well-being was not substandard or deficient. However, he said that he has taken on board my clinical advisor's opinion about this (discussed in more detail below) and intends to comply more diligently with the guidelines on monitoring.

*DHB*

87. The DHB told HDC that the nature and intensity of the threats made by Consumer A towards the family of a member of the team affected them greatly, but despite this, Consumer A continued to receive clinical care from all of the team, which allowed him to remain out of hospital for the longest period of time he had managed to do so in six years. The DHB also noted that prior to Consumer A starting the paliperidone medication regimen, he had had eight hospital admissions over several years. However, after commencing this medication regimen, Consumer A had no further psychiatric admissions and was living successfully in supported accommodation.

88. However, the DHB also told HDC that it accepts that it failed to support Dr E adequately to improve his communication, and that it failed him and Consumer A. The DHB apologised for this, and told HDC that it accepts the proposed recommendations.

## Consumer A Opinion: Dr E — breach

### Tone and manner of written communication — breach

89. Dr E was the psychiatrist responsible for Consumer A's care from his discharge in Month13 following compulsory inpatient admission, until shortly before his death in Month47. Dr E

saw Consumer A regularly in that time and sent clinic letters to Consumer A and his GP, as well as other DHB clinicians involved in his care. Extracts from these letters have been set out in paragraphs 72 to 77 above.

90. For the last three years of his life, Consumer A continued to live with a significant mental health disorder. My clinical advisor, psychiatrist Dr Rosemary Edwards, commented:

> "[Consumer A] presented as is typical for people with chronic unremitting schizophrenia. Most, if not all community adult psychiatrists would have patients with a similar presentation in their clinic. It is a usual part of clinical practice. It can be taxing to provide care for people who have very little insight as the doctor intrinsically wants to help and improve the life of their patients."

91. The Medical Council of New Zealand (MCNZ) publication *Good Medical Practice* discusses the importance of doctors establishing and maintaining trust with their patients,[24] and states: "Relationships based on openness, trust and good communication will enable you to work in partnership with them to address their individual needs." Working in partnership involves "listening to [patients] and responding to their concerns and preferences". *Good Medical Practice* also requires doctors to treat patients as individuals, respect their dignity, and be courteous, respectful, and reasonable.

92. Dr Edwards noted that the documents written by Dr E were seen by a wide number of people. She stated: "All clinical records are best written as if they are read by the patient. In this case the correspondence was sent to [Consumer A] so it is reasonable to assume he could read it." Dr Edwards commented that Dr E's use of language is likely to have influenced the way others who read the documents thought of Consumer A.

93. Dr Edwards considers that the language used by Dr E is a moderately severe to severe departure from the standard of accepted practice. In particular, she advised:

> "He has given personal (rather than professional) judgement, which is not courteous, respectful and reasonable. For example; 'becoming really unpleasant and obnoxious, even more unpleasant than he usually is,' 'was even more hostile, combative and accusative than is his wont,' 'he tried the same stunt, but when firmly told to cut this crap out, he shut up,' 'ill-conceived and misinformed narrative'.
>
> He has not shown compassion and respect for human dignity. For example 'firmly told to cut this crap out,' 'was treated with the contempt which it deserved,' 'responding to such pathetic attempts,' … 'I have little more to offer even as [Consumer A] continues down the path of self-destruction,' 'he will die within the next year,' 'we cannot allow him to commit chronic latent suicide. No leave or smoking breaks will be allowed'.
>
> … It is possible to convey the meaning intended while remaining respectful and compassionate. The language used by [Dr E] is very unlikely to promote a trusting relationship with respect of [Consumer A's] autonomy and freedom of choice. This is

[24] See Appendix E.

> especially difficult when a person is partially treated and does not agree with the treatment. In this situation repeat education and negotiation of treatment is required.
>
> … While the reasons behind the correspondence style are important, the language used is not professional or respectful as is expected in clinical documents."

94. I accept Dr Edwards' advice and consider that the language used by Dr E was not professional or respectful. I also acknowledge the observation from Consumer A's parents that there were no positive comments about Consumer A in any of Dr E's written correspondence.

*Communication — conclusion*

95. Consumer A had a significant mental health condition and a difficult path to recovery, partially hindered by his challenging experiences with, and apparent mistrust of, his medication. This made it all the more important that the clinicians involved in his care worked to foster a trusting and respectful relationship to support him to engage in effective treatment, get better, and live well.

96. I find many of Dr E's comments in his written communication about Consumer A to be inappropriate and unprofessional. I acknowledge RN G's supportive comments about Dr E and his willingness to be challenging; however, in my view, it is possible and more appropriate to be confronting in a manner that maintains mana and dignity and encourages engagement. I agree with Dr Edwards' comment that the language used by Dr E was very unlikely to promote a trusting relationship with Consumer A. I also agree that Dr E's language was likely to have coloured other parties' views of Consumer A. This is concerning, as it may have had a negative impact on the care Consumer A received from other clinicians.

97. I note Dr E's submission that Consumer A was a complex and high-risk case, and that his severe mental health disorder and associated risks, alongside other behaviour patterns, made "a positive therapeutic alliance virtually impossible to establish or maintain". I accept that Consumer A's mental health issues and other factors presented significant challenges to the clinicians involved in his care. That said, I also note Dr Edwards' comment above that Consumer A presented "as is typical for people with chronic unremitting schizophrenia". In any event, this context does not materially mitigate the issues, or render appropriate the language Dr E used in his written communication.

98. In my opinion, the tone and manner of Dr E's written communication amount to a failure to treat Consumer A with respect. Accordingly, I find that Dr E breached Right 1(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[25]

99. In addition, I consider that Dr E's written communication represents a failure to comply with the standards as set out in MCNZ's *Good Medical Practice*. Accordingly, I find that Dr E also breached Right 4(2) of the Code.[26]

[25] Right 1(1) states: "Every consumer has the right to be treated with respect."
[26] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

**Documentation of medication regimen and monitoring — breach**

*Introduction*

100. Consumer A took antipsychotic medication (paliperidone) and lithium medication. Dr E prescribed these for Consumer A from 2014 until 2018 while he was subject to a compulsory treatment order under the MHA. For the majority of this time, Consumer A received three-weekly injections of paliperidone, which I accept was a reasonable off-label use. Dr Edwards commented that "[Consumer A's] medication regimen is likely to be appropriate in the circumstances". However, given that Consumer A did not give his consent to the treatment, a second opinion supporting that the medication regimen was in his best interests needed to be obtained in accordance with the MHA. Dr Edwards advised that while it is "reasonably common" to use psychiatric medications above the stated maximum, "it is important to discuss it with the patient and to ensure clinical benefit, as well as regular monitoring".

101. I accept Dr Edwards' advice that the dose and type of medications that were prescribed for Consumer A was appropriate. However, I have a number of concerns about the management of Consumer A's medication regimen, which are discussed below.

*Second opinion*

102. Because Consumer A was subject to a compulsory treatment order under the MHA, paliperidone could be prescribed and administered to him without his consent, as long as a second opinion was sought that confirmed the treatment approach. Similarly, the RANZCP Guideline, "The use of medication in dosages and indications outside normal clinical practice" (2008) (the RANZCP Off-Label Guideline — set out in Appendix E), requires that informed consent be obtained and recorded for off-label use of medications. Where a consumer is deemed not competent to give consent, the RANZCP Off-Label Guideline states that an independent second opinion supporting the treatment must be obtained (in addition to compliance with the relevant legal framework).

103. As per the MHA, Dr E sought a second opinion from Dr K in Month6. While Dr K's opinion provided support for "the current regime of his treating Psychiatrist [Dr E]", it did not explicitly detail the medication regimen that Consumer A was receiving.

104. In addition, it appears that at the time, Consumer A was prescribed a four-weekly paliperidone dose (according to the notes following the MDT meeting on 17 Month5, it was changed back to a three-weekly dose on 7 Month7). In my view, if Dr E was relying on Dr K's opinion as supporting his off-label prescribing of the three-weekly dose of paliperidone for Consumer A, then Dr E needed to ensure that this was explicit in Dr K's opinion. I do not consider that it was sufficiently clear what treatment regimen was supported by Dr K, especially given that the MDT notes at the time indicated that the treatment regimen was four-weekly paliperidone.

105. Dr E submitted that it was sufficiently clear to him what medication regimen Dr K was supporting, and that there was an error in the clinical documentation,[27] and that Consumer

[27] Which, as noted in paragraph 104 above, indicated that Mr A was prescribed a four-weekly dose of paliperidone at the time of Dr K's opinion.

A continued to receive three-weekly doses of paliperidone from late 2014 — which, Dr E implied, Dr K would have been aware of after reviewing Consumer A's file. While that may be the case, the clinical documentation does not support Dr E's account. I remain of the view that it was not clear what treatment regimen Dr K's opinion was supporting. Given that Dr E was relying on Dr K's opinion as supporting his off-label prescribing of paliperidone, in my view Dr E needed to ensure that the documentation clearly endorsed this.

106. Dr K's opinion was the only occasion on which a second opinion was formally sought in relation to the administration of paliperidone by Dr E, despite Consumer A continuing to have concerns about the effect the medication had on him, and remaining on that medication until 2018.[28] Dr E submitted that second opinions do not expire, and that repeat second opinions are not required.

107. Dr Edwards acknowledged that the Month6 second opinion sought by Dr E met "the required standard", and that "[l]egally the second opinion does not expire". However, Dr Edwards noted:

> "Given [Consumer A's] ongoing concerns about his medications and the subsequent use of off label dose of paliperidone a further application for a second opinion to explicitly address this would have been prudent."

108. I acknowledge Dr Edwards' opinion that it would have been prudent to seek another second opinion to explicitly address the off-label use of paliperidone. However, I also note both her and Dr E's consensus that a second opinion does not expire. In this case, I consider that the primary issue is the lack of clarity in Dr K's opinion, and it was Dr E's responsibility to obtain a second opinion that clearly documented support for the medication regimen he prescribed.

109. Dr E also submitted that Consumer A's long-term management plan was discussed at the Month8 complex case conference. As Dr Edwards noted, the meeting was not a second opinion, and, in any case, the notes from the conference do not refer to specific doses of medication.

*Side effects of medications*

110. As noted in Dr E's review letters and the clinical notes, often it was documented that Consumer A felt that his medications were poisoning him. He also reported specific concerns to Dr E about the effects on his skin and romantic life (including erectile dysfunction) and, according to his parents, weight gain, dry mouth, tiredness, sleepiness, lack of interest, and tremor. In addition, Mrs D told HDC that she had observed involuntary jerking of Consumer A's hands prior to his death. However, none of the concerns noted by Consumer A's parents are documented in the clinical notes, so I am unable to make a finding as to whether Consumer A told his clinicians that he was experiencing any or all of these symptoms. In any case, no contemporaneous documentation was provided to HDC to indicate that, at the

[28] I acknowledge that the forensic psychiatrist also reviewed Mr A in Month5, but Dr Edwards advised that this was not a second opinion for medication pursuant to the MHA. I accept Dr Edwards' advice.

time, Dr E discussed with Consumer A the clinical benefits and side effects of the increased dose (three-weekly injections) of paliperidone.

111. Dr Edwards acknowledged: "It may not have been possible to discuss medications directly with [Consumer A] due to his ongoing beliefs he was being poisoned." However, Dr Edwards considered the lack of documentation showing consideration of the possible side effects of Consumer A's medication to be a mild departure from accepted practice.

112. I note Dr E's submission that Consumer A had been reporting side effects with different medications, rather than any specific drug, over the preceding decade. Dr E's view is that this reflected Consumer A's antipathy towards medication in general and his unwillingness to take any at all. As noted above, I accept that Consumer A had an apparent mistrust of medications. However, in my view, this did not absolve Dr E of his responsibility to discuss with Consumer A the side effects of his medication, and to document such discussions. I accept Dr Edwards' advice, and I am critical of this lack of documentation. I would also be critical if the number of side effects apparently experienced by Consumer A according to his parents, including the involuntary jerking of his hands, were observed by Dr E but not documented.

*Other aspects of medication management*

113. I also have several other concerns about Dr E's management of Consumer A's medication regimen:

- On Dr E's instructions, in Month5 the dosage of paliperidone was changed from three-weekly to four-weekly injections, and then in Month7 it was changed back to three-weekly injections. However, the notes do not record a reason for these changes.
- In Month28, Consumer A requested that his paliperidone dose be decreased to four-weekly injections, and Dr E documented that he agreed to this. However, there is no evidence that this change was implemented, and in clinical notes written in Month32, Dr E noted that Consumer A was receiving three-weekly paliperidone injections. There is also no evidence that Consumer A was informed that the dose change was not made.

114. In my view, the above deficiencies represent substandard medication management. I remind Dr E of the requirements of MCNZ's "Good Prescribing Practice"[29] — in particular in respect of providing appropriate information to consumers, including those under compulsory treatment orders, about medications prescribed to them, and keeping clear, accurate, and timely patient records.

*Metabolic monitoring, weight, and ECG*

115. As noted above, people with severe mental illness, including schizophrenia, are at increased risk of metabolic disturbances such as obesity and diabetes, and antipsychotic medication can cause or aggravate these disorders. Dr Edwards advised that for people on those medications, regular metabolic monitoring should be carried out, including certain blood

[29] Relevant extracts of this guideline are set out in Appendix E.

tests.[30] Dr Edwards noted that few liver function, lipids, and thyroid function tests were performed for Consumer A after 2015, and no glucose tests were performed after 2014. However, she acknowledged that renal function was tested regularly in 2015–2018.

116. In addition, Dr Edwards explained that the majority of antipsychotic medications can result in weight gain. She noted that there is no documentation to show that this was discussed with Consumer A. She also noted that Consumer A was weighed only once in Month35 following his discharge from hospital in 2015 (when the Metabolic Monitoring Sheet was completed), at which point his weight was 89.5 kilograms. His BMI, had it been calculated, would have been approximately 26.7 (overweight).

117. The DHB's Metabolic Monitoring Guidelines required that yearly measurements be taken of weight, height, waist circumference, BP, fasting cholesterol and LDL, and fasting glucose. This was completed only once after Consumer A's discharge (in Month35).

118. Similarly, I note that the RANZCP Off-Label Guideline required that relevant monitoring, including vital signs and other physical signs, be undertaken while a consumer was being prescribed medication above the usually accepted dose range.

119. Dr Edwards considers the lack of complete documentation of weight and glucose/lipid levels to have been a moderate departure from the expected standard, as was the lack of testing of other metabolic indicators after Consumer A's discharge in 2015. She also considers that the lack of documented communication with Consumer A about weight gain was a mild departure from accepted practice. I note Dr E's comment that RN G was undertaking the metabolic monitoring of Consumer A. However, Dr Edwards advised:

> "It is the role of the consultant psychiatrist/Responsible Clinician to be aware of the metabolic monitoring that is undertaken, and to ensure that it occur[s] to a suitable standard."

120. I accept Dr Edwards' advice, and I consider that while Dr E was responsible for Consumer A's care, Dr E should have ensured that appropriate metabolic monitoring occurred, including monitoring of Consumer A's weight. In any case, I am concerned that the basic measurements of Consumer A's physical well-being were not completed regularly and as per the DHB's Guidelines.

121. I note Dr E's submission that Consumer A was overweight, not obese, and that this was caused by his unhealthy eating habits rather than the medication. However, Consumer A gained 13 kilograms between Month3 and Month35. I remain of the view that Dr E should have ensured that Consumer A's weight was being monitored appropriately, especially because Consumer A was being prescribed a medication (paliperidone) that carried a moderate risk of weight gain.[31]

[30] HbA1c (a marker for diabetes), liver function tests, electrolytes and creatinine (renal/kidney function), full blood count, lipids, thyroid function tests, and prolactin.
[31] *The Maudsley Prescribing Guidelines in Psychiatry*, 13th edition (2018).

122. In addition, between 2015 and 2018 there is only one ECG record for Consumer A — the baseline ECG taken in Month7 when Consumer A was an inpatient. Dr Edwards advised that while there were no causes for concern from this ECG, "[i]t is expected for a person on this medication regimen to have a yearly ECG". She added that guidelines from other DHBs, as well as international guidance (the Maudsley Guidelines) state that ideally all patients should be offered ECGs at least yearly.

123. Dr Edwards acknowledged that the DHB's own guidelines did not require yearly ECGs. However, she further advised:

> "[Dr E] had the Maudsley recommendations available to him and has responsibility to ensure his patients receive appropriate physical care, even when carried out by another person."

124. In Dr Edwards' view, the lack of yearly ECGs between Month7 and Month47 was a moderate departure from accepted practice.

125. Dr E submitted that none of the Medsafe guidelines, the prescribing information, the US FDA data sheet, and/or the NHS Guidance mandate yearly ECGs. He also disputed that the Maudsley Guidelines require yearly ECGs. However, as Dr Edwards pointed out, the Maudsley Guidelines do state that ideally all patients on antipsychotic medication should be offered at least yearly ECGs. In addition, the Maudsley Guidelines recommend yearly ECGs for those patients receiving "high dose" antipsychotic medication, which includes where medication is prescribed over the recommended dose (as in Consumer A's case).

126. I therefore accept Dr Edwards' advice, and am critical that Dr E did not ensure that yearly ECGs were at least offered, and ideally completed, for Consumer A in that time period, even though the DHB's guidelines did not require this.

*Conclusion*

127. I accept, as Dr E and the DHB have submitted, that while Dr E was providing care to Consumer A (which included the paliperidone medication regimen), Consumer A had no further psychiatric admissions and was able to live successfully in supported accommodation. As noted above, I am not critical of the type and dose of medication prescribed for Consumer A, and I accept that this contributed to his relative stability over this period.

128. I nonetheless have concerns about several aspects of Dr E's management of Consumer A's medication regimen over a lengthy period and while Consumer A was subject to compulsory treatment. Specifically, and as discussed in more detail above, I am concerned that Dr E:

- Failed to ensure that the second opinion clearly supported the medication regimen.
- Did not document any discussions with Consumer A about the clinical benefits and side effects of the three-weekly dose of paliperidone during the four-year period from 2015 to 2018.

- Failed to ensure that there was a record of the reason why the dosage of paliperidone was changed in Month5 and Month7, and failed to action the reduction in the paliperidone dosage in Month28.
- Failed to ensure that appropriate monitoring of Consumer A occurred, including metabolic and weight monitoring, and that yearly ECGs were offered to Consumer A.

129. As noted above, Consumer A was subject to compulsory treatment under the MHA. This meant that he could be given treatment whether or not he consented to such treatment. Therefore, he was highly vulnerable and heavily reliant on clinicians' engagement, sound decision-making, careful monitoring of his well-being, and thoughtful attention to protecting his rights in accordance with the MHA and under the Code. In my view, and particularly in this context, the above failures amount to a failure to provide services to Consumer A with reasonable care and skill and, accordingly, I find that Dr E breached Right 4(1) of the Code.[32]

## Consumer A Opinion: District health board — breach

### Introduction

130. District Health Boards are responsible for the operation of the clinical services they provide. In addition, they have a responsibility for the actions of their staff, including to ensure that consumers receive appropriate clinical care.

131. I have concerns about aspects of the clinical care provided to Consumer A by the DHB. A number of DHB clinicians, including Consumer A's key worker (RN G), psychiatrist (Dr E), and others were involved in these aspects of Consumer A's care. I discuss these concerns in further detail below.

132. In addition, one of the primary issues in this case is Dr E's tone and manner of communication. I discuss the DHB's responsibility for this in further detail in a separate section of the report (below).

### Clinical care — breach

*ECG monitoring*

133. Between 2015 and 2018 there is only one ECG record for Consumer A — the baseline ECG taken in Month7 when Consumer A was an inpatient. Dr Edwards noted that there were no causes for concern from this ECG, and she also acknowledged that yearly ECGs were not required by the DHB's guidelines. However, Dr Edwards advised: "It is expected for a person on this medication regimen to have a yearly ECG." She noted that guidelines from other DHBs, as well as international guidance,[33] state that ideally all patients should be offered

[32] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[33] *The Maudsley Prescribing Guidelines in Psychiatry*, 13th edition (2018).

ECGs at least yearly. In Dr Edwards' view, the lack of yearly ECGs between Month7 and Month47 was a moderate departure from accepted practice.

134. The DHB submitted that none of the Medsafe guidelines, the prescribing information, the US FDA data sheet, and/or the NHS Guidance mandate yearly ECGs. The DHB also noted that the Maudsley Guidelines referred to were published towards end of the period covered by this report (as it relates to Consumer A). However, I note that earlier editions of the Maudsley Guidelines also included the guidance that ideally all patients on antipsychotic medication should be offered at least a yearly ECG, and that those receiving high-dose antipsychotics (as Consumer A was) should have ECGs every 6–12 months. The RANZCP Schizophrenia Guidelines also recommend yearly ECGs. I therefore accept Dr Edwards' advice, and am critical that the DHB's guidelines did not require this monitoring to be completed.

*Prolactin monitoring*

135. Consumer A took antipsychotic medication (paliperidone) and lithium medication. As noted above, people with severe mental illness, including schizophrenia, are at increased risk of metabolic disturbances such as obesity and diabetes, and antipsychotic medication can cause or aggravate these disorders. Dr Edwards advised that for people on those medications, regular metabolic monitoring should be carried out, including certain blood tests.[34] Dr Edwards noted that the DHB's policy did not require testing of the hormone prolactin,[35] notwithstanding that it is a test recommended by international guidance.[36] She explained that raised prolactin, which can be a side effect of antipsychotic medication, can cause sexual dysfunction.

136. I note the DHB's submission that the NICE Guideline does not recommend regular prolactin monitoring. This is in conflict with the guidance in the Maudsley Guidelines. However, local guidance (the RANZCP Schizophrenia Guideline) does recommend annual monitoring of prolactin levels.

137. I accept that international guidance on this point is inconsistent. However, noting that the local RANZCP Schizophrenia Guideline does recommend yearly prolactin tests, I am critical that prolactin tests were missing from the DHB's monitoring guidelines. Consumer A reported that he was experiencing sexual dysfunction, and paliperidone is known to increase prolactin levels,[37] but it is not possible to know now whether this was caused by raised prolactin as a side effect of his medication. Nonetheless, it is concerning that the DHB did not have a requirement to monitor this possible side effect.

[34] HbA1c (a marker for diabetes), liver function tests, electrolytes and creatinine (renal/kidney function), full blood count, lipids, thyroid function tests, and prolactin.
[35] Prolactin causes the breasts to grow and make milk during pregnancy and after birth.
[36] *The Maudsley Prescribing Guidelines in Psychiatry*, 13th edition (2018).
[37] The RANZCP Guideline; the Maudsley Guidelines; Medsafe New Zealand Datasheet on paliperidone palmitate (Invega Sustenna).

*Documentation — MDT reviews*

138. Reviews were completed for Consumer A roughly every three months following his discharge from the MHU in Month13. These reviews were attended by Consumer A, Dr E, RN G, other DHB staff members, representatives from Consumer A's supported accommodation, and at times one or both of Consumer A's parents. It was not explicitly documented that these reviews were MDT reviews. An MDT review form was completed only once (by RN G on 16 Month35).

139. Dr Edwards advised:

> "[MDT reviews] should be held and documented approximately every 6 months and attended by members of the community Mental Health team, including the psychiatrist, and other staff from the community providing a service to [Consumer A], as well as family/welfare guardians if they want to attend. Within this meeting there should be attention given to regular testing and monitoring as described above. To not have these meetings would be a serious departure from accepted practice. Poor documentation of MDTs that otherwise meet the required standards would be a mild departure from accepted standards."

140. While it was not explicitly stated that the reviews that occurred for Consumer A were MDT reviews, I consider that these reviews, in nature, are similar to MDT reviews. Ideally, an MDT review form would have been completed for every MDT review. As Dr Edwards noted, this may have helped to ensure that appropriate monitoring of Consumer A's physical well-being was taking place.

*Conclusion*

141. As detailed above, I have a number of concerns about the clinical care Consumer A received between 2015 and 2018, during which time he was subject to compulsory treatment, and in particular the monitoring of his physical well-being while he received antipsychotic medication. A number of the DHB clinicians, including Consumer A's key worker, psychiatrist, and others, were involved in these aspects of Consumer A's care. Accordingly, I consider that the DHB had overall responsibility for the following issues:

- The DHB's guidelines did not require yearly ECGs to be completed.
- Prolactin tests were missing from the DHB's monitoring guidelines.
- The MDT review form was completed only once after Consumer A's discharge in 2015 (notwithstanding that regular reviews were taking place).

142. As noted above, Consumer A was subject to compulsory treatment under the MHA. This meant that he could be given treatment whether or not he consented to such treatment. Therefore, he was highly vulnerable and heavily reliant on clinicians' engagement, sound decision-making, careful monitoring of his well-being, and thoughtful attention to protecting his rights in accordance with the MHA and under the Code. In my view, and in particular in this context, the above issues amount to a failure to provide services with reasonable care and skill. Accordingly, I find that the DHB breached Right 4(1) of the Code.

### Dental check-ups — other comment

143. In Month37, a respiratory doctor noted that Consumer A's teeth appeared to be at risk. The following year, he was seen at the ED for a dental abscess, and his GP referred him for review of his "rotten" and broken teeth. The DHB told HDC it believes that dental check-ups were offered to Consumer A. The DHB also noted that it runs an emergency dental clinic at the public hospital, and while it does not usually offer a routine dental care service, it can provide emergency treatment in certain circumstances if the patient is willing to receive it.

144. Dr Edwards noted that dental decay (caries) is common for people with mental illness. In Dr Edwards' view, if Consumer A was not offered and encouraged to have yearly dental assessments, this would be a moderate departure from accepted practice.

145. While I acknowledge Dr Edwards' opinion on this point, I accept the DHB's statement that dental care was suggested to Consumer A, and that the DHB offered access to emergency dental treatment. In my view, this was reasonable in the circumstances of Consumer A being in the community and able to access the same dental care as the general population. However, I suggest that the DHB reflect on Dr Edwards' comments and consider whether it can improve the support provided to mental health consumers to access routine dental care, and in particular for those consumers with known dental issues.

### Sudden Death Review — other comment

146. The DHB undertook a Sudden Death Review. The notes from the review are brief (one page) and largely focus on the physical health conditions that Consumer A had at the time of his death.

147. I acknowledge that Consumer A's death was due to physical causes, according to the post mortem. However, I am concerned that a more comprehensive review (with reference to the Health Quality & Safety Commission's Severity Assessment Code (SAC) rating and triage tool for adverse event reporting) was not undertaken, given the well-established body of evidence about the connection between mental health and physical health conditions, and the impact that some mental health medications have on the physical well-being of consumers. I suggest that the DHB reflect on these comments in respect of its process for Sudden Death Reviews for consumers of its mental health services.

## Consumer B

### Factual background

*Introduction*

148. Consumer B has been involved with the DHB's mental health services since 2006 (at which time, she was in her late teens). She has been diagnosed with anorexia nervosa (an eating disorder characterised by low weight, food restriction, and fear of gaining weight), major depressive disorder, and borderline personality disorder (BPD) (a personality disorder

characterised by character traits that are inflexible and maladaptive and cause either significant functional impairment or subjective distress). She has a history of self-harm.

149. This section of the opinion focuses on Dr E's oral and written communication when he saw Consumer B on two separate occasions in October 2016 and March 2019.

**7 October 2016 consultation**

150. On 7 October 2016, Consumer B was seen by the DHB occupational therapist, who documented that following a discussion about Consumer B's medication, Consumer B expressed an intention to self-harm and left the building. Police were informed, and Consumer B was located approximately one hour later by two clinicians from the Mental Health Emergency Team (MHET). She returned to mental health services and agreed to be seen by the on-call psychiatrist, Dr E.

151. Consumer B saw Dr E for an urgent mental health assessment, along with her psychologist, Mr L, and a MHET nurse, RN M. Dr E recorded in the clinical notes that Mr L told him that Consumer B had been becoming more unwell over the preceding four weeks and had stopped taking her medication (venlafaxine, an antidepressant medication). Dr E documented in the clinical notes:

> "The lady came in and sat down, avoided eye contact. When requested to look at me while talking to me, as is expected in civilized discourse, she burst into rather melodramatic tears and walked out, followed by [Mr L] and [RN M]."

*Audio recording*

152. Consumer B made an audio recording of part of the consultation with Dr E (who was unaware of the recording at the time). She provided HDC with a copy of the recording (which is approximately 10 minutes long).

153. For the first few minutes of the recording, Mr L is heard explaining to Dr E that Consumer B had been "very frustrated" for the preceding two weeks, had been experiencing compulsive binging, and had stopped taking her medication. Dr E asked why Consumer B had not seen her regular treating psychiatrist (Dr J), and expressed his view that Consumer B should be seen by Dr J, rather than him as the on-call psychiatrist.

154. About halfway through the recording, the following interaction is heard:

> Dr E: "So what do you want me to do? [inaudible] Okay, can you please look at me? See, I dislike people who don't look at me. If they don't look at me, then I don't talk to them. If you want to talk to me, please look at me. Please sit back and look at me, I'm not going to do anything —"
>
> Consumer B: [audibly crying] "I want to go."
>
> Dr E: "There's no point in that. If you want to cry, please go. [inaudible]"
>
> Consumer B: "I want to go."

155. Immediately following this interaction, the recording captures the sound of Consumer B leaving the room. RN M spoke with Consumer B immediately after the consultation, and documented that Consumer B experienced a panic attack.

156. Dr E told HDC that he reviewed Consumer B's file before seeing her, and considered that her problems were "long standing, complex and not amenable to a quick fix". He said that he was therefore "puzzled" as to why he, rather than Consumer B's regular psychiatrist Dr J, was booked to see her. Dr E stated:

> "The psychiatrist on-call is not expected to make any substantive decisions with regard to the management plan or make any medication changes (except in dire situations like life-threatening medication-related adverse effects). … It was this that led me to question this rather unusual situation."

157. However, Dr E acknowledged that, on reflection, he had been unduly focused on systemic issues during the consultation, for which he apologised to both Consumer B and Mr L in 2017.

*Mr L's complaint*

158. On 10 October 2016, Mr L sent an email to a number of staff at the DHB's mental health services, including Dr E and RN M, to highlight his concern about the 7 October consultation. In his email, Mr L wrote:

> "[T]he session lasted less than 5 minutes. During these few minutes, I was blamed for not doing what was required including not bringing patient to her usual Psychiatrist's attention … Tension was increasing in the room from both side[s] and immediately patient was asked to keep eye contact during questioning or to leave the office. It was unexpected to me, shocking to witness and unbelievable that it was happening in Psychiatry of [the] 21st century."

159. The DHB told HDC that following this, its Mental Health Service Clinical Director and then-Medical Director met with Dr E to discuss the complaint. Dr E then met with Mr L and apologised. The DHB stated that Dr E and Mr L continued to work together with no further issues. In addition (as noted in paragraph 157 above), on 28 February 2017, Dr E sent Consumer B an apology letter, in which he apologised for the "unfortunate and distressing experience" that Consumer B had when she saw him on 6 October 2016.

**15 March 2019 consultation**

160. Consumer B continued to receive care from the DHB's mental health services from 2016 to 2019.

161. On 15 March 2019, a MHET meeting was held to discuss Consumer B's ongoing care. Dr E was present along with several other MHET staff, including RN I (one of Consumer B's key workers at the time). RN I told HDC that on the previous day Consumer B had been admitted to the public hospital ED to receive a blood transfusion after MHET had completed a safety check and found Consumer B looking pale and unwell.

162. RN I documented that it was discussed at the meeting that inpatient admission was not effective for Consumer B, and that the plan agreed was to continue to manage Consumer B in the community. RN I also documented that Consumer B had agreed to be reviewed by Dr E as the on-call psychiatrist that day. Dr E saw Consumer B at 3pm, along with RN I and RN H (another MHET nurse).

163. Dr E wrote extensive notes about this consultation. He began by recording that Consumer B complied with his request to turn off her mobile phone and place it on the table, noting that he told her that recording the consultation "will be unlawful and constitute a culpable offence". Set out below are some further excerpts from his notes:

- "… [The staff] who had been involved in her 'care' over the years, and had had to be changed as she burnt them out with her frequent suicidal statements/threats, refusal to eat, [self-harm] and, more recently, approach to the news media."
- "It was pointed out to [Consumer B] that … she had sabotaged the plan [for her to have a bed at [a psychiatric hospital] which offers residential care for people recovering from mental illness and addictions] by [harming herself]."
- "It was also pointed out to [Consumer B] that … I shared my view that such conduct constituted antisocial behaviour."
- "[Mental state examination]: Composed, euthymic, smiling at times as if enjoying being able to manipulate everyone at will."
- "It will be in [Consumer B's] interests, and the interest of the mental health staff who have been badly singed by her exploitative, manipulative and highly traumatising behaviour — hospitalisation should be avoided as this will compound the harm already done."

164. RN I documented that following the meeting, Consumer B left the building and refused RN I's offer of transport home.

165. Dr E told HDC:

> "My aim [at this consultation], through Socratic questioning [a method of guided discovery in which the therapist asks a series of carefully sequenced questions] was for [Consumer B] to see that she had deteriorated in the 8 years since I first saw her and that her interactions with mental health services and hospital admissions had not improved her health …"

166. RN H told HDC that during the meeting, Dr E expressed his firm opinion that an inpatient admission would be unhelpful because of Consumer B's previous admissions and previous self-harm on the ward. RN H stated:

> "[Dr E] asked [Consumer B] a number of questions, that appeared rhetorical questions as he seemed to cut her off, challenging the answer she had given. … [Consumer B] was initially reluctant to be seen by [Dr E] and became visibly uncomfortable and distressed during the meeting. ... It was getting to the point where I would have intervened but

> [Consumer B] left of her own accord. I felt from the start of his review of [Consumer B] that [Dr E's] approach was autocratic and authoritarian, with the intent of challenging her, rather than actively listening to her."

167. RN H said that he spoke with Dr E after the meeting and told him that he felt that his approach had been clinically unhelpful. RN H told HDC: "[Dr E] appeared dismissive of my concerns and resolute in his robust approach." RN H also told his manager about his concerns.

168. However, RN I told HDC that her perception of Dr E's tone and manner of communication was that he was direct, to the point, factual and formal, and firm and clear in his delivery. She stated:

> "His manner was professional, but there was a level of frustration in the conversation. I think this reflected the fact that the treating team had worked hard to stick to a plan which was felt to be in [Consumer B's] best interest (to avoid in-patient admission), but [Consumer B] was adamant that she wanted to be admitted."

169. RN I said that Consumer B had recently been repeatedly asking for inpatient admissions, and Dr E had attempted to "[help Consumer B] understand the whole picture of how her choices and behaviour have contributed to her loss of functioning", which RN I acknowledged was very confronting for Consumer B.

*15 March 2019 letter*

170. Following the consultation, Dr E wrote a letter to Consumer B's GP (copies of which were sent to Consumer B, RN H, RN I, and several other staff at the DHB's mental health services). Dr E wrote:

> "The reason for this emergency consultation was that [Consumer B] had been *demanding* to be admitted to the Inpatient Mental Health Unit … She had '*upped the ante*' by contacting the news media and other entities sometime yesterday, a distasteful move which, sans the mental health context, could be arguably termed as an attempt at blackmail/extortion.
>
> [Consumer B] came in with a sense of entitlement and an aura of victimhood. … [Consumer B] was asked what now could be done differently, so that what had failed earlier was not repeated. Her response that she was 'waiting to go to the [psychiatric hospital]' was ironic. She was, in fact, on the point of being transferred there earlier this month when she sabotaged the plan by [harming herself] …
>
> During this entire interaction, I did not see any current evidence of a mental health disorder, nor any suicidal ideation/intent/plan. What I saw was manipulative behaviour, reinforced by attainment of secondary gain in the form of escalating investigation [sic] of mental health resources in her care."

171. Consumer B told HDC that she denies that she was demanding to be admitted; she said that she was scared that she was going to die. She also noted Dr E's use of the words "entitlement" and "victimhood", and commented:

> "I actually entered the meeting terrified (not playing the victim or acting entitled) … it is written even in my care plan that I struggle to make eye contact (low self esteem and anxiety causes this)."

172. Consumer B said that she was barely able to say anything during the assessment because Dr E kept cutting her off.

173. Consumer B also commented:

> "I have become so disillusioned by this mental health service. [Dr E's] behaviour has been going on and on for so long and for so many patients I cannot fathom how it has been allowed to continue. I sincerely hope that I help bring about the end to it because it is not safe for any patient to encounter [this] at [the] mental health services."

**Responses to provisional opinion**

174. Consumer B, Dr E, and the DHB were all given the opportunity to respond to relevant sections of the provisional opinion. Where appropriate, their responses have been incorporated into this report. In addition, I note the following comments.

*Consumer B*

175. Consumer B provided HDC with information to highlight that her medical health was critical owing to her mental health issues. She provided a letter from her current psychotherapist that detailed her history of mental illness from age 17. Consumer B told HDC that she provided this letter because she did not want to be seen as Dr E made her out to be. In the letter, Consumer B's psychotherapist commented: "When not in the grip of her delusional thinking she presents as an intelligent, compassionate and insightful woman. [Consumer B] struggles with much self-condemnation around her inability to free herself from her symptoms."

176. Consumer B also provided HDC with excerpts from another psychiatrist's review of her in May 2019, which noted that Consumer B's "[r]isk to self and risk of imminent death is high due to severe anaemia and ongoing [self-harm]". Consumer B told HDC that she wanted this to be included to show the severity of her health issues. She added: "I wasn't asking for an admission for the fun of it, I was actually very close to dying."

*Dr E*

177. Dr E told HDC that he has no hesitation in admitting that his robust style of communication may have caused unintended upset to Consumer B. He said he deeply regrets this and is making continuing efforts to modify his approach. However, he said that at all times during his interactions with Consumer B, he acted honestly and in good faith, without any intent to cause hurt or harm.

178. Dr E also said that he is familiar with the concept of countertransference (as discussed in more detail below). He pointed out that he has never been involved in psychotherapy or any regular treatment with Consumer B (having seen her only in acute settings). Dr E said that his approach was therefore:

> "objective, transparent and aimed at helping [Consumer B] see her behaviour as it appeared to an outsider, uninvolved in any manner with her personally or as her regular psychiatrist who could be, perhaps, subject to countertransference. In effect, my role was to act as a mirror … In the process, it possibly reflected my values, conditioned … by decades in [previous employment], rather than my personal 'views' or biases. However, in hindsight I do realise that my manner and tone of communication may have caused unintended offence to [Consumer B] for which I offer my sincere apologies."

*DHB*

179. The DHB told HDC that Consumer B was well supported by a multidisciplinary team involving another psychiatrist, Mr L, and others. It stated that this was important context in which to consider the care Dr E provided to Consumer B, as he sought to direct intervention back to her regular psychiatrist, who had the best relationship with her. The DHB added that the team had a comprehensive and widely consulted plan for helping Consumer B to manage her issues, and that the broad themes Dr E refers to in his notes and letter show attempts to help Consumer B to develop more understanding and to realise that she could change and make better choices about accessing treatment and therapy.

180. As noted above, the DHB also told HDC that it accepts that it failed to support Dr E adequately to improve his communication, and that it failed him and Consumer B. The DHB apologised for this, and told HDC that it accepts the proposed recommendations.

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## Consumer B Opinion: Dr E — breach

### Tone and manner of communication

*Introduction*

181. My clinical advisor, psychiatrist Dr Rosemary Edwards, noted that Consumer B's most prominent diagnosis was that of BPD. Dr Edwards explained that people with BPD may be "reluctant to enter into treatment to develop more adaptive responses as during the treatment their unpleasant emotions will be discussed and felt". Dr Edwards noted that treatment for BPD can take a long time and "requires a good and consistent therapeutic relationship with a skilled clinician. To help people with BPD the treating clinicians need to appreciate the patient's underlying defences."

*MCNZ's Good Medical Practice*

182. The Medical Council of New Zealand (MCNZ) publication *Good Medical Practice* (see Appendix E) discusses the importance of doctors establishing and maintaining trust with their patients. The publication states: "Relationships based on openness, trust and good

communication will enable you to work in partnership with them to address their individual needs." Working in partnership involves "listening to [patients] and responding to their concerns and preferences". *Good Medical Practice* also requires doctors to treat patients as individuals, respect their dignity, and be courteous, respectful, and reasonable.

*7 October 2016 consultation*

183. The first of two key interactions between Dr E and Consumer B occurred on 7 October 2016. Consumer B recorded this consultation. The recording (described in more detail in paragraphs 153–155) captured Dr E telling Consumer B to look at him and, after Consumer B began crying, Dr E asking Consumer B to leave. Consumer B's psychologist, Mr L (who was present at the meeting), raised concerns about the interaction.

184. According to Dr Edwards, when an on-call psychiatrist sees a consumer acutely, it can be for a wide range of reasons, and the purpose "is to assess the presenting issue and focus on reducing the distressing emotion and problem solving with the patient to increase their sense of control and ability to manage". However, Dr Edwards noted that Consumer B became more distressed and experienced a panic attack immediately following this assessment.

185. Dr Edwards noted that the recording showed that Dr E's focus was not on Consumer B's presenting concerns but rather on the availability of Consumer B's usual psychiatrist. Dr Edwards said that Dr E interrupted both Consumer B and Mr L, and asked "abrupt" questions "in a tone unlikely to establish a good relationship".

186. Dr Edwards considers that Dr E's oral communication did not meet the general principles of accepted practice. She advised:

> "[Dr E] appears intolerant of behaviour such as lack of eye contact from others which he said to the patient was expected in civilized discourse. Whether a patient makes eye contact or not is irrelevant to the doctor–patient interaction during an acute assessment. The quality of eye contact will be commented on in the clinical record as part of an observed mental state of the patient and will contribute to the opinion of the assessor at the time.
>
> … The use of the description that [Consumer B's] tears were melodramatic lacked empathy and did not show compassion and was not courteous, respectful or reasonable."

*15 March 2019 consultation*

187. The second consultation occurred on 15 March 2019. Dr E began the consultation by asking Consumer B to turn off her phone and place it on the desk, and documented telling her that recording the consultation "will be unlawful and constitute a culpable offence". Dr Edwards commented:

> "In the context of an acute assessment when the person is being seen due to higher than usual distress this language is aggressive and unlikely to promote engagement or rapport for the upcoming discussions. [Dr E] could have asked [Consumer B] if she

> intended to record the appointment and asked her not to. He also could have agreed to having the assessment recorded."

188. I note the differing views of RN H (who considered that Dr E's tone was "autocratic and authoritarian, with the intent of challenging [Consumer B], rather than actively listening to her") and RN I (who considered that Dr E's tone was "direct, to the point, factual and formal" and "professional", although she acknowledged that there was a level of frustration). With respect to RN I's view, and in particular the presence of some frustration, I refer to Dr Edwards' comments about the risk of countertransference (discussed below) in treating someone with BPD. If Dr E was feeling frustration, he needed to recognise and work to counteract this.

189. Dr Edwards also noted several comments[38] written by Dr E in Consumer B's clinical notes. Dr Edwards commented that the language used by Dr E "lacks empathy and does not reflect an understanding of mental illness being a treatable condition of the brain and mind, not the person's fault, and not something they caused". She further noted:

> "In particular, the comment relating to staff burn out, is irrelevant to a discussion in an acute assessment with a patient and unnecessary for [Consumer B's] care and treatment. It does not display an understanding of BPD or convey information in a manner that enables the patient to understand the treatment or advice. … Staff burn-out is a possible experience for staff working with patients with the diagnosis of BPD. This is discussed and managed within the clinician team ..."

190. With respect to Dr E's letter to Consumer B's GP, Dr Edwards advised:

> "[Dr E's] language is very strong and indicates a poor understanding of BPD as a mental illness that can be treated and is not the patient's fault. The goal of an acute assessment is not for the patient to feel 'painted into a corner', but rather to feel their heightened emotion is more controlled so they are at a reduced risk of self-harm ... His knowledge and skills of BPD are out of date."

191. With respect to Dr E's comment that he was using Socratic questioning during this assessment, Dr Edwards noted: "The questioning outlined by [Dr E] is more a statement of his beliefs rather than appropriate exploration of [Consumer B's] beliefs."

**Conclusion**

192. Dr Edwards considers that, overall, the departure from accepted practice with respect to Dr E's tone and manner of communication, both oral and written, was moderately severe to severe. She stated: "[Dr E] has clearly documented his opinion and repeated a consistent theme in a number of instances." Specifically, Dr Edwards noted that repeatedly Dr E's written and oral communication "did not show compassion and was not courteous,

[38] Specifically, that Ms B "began narrating her usual story", which had been "documented extensively" and "which he had heard innumerable times … over the years", and that DHB staff "had to be changed as she burnt them out with her frequent suicidal statements/threats, refusal to eat, [self-harm] and, more recently approach to the news media".

respectful or reasonable", "expressed his personal beliefs in a way likely to cause distress", and "did not respect the doctor–patient relationship".

193. I accept Dr Edwards' advice. I am troubled by the consistent theme (as Dr Edwards noted) in Dr E's communication of what I consider to be inappropriate, non-therapeutic, and disrespectful language towards and about Consumer B. In my view, he allowed his personal views to affect his interactions with Consumer B inappropriately. I agree with Dr Edwards that the tone and manner of communication employed by Dr E was unlikely to foster a beneficial relationship with Consumer B.

194. Dr Edwards also noted that it is important that treating clinicians understand "the high likelihood of countertransference" in treating someone with BPD. She explained:

> "Transference relates to the feelings the patient has for and against the therapist. Countertransference is the feelings the health professional/therapist has towards the patient. Countertransference can interfere with the therapist's ability to remain detached and objective. It is important that the therapist removes such impediments by analysis or recognises that s/he does not work well with this particular type of patient and refers them to a colleague."

195. In my view, this case indicates that Dr E may not recognise possible countertransference issues relating to patients who present with particular traits or behaviours, and therefore may not work to counteract the impact of this. I acknowledge that Dr E said that he is aware of countertransference but felt that he was not affected by this, given his limited involvement in Consumer B's care, and that his approach with Consumer B was to be objective and uninvolved personally, and to "act as a mirror". He did, however, accept that this may have reflected his values. I accept that Dr E has knowledge of BPD and countertransference; however, I remain of the view that the language he used with Consumer B was inappropriate, disrespectful, and affected by his personal views.

196. In my opinion, the deficiencies in Dr E's communication amount to a failure to treat Consumer B with respect. Accordingly, I find that Dr E breached Right 1(1) of the Code.

197. In addition, I consider that Dr E's tone and manner of communication represent a failure to comply with the standards as set out in MCNZ's *Good Medical Practice*. Accordingly, I find that Dr E also breached Right 4(2) of the Code.

198. It is particularly concerning that the same issues reappeared three years after Dr E was first alerted to issues about his communication, following Mr L's complaint. I also acknowledge the courage it took for Consumer B to agree to see Dr E again after the previous consultation in 2016, which had been distressing for her.

## Consumer C

### Factual background

*Introduction*

199. Consumer C (aged in his forties at the time of events) had a history of traumatic brain injury and longstanding cannabis dependence. He had also been treated previously for depression and attention deficit hyperactivity disorder (ADHD) (a developmental disorder that is marked especially by persistent symptoms of inattention, hyperactivity, and/or impulsivity).

200. This section of the opinion focuses on the tone and manner of Dr E's oral and written communication when he saw Consumer C in March 2019.

*Consumer C's mental health in January to March 2019*

201. Consumer C had a number of interactions with the DHB's mental health services in January to March 2019. This included an emergency mental health assessment in January 2019 when he experienced persecutory ideas and thoughts of self-harm, and an inpatient admission in February 2019[39] after an episode of self-harm.

202. Immediately prior to his admission in February 2019, Consumer C's mother, Mrs N, reported to ED staff that Consumer C had expressed suicidal thoughts and had threatened to hurt her physically. On discharge, Consumer C was diagnosed with cannabis-induced psychosis.

203. On 23 March 2019, the DHB's Mental Health Emergency Team (MHET) received a call from Mrs N, who reported that Consumer C was experiencing increased paranoia and concerns triggered by a traumatic public event. The same day, a nurse spoke with Consumer C, who told her that he was continuing to use cannabis regularly but otherwise denied any other safety concerns reported. Consumer C told the nurse that he would arrange to see his key worker at an addiction service, Mr O, and his GP.

204. On 25 March 2019, MHET received another call from Mrs N, who expressed concerns about Consumer C's low mood, and reported that he had taken six 25mg tablets of quetiapine (his prescribed dose was 25mg daily[40]). Initially MHET agreed to see Consumer C, but after reviewing his file, MHET discovered that Consumer C had an open referral to the addiction service. Mrs N was then advised that Consumer C should be seen by Mr O as his key worker, rather than by MHET.

### Consultation on 27 March 2019

205. At 11.50am on 27 March 2019, Mr O saw Consumer C and his mother. Mr O documented that Consumer C had reduced his cannabis consumption,[41] but reported that he was not sleeping properly, not eating regularly, and had not showered or bathed for at least a week. Mr O also noted that Consumer C had harmed himself the night before, and upon waking

[39] Under section 11 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
[40] In response to the provisional opinion, the DHB stated that "the medical risk from this first [episode of self-harm] was very small".
[41] Mr C reported that he had reduced his consumption from approximately $200 worth of cannabis a week to two "spots" a day.

that morning was verbally violent towards his mother and convinced that she had placed cameras in the smoke detectors. Mr O also noted that Mrs N was "very scared" of Consumer C, and that Consumer C could not ensure his personal safety. Mr O arranged for Consumer C to be seen by the on-call psychiatrist, Dr E.

206. Dr E saw Consumer C and Mrs N at 2.40pm. Dr E documented in the notes:

> "[Consumer C] continues to take cannabis and then [harms himself] which, according to his mother, he 'steals'. She is unable to explain why she does not keep the [item used to self-harm] locked.
>
> → There is no evidence of a mental health disorder, nor any psychotic features. He is aware of what he is doing and his 'suicidal' attempts are a consciously motivated attempt at emotional blackmail.
>
> → It was pointed out that such suicidal stunts sometimes succeed by accident and result in a fatal outcome.
>
> → Apart from this, the devastating impact of cannabis use beginning at age 15 [illegible] were highlighted.
>
> → Unfortunately his mother did not seem to like the [illegible] being shown and became abusive, using 4-letter words liberally, threatening to go to the media. Then stalked out screaming, with the patient (who did not seem frightfully keen to get mental health help and had been apparently dragged here by his mother) in tow …"

207. Mr O told HDC that Mrs N was distressed and concerned that Consumer C would harm himself. Mr O said that Dr E factually explained his decision that Consumer C's key issue was substance use, which Mrs N disagreed with. Mr O noted that Mrs N felt unheard and, out of frustration, became verbally abusive and said that she would record the consultation.

*Video recording*

208. Mrs N provided HDC with a copy of the video recording of the consultation. The video captures the following conversation between Mrs N and Dr E:

> Dr E: "… Your blood tests were done earlier this month, they are absolutely fine. Your only problem is cannabis, and unless you stop cannabis nothing is going to improve. It is going to get worse."
>
> Mrs N: "So you're going to send him home to die?"
>
> Dr E: "Well that's up to him, I can't help him … Because if he takes cannabis, and he had cannabis yesterday according to you, so that means he is not trying to help himself at all. As long as he takes cannabis this will continue. It will get worse."
>
> Mrs N: "So it's alright for him to [self-harm] last night, [as well as] three nights before that, and you're doing nothing?"

Dr E: "So why is he [harming himself]? Why [inaudible]."

Mrs N: "Because he wanted to die."

Dr E: "No but why did … why don't you keep the [item used to self-harm] to yourself?"

Mrs N: "Well I thought I had last night but he steals it."

Dr E: "So then keep it under lock and key."

209. In response to the provisional opinion, Dr E noted that the video was not complete and did not reflect the entirety of the consultation.

210. Dr E told HDC that he reviewed Consumer C's file and "identified the core issues (cannabis dependence, drug seeking behaviour, suicidal threats as means of emotional blackmail)". He stated that when he saw Consumer C, he "said little" and "appeared disinterested with a glazed look in his eyes", and Dr E ascertained that Consumer C had consumed cannabis the previous night. Dr E stated:

> "Whilst I respected the concerns regarding [Consumer C's] reported suicidality, there was no evidence of a formal mental health disorder at that point in time and my view was that his psychosis and self-harm attempts were drug induced. … My focus, therefore, had been to focus attention on the underlying cause and driver of such behaviour, rather than the effects of the same in the form of repeated instance of expressed suicidal gestures and [self-harm]."

*28 March 2019 letter*

211. On 28 March 2019, Dr E wrote a letter to Consumer C's GP, copied to Consumer C and Mr O, as well as three other clinicians from MHET. In the letter, Dr E wrote:

> "There is no evidence of a mental health disorder, nor any suicidal ideation/intent/plan, except for 'suicidal' gestures being employed as a means of emotional blackmail. His mother, however, wanted him to be hospitalised immediately despite there being no indication for the same. She became highly agitated, abusive and started yelling, letting loose a torrent of 4-letter words combined with the threat of going to the media. Eventually she stalked out, with a rather disinterested/reluctant [Consumer C] in tow. He showed little inclination to stop cannabis use but agreed, albeit tentatively, to have a urine screen done (cc to you [Consumer C's GP]). No mental health intervention is indicated as of now."

**Subsequent events**

212. Later that evening, on 27 March 2019, Consumer C locked himself in his room. Mrs N rang MHET and then the Police. Consumer C was taken to the public hospital ED by ambulance, and was admitted and treated following an episode of self-harm.

**Responses to provisional opinion**

213. Mrs N, Dr E, and the DHB were all given the opportunity to respond to relevant sections of the provisional opinion. Where appropriate, their responses have been incorporated into this report. In addition, I note the following comments.

*Mrs N*

214. Mrs N commented that even if a patient had been taking drugs (cannabis), they were still entitled to mental health care and services when needed, and they should not just be "fobbed off" without any help because they had been taking drugs. She also said that clinicians see patients only once every few months, whereas the family knows the patient and sees their behaviour, which means they are able to spot any changes. Mrs N felt that Dr E put Consumer C's behaviour down to attention seeking, but Mrs N said she knew the difference between that, and Consumer C being unwell and out of touch with reality.

215. Mrs N added that she was worried sick about her son's safety when they saw Dr E, but she felt as though Dr E thought she was just having an outburst. Mrs N said that doctors need to listen to family members' concerns in these situations.

*Dr E*

216. Dr E told HDC that, as is his usual practice, he had reviewed Consumer C's file before seeing him. Dr E reiterated:

> "It was quite clear that the core problem in his case was heavy and continuing cannabis use since adolescence, which has devastating consequences for brain maturation and mental health … My focus, therefore, was on trying to address the cause (cannabis use) rather than the effect (frequent suicidal/para-suicidal attempts)."

217. Dr E said that he had been working on getting Consumer C into residential rehabilitation in a specialised facility. He said:

> "At the end of the day, it was up to [Consumer C] to assume responsibility and control of his life, with help from expert [addiction] clinicians. Neither medications nor the band-aid resort to an inpatient admission was likely to break this pernicious cycle of repeated [self-harm]/suicidal attempts …
>
> Unfortunately, however, [Consumer C's] mother was unhappy with this evidence-based approach …"

218. Dr E also said that with the benefit of hindsight, he regrets the use of the phrase "emotional blackmail" in his letter to Consumer C's GP, and will ensure that this does not happen again.

*DHB*

219. As noted above, the DHB also told HDC that it accepts that it failed to support Dr E adequately to improve his communication, and that it failed him and Consumer C. The DHB apologised for this, and told HDC that it accepts the proposed recommendations.

## Consumer C Opinion: Dr E — breach

220. Consumer C's drug and alcohol counsellor, Mr O, arranged for Consumer C to be seen by Dr E for an acute assessment on 27 March 2019. Consumer C had not been sleeping, eating, or cleaning himself properly, and had harmed himself the previous night. Mrs N was noted to be "very scared" of Consumer C, and Consumer C could not ensure his personal safety to Mr O.

221. The Medical Council of New Zealand (MCNZ) publication *Good Medical Practice* (set out in Appendix E) discusses the importance of doctors establishing and maintaining trust with their patients. *Good Medical Practice* states: "Relationships based on openness, trust and good communication will enable you to work in partnership with them to address their individual needs." Working in partnership involves "listening to [patients] and responding to their concerns and preferences". *Good Medical Practice* also requires doctors to treat patients as individuals, respect their dignity, and be courteous, respectful, and reasonable.

222. My clinical advisor, Dr Edwards, noted that when an on-call psychiatrist sees a consumer acutely, it can be for a wide range of reasons. She explained that the purpose of an acute assessment "is to assess the presenting issue and focus on reducing the distressing emotion and problem solving with the patient to increase their sense of control and ability to manage". In this context, I expect clinicians to listen to, and communicate sensitively with, consumers and their whānau to help alleviate distress.

223. Mrs N filmed part of the consultation with Dr E. Dr Edwards viewed the video. While acknowledging that the video was likely recorded at the end of the consultation, Dr Edwards observed a "lack of emotion (body language and tone) from [Dr E]", that "[Dr E] appeared dispassionate and disinterested", and that there was a "lack of enquiry or productive discussion with the family". Dr Edwards further advised:

> "There was no attempt to discuss or explain [Consumer C's] serious [self-harm] presentations and suicidal ideation. [Mrs N] was distressed and exited the interview in a highly emotional state. [Dr E's] conduct was not above reproach and he ignored [Mrs N's] emotional state and did not respect the doctor–patient, patient's family relationship."

224. With respect to the clinical notes[42] written by Dr E, Dr Edwards commented:

> "In the context of an acute assessment with recent serious [self-harm] this language [used by Dr E] is aggressive and unlikely to promote engagement or rapport to discuss the reason for the assessment to focus on a positive outcome."

[42] In particular, the lines "unfortunately the mother did not like the mirror being shown and became abusive, … threatening to go to the media. Then stalked out screaming, with the patient (who did not seem frightfully keen to get mental health help and had been apparently dragged here by his mother) in tow."

225. Dr Edwards also considered that Dr E "did not show compassion and was not courteous, respectful or reasonable", and that Dr E's tone was "dismissive". She stated:

> "[Dr E's] approach [was] very unlikely to promote an engaged conversation for the purpose of addressing the acute issue in a positive way for [Consumer C] and his mother and assisting with the following hours or day."

226. I agree, and consider that had Dr E adopted a more compassionate and respectful tone, the assessment might not have ended so prematurely and abruptly.

227. Dr Edwards also advised, with respect to Dr E's letter[43] to Consumer C's GP:

> "[Dr E] is dismissive that the serious [self-harm episodes] are motivated by a need for attention, or blackmail, and says [Consumer C's] presentation is due to cannabis use which he chooses to take. … There is no exploration of recent stressors or explanation of what has triggered this change in behaviour at this time. There is a level of distress from [Consumer C's] mother who is highly concerned at his [self-harming] behaviour and is actively seeking an assessment to understand, and some support as she is very concerned he will kill himself. Even if there is not symptoms of depression or psychosis it should be recognised that [self-harm] behaviour is not normal and indicates distress. This distress could be explored, acknowledged, and a way forward supported."

228. Finally, Dr Edwards commented:

> "I note the use of the term 'emotional blackmail' which has been used by [Dr E] … This term implies extortion or emotional intimidation and that the patient is behaving wilfully in a way to get secondary gain. I believe [Consumer C] was distressed and likely overwhelmed and his behaviour reflected this. The clinical team needs to have space to feel empathy and understanding rather than veiled hostility or blame for the patient in distress."

229. I agree with Dr Edwards that it is difficult to see empathy or compassion in Dr E's written communication. In particular, his use of the term "emotional blackmail" is disparaging and inappropriate when Consumer C was likely feeling distressed. I note that Dr E now regrets the use of this phrase and will make sure this does not happen again.

**Conclusion**

230. Dr Edwards considers that, overall, the departure from accepted practice with respect to Dr E's communication, both oral and written, was moderately severe.

231. I accept Dr Edwards' advice. Dr E saw Consumer C in the context of an acute assessment, following a deterioration in his well-being and shortly after an intentional episode of self-

[43] In particular, the comments in the letter: "*no evidence of a mental health disorder, nor suicidal ideation/ intent/plan, except for 'suicidal' gestures being employed as a means of emotional blackmail",* and "*[Mr C] is aware of what he is doing and his 'suicidal' attempts are a consciously motivated attempt at emotional blackmail".*

harm. As Dr Edwards pointed out, the self-harm indicated distress on Consumer C's part yet, disappointingly, Dr E did not attempt to explore this distress. Additionally, Mrs N had valid concerns about her son's well-being and, as she said, she knew Consumer C best and was able to spot changes in his behaviour. In my view, Dr E should have recognised the distress from both Consumer C and his mother, and appreciated the need to listen to and be receptive to their concerns in an empathetic and respectful way. I am concerned that he failed to do so.

232. Dr E submitted that he was attempting to focus on the "core problem" Consumer C faced (being cannabis use) rather than the effect (the suicidal/self-harm attempts) and, as such, he was working on getting Consumer C into residential rehabilitation. I accept that this may have been an appropriate long-term goal for Consumer C's treatment. However, there was no evidence of a structured treatment plan or attempt to work constructively with Consumer C on this goal, which Dr E said was his focus. In any case, that does not in my view render Dr E's communication appropriate, particularly when he was seeing Consumer C in an acute setting when Consumer C and his mother were experiencing heightened distress.

233. I also acknowledge Mr O's view that Dr E was being "factual"; however, it is possible to be factual, as well as empathetic and respectful. In my view, Dr E failed to achieve this.

234. In my opinion, the deficiencies in Dr E's communication amount to a failure to treat Consumer C with respect. Accordingly, I find that Dr E breached Right 1(1) of the Code.

235. In addition, I consider that Dr E's tone and manner of communication represent a failure to comply with the standards as set out in MCNZ's *Good Medical Practice*. Accordingly, I find that Dr E also breached Right 4(2) of the Code.

## Opinion: Dr E — overall concluding comments

236. In this report, I have found Dr E in breach of Rights 1(1) and 4(2) of the Code for his tone and manner of communication, both oral and written, with respect to three different consumers: Consumer A, Consumer B, and Consumer C. All three consumers, despite having varied backgrounds and life circumstances, were similar in that they were all grappling with significant mental health and/or addiction issues. This meant that when they were receiving care from Dr E, they were particularly vulnerable. It was important that they were treated with respect, and that the clinicians involved in their care worked to develop therapeutic and supportive relationships.

237. In addition, I note the following comments from the Royal Australian and New Zealand College of Psychiatrists' position statement on "The role of the psychiatrist in Australia and New Zealand" (2013) (the RANZCP Statement):

> "At its core, psychiatry involves listening carefully and sensitively to people's most personal thoughts and feelings, understanding their mental state, and working with

them to identify and implement appropriate treatments including psychotherapy, psychotropic medication, social strategies and other interventions."

238. The RANZCP Statement notes that communication skills are one of the fundamental skills required by a psychiatrist: "Excellent communication skills underpin positive interactions with patients, families, carers and other health professionals." I endorse these statements. In psychiatry, it is essential that clinicians listen to and communicate with consumers, whānau, and other providers sensitively, effectively, and respectfully in order to deliver quality care and achieve good outcomes.

239. I find it very troubling that these three cases present consistent themes of Dr E not treating consumers with respect, allowing his personal views (which often were negative and disparaging about the consumer) to affect the care he provided, and using inappropriate language that was, at worst, likely to distress, and certainly unlikely to foster a trusting and therapeutic doctor–patient relationship. These themes persisted across five years.

240. Dr E submitted that he has a particular style of communication that stems from his previous employment. I do not accept that the language and words he used to describe his patients was just blunt, factual, or to the point. On the contrary, particularly in his written referrals to medical colleagues, his words were subjective, his own opinion, unprofessional, and derogatory.

241. I expect Dr E to continue to reflect extensively and work hard to improve his tone and manner of communication. In particular, I draw his attention to the helpful comments from Dr Edwards about the principles of accepted practice with respect to communication.

## Consumers A, B, and C Opinion: District Health Board — breach

242. District health boards are responsible for the operation of the clinical services they provide. In addition, they have a responsibility for the actions of their staff, including to ensure that all consumers receiving care from their staff are treated with respect.

243. Under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), employing authorities are responsible for ensuring that employees comply with the Code. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing, or omitting to do, the things that breached the Code. Dr E had been employed by the DHB since 2005. As an employer, the DHB is potentially vicariously liable for Dr E's breaches of the Code.

244. As detailed above, I have found Dr E in breach of Rights 1(1) and 4(2) of the Code for his tone and manner of communication with Consumer A, Consumer B, and Consumer C.

245. With respect to Consumer A, my findings relate to a discharge summary and clinic letters written by Dr E across a period of three years. A number of other DHB clinicians also received copies of some of the written correspondence.

246. With respect to Consumer B, my findings relate to two consultations between Dr E and Consumer B three years apart. As noted by Dr Edwards, there was a "consistent theme" to Dr E's communication in 2016 and 2019. Following the initial consultation, Consumer B's psychologist, Mr L, raised concerns with DHB staff about Dr E's communication.

247. With respect to Consumer C, my findings relate to Dr E's communication during an acute assessment, and his written communication in respect of the associated clinical documentation, including the letter to Consumer C's GP. I note Dr Edwards' comment that the term "emotional blackmail" used by Dr E was subsequently used by others involved in Consumer C's care.

248. It is concerning that similar issues with Dr E's communication were repeated with three different consumers and across a period of five years (2014–2019). Other DHB clinicians were present at some of his consultations, were copied into his clinical correspondence, and inevitably would have seen many of his clinical notes. This suggests that Dr E's tone and manner of communication was mostly tolerated by other DHB staff, and there is no evidence that management took any steps to address this.

249. I accept that the DHB took some steps to address concerns about Dr E's communication following his consultation with Consumer B in 2016, including meeting with him and supporting him to apologise to Consumer B. However, very similar issues arose again with both Consumer B and Consumer C three years later, and in the intervening period Dr E's written communication with and about Consumer A continued to be inappropriately derogatory and reflective of Dr E's personal views. There is no evidence that the DHB took any steps to address these issues during this time. In my view, this indicates that the DHB failed to support Dr E to communicate in a more appropriate manner.

250. In my opinion, other than arranging the meeting after Dr E's consultation with Consumer B in 2016, the DHB did not take such steps as were reasonably practicable to prevent or address issues with respect to Dr E's communication, and therefore the DHB is vicariously liable for Dr E's breaches in respect of his behaviour towards Consumer A, Consumer B, and Consumer C. I conclude that the DHB is vicariously liable for each of Dr E's breaches of Rights 1(1) and 4(2) of the Code with respect to Consumer A, Consumer B, and Consumer C.

251. I expect DHBs to require their clinicians to communicate in an appropriate manner, and particularly in the context of the mental health sector, where often consumers are especially vulnerable. In my opinion, empathetic and respectful communication is vital to effective psychiatric care. I am concerned and disappointed that the DHB has failed to support Dr E adequately to communicate appropriately. Despite this issue being raised with the DHB previously, Dr E's inappropriate language and lack of empathy towards and about consumers persisted. As a result, three different consumers have had upsetting interactions,

often when they were at their most vulnerable or distressed, and needed and deserved supportive and respectful care.

## Changes made

### Dr E

252. Dr E told HDC that he has carefully noted Dr Edwards' comments about the care he provided and is in the process of incorporating her advice into his practice to improve it further. In particular, he said that he is more sensitive to the need to "introspect, reflect, and constantly adapt in accord with the lived experience in real time". He added: "I have been making continuing efforts to mellow my style and soften the edges. In this, I have received constant guidance and support from DHB management."

253. In response to the provisional opinion, Dr E also provided the results from a Multi-source Feedback survey (MSF) of his patients and colleagues (completed in September–October 2021). The MSF showed that Dr E was scored "Very good" in all areas relating to patient care, including:

- Being polite to patients.
- Making patients feel at ease.
- Listening to patients.
- Explaining patients' condition and treatment.
- Respecting patients' cultural beliefs and values.
- Involving family/whānau in patients' care.

### DHB

254. The DHB told HDC that it has made the following changes since these events:

- It has built into senior medical officer (SMO) performance appraisals the DHB's values.
- In October 2020, it held an SMO development day that focussed on SMO engagement and communication with staff, patients, and families.
- It met with the District Inspector[44] to clarify the process for obtaining consumer consent under section 59 of the MHA, and the DHB then reviewed and clarified the section 59 process with SMOs.
- The DHB's mental health service is working on improving access to psychological therapies, with a focus on upskilling clinicians.

[44] District Inspectors are independent lawyers appointed by the Minister of Health to protect the rights of people receiving treatment under the MHA, or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

- It has asked its Family Advisor and Adult Consumer Advisor to sit in on three appointments each with Dr E, to provide feedback to Dr E and the DHB's mental health service.

## Recommendations

255. Bearing in mind the above changes made by Dr E, and acknowledging the recent positive feedback he received from patients in the MSF, I recommend that he:

a) Provide formal separate written apologies to Consumer A's parents, Consumer B, and Consumer C for the breaches of the Code with respect to the care provided to each of the consumers. The apologies are to be provided to HDC within three weeks of the date of this report, for forwarding.

b) Attend further training, provided by people with lived experience of mental distress, on therapeutic communication, establishing trust and rapport with mental health consumers, treatment of BPD, and how to manage the risk of countertransference. Evidence of this training is to be provided to HDC within six months of the date of this report.

c) Provide to HDC, within one month of completing the above training, a reflective statement detailing how each of these cases and the training has caused him to change his tone and manner of communication, and provide specific examples of how he has incorporated these changes into his daily practice.

256. I recommend that the Medical Council of New Zealand consider whether a review of Dr E's competence or conduct is necessary based on the information contained in this report.

257. Bearing in mind the above changes made by the DHB, I recommend that the DHB:

a) Provide separate formal written apologies to Consumer A's parents, Consumer B, and Consumer C for its breaches of the Code with respect to the care provided to each of the consumers. The apologies are to be provided to HDC within three weeks of the date of this report, for forwarding.

b) Audit a random selection of 20 pieces of clinical documentation written by Dr E (including a selection of discharge summaries, clinic letters, and clinical notes in respect of acute assessments from the six-month period immediately preceding the date of the final report) to assess the appropriateness of Dr E's written communication. The DHB is to report back to HDC on the results of the audit, including any issues identified and the actions taken to address these issues, and the support provided to Dr E to improve his communication style, within three months of the date of this report.

c) Provide HDC with details of the feedback given to Dr E and the DHB's mental health service from the Family Advisor and Adult Consumer Advisor's observations of Dr E in the three consultations. Where the feedback has identified a need for further training

or support for Dr E, the DHB is to provide details of how this will be provided. This information is to be provided to HDC within three months of the date of this report.

d) Consider adopting a new guideline regarding monitoring of consumers on antipsychotic medications, including a requirement that they have yearly ECGs and testing of prolactin as per the Maudsley Guidelines. The DHB is to report back to HDC on the results of its consideration, and provide a copy of any new guidelines that are adopted or are to be adopted, within three months of the date of this report.

e) Consider adopting a new form, to be incorporated into MDT meeting notes, to prompt staff when repeat tests or reviews (including dental reviews, blood tests, and metabolic monitoring markers) are due. The DHB is to report back to HDC on the results of its consideration, and provide a copy of any new form that is adopted or is to be adopted, within three months of the date of this report.

f) Consider adopting a form to request and reply to an application for a second opinion regarding medication regimens for consumers who are subject to the MHA. The DHB is to report back to HDC on the results of its consideration, and provide a copy of any new form that is adopted or is to be adopted, within three months of the date of this report.

## Follow-up actions

**258.** Dr E will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken. In making this referral I have had regard to the significant issues in both Dr E's written clinical notes and correspondence and in his verbal communication in each individual case, as well as the pattern of inappropriate, unprofessional, and/or derogatory language used towards and about vulnerable mental health consumers, and the public interest in holding him to account for those issues.

259. A copy of this report, as it relates to the care provided to Consumer A, will be sent to the Coroner.

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

261. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Deputy Director-General, Mental Health and Addiction Services, the Director of Mental Health and Addiction Services, the Mental Health and Wellbeing Commission, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

## Addendum

262. The Director of Proceedings decided to issue proceedings in the Health Practitioners Disciplinary Tribunal.

## Appendix A: Independent clinical advice to Commissioner — Consumer A

The following expert advice was obtained from psychiatrist Dr Rosemary Edwards:

> "I have been asked to provide expert opinion to the Health and Disability Commissioner on two matters. In this report I am addressing Part A:
>
> 1. The overall management and care of [Consumer A] under the Mental Health (Compulsory Assessment and Treatment) Act 1992.
> 2. Whether [Consumer A's] medication regime was appropriate in the circumstances.
> 3. The adequacy of measures undertaken to monitor [Consumer A] for side effects.
> 4. Any other matters that you consider amount to a departure from accepted standards.
>
> And to focus on [the DHB's] response and clinical documentation from 1 [Month36] to 28 [Month47].
>
> To do this I have used the information provided to me by the HDC.
>
> From the clinical files it appears [Consumer A] presented with chronic unremitting schizophrenia. He was first admitted for mental illness [in his twenties]. He re-presented due to non-compliance with medication and/or use of cannabis. Following alleged threat to his then treating psychiatrist he was transferred to [Dr E's] care on 12 [Month2], during his fifth admission in 12 months. On discharge he remained under the MHA as a community patient and resided at supported accommodation.
>
> He was prescribed Clozapine and Lithium when first transferred to [Dr E]. The Clozapine was changed to intramuscular Paliperidone due to non-compliance with the Clozapine despite a very firm stance by [Dr E]. The Paliperidone was initially 4 weekly and he was discharged on 150mg 3 weekly on 5 [Month13].
>
> There is reference to following the protocol for off label use of this medication in the discharge letter dated 05 [Month13].
>
> From the documentation [Consumer A] did not develop insight into his illness or requirements to remain well. There is no written evidence of a supporting relationship with DHB staff.
>
> It has been difficult to follow [Dr E's] answers as the dot points were not numbered, and his reply had 1 less dot point than the request (his last dot point is a statement 1 rather than an answer), and [Dr E] referred to multiple documents rather than supplying a direct answer to each question. As a result I think there is lack of clarity which I request [Dr E] has the opportunity to respond to.

As I have gone through the report I have raised questions and requests for more information. I have repeated these in a section at the end.

Opinion.

1. The overall management and care of [Consumer A] under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

It is appropriate to treat [Consumer A] under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA). He had a chronic disorder that was resistant to treatment and he was unable to discuss or manage his illness in an insightful fashion.

2. Whether [Consumer A's] medication regime was appropriate in the circumstances.

It is appropriate to use an intramuscular anti-psychotic when there is non-compliance with an oral preparation. [Consumer A] continued to take oral Lithium. I will comment on doses later in this answer.

As [Consumer A] was unable to consent to treatment a second opinion needs to be sought to support the medication regimen. [Dr E] cited a number of documents of second opinion for medication.

A second opinion [in] 2014 was pursuant to section 21 of the MHA and for the purpose of supporting the presence, or not, of a mental disorder. At that time [Consumer A] was on Lithium and Clozapine. This document is not relevant to the question of whether medication was appropriate as suggested by [Dr E] in the second dot point answer in his letter.

The case conference referred to in the second dot point answer dated 6 Month8 noted medication Paliperidone and Lithium. It was not a second opinion. Doses were not mentioned.

The Forensic opinion dated 9 [Month5] was comprehensive and for the purpose of addressing risk, which it did. It noted a change in medication from Clozapine to Paliperidone, supporting a change to intra-muscular anti-psychotic in the light of non-compliance. The opinion was not asked to comment on specific medications or on doses. It is not a second opinion for medication pursuant to the MHA as suggested by [Dr E] in his second dot point reply.

The letter dated 3 [Month6] is a second opinion under the MHA. This does not state his medication regimen or doses but it is likely on that date to be Paliperidone and Lithium. [Dr K] states 'I agree with the current regimen of his treating psychiatrist'. *There should be Section 59 MHA for Referral for Opinion and an Opinion. Can I have copies of these please?*

Document dated 20 [Month13] by Dr … is a progress note and is not a Second Opinion pursuant to the MHA.

The reference to request for second opinion/change of psychiatrist is irrelevant to the second dot point question by HDC. [Consumer A] complained of his medications poisoning him consistently. There is no documentation to support a request for a second opinion to address this.

The adequacy of measures undertaken to monitor [Consumer A] for side effects

[Consumer A] was on Lithium 1500mg daily with a level from [2014]–18 [Month44] that varied between 0.10 mmol/L to 1.40mmol/L. Normal range is less than 1.0mmol/L, with levels up to 1.50mmol/L sometimes being toxic. [Consumer A's] Lithium levels were highest when he was in Supported Accommodation and presumably his medication compliance was supervised. He had his Lithium in the evening (as far as I can tell) and his blood was collected in the morning for testing. It is difficult to speculate reasons for the variability. It is likely the low levels followed a period of non-compliance. His Renal function remained stable over a long period of time so does not explain a high level. *I have not seen documentation of possible side effects of his medication assessed by [Dr E]. Can these be requested please?*

Paliperidone was increased for therapeutic effect and there is recorded benefit, although he continued to experience symptoms of mental illness. It is reasonably common to use psychiatric medications above stated maximum. When this happens it is important to discuss with the patient and to ensure clinical benefit, as well as regular monitoring. If [Consumer A] had a PPP&R Act with Welfare Guardian this would need to be discussed with the guardian as well. *The reasons for increase and discussions of pros and cons with patient, and/or Welfare Guardian need to be documented. Can I see this documentation please?*

He had weight gain and at time of death had a BMI of 31.3 placing him in the obese range. I do not know his weight at the time he was started on Paliperidone. The majority of anti-psychotic medications can result in weight gain. *I would expect yearly records of weight, BMI, Blood pressure for a person on anti-psychotics and mood stabiliser (Lithium). Can these be supplied please?*

Cardiac function and structure assessed by ultrasound [in] 2014 was normal in function and size.

ECG records: [Three occasions in] 2014, 1&9 [Month3] — borderline QTc, sinus tachycardia. QT 344. 16 [Month7] normal sinus rhythm. QT 362. There is no raised QT interval that was cause for concern. All anti-psychotic medication will have a similar effect, to more or less degree, although some are more likely than Paliperidone. The relevance of ECG at baseline is to exclude any possible familial prolongation of QT interval, and this is excluded for [Consumer A]. Other medications such as some antibiotics, or derangement of electrolytes can also have a detrimental effect on QT length. A QT length above 500 would be a cause for concern. *I expect yearly ECG for a person on this medication regimen. Are there ECGs between [2014] and [Month47]? Other annual blood tests for people on anti-psychotics are HbA1c, LFT, Electrolytes and*

*creatinine (6 monthly for Lithium) FBC (6 monthly for both medication types), Lipids, TFT (6 monthly for Lithium). Can these records be supplied please?*

My understanding is that medication levels taken at post mortem can be artificially inflated and not represent blood levels prior to death. The Pathology report states there is higher than expected levels of Paliperidone. *Can this be quantified and commented on? My understanding is that there is a possibility of post mortem redistribution of medication altering blood levels.*

The Pathology report also says the medication was apparently increased prior to death and side effects like tardive dyskinesia were apparently present. *Could the Pathologist produce the information he was referring to please?*

Any other matters that you consider amount to a departure from accepted standards

…

[Consumer A] presented to the ED on two occasions just prior to his death; 22 and 24 [Month46]. Poor dentine and a tooth abscess noted. An infection results in increased metabolic load for the body. *Did he have a regular (yearly) dental assessment?*

Summary to date

[Consumer A] had both psychiatric and mental health issues. The medication for his mental health is known to have physical health risks. The medication is used as the benefits of being mentally well are considered greater than the possible side effects. Most DHBs would have a form for recording the required 6 monthly and yearly tests (ECG and blood, BP, weight, dental at least). Is this provided for [Dr E's] DHB?

It is also possible for a patient under the MHA in the community at Supported Accommodation that he had a General Practitioner. Unfortunately this group of patients are not always good at visiting a GP. Either way it is the psychiatrist's responsibility to ensure regular monitoring.

…

It may be possible for [the DHB] to improve processes and protocols to support people with mental illness to have optimal physical health, if not already in place.

Requests for further information.

There should be Section 59 MHA for Referral for Opinion and an Opinion. Can I have copies of these please?

…

Did [Consumer A] have regular (yearly) dental assessment? Or was he offered the appointment?

Are there ECGs between [2014] and [Month47]?

Other annual blood tests for people on anti-psychotics are HbA1c, LFT, Electrolytes and creatinine (6 monthly for Lithium) FBC (6 monthly for both medication types), Lipids, TFT (6 monthly for Lithium). Can these records be supplied please?

The reasons for increase in medication and discussions of pros and cons with patient, and/or Welfare guardian need to be documented. Can I see this documentation please?

Is there a document/protocol used within [Dr E's] DHB to monitor 6 monthly and yearly bloods, dental, ECG etc?

Does [Dr E] within his multi-disciplinary team have regular wider team reviews of patients under their care? If so are there records of these?

Dr Rosie Edwards MBChB FRANZCP
**Consultant psychiatrist**"

The following further advice was obtained from Dr Edwards:

"I have been asked to provide expert opinion to the Health and Disability Commissioner (HDC) on two matters. In this report I am addressing Part B; the appropriateness of [Dr E's] manner and tone in his written correspondence to providers involved in [Consumer A's] care.

To do this I have used the information provided to me by the HDC.

I have read the Medical Council of New Zealand documents: Good Medical Practice and Information, choice of treatment and informed consent, Medical Protection United Kingdom Document Chapter 2 — Professionalism — What does it look like? And New Zealand Medical Association document Code of Ethics, Principles and Recommendations.

As discussed, I approached several senior consultant psychiatrists and sought their opinion as peers. To do this I used the statements in italics below and said they were written in clinical correspondence by a peer. I did not disclose name, area, or DHB.

From the correspondence by [Dr E] I have noted the following statements:

<u>Discharge summary dated 5 [Month13].</u>

*… dysfunctional lifestyle and innumerable relapse,*

*… has become routinely breeching boundaries and getting away with grossly offensive and often abusive/assaultive behaviour by using intimidation as a tool, an art which he has practiced to perfection.*

*… He tried the same stunt, but when firmly told to cut this crap out, he shut up, but not before making a final attempt at physical intimidation ... however this tactic was treated with the contempt which it deserved, his bravado instantly deflated.*

*… Responding to such pathetic attempts …*

*… While dealing with him … [t]here will be no negotiation, no accommodation, no compromise.*

*… No dilution of this strategy is permissible.*

*… he will die within the next one year … we cannot allow him to commit chronic latent suicide no leave or smoking breaks will be allowed.* (while an inpatient I presume)

Letter to GP dated 24 [Month18]

*… ill-conceived and misinformed narrative …*

Letter to GP dated 18 [Month32]

*... excitable, accusative and even more unpleasant than he usually is.*

Letter to GP dated 16 [Month38]

*… he remains in denial, contemptuous and dismissive of medication, becoming really unpleasant and obnoxious …*

*… conveniently forgets …*

*… I have little more to offer, even as [Consumer A] continues down the path of self-destruction.*

Email from [Dr E] to supported accommodation manager dated 30 [Month43]

*… regard to the pejorative and, in my view utterly irresponsible and despicable, allegation made by [Consumer A's] father …*

Letter to GP dated 13 [Month41]

*… [Consumer A] was even more hostile, combative and accusative than is his wont.*

*… in this rather regressive narrative …*

Letter to GP dated 28 [Month42]

*if such disruptive behaviours persist …*

To address the manner and tone in [Dr E's] correspondence I used the following documents to inform a standard of principles of professionalism

Medical Council of New Zealand documents: Good Medical Practice and Information, choice of treatment and informed consent,

Medical Protection United Kingdom Chapter 2 — Professionalism — What does it look like?

New Zealand Medical Association document Code of Ethics, in particular Principles and Recommendations.

Using the above documents, I summarised general themes:

Practise the science and art of medicine to the best of your ability with moral integrity, compassion and respect for human dignity.

Respect the rights, autonomy and freedom of choice of the patient.

Honour the profession, its values and its principles in the ways that best serve the interests of patients.

Doctors should ensure that all conduct in their practise of their profession is above reproach. Exploitation of any patient, whether physical, sexual, emotional or financial, is unacceptable and the trust embodied in the doctor–patient relationship must be respected.

Doctors should ensure that information is recorded in an accurate and timely manner.

Patients are entitled to good doctors. Good doctors make the care of their patients their first concern; they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy and act ethically.

The MCNZ expects doctors to be competent in (among other things) respecting patients.

Keep clear and accurate patient records that report relevant clinical information.

Be courteous, respectful and reasonable.

Be aware one's culture may impact the doctor–patient relationship.

Do not express personal beliefs to patients in ways that exploit their vulnerability or that are likely to cause them distress.

You must convey information to the patient in a form, language and manner that enables the patient to understand the treatment or advice.

The consumer has the right to the information that a reasonable consumer, in that consumer's circumstances would expect to receive.

From the information available to me [Consumer A] presented with schizophrenia which was partially treated at best. His insight was poor. He had a history of substance misuse, non-compliance with medication and repeat admissions to hospital.

Opinion

Clinical letters to the GP and discharge summary are seen by a wide number of people. This includes members of the multidisciplinary team caring for [Consumer A], the Non-Government Organisation providing supported accommodation, the typist, members of the caring team, the General practitioner, and the patient, [Consumer A].

All clinical records are best written as if they are read by the patient. In this case the correspondence was sent to the patient so it is reasonable to assume he could read it.

[Consumer A] presented as is typical for people with chronic unremitting schizophrenia. Most, if not all community adult psychiatrists would have patients with a similar presentation in their clinic. It is a usual part of clinical practice. It can be taxing to provide care for people who have very little insight as the doctor intrinsically wants to help and improve the life of their patients.

The language used by [Dr E] does not meet a standard of accepted practice.

He has given personal (rather than professional) judgement, which is not courteous, respectful and reasonable. For example; *'becoming really unpleasant and obnoxious, even more unpleasant than he usually is, was even more hostile, combative and accusative than is his wont, he tried the same stunt, but when firmly told to cut this crap out, he shut up, ill-conceived and misinformed narrative'.*

He has not shown compassion and respect for human dignity. For example *'firmly told to cut this crap out, was treated with the contempt it deserved, responding to such pathetic antics, if such disruptive behaviours persist, I have little more to offer even as [Consumer A] continues down the path of self-destruction, he will die within the next year, we cannot allow him to commit chronic latent suicide. No leave or smoking breaks will be allowed'.* The information in these documents does not convey information to the patient in a form, language and manner that enables the patient to understand the treatment or advice. The written information is not what a reasonable consumer, in that consumer's circumstances would expect to receive.

It is possible to convey the meaning intended while remaining respectful and compassionate. The language used by [Dr E] is very unlikely to promote a trusting relationship with respect of [Consumer A's] autonomy and freedom of choice. This is especially difficult when a person is partially treated and does not agree with the treatment. In this situation repeat education and negotiation of treatment is required. It may be possible to use a rehabilitation service if one is available. And inclusion of other mental health professionals and family.

[Dr E's] use of language is likely to have influenced the way others, who read the documents, thought of [Consumer A].

While the reasons behind the correspondence style are important, the language used is not professional or respectful as is expected in clinical documents.

This departure is moderately severe to severe. My view would be shared by many peers.

I trust this is of assistance.

Please do not hesitate to contact me for further comment.

Yours sincerely,

Dr Rosie Edwards. MB.ChB FRANZCP"

The following further advice was obtained from Dr Edwards:

"I have been asked to provide expert opinion to the Health and Disability Commissioner on two matters. I previously responded as Part A dated 10 October 2019 and this is an update following further information supplied and replaces the previous report. In this report I responding to the following:

- The overall management and care of [Consumer A] under the Mental Health (Compulsory Assessment and Treatment) Act 1992.
- Whether [Consumer A's] medication regime was appropriate in the circumstances.
- The adequacy of measures undertaken to monitor [Consumer A] for side effects.
- Any other matters that you consider amount to a departure from accepted standards.

In the letter of 25 June 2020 I was also asked to comment in addition on the appropriate use of seclusion and the way in which seclusion was carried out in the time period [Month1] to [Month13].

To do this I have used the information provided to me by the HDC.

From the clinical files it appears [Consumer A] presented with chronic unremitting schizophrenia. He was first admitted for mental illness [in his twenties]. He re-presented due to non-compliance with medication and/or use of cannabis. Following an alleged threat to his then treating psychiatrist he was transferred to [Dr E's] care on 12 [Month2], during his fifth admission in 12 months. On discharge he remained under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) as a community patient and resided at supported accommodation. He remained under the care of [Dr E] until transferred to [Dr F] who saw [Consumer A] for the first time on 21 [Month47].

[Consumer A] was prescribed Clozapine and Lithium when first transferred to [Dr E]. The Clozapine was changed to intramuscular Paliperidone due to non-compliance with the Clozapine. The Paliperidone was initially 4 weekly and then increased and he was discharged on 150mg 3 weekly on 5 [Month13]. There is reference to following the protocol for off label use of this medication in the discharge letter dated 05 [Month13].

From the documentation [Consumer A] did not develop insight into his illness and he continued to experience residual symptoms despite treatment. [Consumer A] had respiratory disease and was counselled to stop smoking cigarettes on several occasions.

Opinion

The overall management and care of [Consumer A] under the Mental Health (Compulsory Assessment and Treatment) Act 1992

It was appropriate to treat [Consumer A] under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA). He had a chronic disorder that was resistant to treatment and he was unable to discuss or manage his illness in an insightful fashion. He resided in supported accommodation as he was unable to care for himself, and could be hostile and threatening when acutely unwell.

Whether [Consumer A's] medication regime was appropriate in the circumstances

It is appropriate to use an intramuscular anti-psychotic medication when there is non-compliance with an oral preparation. [Consumer A] continued to take oral Lithium but was non-compliant with oral clozapine. [Consumer A] was started on intra-muscular Paliperidone 150mg 4 weekly on 17 [Month5], and it was increased to 3 weekly on 07 [Month7].

As [Consumer A] was unable to consent to treatment a second opinion pursuant to section 59 of the MHA needs to be sought to support the medication regimen.

A second opinion dated [2014] was pursuant to section 21 of the MHA and for the purpose of supporting the presence, or not, of a mental disorder. At that time [Consumer A] was on Lithium and Clozapine. This document is not relevant to the question of whether paliperidone and lithium were supported by a second clinician.

The Forensic opinion dated 9 [Month5] was comprehensive and for the purpose of addressing risk. It was not a second opinion pursuant to the MHA for medication.

The letter dated 3 Month6 is a second opinion under the MHA. The letter does not state his medication regimen or dose, but it is likely on that date to be Paliperidone and Lithium. [Dr K] states 'I agree with the current regimen of his treating psychiatrist'.

The document dated 20 [Month13] by Dr … is a progress note and is not a second opinion pursuant to the MHA.

I have not seen the specific form application for a second opinion for medication pursuant to section 59 of the MHA. In the documents supplied there is one letter supporting a second opinion for medication dated 3 Month6. It is not clear what medication is being supported. At this time [Consumer A's] dose of Paliperidone was 150mg 4 weekly. Legally the second opinion does not expire. Given [Consumer A's] ongoing concerns about his medications and the subsequent use of off label dose of paliperidone a further application for a second opinion to explicitly address this would have been prudent.

[The DHB] most likely has a specific form to request and reply to an application for a second opinion regarding medication under the MHA. This allows for clear record keeping of medication consent. These forms have not been supplied despite being requested. The Director of Area Mental Health Service (DAMHS) office should have the original form with copies in the patient notes. The form stipulates the medication being considered and the reason for the application, such as the person being unable to consent (the likely reason in this case).

In my opinion the lack of specific application form for a second opinion and second opinion letter not detailing medication is a mild departure from an accepted standard.

The adequacy of measures undertaken to monitor [Consumer A] for side effects

Lithium

[Consumer A] was on Lithium 1500mg daily with a blood level from … 2014 to 18 [Month44] that varied between 0.10 mmol/L to 1.40mmol/L. Normal range is less than 1.0mmol/L, with levels up to 1.50mmol/L sometimes being toxic. [Consumer A's] Lithium levels were highest when he was in supported accommodation and presumably his medication compliance was supervised. He had his Lithium in the evening (as far as I can tell) and his blood was collected in the morning for testing. It is difficult to speculate reasons for the variability. It is likely the low levels followed a period of non-compliance. His Renal function remained stable over a long period of time so does not explain a high level. [Dr E] writes in his undated reply to the HDC that the high levels were attributable to timing issues with the blood level collected too soon after administration of the medication. This is possible if [Consumer A] was prescribed his medication in the morning and his dose not withheld until after the blood test. In my opinion there was adequate monitoring of [Consumer A's] lithium levels.

Anti-psychotic medication

Paliperidone was increased for therapeutic effect and there is recorded benefit, although [Consumer A] continued to experience symptoms of mental illness. It is reasonably common to use psychiatric medications above the stated maximum. When this happens, it is important to discuss it with the patient and to ensure clinical benefit, as well as regular monitoring. If [Consumer A] had an EPOA or PPP&R Act with a Welfare Guardian this should be discussed with the guardian as well. The reasons for increase and discussions of pros and cons with patient, and/or Welfare Guardian need to be documented. The rationale for use of an intramuscular anti-psychotic, and the reason for the increase from 4 to 3 weeks was documented in the discharge summary dated 14 [Month1]. However, there is no other documentation of observations of side effects or discussion of side effects or of medications. [Dr E] in his reply to the HDC undated wrote 'no evidence of toxicity, nor any adverse effects, was ever observed by anyone in his treating team'. I have not seen this documented by the treating team in their interactions with [Consumer A]. It may not have been possible to discuss medications directly with [Consumer A] due to his ongoing beliefs he was being poisoned. The lack of documentation to show consideration of possible side effects of medication in my

opinion is a mild departure from accepted practice. Future efforts to address and record consideration of possible side effects would be an improvement.

Weight

[Consumer A] at time of death had a BMI of 31.3 placing him in the obese range. His BMI on 22 [Month3] was 22.9 with a weight of 76.2kg. He showed a steady rise in weight and BMI as recorded on 26 [Month8] and [Month35]. His parameters of blood pressure, glucose and cholesterol recorded twice in 2015 showed some increase. He had one recording following discharge from hospital in 2017 showing increasing weight and no recordings of lipids and cholesterol.

The majority of anti-psychotic medications can result in weight gain. There is no documentation to show discussion of this and the recording after discharge was completed once in [Month35]. In my opinion the lack of communication is a mild departure from accepted practice. Future efforts to address and record consideration of a response to weight gain (diet or medication) would be an improvement. There is a lack of complete documentation of weight and glucose/lipids level following discharge. In my opinion this is a moderate departure from expected standard.

Electrocardiogram

Cardiac function and structure assessed by ultrasound [in] 2014 was normal in function and size. Electrocardiogram (ECG) records: [Three occasions in] 2014, 1&9 [Month3] — borderline QTc, sinus tachycardia. QT 344. 12 Month5 no abnormality reported. 16 [Month7] normal sinus rhythm. QT 362. There is no raised QT interval that was cause for concern. All anti-psychotic medication will have a similar effect. The relevance of ECG at baseline is to exclude any possible familial prolongation of QT interval, and this is excluded for [Consumer A]. Other medications such as some antibiotics, or derangement of electrolytes can also have a detrimental effect on QT length. A QT length above 500 would be a cause for concern. It is expected for a person on this medication regimen to have a yearly ECG. There are no ECGs between [Month7] and [Month47]. In my opinion this is a moderate departure from accepted practice given [Consumer A's] associated physical concerns. Along with other yearly requirements a form could be helpful to prompt staff when repeat tests are due. Most often such forms can form part of a multi-disciplinary team (MDT) review in the community on approximately a 6 month basis. [The DHB] should have a protocol regarding best practice for monitoring for people on psychotropic medication.

Blood tests

The blood tests are complete in 2014. Renal function was then collected most frequently, although there are no records for 2017. I cannot see liver function, lipids and thyroid function tests since 2015, and glucose since 2014. There is no prolactin level. It is recommended for metabolic monitoring for people on anti-psychotic and lithium medication the following tests 6 to 12 monthly as per the protocol: HbA1c (diabetic marker), Liver Function Tests, Electrolytes and creatinine (renal function), Full Blood Count, Lipids, Thyroid Function Tests, and prolactin. In my opinion this is a

moderate departure from accepted practice given the associated physical concerns. [The DHB] is likely to have a metabolic monitoring protocol which includes these tests and should be followed. Most often these protocols are included as part of a multi-disciplinary review in the community on approximately a 6 month basis.

Monitoring protocols

[Consumer A] had both physical and mental health issues. The medication for his mental health is known to have physical health risks. The medication is used as the benefits of being mentally well are considered greater than the possible side effects. Most DHBs would have metabolic monitoring protocols and a form for recording the required 6 monthly and yearly tests including ECG and blood levels (HbA1c — diabetic marker, Liver Function Tests, Electrolytes and creatinine, Full Blood Count, Lipids, Thyroid Function Tests, and prolactin), Blood pressure, weight, and dental.

It is also possible for a patient under the MHA in the community at Supported Accommodation that he had a General Practitioner (GP). Unfortunately, this group of patients are not always good at visiting a GP. It is part of the psychiatrist and MDT responsibility to ensure regular monitoring.

Any other matters that you consider amount to a departure from accepted standards

[Consumer A] presented to the ED on two occasions just prior to his death; 22 and 24 [Month46]. Poor dentine and a tooth abscess noted. There is no documentation to support yearly dental review. In my opinion this is a moderate departure from accepted practice given the associated physical concerns. Along with other yearly requirements a form could be helpful to prompt staff when repeat tests are due. Most often such forms can form part of a multi-disciplinary review in the community on approximately a 6 month basis.

[Consumer A] had respiratory checks and he was a smoker. This was a concern that was documented frequently. Considerable efforts were made to encourage [Consumer A] to discontinue cigarettes.

The records for the MDT held while an in-patient in 2014/15 are accompanied by a sign in form that does not have a patient label and seems not specific to any one individual's MDT. It is a long list of people, sometimes with up to 5 doctors. In my opinion it would be clearer if the people present at an individual's MDT be stated specifically on their MDT paperwork.

There are two MDT forms following discharge dated 16 [Month35] and 5 [Month45] supplied following [Consumer A's] discharge from hospital. The 2017 form referred the reader to a clinical note rather than supplying information. The form named 3 people and not their designation so I am unclear whether this is a MDT or an appointment. The 2018 form had slightly more information with social worker and case manager but no doctor present and did not contain any information relevant to medication, monitoring or health concerns. There were no other records of MDTs held when [Consumer A] was

in the community as part of the documentation supplied. These should be held and documented approximately every 6 months and attended by members of the community Mental Health team, including the psychiatrist, and other staff from the community providing a service to [Consumer A], as well as family/welfare guardians if they want to attend. Within this meeting there should be attention given to regular testing and monitoring as described above. To not have these meetings would be a serious departure from accepted practice. Poor documentation of MDTs that otherwise meet the required standards would be a mild departure from accepted standards.

In the letter of 25 June 2020 I was also asked to comment in addition on the appropriateness of the use of seclusion and the way in which seclusion was carried out in the time period [Month1] to [Month13].

There are four documented seclusion events. Each event was well documented with a clear clinical reason for the seclusion. The seclusion was kept to the least possible time and used when [Consumer A] was hostile and non-compliant with medication. His needs were attended to and family contacted. On one occasion he was given a hospital gown for his own protection. There is no documentation regarding his clothing on other occasions. In my opinion this is an acceptable standard of care. In future additional documentation of clothing worn could be beneficial.

In all of my opinions regarding standard of care I believe my peers would opine similarly.

Yours sincerely

Dr Rosie Edwards MBChB FRANZCP
**Consultant psychiatrist**"

The following further advice was obtained from Dr Edwards:

"Thank you for the request to read the additional information provided and consider whether it causes me to amend conclusions provided previously: Part A dated 10 October 2019 and Part B dated 2 January 2020.

The two reports were a response to the following:

Part A:

The overall management and care of [Consumer A] under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Whether [Consumer A's] medication regime was appropriate in the circumstances.

The adequacy of measures undertaken to monitor [Consumer A] for side effects.

Any other matters that you consider amount to a departure from accepted standards.

And to focus on [the DHB's] response and clinical documentation from 1 [Month36] to 28 [Month47].

Part B: The appropriateness of [Dr E's] manner and tone in his written correspondence to providers involved in [Consumer A's] care.

In response to [Dr E's] letter dated 6 October 2020 in response to expert advisor's reports.

Whether medication regimen was appropriate in the circumstances

The information given is largely a repeat of previous information. The medication regimen is likely to be appropriate in the circumstances, however, the documentation and information recorded does not support best practice. There was only one request for a second opinion relevant to the 150mg paliperidone 3 weekly pursuant to the mental health act s 59 (policy and informed consent documents provided in appendices O, P, Q, R) and the form indicating a request pursuant to s59 has not been provided and may not have been used. The response to a request for a second opinion dated 03 Month6 did not state the medication [Consumer A] was on at the time.

In reading further information, the date of prescribing paliperidone 150mg 3 weekly is stated as 18 [Month3] on his discharge summary of 05 [Month13]. This indicates the second opinion by [Dr K] is for the dose of paliperidone [Consumer A] remained on in the community. This meets the required standard. However, the documentation does not meet the required standard and is a mild departure.

Discussion and documentation of possible side effects, weight gain and monitoring

There has been no reply to whether [Consumer A] was subject to a PPP&R Act so I presume he was not. His parents were involved in his care and had conversations with [Dr E]. They did not always agree with his medication regimen, although at the time of discharge on 5 [Month13] it is documented the father agreed. [Dr E] wrote that written booklets are 'invariably provided' to provide information about side effects. This has not been included in the information provided to me. There is no mention of this booklet in the documentation I have seen.

[Consumer A's] weight gain was noted and recognised to be a side effect of anti-psychotic medication. I note the policy for metabolic monitoring has been updated from 2014 to 2020, the latter providing clearer criteria to follow. The information used from Alberti et al 2009 indicated [Consumer A] met 2 of 5 criteria on 14 [Month6] and therefore did not meet criteria for metabolic syndrome as defined by Alberti. Monitoring of these parameters was recommended in both policies to be yearly. The documentation provided is difficult to read but seems to have been last recorded fully in 2015. My advice remains unchanged regarding lack of documentation of weight.

The blood results provided include lipids and glucose in [Month35] with increases in the lipid (cholesterol) parameters. The results recorded in 2017 and 2018 are incomplete for LFT, HbA1c, TSH. If there is no yearly assessment of metabolic monitoring (as per

2014 policy weight, height, waist circumference, blood pressure, fasting cholesterol and LDL, and fasting glucose) then this is a departure from the required standard. It was documented that there were no side effects apparent on a number of occasions and no mention of weight gain. This is a moderate departure given [Consumer A's] observed weight gain, and his complaints that he was gaining weight, and had sexual side effects (no further detail given. Raised prolactin can be a causal factor).

Yearly ECG from [Month7] to [Month47]

[Consumer A] had a baseline ECG in 2015. The 2 ECGs included in the additional documentation document the same date. None of [the DHB] policies made available recommend yearly ECGs. Maudsley guidelines (as referred to by [Dr E]) and other DHB guidelines state that ideally all patients should be offered ECGs at least yearly. A guideline for a yearly ECG should be considered by [the DHB] for patients on anti-psychotic medication. [Dr E] had the Maudsley recommendations available to him and has responsibility to ensure his patients receive appropriate physical care, even when carried out by another person. I continue to consider this is a moderate departure from accepted practice. Lipid test and a full blood count was included in the additional information for 2017. I have not seen a record for 2016 so if this was not done it would be a mild departure from accepted practice, a reduction from my previous advice that lack of testing since 2015 would be a moderate departure.

There is a 6 monthly review form document dated 02 [Month29]. This states the previous review was 26 [Month19] although I have not seen a copy of that review. This is adequate practice for yearly reviews. This is a change from what I stated in my previous report.

Prolactin should be taken at baseline, 6 months and then yearly according to the Maudsley guidelines. I cannot see this recommended in the [DHB] policies available to me.

Yearly dental checks are recommended in [DHB] policy. The response from [the CEO] in [the] letter dated 18 September 2020 said I understand that dental treatment was offered to [Consumer A]. This is not documented. And is not part of team or parent meetings I have seen. Dental caries is common for people with mental illness. To not be offered and encouraged to have dental assessments yearly is a moderate departure from accepted practice.

I have no further comment regarding multidisciplinary team (MDT) meetings.

With regard to [Dr E's] responses to the expert opinion report Part B

I agree with [Dr E] that letters need to be factual and accurate and cater to a range of readers. The information can also be professional, respectful, courteous and compassionate. I have no additional information to provide to add to my opinion of 2 January 2020.

Yours sincerely

Dr Rosie Edwards MBChB FRANZCP
**Consultant psychiatrist**"

The following further advice was obtained from Dr Edwards:

"I have been given additional information and asked to advise whether this causes me to amend advice previously given to the Health and Disability Commissioner on the care provided by [the DHB] to [Consumer A].

To do this I have read the letter by [Dr E] dated 10 March 2021, letters and blood levels I have seen previously, undated letter from [RN G], and information on Lithium.

OPINION

My previous report outlines [Consumer A's] history and presentation. I have no changes to make to the advice I gave previously.

Regarding the additional consideration raised in [Dr E's] letter.

There is a prescribed format for requesting second opinion pursuant to the Mental Health (Compulsory Assessment and Treatment) Act, section 59 — treatment while subject to compulsory treatment order, that [Consumer A] was subject to. This process is required as [Consumer A] was unable to give consent.

I have nothing else to add to my previous comments regarding the second opinion.

[RN G], in his letter, shows an understanding of the possible side effects of the medication [Consumer A] was prescribed. Of course, it is reasonable to ask a patient if they are experiencing side effects however, it is also necessary to ask specific questions to elicit possible side effects.

It is the role of the consultant psychiatrist/Responsible Clinician to be aware of the metabolic monitoring that is undertaken, and to ensure it occur[s] to a suitable standard.

I have no further comments to make.

Dr Rosie Edwards MBChB FRANZCP
**Consultant psychiatrist**"

## Appendix B: Independent clinical advice to Commissioner — Consumer B

The following expert advice was obtained from psychiatrist Dr Rosemary Edwards:

"Reference: C19HDC00558

I have been asked by the Health and Disability Commissioner (HDC) to advise on the appropriateness of [Dr E's] manner and tone in his clinical documentation and verbal communication following the care provided by [Dr E] to [Consumer B] on 7 October 2016, 12 July 2017, 21 June 2018, and 15 March 2019.

I have also been asked to address the following matters:

1. What is the accepted practice for documentation, correspondence, and verbal communication?
2. If there has been a departure from accepted practice, to identify whether the departure is mild/moderate/severe.
3. How would it be viewed by my peers?
4. Any other matters that warrant comment.
5. Recommendations for improvement that may help prevent a similar occurrence in the future.

To complete this report, I have read the supplied documentation and listened to the audio recording in relation to 7 October 2016 interview.

I have read the following documents:

- Medical Council of New Zealand Good Medical Practice and Information, choice of treatment and informed consent;
- New Zealand Medical Association document Code of Ethics, Principles and Recommendations; and
- Medical Protection United Kingdom Document Chapter 2: Professionalism — what does it look like?

Background

[Consumer B] is a patient of [the DHB]. According to a letter written by her treating psychiatrist, [Dr J], dated 12 October 2016, she has a diagnosis of Borderline Personality Disorder (BPD) complicated by an Eating Disorder (Anorexia), and Major Depressive Disorder. Throughout the clinical notes covering the period from 7 October 2016 to 15 March 2019 provided by the HDC, that focus on the dates [Consumer B] was assessed by [Dr E], the diagnosis that is most prominent is Borderline Personality Disorder. [Consumer B] had at least three members of the community Mental Health Team (MHT) involved with her care at any one time. She was seen by [Dr E] in his capacity as psychiatrist on call on the dates noted above. He documented that he was aware of

[Consumer B's] diagnoses and treatment from listening to her case being presented in clinical meetings, having read her notes, and reviewing her previously when asked.

In general, the purpose of an acute assessment is to focus on reducing the presenting distressing emotion and to focus on problem solving with the patient in order that the patient is able to increase their sense of control and ability to manage. It is possible to make changes to medication and supports available to the person in the community or to consider admission.

On 7 October 2016 at 15:25 [Dr E] saw [Consumer B] with two other members of staff, psychologist [Mr L] and [RN M] (written documentation not clear of her designation). He documented a 4 week decline in [Consumer B's] presentation. He wrote that [Consumer B] avoided eye contact and 'when requested to look at me while talking to me, as is expected in civilized discourse, she burst into (unclear word) melodramatic tears'.

Following the assessment with [Dr E] she was seen by a Registered Nurse who documented [Consumer B] experienced a panic attack immediately after leaving the assessment.

[Consumer B] was seen by her usual psychiatrist [Dr J] on 11 October 2016. In this session [Dr J] documented the diagnoses and treatments, including psychological, that were recommended. [Dr J] noted he had been caring for [Consumer B] for many years and that it was a challenge for the treating team that [Consumer B] remained disengaged from her treatment plan. There was clarification about an appointment that resulted in [Dr E] seeing this patient on 7 October. In-patient admission was not recommended.

On 30 Month28 [Consumer B's] mother complained about the care her daughter had received from Mental Health (MH) Services. Among other things she asked that her daughter receive a written apology for the 7 October 2016 appointment with [Dr E].

In a letter dated 28 February 2017 [Dr E] wrote to [Consumer B]. He wrote that he was 'sorry for the unfortunate and distressing experience' regarding the 7 October 2016 assessment. He wrote that the 'conversation regarding the cancelled appointments … should not have taken place'. He wrote 'while what happened cannot be undone, I hope this will help address your rightly felt sense of having been treated inappropriately'. He said he hoped she was 'feeling better' and 'wished her well for the future'.

In [Dr E's] response to the HDC dated 15 May 2019 and regarding the 7 October 2016 assessment, he said he regretted the focus on systemic issues (i.e. discussion on why she was not being seen by her usual psychiatrist) which had distressed [Consumer B] and the psychologist [Mr L]. He referenced a complaint made by the psychologist [Mr L] who said he felt interrogated during the interview. [Dr E] said there was a formal letter to [Consumer B], and he had verbally apologised to [Mr L] and they continued to have a 'warm professional and personal relationship'.

[Dr E] made a further response to the HDC dated 26 August 2019 regarding further information supplied in the form of an audio recording of the 7 October 2016 assessment. He said that in his recollection of the meeting he had made a clinical note that indicated he expected [Consumer B] may return. However, having listened to the recording, he said it indicated he 'asked her to leave as she wanted to go'. He said this was not appropriate and that he had apologised for 'the same' in his letter dated 28 February 2017. Further, that on reflection he was able to 'understand that my manner may have appeared abrupt and unsympathetic' and he was 'sorry for any upset this may have caused'. He said he was 'perplexed' why he had been consulted with at that time. He said that the 'consult was over three years ago … and he was continuing to improve his communication style'.

On 3 September 2019 [the] Chief Executive Officer from [the DHB] replied to the HDC. [Dr E's] responses to the complaint were noted as was an excerpt from the Directorate response on 16 March 2017 'We certainly don't condone what happened'.

On 12 July 2017 [Dr E] saw [Consumer B] in the Emergency Department (ED) with two people (of unclear designation) [RN M] and … and had input from Dr … (I presume from prior to the meeting. His role not stated). [Dr E] recorded that [Consumer B] had no intention of killing herself and would like admission to the Mental Health Unit (MHU) to prevent [self-harm] which she did not want to do but could not help herself from doing to relieve stress. There was a plan for admission to [the psychiatric hospital] in the future. [Consumer B] was admitted as a voluntary patient.

In [Dr E's] response to the HDC dated 15 May 2019 he confirmed admitting [Consumer B] to hospital on 12 July 2017.

On 21 June 2018 [Dr E] saw [Consumer B] with a person (writing not clear) and a Support Person and had input (I presume before the meeting) from [her key worker] in the ED. [Consumer B] had received 1 unit of blood and an admission to the MHU was planned. She appeared anxious, composed and was not suicidal. A contract was mentioned but not included in the information.

In [Dr E's] response to the HDC dated 15 May 2019 and regarding the admission on 21 June 2018 [Dr E] stated there was an agreed contract for a 5-day admission which [Consumer B] breached by [harming herself] while on leave, staying on the ward for several weeks.

On 15 March 2019 [Dr E] assessed [Consumer B] with [RN I] and [RN H] (designation not stated). [Dr E] wrote that he 'cautioned' [Consumer B] about recording their conversation saying it will be 'unlawful and constitute a culpable offence which will be reported to the law enforcement agencies'. He wrote that [Consumer B] 'began narrating her usual story', which had been 'documented extensively' and 'which he had heard innumerable times … over the years' and that staff 'had to be changed as she burnt them out with her frequent suicidal statements/threats, refusal to eat, [self-harm] and, more recently approach to the news media'. [Dr E] wrote that he asked

[Consumer B] about her expectations 'specifically excluding what has not worked in the past'. [Dr E] said to provide objective evidence during this assessment he showed [Consumer B] copies of letters he had written dated 7 and 11 October 2011. These letters were records of a previous assessment of [Consumer B] by [Dr E]. He asked whether she was better or worse since then. He said if she appeared much worse then it would be 'reasonable to assume that the many MH interventions/hospital admissions had actually made her worse. That was it time to stop repeating what had failed repeatedly in the past and assume responsibility for her life, ask for a discharge from MH Services and move on with her life.' [Consumer B] replied that she had improved and was waiting for admission to [a psychiatric hospital]. [Dr E] said, 'it was pointed out to her … she had sabotaged an admission by [harming herself]'. He wrote that he said '…'. And that he considered that 'such conduct constituted antisocial behavior'. [Dr E] said he asked [Consumer B] again to 'suggest what would help her excluding [underlined twice] medications … or admissions which he said had been counterproductive in the past'. He said he showed her the list of her admissions and commented that a 5 day contract drawn up by staff who had 'negotiated for a whole day with her' but that she had 'violated the written contract' for 'months' while [Consumer B] stayed on the ward, 'using the threat of [self-harm] … in an extortionist attempt to blackmail emotionally'.

The letters written by [Dr E] that he referred to in the 15 March 2019 assessment and dated 7 and 11 October 2011 were written to [Consumer B's] General practitioner (GP). [Consumer B] was seen for an urgent assessment on 7 October 2011 and then in follow up for this 3 days later. She was seen with her Key Worker … who was concerned at [Consumer B's] self-harm behaviour. [Dr E] prescribed an anti-depressant Sertraline. It was noted at the next appointment that [Consumer B] was taking the medication.

[Dr E] assessed [Consumer B's] presentation as 'composed, euthymic, smiling at times as if enjoying being able to manipulate everyone at will'. He opined there was no evidence of mental disorder and mental health intervention would be counterproductive and would reinforce maladaptive behaviour. That MH services had 'unintentionally, served her ill', and MH Staff had been 'badly singed by her exploitative manipulative and highly traumatising behaviour'.

In his letter to the HDC dated 15 May 2019 and regarding the letters of 7 and 11 October 2011 [Dr E] could not recall focusing on [Consumer B's] Eating Disorder, and said he used a Strengths Model to build on positive elements that patients have in their life. He wrote that it was 'possible that this might have been interpreted in a simplistic way, i.e. *one shouldn't be depressed while living in a nice country'* [Dr E's italics].

[Dr E] wrote a letter dated 18 March 2019 to [Consumer B's] GP following his assessment on 15 March 2019. He wrote that [Consumer B] had been 'demanding' to be admitted. This was declined for clinical reasons. He stated [Consumer B] 'upped the ante by contacting the media … a distasteful move … could be termed an attempt at blackmail/extortion'. He said [Consumer B] had a 'sense of entitlement and an aura of victimhood' and he provided 'reality therapy' via 'Socratic interrogation'. He said her comment that she was waiting for a bed at [the psychiatric hospital] was 'ironic' as she

had previously 'sabotaged' a previous admission opportunity. He said she 'recently violated' an agreement made regarding an admission to the MHU, and the 'charade went on for months'. In [Dr E's] opinion when [Consumer B] 'felt painted into a corner' she 'stalked out of the room'. [Dr E] opined that he saw no evidence of a MH disorder but rather what he 'saw was manipulative behaviour, reinforced by attainment of secondary gain in the form of escalating investment of mental health resources in her care'. And concluded that in his view he was 'not sure what further benefit MHS can offer to [Consumer B]'. This letter was copied to [Consumer B] and 8 other people.

In [Dr E's] response to the HDC dated 15 May 2019 and regarding the assessment of 15 March 2019 [he] included previously documented details. He expanded on Socratic questioning as a therapeutic method saying it was a critical component of Cognitive Behavioural Therapy and noting that his analytical approach 'did not appear to sit well' with [Consumer B]. He wrote that he was sorry 'if the use of this approach and technique, which by its nature is robust and meant to challenge the patient, was considered *aggressive and argumentative'* [Dr E's italics]. 'I did not intend for it to be so.' He said that neither of the clinicians present 'expressed any concern or disquiet in respect of these interactions'.

National event history of [Consumer B's] admissions to hospital

There have been 18 separate entries for admissions with a psychiatric diagnosis. Due to readmissions on the day of discharge there have been a total of 11 admission durations.

The first Mental health admission was in 2006 for a diagnosis of an Eating Disorder and lasted 75 days. She was readmitted for the same diagnosis as follows:

- 2009 twice for 19 and 16 days.[1]
- 2016 for 41 days.
- 2017 for 20 days. This admission included other diagnoses for a total of 45 days.
- 2018 for 61 days.

There were admissions following [self-harm]; 2011 for 1 day, two admissions in 2017 for 1 day although the second was immediately followed by an admission for a personality disorder for 66 days.

In 2017 [Consumer B] was admitted for two long admissions and three one day admissions:

- She was admitted on 3 February with a diagnosis of an Eating Disorder for 20 days, the following day for [self-harm], and then admitted with a diagnosis of Emotionally Unstable PD, Borderline type for 25 days until 21 March, a total of 45 days in hospital.

[1] Consumer B told HDC she is not certain that these time periods are correct, as she recalls first being admitted in 2009 for only a few hours (although she did recall her second admission in 2009 was up to three weeks).

- She was admitted on 30 April diagnosed with an [episode of self-harm] for 1 day, and 1 day in May and July for [self-harm].
- She was admitted continuously from 12 July until 2 October with 6 separate admission entries including diagnoses of Emotionally Unstable PD for 3, anaemia for 2 and [self-harm] for 1 entry, for a total of 82 days.

In 2018 [Consumer B] was admitted with Iron deficiency anaemia secondary to … on three occasions:

- 2 June for 1 day.
- 21 June to 17 July (62 days) with 4 diagnostic entries; 2 for an Eating Disorder and 2 for anaemia.
- 14 September until 29 November (76 days) with 4 diagnostic entries; 2 for an Eating Disorder and 2 for anaemia.

There were approximately 24 admissions related to anaemia secondary to … starting in 2014 and until 21 January 2020.

Borderline personality disorder (BPD) is a type of personality disorder. As outlined in Kaplin and Saddock's Synopsis of Psychiatry 7th edition, personality disorders (PD) are characterized by character traits that are inflexible and maladaptive and cause either significant functional impairment or subjective distress. Patients with a personality disorder show deeply ingrained, inflexible, and maladaptive patterns of relating to and perceiving both the environment and themselves. In the American Psychiatric Association Diagnostic Criteria from DSM 5, personality disorders are grouped into 3 clusters. Cluster B includes borderline along with three other types of PD. Borderline PD and a mood disorder often coexist. People with BPD develop their own defensive style to reduce unpleasant emotions of anxiety, depression, anger, guilt, and shame. The behaviour entered into by people to manage these emotions may not cause the person themselves any distress, despite it being distressing to others … The emotional distress (or pain) is distracted by the physical pain felt due to [self-harm]. Physical pain can be perceived as more under the person's own control and therefore preferable. The person may also be reluctant to enter into treatment to develop more adaptive responses as during the treatment their unpleasant emotions will be discussed and felt. In preparation for this treatment the person is required to learn a broader range of skills designed to encourage the use of adaptive skills in response to unpleasant emotions. This is a process that takes time and requires a good and consistent therapeutic relationship with a skilled clinician. To help people with BPD the treating clinicians need to appreciate the patient's underlying defences.

The Royal Australian and New Zealand College of Psychiatrists guide on Borderline personality disorder 2017 states that BPD people stand on the border between neurosis and psychosis and are characterized by very unstable affect, mood, behaviour, object relations (resulting in transference and countertransference) and self-image. BPD is also known as emotionally unstable PD. A state of crisis and mood swings are common. Their behaviour can be unpredictable and they rarely achieve to the level of their ability. They

repetitively self-harm to elicit help from others, to express anger, or to numb themselves from overwhelming affect. They feel both dependent and hostile and can express disproportionate anger to close friends when frustrated. However, they are unable to tolerate being alone and it is common to complain of boredom, feeling empty, and a lack of sense of identity. BPD people distort all their relationships by categorising people as all good or all bad.

It is important that all health professionals understand the cause and expression of BPD symptoms and the high likelihood of countertransference. Transference relates to the feelings the patient has for and against the therapist. Countertransference is the feelings the health professional/therapist has towards the patient. Countertransference can interfere with the therapist's ability to remain detached and objective. It is important that the therapist removes such impediments by analysis or recognises that s/he does not work well with this particular type of patient and refers them to a colleague.

Treatment of BPD involves both psychotherapy and pharmacological tools. The main goals for treatment include overcoming emotional problems, finding more purpose in life, building better relationships and taking control of their own life. Psychotherapy needs to be well organised and structured and tailored for people with BPD, and the treatment explained to the patient. The relationship between the patient and the therapist is an important part of the treatment. This requires specifically trained health professionals. The therapist listens, guides, and pays attention to the person's emotions and accepts that their experiences and feelings are real. Medication can be helpful to manage specific symptoms. The disorder is treatable, and people can recover.

The Socratic method in Cognitive Behavioural Therapy (CBT) has been defined as a 'method of guided discovery in which the therapist asks a series of carefully sequenced questions to help define problems, assist with identification of thoughts and beliefs, examine the meaning of events, or assess the ramifications of particular thoughts or behaviours'. Beck and Dozois (2011) Cognitive therapy: Current status and future directions. *Annual Review of Medicine,* 62, 397–409.

It is important to try to elicit from the patient what they are thinking rather than telling the patient what the therapist believes they are thinking. Pushing the patient towards a conclusion where the therapist believes they know the answer can result in disengagement. The aim is to reduce distress due to unhelpful cognitions, to help the patient develop skills of critical thinking, promote more memorable and convincing insights, increase engagement and autonomy in therapy, and to improve the outcome of therapy and reduce the likelihood of relapse. While this method can be robust and challenging it is the skill of the therapist to moderate the approach to match the need of the patient. Beck et al. (1970) *Cognitive therapy of depression*. New York: Guilford.

As well as CBT, Dialectical Behavioural Therapy (DBT) has been found to be effective in treating BPD. Both therapies need to be continued over a period of a year or more.

**The Strengths Model** articulated by Charles A. Rapp in the 1980s is a case management model for mental health patients in the community. It is designed to focus on an individual's strengths to improve their quality of life, which usually occurs when goals are reached. Goals can relate to income, a job, contribution to others, independent living, and friends.

There are six principles underlying the model, as follows:

- focus on individual strengths rather than pathology,
- case manager — patient relationship is essential,
- intervention is based on patient self-determination (control of their own life),
- the community is viewed as an oasis of resources, not an obstacle,
- aggressive outreach is preferred mode of intervention, and
- people with severe mental illness can continue to learn, grow and change.

This model was introduced to provide an alternative to the Medical Model, which focuses of diagnostic categories. The Strengths Model clinician encourages the consumer to cultivate their interests, identify strengths and assist them to use these strengths to achieve goals. The therapeutic relationships are important, and the therapist and consumer are viewed as equal partners. The consumer depends on the clinician for technical advice, while the consumer helps the clinician understand them better. The clinician, among other things, asks the consumer how they have got through acute phases of their illness and other achievements. The shift in focus is from what the clinician perceives as important to focus on issues the consumer identifies.

Opinion

1. What is the accepted practice for documentation, correspondence, and verbal communication?

To assess the appropriateness of [Dr E's] manner and tone in his clinical documentation and verbal communication following the care provided by [Dr E] to [Consumer B] on 7 October 2016, 12 July 2017, 21 June 2018, and 15 March 2019, I used the following documents to determine accepted practice:

- Medical Council of New Zealand documents: Good Medical Practice and Information, choice of treatment and informed consent;
- New Zealand Medical Association document Code of Ethics; Principles and Recommendations; and
- Medical Protection United Kingdom Chapter 2. Professionalism — What does it look like?

In my opinion the general principles of accepted practice are:

- Doctors should practise the science and art of medicine to the best of their ability with moral integrity, compassion, and respect for human dignity.
- Doctors should respect the rights, autonomy, and freedom of choice of the patient.

- Doctors should honour the profession, its values and its principles in the ways that best serve the interests of patients.
- Doctors should ensure that all conduct in their practise of their profession is above reproach. Exploitation of any patient, whether physical, sexual, emotional, or financial, is unacceptable and the trust embodied in the doctor–patient relationship must be respected.
- Doctors should ensure that information is recorded in an accurate and timely manner.
- Patients are entitled to good doctors. Good doctors make the care of their patients their first concern; they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy and act ethically.
- The Medical Council of New Zealand expects doctors to be competent in (among other things) respecting patients.
- Doctors should keep clear and accurate patient records that report relevant clinical information.
- Doctors should be courteous, respectful and reasonable.
- Doctors will be aware that their own culture may impact the doctor–patient relationship.
- Doctors do not express personal beliefs to patients in ways that exploit their vulnerability or that are likely to cause them distress.
- Doctors must convey information to the patient in a form, language and manner that enables the patient to understand the treatment or advice.
- The consumer has the right to the information that a reasonable consumer, in that consumer's circumstances would expect to receive.

In my opinion, some of the documentation, correspondence, and verbal communication used by [Dr E] does not meet a standard of accepted practice.

For example:

Regarding the 7 October 2016 assessment.

[Dr E] wrote that [Consumer B] avoided eye contact and '*when requested to look at me while talking to me, as is expected in civilized discourse, she burst into (unclear word) melodramatic tears'.*

In [Dr E's] response to the HDC dated 15 May 2019 and regarding the 7 October 2016 assessment, he said he regretted his focus on systemic issues which had distressed [Consumer B] and the psychologist [Mr L]. He apologized to [Mr L] who '*communicated late'* that he felt interrogated during the interview and his apology was accepted.

In his letter dated 26 August 2019 and having listened to the recording of the 7 October 2016 appointment [Dr E] said the audio recording indicated he '*asked her to leave as she wanted to go'*. He said this was not appropriate and that he had apologised for '*the same'*. Further, that in reflection he was able to '*understand that his manner may have*

*appeared abrupt and unsympathetic'* and he was sorry for any upset he may have caused. He said it was an unusual consultation and he was perplexed why he had been consulted with at that time. He wrote that the consult was over three years ago and he was seeking to improve his communication style.

In a letter to [Consumer B] dated 28 February 2017 from [Dr E] he apologised for an '*unfortunate and distressing experience … and the conversation about cancelled appointments should not have taken place. While what happened cannot be undone, I hope this will help address your rightly felt sense of being treated inappropriately*.'

In my opinion the above examples fail to meet the principles in the following way:

- [Dr E] appears intolerant of behaviour such as lack of eye contact from others which he said to the patient was expected in civilized discourse. Whether a patient makes eye contact or not is irrelevant to the doctor–patient interaction during an acute assessment. The quality of eye contact will be commented on in the clinical record as part of an observed mental state of the patient and will contribute to the opinion of the assessor at the time. [Dr E] was aware of [Consumer B's] diagnosis and did not make her care at that time his first concern or establish a good relationship. He did not show compassion and was not courteous, respectful or reasonable. [Consumer B's] freedom of choice was not respected. He did not convey information in a manner that enabled [Consumer B] to understand.
- A staff member who was present during this assessment complained about [Dr E's] conduct. I have not had any information to specify the complaint however, it is significant to have a non-doctor staff member complain about the conduct of a doctor.
- The use of the description that [Consumer B's] tears were melodramatic lacked empathy and did not show compassion and was not courteous, respectful or reasonable.
- When on call, a psychiatrist can be asked to see people by a clinician, as in this instance, for a wide range of reasons. The purpose of an acute assessment is to assess the presenting issue and focus on reducing the distressing emotion and problem solving with the patient to increase their sense of control and ability to manage. The failed principles are [Dr E's] practice of the science and art of medicine to the best of his ability with integrity, compassion and dignity. He should be aware that his own culture may impact the patient–doctor relationship. He should convey information to the patient in a form, language and manner that enables the patient to understand the treatment or advice. This did not occur. [Consumer B] became more distressed and experienced a panic attack immediately following this assessment. She received care from another clinician to manage her heightened emotion.
- This interview was recorded and was available to me. The quality was poor but it was possible to hear a large part of the conversation. [Consumer B] spoke on a few occasions as did the psychologist, [Mr L]. The focus of the interview was

not on [Consumer B's] presenting concerns and concentrated on why [Consumer B's] usual psychiatrist was not available to conduct the assessment. When [Dr E] asked questions, he was abrupt and, in a tone, unlikely to establish a good relationship. He interrupted the answers from both [Consumer B] and [Mr L]. [Dr E] spent the assessment expressing his personal beliefs about the availability of [Consumer B's] usual psychiatrist in a way that was likely to cause distress. There was a lack of discussion with [Consumer B] about her presenting issues and the information that was conveyed was not in a form, language or manner that enabled [Consumer B] to understand or benefit. He did not show compassion and was not courteous, respectful or reasonable. Discussing the availability of another doctor with a patient shows a lack of respect for the profession, its values and its principles in a way that best serves the interests of the patient. [Dr E's] conduct was not above reproach and he exploited [Consumer B's] emotional state and did not respect the doctor–patient relationship.

Regarding the admission on 21 June 2018.

In [Dr E's] correspondence following the 15 March 2019 appointment he wrote that he had said to [Consumer B], among other things, she had '*violated the written contract*' for '*months*'.

In [Dr E's] response to the HDC dated 15 May 2019 he wrote there was a 5-day contract which [Consumer B] breached by [harming herself] while on leave and stayed on the ward for several weeks.

In my opinion, the above example fails to meet the principles in the following way:

- Admission records show [Consumer B] was admitted on 21 June 2018 to 17 July 2018 for Iron deficiency anaemia secondary to … and received this diagnosis on two occasions during this time period with an additional two diagnostic entries for an Eating Disorder. The admission was for a total of 62 days. The length of a previous admission is not clinically relevant in the context of an acute assessment. [Dr E] conveyed the length of her admission in an exaggerated way that was not in a form, language or manner that enabled [Consumer B] to understand or benefit. He did not show compassion and was not courteous, respectful or reasonable. [Dr E's] conduct was not above reproach and he exploited [Consumer B's] emotional state and did not respect the doctor–patient relationship.

Regarding the 15 March 2019 assessment.

[Dr E] wrote that he '*cautioned*' [Consumer B] about recording their conversation saying it was '*unlawful and constitute[s] a culpable offence which will be reported to the Law Enforcement Officers*'.

In my opinion the above example fails to meet the principles as follows:

- In the context of an acute assessment when the person is being seen due to higher than usual distress this language is aggressive and unlikely to promote engagement or rapport for the upcoming discussions. [Dr E] could have asked [Consumer B] if she intended to record the appointment and asked her not to. He also could have agreed to having the assessment recorded. He did not show compassion and was not courteous or respectful. He did not respect [Consumer B's] freedom of choice. He expressed his personal beliefs in a way likely to cause distress.

[Dr E] said [Consumer B] '*began narrating her usual story*', which had been '*documented extensively*' and '*which he had heard innumerable times … over the years*' and that staff '*had to be changed as she burnt them out with her frequent suicidal statements/threats, refusal to eat, [self-harm] and, more recently approach to the news media*'.

In my opinion the above example fails to meet the principles as follows:

- This language lacks empathy and does not reflect an understanding of mental illness being a treatable condition of the brain and mind, not the person's fault, and not something they caused. It is treatable and with treatment most people can recover. There is a lack of compassion and respect for human dignity and is not courteous or reasonable.
- In particular, the comment relating to staff burn out, is irrelevant to a discussion in an acute assessment with a patient and unnecessary for [Consumer B's] care and treatment. It does not display an understanding of BPD or convey information in a manner that enables the patient to understand the treatment or advice. It shows a lack of compassion and is not courteous or reasonable and is an expression of [Dr E's] personal beliefs presented in a way likely to cause distress. It does not show respect for the doctor–patient relationship.
- Staff burn-out is a possible experience for staff working with patients with the diagnosis of BPD. This is discussed and managed within the clinician team and is not relevant to a discussion with the patient at any time.

[Dr E] wrote that he asked about [Consumer B's] expectations '*specifically excluding what has not worked in the past*'. [Dr E] said to support his question with objective evidence he showed [Consumer B] copies of previous letters he had written dated 7 and 11 October 2011. He asked whether she was better or worse since then. He said if she appeared much worse then it would be '*reasonable to assume that the many MH interventions/ hospital admissions had actually made her worse. That was it time to stop repeating what had failed repeatedly in the past and assume responsibility for her life, ask for a discharge from MH Services and move on with her life*.' [Consumer B] replied that she had improved and was waiting for admission to [the psychiatric hospital]. [Dr E] said, '*it was pointed out to her … she had sabotaged*' an admission by '*[self-harm]*'.

[Dr E] wrote that he asked [Consumer B] again to '*suggest what would help her excluding (underlined twice) medications … or admissions which he said had been counterproductive in the past. He said he showed her the list of her admissions and*

*commented that a 5-day contract drawn up by staff who had 'negotiated for a whole day with her'* but that she had '*violated the written contract'* for '*months'* while [Consumer B] stayed on the ward, '*using the threat of [self-harm] … in an extortionist attempt to blackmail emotionally'*.

To the GP in a letter regarding this assessment which was copied to [Consumer B] and others he said [Consumer B] had a '*sense of entitlement and an aura of victimhood'* and he provided '*reality therapy'* via '*Socratic interrogation'*. He said her comment that she was waiting for a bed at [the psychiatric hospital] was '*ironic'* as she had previously '*sabotaged'* a previous admission opportunity.

In the letter dated 15 May 2019 [Dr E] expanded on Socratic questioning as a therapeutic method saying it was a critical component of Cognitive Behavioural Therapy and noting that his analytical approach 'did not appear to sit well' with [Consumer B]. He wrote that he was sorry '*if the use of this approach and technique, which by its nature is robust and meant to challenge the patient, was considered aggressive and argumentative ([Consumer B's] words). I did not intend for it to be so'*. He said that neither of the clinicians present '*expressed any concern or disquiet in respect of these interactions'*.

<u>In my opinion the above example fails to meet the principles as follows:</u>

- [Dr E] wrote that his questioning was an example of Socratic interrogation. Socratic questioning (not interrogation) can be used to guide the patient to consider their beliefs in a therapeutic manner. The questioning outlined by [Dr E] is more a statement of his beliefs rather than appropriate exploration of [Consumer B's] beliefs. [Dr E] could have asked [Consumer B] what had happened to bring her to the appointment. And listened to her answer. And then used questions designed to help [Consumer B] articulate a possible solution to her situation. The purpose of an acute assessment is to support the patient and to use the plan made with input from her MH team to move forward and learn to manage distressing emotions. The goal is to reduce the patient's heightened emotion and promote the patient's feeling of control and insight to improve the outcome of the interaction with the clinician.
- I have not seen but I assume that there was a contract for a 5-day admission period drawn up by the treating team and [Consumer B]. Even if this was the case each admission must be assessed on a day by day basis. To state the length of admission had been *violated for months* (63 days) and she had been *using the threat of [self-harm] … in an extortionist attempt to blackmail emotionally* does not adequately allow for the symptoms of BPD and misses the emotional dysregulation and use of [self-harm] in the form of physical pain to mitigate emotional distress. [Dr E's] documentation seems to reflect a belief that [Consumer B] is mentally well and in control of her emotions. This is not the belief of [Consumer B's] treating team.
- The tone [Dr E] used was aggressive and the approach very unlikely to promote an engaged conversation for the purpose of addressing the acute issue in a

positive way for [Consumer B]. There is a lack of compassion or respect. The language that [Dr E] used in all these examples was not in a form, language or manner that enabled [Consumer B] to understand or benefit. He did not show compassion and was not courteous, respectful or reasonable. [Dr E's] conduct was not above reproach and he exploited [Consumer B's] emotional state and did not respect the doctor–patient relationship. [Dr E's] skills and knowledge using the models he describes seems to reflect that he is not up to date.

[Dr E] wrote that he said '*…*'. And that he considered that '*such conduct constituted antisocial behaviour*'.

In my opinion the above example fails to meet the principles as follows:

- [Dr E] has expressed his personal beliefs to [Consumer B] in a way that was likely to cause distress and in a manner that does not assist a patient to understand the treatment or advice. It was not expressed in a form, language or manner that enabled [Consumer B] to understand or benefit. He did not show compassion and was not courteous, respectful or reasonable. [Dr E's] conduct was not above reproach and he exploited [Consumer B's] emotional state and did not respect the doctor–patient relationship.

[Dr E] assessed [Consumer B's] presentation as '*composed, euthymic, smiling at times as if enjoying being able to manipulate everyone at will*'. He opined there was no evidence of a mental disorder and mental health intervention would be counterproductive and would reinforce maladaptive behaviour. MH Staff had been '*badly singed by her exploitative manipulative and highly traumatising behaviour*'.

In my opinion the above example fails to meet the principles as follows:

- [Dr E] documented [Consumer B] seeming to enjoy her situation and exerting control over the health professionals. It is important that all health professionals understand the process of BPD and the high likelihood of countertransference. [Dr E] has expressed his personal beliefs to [Consumer B] in a way that was likely to cause distress and in a manner that does not assist a patient to understand the treatment or advice. This indicates [Dr E's] knowledge and skills are not up to date.
- Saying that MH staff have been badly singed by [Consumer B's] behaviour is not relevant to an acute assessment. And is never relevant to discuss with the patient the possible effect of their mental illness on staff. It was not therapeutic or expressed in a form, language or manner that enabled [Consumer B] to understand or benefit. He did not show compassion and was not courteous, respectful or reasonable. His knowledge and skills of BPD are not up to date.

On 18 March 2019 [Dr E] wrote to [Consumer B's] GP following his assessment on 15 March 2019. He wrote that [Consumer B] had been '*demanding*' to be admitted. This was declined for clinical reasons. He stated [Consumer B] '*upped the ante by contacting the media … a distasteful move … could be termed an attempt at blackmail/extortion*'.

He said she '*recently violated'* an agreement made regarding an admission to the MHU, and the '*charade went on for months'*. In [Dr E's] opinion when [Consumer B] '*felt painted into a corner'* she '*stalked out of the room'*. [Dr E] opined that he saw no evidence of a MH disorder but rather what he '*saw was manipulative behaviour, reinforced by attainment of secondary gain in the form of escalating investment of mental health resources in her care*'. And concluded that in his view he was '*not sure what further benefit MHS can offer to [Consumer B]'*. This letter was copied to [Consumer B] and 8 other people.

In my opinion the above example fails to meet the principles as follows:

- [Dr E] is expressing his personal beliefs in a way likely to cause distress. His language is very strong and indicates a poor understanding of BPD as a mental illness that can be treated and is not the patient's fault. The goal of an acute assessment is not for the patient to feel 'painted into a corner', but rather to feel their heightened emotion is more controlled so they are at a reduced risk of self-harm … He did not show compassion and was not courteous, respectful or reasonable. [Dr E's] conduct was not above reproach and he exploited [Consumer B's] emotional state and did not respect the doctor–patient relationship. His knowledge and skills of BPD are out of date.

In [Dr E's] response to the HDC dated 15 May 2019 and regarding the 2011 letters that he showed to [Consumer B] as objective evidence in the 15 March 2019 appointment, he said he could not recall a diagnosis of eating disorder being a key issue. He wrote that '*for suicidal people he uses a Strengths Model which emphasises and builds on the positive elements that patients have going for them, including family ties/support, being in a peaceful country with robust social security networks, an excellent school system and health care free at the point of delivery. It is possible this may have been interpreted in a simplistic way, i.e. one shouldn't be depressed while living in a nice country*.'

In my opinion the above example fails to meet the principles as follows:

- The role of the Strengths Model clinician is to encourage the consumer to cultivate their interests, identify strengths and assist them to use these strengths to achieve goals. The shift in focus is from what the clinician perceives as important to focus on issues the consumer identifies. [Dr E] has expressed his personal beliefs of the benefits of living in New Zealand to [Consumer B] in a way likely to continue her distress and in a way that is not an example of the Strengths Model. In the Strengths Model the opinion and strengths of the consumer is the relevant component and focus of the discussion. The use of the letters as evidence is irrelevant to the acute assessment. His knowledge and skills of the Strengths Model is not up to date.

2. If there has been a departure from accepted practice, to identify whether the departure is mild/moderate/severe.

This departure is moderately-severe to severe. [Dr E] has clearly documented his opinion and repeated a consistent theme in a number of instances and, in my opinion, has not met a number of principles as outlined above.

3. How would it be viewed by my peers?

In my opinion, many, probably most of my peers would view [Dr E's] manner and tone in his clinical documentation and verbal communication as a moderately-severe to severe departure from accepted practice.

4. Any other matters that warrant comment.

In the letter dated 15 May 2019 [Dr E] wrote that neither of the clinicians present '*expressed any concern or disquiet in respect of these interactions'*.

In my opinion:

- The lack of expressed concern from other clinicians present is not evidence of the quality of the interaction.

5. Recommendations for improvement that may help prevent a similar occurrence in the future.

In my opinion [Dr E] would benefit from supervision from a senior psychiatrist appointed by an authority, whom the supervising psychiatrist would report to. A supervisor should have access to a copy of this report and other examples of [Dr E's] clinical work.

[Dr E] may benefit from education and training on a therapeutic style of communication.

[Dr E] may benefit from education on New Zealand culture in general, and specifically Māori or Pacifica if he has clients of this cultural background as part of his practice.

Dr Rosie Edwards
MB.ChB FRANZCP
**Consultant psychiatrist**"

Dr Edwards provided the following further advice:

"Thank you for the request for further clinical advice. I have read the additional information provided on 17 November 2020.

I acknowledge [Dr E's] letter dated 6 October 2020 in which he accepts comments regarding the matters asked of me by the HDC and provided by letter dated 23 April 2020.

I would also like to acknowledge the additional information provided that summarized many complex case reviews documenting the considerable effort the mental health

service undertook to discuss and plan ongoing care for [Consumer B]. These did not include [Dr E] as he was not part of her care team.

Appendices H and I were absent from the files and were not relevant to the questions before me.

I have not commented on appendices C and D as the symposium or information on the Strengths Model is not relevant to the questions asked by the HDC.

Appendices E and G are relevant and support my previous decisions.

Appendices J and S support my previous choice of documents to compare [Dr E's] behaviour. The [DHB's] code of conduct and integrity includes, among other things, show respect for others.

Appendices K and T, the code of ethics policy provides expectations of behaviour that supports the documents I used to provide a standard of behaviour for a doctor.

Appendices N, O, W and X were absent. I do not think they are required for this opinion. I have no further comment to make.

Yours sincerely,

Dr Rosie Edwards MB.ChB FRANZCP

**Consultant psychiatrist**"

## Appendix C: Independent clinical advice to Commissioner — Consumer C

The following expert advice was obtained from psychiatrist Dr Rosemary Edwards:

"RE: Complaint: [Consumer C]/[the DHB].

HDC Ref: C19HDC01179

I have been asked to provide expert opinion to the Health and Disability Commissioner on the care provided by [the DHB] to [Consumer C] between January and March 2019.

In this report I responding to the following:

- The appropriateness and adequacy of [Consumer C's] discharge from inpatient mental health services in February 2019;
- The adequacy of [Consumer C's] care in the community between January and March 2019;
- Whether consideration should have been given to sectioning [Consumer C] under the Mental Health Act at any time;
- The appropriateness of [Dr E's] manner and tone in his clinical documentation and verbal communication; and
- Any other matters in this case that warrant comment or amount to a departure from accepted practice.

To do this I have used the information provided to me by the HDC.

[Consumer C] was born on … His clinical files include a diagnosis of attention deficit hyperactivity disorder (ADHD) treated until age 17 years, severe head injury due to [an] accident with residual right arm paralysis with limited movement and dysphasia at approximately age 18 years. He was in a coma and spent 1 year with … (a head injury rehabilitation facility). There is no documentation relevant to brain function sequelae. I note he has ACC but it is not clear what this is for specifically. Cannabis use/ abuse/addiction starting at age 15 years. He had a medical admission for [self-harm] on 1 February 2019, a mental health admission for … psychosis age … years from 1–11 February 2019, and a medical admission for [self-harm] in 27–29 March 2019.

[Consumer C] was assessed on 31 January 2019 by the Emergency Department at 1600 hours expressing persecutory ideas and thoughts of self-harm. He was reviewed by [a psychiatrist] who did not opine admission was necessary. He was given medication and a referral to AOD services. A follow up phone call was made and [Mrs N] is reported saying there were no safety concerns at that time.

[Consumer C's] first admission to the mental health service was from 1 to 11 February 2019 and diagnosed as due to a drug (cannabis) induced psychotic disorder following an [episode of self-harm] the previous day. In the Emergency Department he said he

wanted to sleep due to psychotic symptoms and denied wanting to die. His mental state settled rapidly with the anti-psychotic olanzapine. He was admitted under the Mental Health Act (MHA) and discharged as a voluntary patient. He was seen in follow up on 28 February and was well and agreed to ongoing medication. He was discharged from the Mental Health Service with a 3-month script of olanzapine 10mg at night and referred to Alcohol and Other Drug (AOD) services, and his GP.

During the admission [Consumer C] expressed that he would reduce his cannabis intake as he noticed it caused paranoia. This was thought to be displaying some insight.

On 27 March 2019 at 1150 hours [Consumer C] was seen by an AOD counsellor, [Mr O]. He complained of poor sleep and vivid dreams that scared him and his mother reported she was scared of him, and he was taking medication (sertraline — ?from GP as not in DHB notes, olanzapine and quetiapine). The AOD counsellor organised psychiatry follow up.

On 27 March 2019 at 1440 hours [Consumer C] was seen by [Dr E]. His mother and [Mr O] were present. The assessment written by [Dr E] (in italics) was that [Consumer C] '*continues to take cannabis and then [self-harms], according to his mother, he "steals". She is unable to explain why she does not keep the [item used for self-harm] locked'.* [Dr E] opined [Consumer C] presented as intoxicated with cannabis and '*there was no evidence of a mental disorder'.* He pointed out '*such suicidal stunts sometimes succeed by accident and result in a fatal outcome … the devastating impact of cannabis beginning at age 15'.* He wrote that his mother '*did not seem to like the (?)mirrors (nearly illegible) being shown and she became abusive, using 4-letter words liberally, threatening to go to the media. Then stalked out screaming with the patient'.*

On 27 March 2019, just under 3 hours later, at 1730 hours there was a call from Police to advise [Consumer C] had [harmed himself]. It was recorded he had a marked deterioration in previous 3 weeks with several attempts to have him admitted to the mental health service. He was admitted to a medical ward for 2 days until 29 March 2019. A mental health assessment was expected before discharge but had not occurred by 6pm so [Consumer C] left the hospital.

There is a handwritten entry at 1900 hours possibly by a psychiatrist saying he had gone home.

On 27 March at 1930 a medical registrar wrote he had presented with [self-harm] and a history of headaches, insomnia and complaining that 'they are after me'. And that [Consumer C] and his mother were both upset at the lack of help they were receiving. [Consumer C] said he [harmed himself] as he 'was sick of it all, sick of being disabled and no one wants to help'. A referral to mental health for an assessment was made.

Documentation dated 28 March 2019 to the GP by [Dr E] included comments similar to his clinical note (in italics) and added — *there is no evidence for a mental disorder, nor any suicidal ideation/intent/plan except for 'suicidal gestures being employed as means of emotional blackmail'.* And — *his mother became highly agitated, abusive and started*

*yelling, letting loose a torrent of 4 letter words combined with a threat to go to the media. Eventually she stalked out …*

On 31 March 2019 a note by a registered nurse said [Consumer C] was feeling suicidal, that life is not worth living and he doesn't feel safe. An appointment with [a psychiatrist] was organised. This assessment is only partially legible. There is reference to an ACC case manager and to the family being happy … when they left.

[Consumer C] was seen from April 2019 by [an] RN, on two occasions, and Mr … once, and then by AOD counsellor [Mr O].

Opinion

[Consumer C], in the period January to March 2019, was a single [man in his forties] who lived with his mother and together they requested assistance from mental health services. He had a history of ADHD and a severe head injury with at least physical sequelae, and likely cognitive sequelae/deficits although these are not clear in the documentation. He used cannabis from age 15 years, predating the head injury, and it was documented he took for headaches (? secondary to the head injury). He presented to health services on 3 occasions [after harming himself] and was admitted to mental health services for one occasion of 10 days with a diagnosis of … psychosis. There was no documentation to address why he was presenting to the mental health service at this time.

The appropriateness and adequacy of [Consumer C's] discharge from inpatient mental health services on 11 February 2019

[Consumer C's] admission and discharge are appropriate. As he was unable to give consent he was placed under the MHA. He responded to medication and was not psychotic from 2 February and had successful overnight leave to his mother from 5 February. He likely regained the ability to consent to treatment as he was discharged as a voluntary patient. There was a discharge meeting on 11 February and a discharge plan provided (unclear if this was in written form). He was seen as an out-patient 17 days later, medication continued and discharged to his GP and AOD counsellor.

The adequacy of [Consumer C's] care in the community between January and March 2019

[Consumer C] presented on 31 January to the ED and was assessed by a psychiatrist, he was reassessed and admitted on 1 February. On 27 March he was seen by his AOD counsellor who referred him for an assessment and he was seen by [Dr E]. Later that day he had an admission to a medical ward due to an [episode of self-harm]. On 31 March he was assessed by a nurse and a psychiatrist and not admitted. There were several phone calls from mental health and addiction services during this time. [Consumer C] was presenting with heavier than usual cannabis use, [self-harm] and multiple expressions of deliberate self-harm … and suicidal ideation (intentional [self-harm] with psychotic symptoms). It is not clear from the documentation the trigger for this change in behaviour and presentation to the ED as his head injury and cannabis use

had been for many years. There was a general deterioration in the weeks leading up to his presentation with a reduction in cannabis and vivid dreams, poor sleep, and [a family member] bringing attention to his disability. He [was in his forties] and was living with his mother which may be relevant. He was not employed as far as I can tell, and I do not know how he generally spent his time to be occupied.

It was appropriate to refer him to AOD services and to discharge him from Mental Health out-patients on 28 January 2019.

The AOD counsellor has multiple contacts with [Consumer C] and was appropriately reactive to his presentations and offered more support as needed.

The [Mental Health Emergency Team (MHET)] nurse followed up after he was discharged from the medical ward in late March 2019 and organised a psychiatrist appointment, which in part seems to suggest there was discussion of the diagnosis and reason for the proposed treatment. This assessment is only just legible. There are positive follow ups in April and May from AOD nurses indicating that the proposed AOD pathway treatment was the correct direction to take.

Whether consideration should have been given to sectioning [Consumer C] under the Mental Health Act at any time

Consideration was given to the use of the MHA at other times. I believe it is appropriately not used at those times.

The appropriateness of [Dr E's] manner and tone in his clinical documentation and verbal communication

I have documentation of [Dr E's] assessment of 27 March 2019 at 1440 hours, his letter to the GP dated 28 March 2019, watched a DVD of his interaction in the assessment and a transcript of this DVD interaction.

To assess the appropriateness of [Dr E's] manner and tone in his clinical documentation and verbal communication during the care provided to [Consumer C], accompanied by his mother, I used the following documents to determine accepted practice:

- Medical Council of New Zealand documents: Good Medical Practice and Information, choice of treatment and informed consent.
- New Zealand Medical Association document Code of Ethics; Principles and Recommendations; and
- Medical Protection United Kingdom Chapter 2. Professionalism — What does it look like?

In my opinion the general principles of accepted practice are:

- Doctors should practise the science and art of medicine to the best of their ability with moral integrity, compassion, and respect for human dignity.

- Doctors should respect the rights, autonomy, and freedom of choice of the patient.
- Doctors should honour the profession, its values and its principles in the ways that best serve the interests of patients.
- Doctors should ensure that all conduct in their practise of their profession is above reproach. Exploitation of any patient, whether physical, sexual, emotional, or financial, is unacceptable and the trust embodied in the doctor–patient relationship must be respected.
- Doctors should ensure that information is recorded in an accurate and timely manner.
- Patients are entitled to good doctors. Good doctors make the care of their patients their first concern; they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy and act ethically.
- The Medical Council of New Zealand expects doctors to be competent in (among other things) respecting patients.
- Doctors should keep clear and accurate patient records that report relevant clinical information.
- Doctors should be courteous, respectful and reasonable.
- Doctors will be aware that their own culture may impact the doctor–patient relationship.
- Doctors do not express personal beliefs to patients in ways that exploit their vulnerability or that are likely to cause them distress.
- Doctors must convey information to the patient in a form, language and manner that enables the patient to understand the treatment or advice.
- The consumer has the right to the information that a reasonable consumer, in that consumer's circumstances would expect to receive.

In my opinion, some of the documentation, correspondence, and verbal communication used by [Dr E] does not meet a standard of accepted practice. I consider it to be a moderately severe departure from accepted practice.

For example:

In the DVD of the 27 March 2019 assessment I notice the lack of emotion (body language and tone) from [Dr E], and for the duration of the DVD a lack of enquiry or productive discussion with the family. I accept this recording is likely towards the end of the assessment.

His communication on the DVD included '*your only problem is cannabis'* and when asked if he was going to send [Consumer C] home to die '*well that's up to him, I can't help him. Because he takes cannabis … so that means he is not trying to help himself at all. Why don't you keep the [item used to self harm] yourself* (to [Mrs N]), and *'so keep it under lock and key'*.

In my opinion the above examples fail to meet the principles in the following way:

- When on call, a psychiatrist can be asked to see people for a wide range of reasons. The purpose of an acute assessment is to assess the presenting issue and focus on reducing the distressing emotion and provide problem solving with the patient to increase their sense of control and ability to manage.
- [Dr E] appeared dispassionate and disinterested in the DVD. There was no attempt to discuss or explain [Consumer C's] serious [self-harm] presentations and suicidal ideation. [Mrs N] was distressed and exited the interview in a highly emotional state. [Dr E's] conduct was not above reproach and he ignored [Mrs N's] emotional state and did not respect the doctor–patient, patient's family relationship.
- The failed principles are [Dr E's] practice of the science and art of medicine to the best of his ability with integrity, compassion and dignity.
- He should be aware that his own culture may impact the patient–doctor relationship.
- He should convey information to the patient in a form, language and manner that enables the patient to understand the treatment or advice.

At 1440 hours on 27 March 2019 [Dr E] wrote [Consumer C] *'continues to take cannabis and then [harm himself with objects] which according to his mother he "steals". She is unable to explain why she does not keep the [objects] locked. There is no evidence of mental disorder, nor any psychotic features. He is aware of what he is doing and his "suicidal" attempts are a consciously motivated attempt at emotional blackmail*.' [Dr E] wrote that he *'pointed out that such suicidal stunts sometimes succeed by accident'.*

[Dr E] commented on the early age [Consumer C] first used cannabis and the *'devastating impact of this'.*

He wrote *'unfortunately the mother did not like the mirror being shown and became abusive, using ... threatening to go to the media. Then stalked out screaming, with the patient (who did not seem frightfully keen to get mental health help and had been apparently dragged here by his mother) in tow.'*

[Dr E] opined that no mental health intervention was indicated. He prescribed olanzapine anti-psychotic. He wrote that in about 4 weeks' time residential rehabilitation would be available to him — (I presume for cannabis use).

In his letter to the GP [Dr E] repeated some of the above comments and added *there was no evidence of a mental health disorder, nor suicidal ideation/intent/plan, except for 'suicidal' gestures being employed as a means of emotional blackmail.*

In my opinion the above examples fail to meet the principles in the following way:

- In the context of an acute assessment with recent serious [episodes of self-harm] this language is aggressive and unlikely to promote engagement or rapport to discuss the reason for the assessment to focus on a positive outcome.

- The information regarding his age of onset of cannabis use is irrelevant to the situation and not helpful in the acute setting.
- The tone [Dr E] used was dismissive and the approach very unlikely to promote an engaged conversation for the purpose of addressing the acute issue in a positive way for [Consumer C] and his mother and assisting with the following hours or days.
- The language that [Dr E] used in all these examples was not in a form, language or manner that enabled [Consumer C] or his mother to understand or benefit.
- He did not show compassion and was not courteous, respectful or reasonable.
- [Dr E's] conduct was not above reproach and he exploited [Mrs N's] emotional state and did not respect the doctor–patient (patient representative) relationship.

The comment in his letter *'no evidence of a mental health disorder, nor suicidal ideation/intent/plan, except for "suicidal" gestures being employed as a means of emotional blackmail'* and he *'is aware of what he is doing and his "suicidal" attempts are consciously motivated attempts at emotional blackmail'.*

In my opinion the above examples fail to meet the principles in the following way:

- [Dr E] is dismissive that the serious [episodes of self-harm] are motivated by a need for attention, or blackmail, and says [Consumer C's] presentation is due to cannabis use which he chooses to take. [Consumer C] has presented to MH services for the first time at age 40 years with a background in ADHD and head injury before age 18 years. There is no exploration of recent stressors or explanation of what has triggered this change in behaviour at this time. There is a level of distress from [Consumer C's] mother who is highly concerned at his [self-harming] behaviour and is actively seeking an assessment to understand, and some support as she is very concerned he will kill himself. Even if there is not symptoms of depression or psychosis it should be recognised that [self-harming] behaviour is not normal and indicates distress. This distress could be explored, acknowledged, and a way forward supported. [Consumer C] presented approximately 3 hours later with a serious [episode of self-harm].
- The language that [Dr E] used in these examples was not in a form, language or manner that enabled [Consumer C] or his mother to understand or benefit. He did not show compassion and was not courteous, respectful, or reasonable. [Dr E's] conduct was not above reproach and he exploited [Mrs N's] emotional state and did not respect the doctor–patient (patient representative) relationship.
- [Dr E] did not honour the profession, its values and its principles in the ways that best serve the interests of patients.
- Patients are entitled to good doctors.

At 1758 hours on 27 March 2019 [Consumer C] was seen in the ED for [an episode of self-harm] and admitted to the Coronary Care Unit to support his body to recover medically.

Any other matters in this case that warrant comment or amount to a departure from accepted practice.

I have nothing additional to add.

In all my opinions regarding standard of care I believe my peers would opine similarly.

Yours sincerely,
Dr Rosie Edwards
MBChB FRANZCP.
**Consultant psychiatrist**"

The following further advice was received from Dr Edwards:

"RE: Complaint: [Consumer C]/[the DHB].

HDC Ref: C19HDC01179

I have been given additional information and asked to advise whether this causes me to amend advice previously given to the Health and Disability Commissioner on the care provided by [the DHB] to [Consumer C] between January and March 2019.

And to specifically consider and provide advice on:

1. Whether [Consumer C] should have been offered inpatient admission earlier during his interactions with the mental health services.
2. The overall responsiveness of the mental health service to [Mrs N's] concerns about [Consumer C's] well-being.
3. And to consider if there are any further additional recommendations identified for improvement.

In order to respond to these questions, I have read the responses provided by [Dr E] dated 19 February 2021, DHB response from [the CEO] dated 24 February 2021, a statement from [Mr O] dated 3 February 2021, and additional clinical notes including an admission 1 February 2019 and clinical files.

OPINION.

My previous report outlines [Consumer C's] history and presentation. I have no changes to make to the advice I gave previously.

Regarding the additional questions:

1. **Whether [Consumer C] should have been offered inpatient admission earlier during his interactions with the mental health services.**

Consideration was given to admission in assessments prior to his admission 1–11 February 2019. While [Consumer C] eventually did require admission, I believe the previous attempts to manage his presentation in the community were valid.

Consideration would have been given to many factors of his presentation including that he was willing to take medication (which initially worked well), and oversight from an adult. It is only because these interventions ultimately did not work that admission was required. While in hindsight it may appear clear that an admission would be required, the skill is in the timing of this. I believe he was admitted when there was no alternative and the timing of this was clinically appropriate.

**2. The overall responsiveness of the mental health service to [Mrs N's] concerns about [Consumer C's] well-being.**

The mental health service responded to [Mrs N] many times. Different staff responded to her concerns. I believe this was appropriate.

**3. To consider if there are any further additional recommendations identified for improvement.**

[Dr E] made a statement in his letter (a) (last dot point) … following the index encounter on 27 March 2019 … no further 'suicidal' attempts. Nor has he had any further formal contact with the community mental health team … This would indicate some form of therapeutic effect …

The records I reviewed included an assessment by mental health services, Dr …, psychiatrist on 31 March 2019. This lasted 1-hour 15 minutes according to the notes and [Mrs N's] satisfaction with the outcome was noted.

I note the use of the term 'emotional blackmail' which has been used by [Dr E] … This term implies extortion or emotional intimidation and that the patient is behaving wilfully in a way to get secondary gain. I believe [Consumer C] was distressed and likely overwhelmed and his behaviour reflected this. The clinical team needs to have space to feel empathy and understanding rather than veiled hostility or blame for the patient in distress.

It is noted [Consumer C] was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). I presume there was consideration of this diagnosis which is associated with poor sleep and cannabis use. Approximately 60% of children with ADHD have symptoms that continue into adulthood.

I have no further comments to make.

Yours sincerely,

Dr Rosie Edwards
MBChB FRANZCP
**Consultant psychiatrist**"

## Appendix D: Relevant policies

### Metabolic Monitoring Guidelines

The DHB's policy "Metabolic Monitoring Guidelines" (dated September 2014) states that it applies to all consumers receiving antipsychotic medication in both the inpatient and community settings. It further states that, after baseline measurements are taken and for consumers who have been taking the antipsychotic medications for more than six months, the following measurements are to be taken yearly:

- Weight (measured in kilograms)
- Height (measured in centimetres)
- Waist circumference
- Blood pressure
- Fasting cholesterol and LDL (low-density lipoprotein, a certain type of cholesterol)
- Fasting glucose (blood sugar level).

The Metabolic Monitoring Guidelines do not state who is responsible for taking the measurements.

The DHB's "Physical Health Guidelines" (dated July 2016) state that baseline assessments of a consumer's physical health are to be completed within 24 hours of a consumer's entry into inpatient mental health services. Those assessments include physical health history and basic observations, as well as "[o]ther assessments as indicated such as ECG, blood sugar level, blood tests, peak flow". There was no requirement for ECGs to be repeated.

## Appendix E: Relevant standards

### Medical Council of New Zealand — *Good Medical Practice*

The Medical Council of New Zealand's publication *Good Medical Practice* (both the 2013 and the 2016 versions) states the following:

"**Respecting patients**

Aim to establish a relationship of trust with each of your patients.

Be aware of cultural diversity, and function effectively and respectfully when working with and treating people of different cultural backgrounds.

Treat patients as individuals and respect their dignity by:

- treating them with respect
- respecting their right to confidentiality and privacy.

**Working in partnership with patients and colleagues**

Work in partnership with patients by:

- listening to them and responding to their concerns and preferences
- giving them the information they want or need in a way they can understand and ensuring they understand it
- respecting their right to reach decisions with you about their treatment and care
- supporting them in caring for themselves to improve and maintain their health.

…

**Establishing and maintaining trust**

14. You should aim to establish and maintain trust with your patients. Relationships based on openness, trust and good communication will enable you to work in partnership with them to address their individual needs.

15. Make sure you treat patients as individuals and respect their dignity and privacy.

16. Be courteous, respectful and reasonable.

…

**Personal beliefs and the patient**

19. You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. Nor should you unfairly discriminate against patients by allowing your personal views to affect your relationship with them.

20. Your beliefs, including political, religious and moral beliefs, should not affect your advice or treatment. …

21. Do not express your personal beliefs to your patients in ways that exploit their vulnerability or that are likely to cause them distress."

**Medical Council of New Zealand — Good Prescribing Practice**

The Medical Council of New Zealand's statement "Good Prescribing Practice" (2016) states the following:

"Make the care of patients your first concern. … To ensure that your prescribing is appropriate and responsible you should:

…

- Ensure that the patient (or other lawful authority) is fully informed and consents to the proposed treatment and that he or she receives appropriate information, in a way they can understand, about the options available; including an assessment of the expected risks, adverse effects, benefits and costs of each option.

…

- Periodically review the effect (benefit and harms) of the treatment and any new information about the patient's condition and health if the treatment is being prescribed for an extended period of time.

…

- Keep a clear, accurate and timely patient record containing all relevant clinical findings; decisions made; adverse drug reactions (date, name of medicine and description of reaction); information given to the patient about the medicines and any other treatment prescribed."

**Royal Australian and New Zealand College of Psychiatrists Off-Label Guideline**

The RANZCP Guideline "The use of medications in dosages and indications outside of normal clinical practice" (2008)[46] states:

"1. Prescription of medication in doses above usually accepted ranges or outside usual indications is recommended to be reserved for those patients where standard treatments have failed or is considered inappropriate. The reasons that require the non standard treatment should be clearly and accurately documented, along with a thorough assessment of the patient's diagnosis and clinical (both mental and physical) state.

2. Consultation with an experienced colleague is recommended, including consideration of a formal written request for a second opinion on treatment

[46] This has since been replaced with RANZCP's guideline "'Off-label' prescribing in psychiatry" (2018).

options, prior to commencing treatment. Documentation of the evidence that substantiates the new treatment plan will help to support the decision.

3. Relevant monitoring, including therapeutic serum level monitoring where available, should be undertaken and recorded. Appropriate vital signs and other physical signs should be monitored regularly as needed. Clinical progress should be monitored at a frequency appropriate to the patient's mental and physical status.

4. Some treatments may be so significantly beyond normal clinical practice and lacking in an evidence base that they could be considered to constitute an experimental treatment. Such treatment should be referred to an appropriate Institutional Ethics Committee for advice and review.

5. Informed consent should be obtained and recorded. If the patient is deemed not competent to give informed consent, such treatment should only be given if the patient is being treated under the appropriate local legal framework and with the support of an independent second opinion (Note: in New Zealand such a second opinion should be by a psychiatrist approved by the Review Tribunal for the giving of such opinions). The patient may withdraw consent at any time.

6. An end point should be decided as part of the overall treatment plan to determine whether the treatment should continue or be ceased. The parameters for this should also be discussed with the patient, where possible, and documented. Before initiating such treatment the management plan should contain a maximum duration of treatment to be undertaken to assess benefit. Continuation of the treatment may proceed with documentation of the benefit and with specific ongoing review of progress."