General Practitioner, Dr C

A Report by the

Health and Disability Commissioner

(Case 04HDC10605)

Parties involved

Mrs A	Consumer
Mr A	Consumer's husband
Ms B	Complainant/Consumer's daughter
Dr C	Provider/General practitioner
Dr D	General practitioner
The first private hospital	Private rest home and hospital
The Second private hospital	Private rest home and hospital

Complaint

On 23 June 2004, the Commissioner received a complaint from Ms B about the services provided by Dr C to her mother, Mrs A. The following issues were identified for investigation:

- *Whether Dr C conducted timely and appropriate review/s of Mrs A's dementia condition and medication regime.*
- *Whether Dr C sought appropriate specialist assessment for Mrs A.*

An investigation was commenced on 22 November 2004.

Information reviewed

- Complaint from Ms B
- Response from Dr C
- Information from Dr D
- Medical records from:
  - The public hospital
  - The first private hospital
  - The second private hospital

Independent expert advice was obtained from Dr Keith Carey-Smith, general practitioner.

Information gathered during investigation

Overview
Mrs A (aged 78 years) was admitted to a public hospital in January 2001 with increasing leg weakness, vomiting and diarrhoea. She had a history of osteoarthritis, double knee joint replacements, a right hip joint replacement and a fractured femur. However, Mrs A had remained relatively mobile and was living independently with her husband, Mr A. Mrs A also had a history of depression, heart failure and renal impairment, and was on anti-coagulation therapy.

While in the public hospital Mrs A received an occupational therapy assessment and was noted to have significant cognitive and physical difficulties. She had no previous history of cognitive impairment. In February 2001, Mrs A was transferred to the first private hospital for permanent residential care. Ms B (Mrs A's daughter) recalled that her mother became increasingly disorientated and depressed over the next two years. Ms B was told that her mother had dementia. Mrs A continued to be treated by her general practitioner, Dr C, while at the first private hospital. She was not referred for specialist assessment of her symptoms.

In November 2003, Mrs A was transferred to the second private hospital and her medications were adjusted, following review by her new general practitioner. Ms B has observed a marked improvement in her mother's condition and is concerned that Mrs A may have been misdiagnosed with dementia and over-medicated while at the first private hospital.

The public hospital admissions
In August 2000, Mrs A was admitted to the public hospital and received treatment for asthma and atrial fibrillation. Her discharge medications included warfarin.

In September 2000, Mrs A was admitted to the public hospital with leg weakness and urinary incontinence. She was regarded as being medically stable and her leg weakness was thought to be secondary to a loosening of her right hip joint replacement. Further surgery was not indicated and Mrs A was transferred to the assessment and rehabilitation ward, for strengthening of her leg muscles. Mrs A made good progress and was independent with crutches on discharge.

On 3 January 2001, Dr C again referred Mrs A to the public hospital. Dr C's referral letter stated:

> "This woman has had 2 or 3 falls this evening at home and her husband is unable to physically manage caring for her. She has V & D [vomiting and diarrhoea] starting on the weekend … Vomiting has stopped but still has diarrhoea. Feels weak all over."

Mrs A was admitted to the general surgical and medical ward, and was assessed by the house surgeon as suffering from decreased mobility and gastro-enteritis. Mrs A gradually improved over the next few days with resolution of vomiting and slow improvement in her

mobility, although she continued to experience intermittent diarrhoea/incontinence, muscular-skeletal pain and depression. On 5 January 2001, nursing staff noted concern about her mental condition, as follows:

> "? Mental impairment present, requesting to walk into the kitchen and that her husband would be bringing the children in soon. When asked what age the children were, she acknowledged that they were adults (laughing).
>
> …
>
> Conversation inappropriate at times although aware of her 'muddled thoughts'."

On 9 January 2001, Mrs A was transferred to the ward. She was noted to be "muddled" and "wander off on other subjects" during her admission interview. On 10 January 2001, Mrs A was reviewed by the house surgeon, who noted:

> "There is considerable concern that [Mrs A's] condition has slipped significantly since her last admission, and that only limited progress may be made on this occasion.
>
> …
>
> It is reasonable to attempt rehabilitation, but our expectations are realistic and a finite trial/rehabilitation period must be determined."

On 12 January 2001, Mrs A was commenced on Brufen (an anti-inflammatory medication) to assist with pain relief. Ms B stated that this was done despite Mrs A informing the prescribing doctor that she had a history of stomach upsets caused by anti-inflammatory medication. On 14 January, Mrs A suffered a severe gastric bleed and was transferred to the intensive care unit. She received several blood transfusions and her bleeding gradually resolved over the next day.

On 17 January 2001, Mrs A was returned to the ward to continue with her rehabilitation. A further medical assessment noted her multiple medical problems, including light-headedness, atrial fibrillation and impaired renal function. Her decreased mobility was noted to be secondary to obesity, muscular-skeletal pain and depression. During this time Mrs A continued to be unwell with episodes of nausea, dizziness and intermittent anxiety. She was given regular physiotherapy in an endeavour to improve her mobility.

On 24 January, Mrs A was assessed by the public hospital occupational therapist who considered that her mobility required considerable improvement before she could return home. The hospital occupational therapist also visited Mr A at home and noted that he had been struggling to cope with Mrs A.

On 29 and 30 January, the hospital occupational therapist assessed Mrs A's cognitive functioning as impaired. The occupational therapist recorded:

> "Continues to require detailed verbal cues and appears to still lack understanding of what is required of her during transfers.
>
> …
>
> Deafness accommodated for by speaking very clearly and quite loudly whilst sitting facing her. Vision poor, glasses for reading. Attention within normal range for above situation. Unable to carry out 3 step command, not consistent with 2 step commands, 1 step followed well.
>
> Constructional ability and memory showing severe impairment. Abstract reasoning within normal range but judgement mildly impaired.
>
> Assessment reflecting [Mrs A's] lack of ability to follow instructions when transferring, even allowing for noise and distractions on ward.
>
> …
>
> Whilst technically possible to hoist [Mrs A] in/out of bed, wheelchair and shower chair, the home layout would be difficult to manage and access would require alteration. Practically it would be very difficult for [Mr A] to manage his wife at home, even with support."

Ms B was concerned that her mother had been assessed when she was in a poor physical state, compounded by her recent severe gastric bleed. She stated:

> "In hindsight it seems that this important assessment was done when [Mrs A] was in a poor physical state and therefore it was not an accurate assessment."

On 30 January, Mrs A was commenced on 4mg morphine elixir (as required) for her increasing muscular-skeletal (back) pain. (Mrs A was given liquid morphine daily between 1 and 8 February.)

The concerns about Mrs A's mental and physical condition were discussed at a family meeting on 31 January. Mr A agreed that he would not be able to adequately care for his wife at home, unless her condition improved, and it was decided that Mrs A required hospital-level care. On 13 February 2001, Mrs A was transferred to the first private hospital. Her discharge summary stated:

> "Her diarrhoea [has] settled down. She was unfortunately given anti-inflammatory for pain and had haematemesis. This required transfusion and her anticoagulants were stopped. She was eventually able to be discharged on 13 February with an indwelling catheter to [the first private hospital], taking Frusemide 40mg in the morning. Metoprolol CR 47.5mg daily, Pantoprazole 40mg in the morning, Clonazepam, Fluoxetine [20mg], Fluticasone inhaler, Warfarin and Trimethoprim with advice not to receive any non-steroidal anti-inflammatory drugs."

Mrs A's care at the first private hospital

Dr C had cared for Mrs A (and her husband) since 1992. He recalled that she had not shown any dementia symptoms prior to her January admission to the public hospital. However, following Mrs A's admission to the first private hospital he observed dementia symptoms that included hallucinations, belligerence interspersed with passivity, and poor memory with confabulation. Dr C explained that he visited Mrs A on a regular basis and assessed her cognitive functioning "in the normal fashion". He continued treatment of Mrs A based to "a large extent" on decisions made while she was a patient at the public hospital. He commented:

> "She [Mrs A] did not suddenly develop an acute toxic confusion state. Because she has a long history of depression which I treated with Fluoxetine 10mg and later increased to 20mg I did not feel that she was suffering from pseudo-dementia.
>
> …
>
> [Mrs A] did exhibit classic signs of dementia [while in the public hospital] and was not diagnosed as having dementia by a specialist, but was diagnosed by an occupational therapist after a thorough assessment, and the family was fully informed of this diagnosis the following day at a specially convened family meeting.
>
> …
>
> I was in full agreement with the assessment that was carried out in Hospital under the auspices of a consultant Physician and/or consultant Geriatrician that I was at ease with the diagnosis. I also assessed [Mrs A] every three months when I visited her, with the usual questions that are pitched at people who you suspect may have dementia, eg the date, day of the week, Prime Minister's name, when did I last visit her, when did her husband last visit her etc, etc."

Dr C initially reviewed Mrs A at the first private hospital on 14 February and documented her depressive illness and asthma in her medical assessment notes. Dr C also made a corresponding record of Mrs A's care in his own general practitioner medical records. On 15 February, Dr C prescribed MST 10mg twice daily as Mrs A's muscular-skeletal pain was not being adequately controlled by codeine. Dr C stated:

> "… [Mrs A] was assessed prior to starting Morphine and [she] was only prescribed this because of ongoing pain. Initially she was on 10mg of MST bd and the MST was not increased to 20mg until the 14 of April 2003."

On 19 February 2001, Dr C documented in his medical records that the registered nurse had reported to him that Mrs A was hallucinating. He wrote:

> "… [Mrs A] is hallucinating, very unsettled especially nocte [during the night], disturbing other residents, weepy."

In response to the report of hallucinations, Dr C requested that Mrs A be given 10mg Melleril, which was increased to 20mg on 23 February following a further report of restlessness at night.

Ms B is concerned that the prescription of MST by Dr C contributed to the deterioration in her mother's condition. She stated:

> "Because of her chronic pain, [Mrs A] was charted MST 20MG BD [as noted above [Dr C] prescribed 10mg MST on 15 February 2001 and 20mg on 14 April 2003] by her G.P. [Dr C]. Over the next weeks and months, [Mrs A] became increasingly disorientated and very depressed. She frequently told me she wished to die and it was later recorded in the notes [see below] that she procured a knife and tried to harm herself. I visited from [the city] frequently and I talked to [the manager at the first private hospital], about [Mrs A's] medication which seemed to make her 'hallucinate'. Sometimes, she seemed all right. She was able to talk to me on the phone when I rang, although her voice was always slurred and sometimes she made up fantastic stories."

Dr C did not consider that there was a relationship between the development of hallucinations/dementia and the prescription of morphine. He noted that Mrs A had exhibited symptoms of dementia while in the public hospital prior to the introduction of morphine on 30 January 2001 and there is no reference to the development of hallucinations after this date. He also acknowledged that, at the time he prescribed morphine for Mrs A, he had not received her discharge summary "and cannot be sure that I was even aware that she [had been] on Morphine".

The first specific reference to "dementia" in Dr C's medical records occurred after his review of Mrs A on 27 March 2001. Dr C wrote:

> "Depressed and demented. Tearful.
>
> Can't accept that can't walk and that husband can't look after her.
>
> Not on melleril now …
>
> On 20mg Prozac
>
> ?Psych [psychiatric] opinion."

Mrs A's medical assessment notes at the first private hospital for 27 March state:

> "Tearful and miserable
>
> …
>
> She really is demented and depressed …
>
> I'm loathe to increase [Prozac] above 20mg …"

Dr C explained that he prescribed risperidone 1mg daily in March "because of increased hallucinations and being very unsettled at night and disturbing the other resident".

Dr C's medical records indicate that he considered seeking a psychiatric opinion for Mrs A in March 2001 in light of her deteriorating mental condition. However, Dr C was confident that Mrs A was exhibiting classical signs of dementia, which had been diagnosed during her admission to the public hospital. In these circumstances, Dr C decided that specialist review was required, either to confirm the diagnosis or to guide treatment. He stated:

> "It is not my practice to refer every patient under my care who's suffering from dementia for a geriatrician's opinion."

On 17 July, Dr C recorded (in the first private hospital medical assessment notes):

> "Aware that she 'went bonkers for a while' and that it has been seventeen weeks since I last visited
>
> Good pain, continue with MST
>
> Continue prozac and risperidone
>
> Still tearful."

Dr C's general practitioner records for 17 July make a corresponding entry and note that Mrs A "still admits" to depressive symptoms.

Ms B commented that her mother became more depressed and demented. She recalled:

> "Her GP [Dr C] was contacted by the family about this and he said there was nothing more that could be done about her depression as she was on the maximum dose of antidepressants possible."

Dr C disagreed that Mrs A became progressively more depressed and demented. He commented that her mental state was variable and some days she was bright and happy. In particular, when he reviewed Mrs A on 17 July 2001 she was lucid and her comment that "she had gone bonkers for a while" revealed insight into her fluctuating mental condition. Dr C explained that Mrs A was not on the maximum dosage of anti-depressants (and disputed that he made comments to that effect), but confirmed his reluctance to increase the dosage due to the potential side effects.

Dr C reviewed Mrs A on 11 September 2001 and noted that she was miserable and demented. He planned to continue with risperidone and fluoxetine (Prozac).

On 7 December 2001, Dr C made the following record concerning Mrs A (in his general practitioner records):

> "'Fighting fit' but always tearful when I see her.

In denial about legs.

Dementia? Ideas of confusion

? hallucinating — thought she saw me on TV."

(Dr C's medical assessment notes for 7 December 2001 also note the decision to continue with risperidone, fluoxetine and MST.)

Further relevant extracts from Dr C's medical records for 2002/2003 are as follows:

"• On 26 February 2002 [Dr C] recorded that [Mrs A] was stable and demented but comfortable. She 'cried as usual' when he visited.

- On 18 April 2002 [Dr C] noted that [Mrs A] was much more cheerful and was becoming more mobile.

- On 24 September 2002 [Dr C] recorded [Mrs A] was stable but in denial about her mobility.

- On 10 October 2002 [Dr C] noted that [Mrs A] was well with 'good and bad days' and making progress with walking.

- On 11 February 2003 [Dr C] noted that [Mrs A] was stable and cheerful."

On 10 April 2003 (and 22 July 2003), Mrs A was reviewed by a visiting consultant urologist, who noted that dementia was among the multiple possible sources for Mrs A's urinary incontinence.

On 14 April 2003, Dr C increased Mrs A's MST to 20mg twice daily as the lower dose was not controlling her pain. Dr C stated:

> "This was undertaken because [Mrs A], at the time, had a very painful right shoulder with a large bruise over the scapula which I thought may have [been] secondary to the hoist. I was also concerned at this point that she may be developing polymyalgia rheumatica and ordered an ESR which came back at 84 millimetres per hour on the low dose of 10mg Prednisone daily."

Dr C considered it "humane" to increase Mrs A's morphine dosage and noted that there was no subsequent record of any increase in dementia symptoms. On 8 August 2003 Dr C noted that Mrs A was stable and she was achieving good pain control on 20mg MST. On 5 September 2003 Dr C recorded that Mrs A "feels that she is depressed" and doubled her fluoxetine dosage.

On 26 September 2003, nursing staff at the first private hospital noted that Mrs A had exhibited "more paranoia" over the last few weeks and had been found trying "to injure

herself with a knife". Dr C was informed of the incident and, in response, reduced Mrs A's fluoxetine prescription. He stated:

> "… I had increased her Fluoxetine [on 5 September] because of increasing depressive symptoms two weeks earlier and her behaviour became more paranoid involving a vegetable knife. I thought at that stage it could be perhaps related to the increased dosage of Fluoxetine and therefore reduced again with the advice that if psychotic symptoms continued we would reintroduce r[i]speridone."

No further concerns about Mrs A's behaviour are documented in her medical records, following the reduction of fluoxetine. Dr C observed:

> "As you will see from the medical records she was seen at least three monthly on a regular basis. Some of the entries show she was demented during my visit. On other visits they show that in fact she was quite lucid. For example, the visit in July 2001 shows her to be quite lucid, whereas the visits in March 2001, September 2001, December 2001, February 2002, September 2002, all state that she was demented."

Dr C commented that the first private hospital did not express any concern about the treatment he provided Mrs A, and noted that in his experience nursing staff have a "fair idea" of whether doctors are fulfilling their obligations and are quick to ask for specialist opinion if they have any concerns. In addition he "enjoyed an excellent relationship" with Mr and Mrs A and "never at any time had any criticism from [Mr A] with regard to treatment of either himself or his wife …".

Dr C explained that he did not consider a drug holiday for Mrs A at any stage, as he did not consider her symptoms were iatrogenic (caused by treatment). He also did not consider Mrs A's acutely demented phases were associated with any specific illnesses or conditions.

On 23 October 2003, Mrs A was assessed by a facilitator from a support needs organisation. The facilitator (name unknown) noted that Mrs A exhibited fluctuating memory loss, and on occasion could be disorientated with episodes of paranoia and mild/occasional hallucinations.

On 30 October 2003, Mrs A was seen by a medical officer, who included "depression" and "increasing dementia" on the diagnosis list. The medical officer stated:

> "[Mrs A] is keen to move to [the city]. She has been at hospital level care for some months now. Although her mental state is variable she does not require dementia level care."

Move to second private hospital

Mr A had been experiencing increasing difficulties with his health and it was eventually decided that he and Mrs A would move to the city. On 4 November 2003, Mrs A was transferred to the second private hospital. Her new general practitioner, Dr D, reviewed her

medication regime and ceased Mrs A's prednisone and MST, and substituted codeine phosphate for pain management.

In November 2003, the community gerontology nurse visited the second private hospital and documented that Mrs A had short-term memory loss but no behavioural issues. Mrs A was regarded as being appropriately placed.

Ms B stated that her mother's condition improved significantly following her transfer to second private hospital:

> "[Mrs A's] mental and physical health improved rapidly after her MST was stopped. Her dementia and delirium ceased and she became lucid and aware.
>
> …
>
> I talked to her current GP [Dr D], and he told me [Mrs A] has never had dementia and that her previous excessive medication had caused her to hallucinate.
>
> …
>
> [Mrs A] now takes an active part in activities that she can manage. She listens to audio tapes from the library, engages with the residents and staff, goes swimming and regularly goes out on visits, and eats normal tasty food. Because of her experiences, [Mrs A] has become timid and unassertive.
>
> …
>
> I think that [Mrs A] was lucky to be moved to [a city] because on [the] information I received from medical staff in [a town], I would never have known that my mother's health could improve so dramatically."

Mr A died shortly after the move to the city, but was able to see Mrs A's condition improve.

Dr D confirmed that his general impression was that there had been an improvement in Mrs A's condition, particularly with the stopping of MST. He stated:

> "I can honestly say that in my assessment I have never seen aspects of dementia in [Mrs A]."

Dr D suggested that a more likely diagnosis for Mrs A's symptoms may be delirium, related to depression and anxiety, and has continued to prescribe risperidone (an antipsychotic agent) for Mrs A.

Independent advice to Commissioner

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

"**REPORT ON HDC COMPLAINT FILE 04/10605/WS**

Introduction

In order to provide an opinion to the Commissioner on case number 04/10605, I have read and agree to follow the Commissioner's Guidelines.

My opinion is based on my training in medicine and general practice, and my experience and ongoing CME as a rural general practitioner in Taranaki for over 30 years. This includes general practice care of patients in three rest homes, including hospital level beds. I do not have specific additional training in psychological assessment or psychogeriatrics. My qualifications are FRNZCGP, Dip Obstetrics (NZ) and DA(UK).

Purpose

To provide independent expert advice about whether general practitioner [Dr C] provided an appropriate standard of care to [Mrs A].

Background

The events surrounding the case are summarised in the Expert Advice notice. The summary relating to the consultations and actions taken by [Dr C] are repeated below as relevant.

Complaint /Issues under investigation

- *Whether [Dr C] conducted timely and appropriately review/s of [Mrs A's] dementia condition and medication regime.*
- *Whether [Dr C] sought appropriate specialist assessment for [Mrs A].*

Documents and records reviewed

Information from:

- Letter of complaint and accompanying document, from [Ms B], received 23 June 2004, marked 'A' (pages 1 to 5).
- Response to the Commissioner from [Dr C], with accompanying clinical records, dated 28 July 2004, marked 'B' (pages 6 to 63).
- Notes taken during a telephone conversation with [Mrs A] on 11 October 2004, marked 'C' (pages 64 and 65).
- Response to the Commissioner from [Dr C], dated 8 Dec 2004, marked 'D' (pages 66 to 68).

- [Mrs A's] clinical records from [the District Health Board] for her admission 17 January 2001 to 13 February 2001, marked 'E' (pages 69 to 178).
- Response to the Commissioner from [Dr D], with accompanying clinical records, dated 20 January 2005, marked 'F' (pages 179 to 332).
- Letter to the Commissioner from [Dr C], dated 10 February 2005, marked 'G' (page 333).
- Letter to the Commissioner, and accompanying documents, from [Dr D], dated 11 February 2005, marked 'H' (pages 334 to 350).

Expert advice requested:

To advise the Commissioner whether, in your expert opinion, [Dr C] provided [Mrs A] with services of an appropriate standard, including:

1. Was [Dr C's] prescription of MST for [Mrs A] in February 2001 appropriate?
2. Was it reasonable for [Dr C] to consider [Mrs A] was suffering from dementia?
3. Was the medication regime prescribed by [Dr C] for [Mrs A] appropriate?
4. Was [Dr C's] assessment and management of [Mrs A] appropriate when she started hallucinating, and her mental condition and behaviour deteriorated?
5. Did [Dr C] undertake appropriate reviews of [Mrs A]?
6. Should [Dr C] have sought specialist assessment of [Mrs A]? If so, when?
7. Should [Dr C] have undertaken a drug holiday or medication reduction programme? If so, when?
8. Was it appropriate that [Dr C] increased [Mrs A's] MST prescription to 20mg in April 2003?
9. Why do you consider [Mrs A's] symptoms have improved since her transfer to [the second private hospital]?
10. What further actions, if any, should [Dr C] have undertaken?

If, in answering any of the above questions, you believe that [Dr C] did not provide an appropriate standard of care, please indicate the severity of his departure from that standard. To assist you on this last point, I note that some experts approach the question by considering whether the providers' peers would view the conduct with mild, moderate, or severe disapproval.

Are there any aspects of the care provided by [Dr C] that you consider warrant additional comment?

General comments:

The course of events is clearly documented in the records and documents provided. [Mrs A] had been a patient of [Dr C] for over 10 years, both before and after her admission to [the first private hospital] in January 2001 (after her the public hospital admissions from 3 January–13 February because of weakness, vomiting and falls). His records indicate regular consultations approximately two-monthly, and suggest thorough competent management of her various conditions.

The complaints relate to [Dr C's] management during her time at [the first private hospital] (after discharge from hospital, during which she was clearly very ill with suspected septicaemia), but his previous knowledge and care of [Mrs A] are important factors in considering this case.

[Dr C's] records indicate that [Mrs A] had back pain from 1994, initially treated with paracetamol. She has a history of hip and knee replacements for arthritis, and sustained a fractured femur in 1998. During her January 2001 admission she had a haematemesis thought to be due to anti-inflammatory medication, which was stopped.

She was noted to be depressed in 1997, treated with prozac with improvement, and was on rivotril for restless legs at night. She was admitted to hospital several times in 2000 with atrial fibrillation, heart failure, weakness and urinary problems. No comment was made about her cognition or mental state. Dyspepsia was noted in 1993.

No nursing or medication records are available from [the first private hospital]. This limits my ability to clarify [Mrs A's] exact condition, and the actual analgesic medication administered.

The medication she was discharged on (and presumably remained on at [the first private hospital] after 13/2/01) was: frusemide, warfarin, metoprolol, pantoprazole, clonazepam, fluoxetine, fluticasone inhaler, trimethoprim, with a note to avoid NSAIDs [non-steroidal anti-inflammatory drugs]. Codeine and paracetamol were also prescribed.

Specific advice requested:

1. Was [Dr C's] prescription of MST for [Mrs A] in February 2001 appropriate?

[Dr C] states, and the notes confirm, that he authorised MST 10mg twice daily on 15/2/01 when her pain was not controlled by codeine. Although the hospital discharge summary did not mention pain or analgesic drugs, the discharge prescription lists codeine and paracetamol, both of which she had received in hospital. The hospital medication charts also list morphine elixir, given on an 'as required' basis (p 164), though not needed on the days prior to discharge. [Dr C] may have been aware of this previous morphine use, and was also aware of the contraindication to non-steroidal anti-inflammatory agents (which had induced gastric bleeding during her hospital stay).

Morphine is the appropriate analgesia to introduce if pain is not controlled by weaker analgesics, and when anti-inflammatory agents (NSAIDs) are contraindicated. No other strong analgesic has the efficacy and safety profile. The dose prescribed (10mg bd) is appropriate as a starting dose in a patient already on codeine 60mg several times daily with paracetamol and intermittent morphine elixir. This dose was continued without further adjustment for several months, suggesting that pain was reasonably controlled.

However no nursing records are available from [the first private hospital] to confirm this.

Records indicate that pain continued to be a problem. Morphine was stopped after discussion with [Mrs A's] daughter, but later paradex and codeine had to be augmented by the strong opioid analgesic tramadol (equivalent to morphine).

A point to be made is that [Dr C] states (p 0067) 'at this stage (19 Feb 2001) I had not received a Discharge Summary and cannot be sure that I was even aware that she was on morphine'. However this does not change my opinion stated above.

2. Was it reasonable for [Dr C] to consider [Mrs A] was suffering from dementia?

[Mrs A] was described by Dr C as: 'depressed and demented. Tearful. Can't accept that she can't walk and that husband can't look after her. Not on melleril now &? amt. On 20mg Prozac. ?psych opinion' (p 0014.5). In the rest-home notes he stated: 'tearful & miserable……she really is demented and depressed….I'm loathe to increase (fluoxetine) above 20mg….?' (p 0017). The referral for a psychiatric opinion was not carried out. The exact grounds for the diagnosis of dementia are not clear from the records, and no nursing notes are available. [Dr C] states that '[Mrs A] exhibited classical symptoms of dementia while she was in hospital and throughout the two years that she was in [the first private hospital]. She suffered from hallucinations, belligerence interspersed with passivity, poor memory with confabulation' …… 'her mental state was often variable. Some days ….bright reasonably cheerful, and even had the insight to state on 17 July 2001 "that she had gone bonkers for a while".' He also states that he 'assessed her cognitive ability in the normal fashion, ie. asking her what day of the week it was, who the Prime Minister was, what month of the year it was, what her home phone number was, etc etc'. There is no specific note of a cognitive test such as the MSQ.

She had been discharged on the antidepressant fluoxetine (prescribed for depression since 1997) and clonazepam (normally prescribed for anxiety or epilepsy). Melleril appears to have been prescribed by [Dr C] on 19/2/01 because of hallucinations especially at night, with a dose increase four days later (it is not clear if clonazepam was stopped, or melleril continued). In May risperidone was given (no reason specified in records but [Dr C] states that this was because of increased hallucinations and '… unsettled at night. … disturbing the other residents'). There was mention again of clonazepam from Nov 2002. However the exact medication regime over this period is not available.

[Dr C's] subsequent notes indicate a variable mental state, at times showing confabulation 'dementia -? ideas of reference, ? hallucinating, at other times showing insight' quote: 'went bonkers for a while' 'knows that it was 17/52 since I last visited'.

It should be noted that there is no indication of dementia or behavioural problems in the records, either before, during her hospital admission January 2001, or on the discharge summary. The only hospital cognitive assessment (performed on 30/1/01 by an

occupational therapist using 'Cognistat' to determine her ability to manage at home) noted orientation 10/12, attention within normal range, inconsistency in 2 and 3 step commands, but severe impairment of constructional ability and memory. Calculation and judgement showed mild impairment and abstract reasoning was within normal range (p 107). There is no mention of a specific cognitive test such as MMSE [Mini Mental State Exam]. This OT assessment suggests but does not prove significant global dementia. It is unlikely that [Dr C] had access to this report at the time of Mrs A's discharge; the discharge summary only stated that cognitive state fluctuated & 'muddled at times' (p 74).

Of note is the mention in the hospital notes (29/1/01, p 106) of the possibility of a CVA, with right arm weakness and neglect. It is clear that [Mrs A] was depressed much of the time, despite fluoxetine.

Although dementia was one possible cause of [Mrs A's] symptoms, I do not consider there was sufficient evidence to diagnose this with certainty on 27/3/01. Other causes of delirium should first have been excluded. In my opinion [Dr C] should have visited and performed a physical and mental assessment when hallucinations were reported on 19/2/01; it appears that he did not do so until 27 March. In addition I consider he used the term 'dementia' loosely to describe an undiagnosed mental dysfunction. This is particularly unwise when the term has major connotations with regard to prognosis.

Subsequent developments suggest continuing fluctuating cognition on a background of dementia. The cognition assessment on 23/10/03 notes '?dementia' (p 310) and 'variable memory loss and disorientation, with episodes of paranoia' (p 304), and the letter from [the public hospital] AT & R medical officer on 30 October 2003 (p. 45) lists 'increasing dementia' as a firm diagnosis, though not sufficient to require dementia level care. The transfer letter (4/11/03 — p 286) notes 'periods when she becomes very weepy & confused & disorientated as to time and place'. A further note states 'very lucid at time of assessment, but noted to wander and be confused as she tired …' A nurse assessment on 24/11/03 in […] (p 206) lists significant short term memory loss but no major behavioural issues. Her new GP [Dr D] states that he has never seen aspects of dementia (p 335). This suggests no great change in [Mrs A's] fluctuating mental state during 2001–2003, with continuation of memory deficit, but improvement in mental state subsequent to her move to [a city].

Delirium is the appropriate term to describe an abrupt and fluctuating change in mental state, associated with impaired cognition, inattention, and sometimes disorganised thinking, altered levels of consciousness, emotional changes, or hallucinations (ref 1). It can occur in a person with dementia, which is a non-fluctuating stable but slowly worsening memory failure.

Thus [Mrs A] appeared to suffer from poor memory (which could indicate early dementia), but clearly showed a fluctuating mental state, especially when tired, suggesting delirium. This seems to date from her January 2001 hospital admission, the cause is unclear, and the label 'dementia' unjustified at that stage without more formal

cognitive testing. Apart from the hospital OT assessment which reported 'severe' memory impairment, the degree of memory loss over the years in question, and the evidence on which [the public hospital] based the diagnosis in 2003, cannot be clearly determined.

In summary, although a primary feature of dementia, memory loss, appeared to be present, the apparent semi-acute onset, the periods of insight, and the fluctuation in mental state and symptoms, suggests delirium, and a possible reversible cause for her hallucinations and confusion. Even though early dementia may well have been present in 2003, it would appear that [Dr C] has made an assumption without clear justification, suggesting a moderate knowledge deficiency in this area, which is compounded by the apparently inadequate assessment noted below. [Dr C's] responses on 8/12/04 (p 67 — Question 9–10) regarding the variation between 'demented' and 'lucid' on successive visits, and 'acutely demented phases', tend to support this view.

3. Was the medication regime prescribed by [Dr C] for [Mrs A] appropriate?

Records are incomplete regarding the exact medication prescribed, but it is presumed that the hospital medications were continued at discharge on 13 February, with the addition of morphine (MST) (for pain not controlled by codeine) on 14 February, and melleril 10mg bd, metoclopramide and laxatives (presumably by phone) on 19 February. An antipsychotic such as melleril is appropriate to control symptoms such as agitation or hallucinations, although haloperidol is generally preferred. Other than lack of clarity about whether or not clonazapine was continued, I consider this medication regime to be appropriate though not ideal.

Morphine, to my knowledge, does not commonly induce hallucinations, although the sedation produced by morphine initially might precipitate confusion in someone predisposed by other medical conditions. However, narcotics are listed as one of the causes of delirium (ref 1), as are benzodiazepines (such as clonazepam), neuroleptics (eg melleril), and a number of other non-drug related conditions, but I would not expect an average general practitioner to be aware of the full list. It appears that these three drugs were prescribed over the period 2001–03. It is not therefore possible to determine if the various medications, or some other cause, induced the mental symptoms, although in retrospect, there appears to have been improvement when she moved to [the city] and stopped both agents.

Subsequent adjustments to medication (adjusting dose of fluoxetine, addition of risperidone) appear appropriate — both of these agents have been continued.

Overall, the initial and subsequent medication regimes were satisfactory, though not ideal, and I would not class this as a significant departure from normal general practice standards.

4. Was [Dr C's] assessment and management of Mrs A appropriate when she started hallucinating, and her mental condition and behaviour deteriorated?

It appears that [Mrs A] started hallucinating on 19 February. There is no record of [Dr C] visiting at this time, and the medication (melleril) was verbally prescribed. The appropriateness of this drug is discussed above. Also as stated above, I consider that a fuller assessment should have been performed sooner after her mental state deteriorated, rather than 5 weeks later on 27 March. However it is likely that [Mrs A's] mental state improved over this period; otherwise the staff [at the first private hospital] would have notified [Dr C]. If this is the case, failing to visit was not a serious deficiency in care.

Subsequent management during 2001 and 2003, including the addition of risperidone, appears to have been appropriate. At one stage [Dr C] says he increased the fluoxetine because of increasing depression, and later reduced it because of paranoid behaviour. I do not feel any additional measures were indicated, and there was no particular reason to suspect morphine or any other drug as a cause of her fluctuating symptoms.

5. Did [Dr C] undertake appropriate reviews of [Mrs A]?

Records indicate regular reviews every 2–3 months over the 10 years that [Dr C] was managing [Mrs A]. I would have expected more frequent reviews (at least monthly) for a few months after her hospital admission, particularly in view of the change in mental state, and only one visit (27 March) is recorded between 14 February and 17 July 2001. Visits every 2–3 months since then were at appropriate intervals. An additional deficit noted is the absence of any blood tests (such as renal function) during the months following [Mrs A's] hospital admission. Fluctuations in mental status could indicate delirium due to metabolic upset. However, several checks were done for urinary infections, another possible cause of delirium. My disapproval regarding this question is classed as 'mild'.

6. Should [Dr C] have sought specialist assessment of [Mrs A]? If so, when?

[Dr C] appears to have experience in managing medication regimes in elderly patients. His records and statements indicate that he was confident in the diagnosis of 'dementia' and that he instituted management, which appears to have been at least in part successful in controlling [Mrs A's] symptoms. He considered psychiatric referral on 27 March 2001, but did not proceed with this (no reason stated). Ideally, since [Mrs A's] mental state continued to fluctuate, a psychogeriatric referral should have been made during 2001. It is unclear as to whether any significant deterioration necessitating referral occurred over this period; none is recorded in the notes. I consider the lack of referral constitute a mild departure from the appropriate standard.

7. Should [Dr C] have undertaken a drug holiday or medication reduction programme? If so, when?

'Drug holidays' are not indicated for any of the medications prescribed; in fact in the case of fluoxetine, clonazepam, and morphine, as well as most of the cardiac drugs, sudden withdrawal is fraught with risk, or likely to produce rapid recurrence of

symptoms. Medication reduction is sometimes indicated if the patient is very stable, but [Mrs A's] fluctuating mental status would not suggest to me that medication reduction was indicated. The only other reason to reduce a drug would be when an adverse effect is suspected. Clearly [Dr C] did not consider that the case with [Mrs A]. Withdrawing morphine when the hallucinations started was a matter of clinical judgement, weighing up the likelihood of pain recurrence, against the small chance of a side effect. This is not considered a significant departure from appropriate standard[s].

8. Was it appropriate that [Dr C] increased [Mrs A's] MST prescription to 20mg in April 2003?

Records confirm that the increased dose was due to a painful bruised shoulder, and that the increased led to good pain control. The only other option was to add paracetamol; it is not clear if this was trialed before increasing morphine dose. Appropriate management, including checking the INR and ESR, was undertaken. Prednisone was prescribed for the suspected polymyalgia rheumatica, but the effect of this can be delayed. Adequate analgesia is more important than the possible side effect of increased drowsiness (and sometimes secondary confusion) produced by morphine dose increases. Normally the morphine dose would be reduced when pain becomes controlled; the records do not indicate if this was done.

9. Why do you consider [Mrs A's] symptoms have improved since her transfer to [the second private hospital]?

I am not able to determine the degree of improvement in [Mrs A's] symptoms from the information provided. As stated above, memory loss continued, although it appears that many of the fluctuating symptoms, including paranoia and disorientation clearly resolved. It is possible that the change in analgesic regime and the stopping of prednisone reduced her symptoms. Another possible reason would be improvement in her physical health or change in her environment.

10. What further actions, if any, should [Dr C] have undertaken?

Ideally, as mentioned above, a fuller physical and mental assessment should have been undertaken when the symptoms first presented, with referral when the fluctuating mental state continued despite the drugs prescribed. Otherwise, no other particular actions were in my opinion indicated.

Other issues:

Are there any aspects of the care provided by [Dr C] that you consider warrant additional comment?

[Dr C's] records overall suggest a caring and competent practitioner. However he appears to have a knowledge deficit regarding the difficult differentiation of dementia and delirium. I believe many GPs have trouble in this area, but if [Dr C] is responsible for elderly patients in rest homes, a clinical update in psychogeriatrics is suggested.

CONCLUSION

Overall, I would view with moderate disapproval [Dr C's] initial assessment and management of Mrs A in early 2001, but in other respects his actions are satisfactory for a general practitioner, apart from mild disapproval regarding several [of] the issues raised.

Ref 1: Guidelines for Care of Patients with Delirium, Canterbury DHB, 2002."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

Opinion: Breach — Dr C

Standard of care
Ms B complained that general practitioner Dr C misdiagnosed her mother, Mrs A, with dementia and over-medicated her during her stay at the first private hospital between January 2001 and November 2003. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) requires services to be provided with reasonable skill and care. In my view, Dr C should have undertaken, or sought, a more formal assessment of Mrs A's cognitive impairment to clarify whether there were any possible reversible causes for her fluctuating mental condition. Dr C made an unjustified

assumption that Mrs A had dementia and therefore breached Right 4(1) of the Code. The basis for my decision is set out below.

The development of cognitive impairment
Prior to her admission to the public hospital in January 2001, Mrs A had no history of cognitive impairment. However, Mrs A had a complex medical history which included osteoarthritis, double knee joint replacements, a right hip joint replacement and a fractured femur. Mrs A also had a history of depression, heart failure and renal impairment, and was on anti-coagulation therapy.

She was admitted to the public hospital on several occasions in 2000 and received treatment for her heart condition, leg weakness and urinary incontinence. No concern about her mental condition was noted during these admissions.

On 3 January 2001, Mrs A was admitted to the public hospital with vomiting, diarrhoea and increased leg weakness. On 5 January 2001, nursing staff documented signs of cognitive impairment and noted "muddled thoughts". Mrs A's constructional ability and memory were assessed by the occupational therapist as being "severely impaired". My expert advisor, Dr Carey-Smith commented:

> "It should be noted that there is no indication of dementia or behavioural problems in the records, either before, during her hospital admission January 2001, or on the discharge summary. The only hospital cognitive assessment (performed on 30/1/01 by an occupational therapist using 'Cognistat' to determine her ability to manage at home) noted orientation 10/12, attention within normal range, inconsistency in 2 and 3 step commands, but severe impairment of constructional ability and memory. Calculation and judgement showed mild impairment and abstract reasoning was within normal range. There is no mention of a specific cognitive test such as MMSE [Mini Mental State Examination]. This OT assessment suggests but does not prove significant global dementia."

Dementia symptoms
Mrs A was assessed as requiring permanent hospital-level care and on 13 February 2001 was transferred to the first private hospital. On 19 and 23 February, nursing staff at the first private hospital advised Dr C that Mrs A had been hallucinating at night. On 27 March, Dr C visited Mrs A at the first private hospital and observed that she was "demented and depressed". Dr C considered seeking a psychiatric opinion but did not do so. He was confident in his ability to recognise and manage dementia. He commented that, during her time at the first private hospital, Mrs A exhibited classic dementia symptoms, including hallucinations, belligerence interspersed with passivity and poor memory with confabulation. He reviewed Mrs A at regular intervals and assessed her level of cognitive impairment by asking her simple questions. He considered that Mrs A's mental state was variable and at times she was cheerful and lucid, although she was often tearful and depressed.

Dr C also stated that his treatment of Mrs A was based to "a large extent" on decisions made while she was a patient at the public hospital, where she was diagnosed with dementia after a thorough assessment by an occupational therapist.

My advisor commented that there was no record of any standard cognitive test for dementia being undertaken by Dr C. He stated:

> "Although dementia was one possible cause of [Mrs A's] symptoms, I do not consider there was sufficient evidence to diagnose this with certainty on 27/3/01. Other causes of delirium should first have been excluded. In my opinion [Dr C] should have visited and performed a physical and mental assessment when hallucinations were reported on 19/2/01; it appears that he did not do so until 27 March. In addition I consider he used the term 'dementia' loosely to describe an undiagnosed mental dysfunction. This is particularly unwise when the term has major connotations with regard to prognosis."

Mrs A's medical records confirm that she experienced a fluctuating mental state while at the first private hospital. Dr C stated:

> "As you will see from the medical records she was seen at least three monthly on a regular basis. Some of the entries show she was demented during my visit. On other visits they show that in fact she was quite lucid. For example, the visit in July 2001 shows her to be quite lucid, whereas the visits in March 2001, September 2001, December 2001, February 2002, September 2002, all state that she was demented.
>
> …
>
> You will see from the clinical records that [Mrs A] did not specifically become more depressed and demented and that her mental state was often variable. Some days she was bright, reasonable cheerful, and even had the insight to state on 17 July 2001 'that she had gone bonkers for a while'."

My advisor considered that the medical records suggest there was no significant change in Mrs A's variable mental state during her time at the first private hospital and that her mental state was more indicative of delirium than dementia. He stated:

> "Delirium is the appropriate term to describe an abrupt and fluctuating change in mental state, associated with impaired cognition, inattention, and sometimes disorganised thinking, altered levels of consciousness, emotional changes, or hallucinations (ref 1). It can occur in a person with dementia, which is a non-fluctuating stable but slowly worsening memory failure.
>
> Thus [Mrs A] appeared to suffer from poor memory (which could indicate early dementia), but clearly showed a fluctuating mental state, especially when tired, suggesting delirium. This seems to date from her January 2001 hospital admission, the cause is unclear, and the label 'dementia' unjustified at that stage without more formal cognitive testing. Apart from the hospital OT assessment which reported 'severe' memory impairment, the degree of memory loss over the years in question, and the

> evidence on which [the public hospital] based the diagnosis in 2003, cannot be clearly determined.
>
> **In summary**, although a primary feature of dementia, memory loss, appeared to be present, the apparent semi-acute onset, the periods of insight, and the fluctuation in mental state and symptoms, suggests delirium, and a possible reversible cause for her hallucinations and confusion. Even though early dementia may well have been present in 2003, it would appear that [Dr C] has made an assumption without clear justification, suggesting a moderate knowledge deficiency in this area, which is compounded by the apparently inadequate assessment …"

My advisor considered that, ideally, Mrs A should have been referred for specialist assessment after her mental condition fluctuated throughout 2001. Dr C's regular reviews at two- to three-monthly intervals were appropriate, although Mrs A should have been reviewed more frequently following her initial transfer to the first private hospital. Blood tests (eg, for renal function) should have been taken during these months following her transfer to the first private hospital.

Medication regime/prescription of morphine

Ms B was concerned that her mother's medication regime while at the first private hospital made her increasingly disorientated and depressed, and that the prescription of morphine caused hallucinations. Mrs A was prescribed morphine elixir in January 2001 while in the public hospital to alleviate muscular-skeletal pain. On 15 February 2001, Dr C prescribed MST 10mg daily for control of muscular-skeletal pain. In April 2003, Dr C increased Mrs A's morphine dosage to 20mg, because of her shoulder pain.

Dr C did not consider that there was any relationship between the contemporaneous development of hallucinations in February and his prescription of morphine. In response to reports by staff at the first private hospital that Mrs A had been hallucinating, Dr C prescribed Melleril in February 2001 (antipsychotic medication for anxiety and depression) and risperidone in May 2001 (antipsychotic medical for behavioural disturbances). Dr C increased Mrs A's antidepressant medication in September 2003 but subsequently reduced it after the development of symptoms of paranoia. Dr C did not consider her symptoms were iatrogenic. He stated:

> "She [Mrs A] did not suddenly develop an acute toxic confusion state. Because she has a long history of depression which I treated with Fluoxetine 10mg and later increased to 20mg I did not feel that she was suffering from pseudo-dementia."

My advisor was not provided with a copy of Mrs A's nursing records or medication charts from the first private rest home and hospital, which limited his ability to ascertain the exact medication regime Mrs A received. (He assumed that Mrs A's hospital discharge medications were continued by Dr C.) However, Dr Carey-Smith considered it appropriate for Dr C to prescribe morphine for Mrs A, particularly in circumstances where anti-inflammatory agents were contraindicated. Morphine is not known to cause hallucinations, and adequate analgesia is more important than the possible side effect of increased drowsiness (and occasional secondary confusion) produced by morphine dose increases.

My advisor stated:

> "No other strong analgesic has the efficacy and safety profile. The dose prescribed (10mg bd) is appropriate as a starting dose in a patient already on codeine 60mg several times daily with paracetamol and intermittent morphine elixir. This dose was continued without further adjustment for several months, suggesting that pain was reasonably controlled."

An increased dosage of MST (20mg) was provided in April 2003 for Mrs A's painful bruised shoulder, and led to good pain control.

It appears that the medications introduced by Dr C to control Mrs A's hallucinations were generally appropriate. My advisor regarded the medication regime prescribed by Dr C for Mrs A as satisfactory, but not optimal. He stated:

> "An antipsychotic such as melleril is appropriate to control symptoms such as agitation or hallucinations, although haloperidol [antipsychotic for severe symptoms] is generally preferred. Other than lack of clarity about whether or not clonazapine [anticonvulsant] was continued, I consider this medication regime to be appropriate though not ideal.
>
> …
>
> Subsequent management during 2001 and 2003, including the addition of risperidone, appears to have been appropriate. At one stage [Dr C] says he increased the fluoxetine because of increasing depression, and later reduced it because of paranoid behavour. I do not feel any additional measures were indicated, and there was no particular reason to suspect morphine or any other drug as a cause of her fluctuating symptoms."

Mrs A's mental condition appears to have improved following her transfer to the second private hospital in November 2003, with the resolution of paranoia and disorientation, together with an apparent continuation of her memory deficit. Dr Carey-Smith commented:

> "… [N]arcotics are listed as one of the causes of delirium (ref 1), as are benzodiazepines (such as clonazepam), neuroleptics (eg melleril), and a number of other non-drug related conditions, but I would not expect an average general practitioner to be aware of the full list. It appears that these three drugs were prescribed over the period 2001–03. It is not therefore possible to determine if the various medications, or some other cause, induced the mental symptoms, although in retrospect, there appears to have been improvement when she moved to [the city] and stopped both agents.
>
> …

> It is possible that the change in analgesic regime and the stopping of prednisone reduced her symptoms. Another possible reason would be improvement in her physical health or change in her environment."

Overall, my advisor considered Dr C demonstrated a lack of knowledge concerning the "difficult differentiation of dementia and delirium". He should have provided a fuller assessment when Mrs A developed symptoms of cognitive impairment and reassessed her when her mental symptoms continued to fluctuate. In all other respects, Dr C provided competent care.

Conclusion

Mrs A was assessed by the public hospital occupational therapist as having severe impairment of constructional ability and memory. Other aspects of her cognitive abilities, such as abstract reasoning and orientation, were in the normal range, although some were mildly impaired. However, Mrs A did not receive a formal diagnosis of dementia from specialist medical staff while in hospital. The occupational therapy assessment was indicative but not determinative of significant global dementia. Many of Mrs A's fluctuating symptoms have now resolved following the review of her medication regime, although a variety of factors may have contributed to this improvement.

Dr C assessed Mrs A's mental state by asking her simple questions during his two- to three-monthly reviews. He continued treatment "based to a large extent" on the occupational therapy assessment. My advisor considered Dr C was unwise to describe Mrs A as demented, even though early dementia may have been present. The continual fluctuation in Mrs A's mental state was suggestive of delirium and a possible reversible cause. My advisor noted with mild disapproval that Dr C did not conduct any blood tests to rule out possible physical causes such as renal failure. Dr C should have sought specialist review after it became evident that Mrs A's mental state was variable. Apart from these shortcomings, Dr C's overall management of Mrs A's complex conditions, including her medication regime, was generally appropriate. In particular, the prescription of morphine as an alternative to anti-inflammatory medication was appropriate and unlikely to have caused or contributed to the development of hallucinations.

In my view, Dr C competently managed Mrs A's various medical conditions over a long period of time. Unfortunately, Dr C made an unjustified assumption that Mrs A was suffering from dementia. In this respect, Dr C should have assessed and reviewed Mrs A more carefully. His failure to do so amounts to a breach of Right 4(1) of the Code.

Actions taken

Dr C confirmed that he has reviewed his practice in light of this case and now refers all patients under his care who have dementia symptoms for geriatric assessment.

Dr C has undertaken to update his clinical skills in psychogeriatrics by undertaking a suitable postgraduate course.

Recommendations

I recommend that Dr C:

- apologise to Mrs A and her family for his breach of Code;
- update his clinical skills in psychogeriatrics, by undertaking a suitable postgraduate course.

Follow-up actions

- A copy of my report will be forwarded to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners.

- A copy of my report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.