HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC01771)

Introduction 1
Background 2
Opinion: Dr A — breach 6
Changes made since events 15
Recommendations 15
Follow-up actions 15
Appendix A: Independent clinical advice to Commissioner 16

Introduction

1. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to Mx B by psychiatrist Dr A. Mx B raised concerns to HDC about the psychiatry assessment and diagnosis of anxiety and depression Mx B received from Dr A. In making this complaint, Mx B questioned whether Dr A missed a diagnosis of attention deficit hyperactivity disorder (ADHD),[1] also raising concerns with the overall communication Mx B had with Dr A.

3. The following issue was identified for investigation:

- *Whether Dr A provided Mx B with an appropriate standard of care in 2021.*

4. The parties directly involved in the investigation were:

Dr A	Provider
Mx B	Consumer

[1] ADHD is a chronic condition including attention difficulty, hyperactivity, and impulsiveness. Often it begins in childhood and can persist into adulthood.

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5. Dr C, Mx B's general practitioner (GP), is also referred to in the report.

6. As part of my assessment of this complaint, I sought independent psychiatry advice from Associate Professor Giles Newton-Howes (Appendix A). I obtained in-house guidance from Dr David Maplesden.

Background

7. Mx B (aged in their thirties at the time of these events) was referred by GP Dr C to Dr A for a 'psychiatry assessment'. Dr C noted Mx B's mental health history,[2] recent withdrawal from migraine medication,[3] and current symptoms of difficulty sleeping and 'intrusive thoughts',[4] among others. The referral concluded: '[Mx B] thinks [they] may have ADHD and I would be most grateful if you could assess [Mx B].'

8. Mx B saw Dr A on two occasions via a video call — first on 18 March 2021 and secondly on 29 April 2021. Mx B's initial complaint to HDC states that at the second video-call appointment, a 'comprehensive assessment' was requested.

9. Prior to the first appointment, Mx B was provided with an Adult ADHD Self-Report Scale (ASRS-V1.1) self-assessment by Dr C, which involves answering 18 questions and is a screening tool to identify people who would benefit from a professional assessment for ADHD. Mx B's self-assessment showed a 'positive' result.[5] Dr A told HDC that Mx B's questionnaire 'results were suggestive of ADHD', but he said that 'this is a screening test and the authors of it do not claim that it is diagnostic'. Mx B's initial complaint stated that 'no screening had been completed by [Dr A]' and in response to my provisional opinion, Mx B again stated that the ASRS-V1.1 was never sent to them by Dr A, nor any other screening tools until Dr A sent the Conners assessment form[6] on 6 May 2021.

10. During the first video-call appointment on 18 March 2021, Dr A met with Mx B for 90 minutes to discuss Mx B's concerns and symptoms. Dr A's notes from this appointment state that Mx B's symptoms included previous migraines, a 10-year history of generalised anxiety disorder diagnosed in 2007 and the use of venlafaxine,[7] which had been withdrawn, considerable problems with insomnia,[8] procrastination, impulsive spending, decreased concentration and low frustration tolerance, being disturbed daily by noises and smells,

[2] History of … (removed for privacy reasons), mood disorder, and anxiety disorder.
[3] Amitriptyline and venlafaxine, both of which are used to treat depression and general anxiety disorder. Mx B clarified that they were prescribed amitriptyline for migraine prevention.
[4] Mx B told HDC that they did not have any experiences of intrusive thoughts, but did at times experience hyper-fixation or active mind — internal hyperactivity.
[5] A positive result means that the screening tool identified symptoms indicative of ADHD. Mx B scored 66 out of 72, and '[t]he higher the point total, the greater the likelihood that [the person] show[s] signs of attention deficit disorder'.
[6] The Conners rating scale is a questionnaire that focuses on behaviour and social and academic issues and can help diagnose attention deficit hyperactivity disorder (ADHD).
[7] A medication used to treat depression, general anxiety disorder, social anxiety disorder, and panic disorder.
[8] A sleep disorder that can make it hard for a person to fall asleep or stay asleep.

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trichotillomania,[9] and possible ADHD. Dr A told HDC that much of this appointment involved an explanation of Mx B's difficult life history. Dr A stated: '[W]hen taking a history such as this I tend to let the patient tell their story without a lot of direct questions.' During this appointment, Mx B voiced concerns that they may be suffering from ADHD or an autistic spectrum disorder.[10] Dr A told HDC that after his first assessment with Mx B, he gained a strong impression that Mx B's symptoms were predominately related to anxiety and depression. However, under the title 'conclusion' in his handwritten notes of 18 March 2021, Dr A wrote '?ADHD' and noted that he had requested Mx B's school reports. Dr A told HDC that when he considers a possible ADHD diagnosis, he bases this on interviews, and he finds old school reports a helpful tool, as often symptoms of ADHD are worse during childhood.

11. In response to my provisional opinion, Mx B provided evidence that clarified that they provided their school reports to Dr A's office in jpeg format at 9.20am on 17 March 2021 — the day prior to the initial appointment. The email thread also confirmed that at 10.27am on 18 March 2021, Dr A's office confirmed that the reports were passed on to Dr A prior to the initial appointment.

12. On 21 March 2021, Mx B sent Dr A additional information relating to their symptoms and what they felt had not been said during the appointment. Mx B also noted in the email to Dr A that their partner and father would be happy to talk to Dr A as part of the assessment process if necessary.

13. Dr A reviewed the reports and assignments provided by Mx B after the first appointment and concluded: '[These indicate a] teenager working diligently under difficult circumstances. This argues strongly against a diagnosis of ADHD.'

14. In response to my provisional opinion, Mx B told HDC:

> 'At the end of the first appointment there was no indication that there would be any further appointment or assessing. This led me to feel I had to write to [Dr A] providing more information about my experiences as I felt they were important to be considered and hoped to be granted more time to be assessed more fully.
>
> …
>
> Had time been given to discuss my school experiences, [Dr A] would have been able to consider the [school] reports in context.'

15. Dr A sent a summary of his findings to Dr C on 22 March 2021 outlining what was discussed in the initial appointment. Within this letter, Dr A stated that he interviewed Mx B via a video call, 'which is useful, but difficult to fully assess mood'. Dr A considered that the problems described by Mx B 'could be caused by ADHD but could also be the result of depression'. He

[9] Also known as 'hair pulling disorder'. It is a mental health condition that involves frequent, repeated, and irresistible urges to pull out hair from the scalp, eyebrows, or other areas.

[10] A neurological and developmental disorder that affects how people interact with others, and how they communicate, learn, and behave.

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concluded by noting: '[A]t the time of writing I am a little uncertain as to how to proceed and shall re-read the available information before reaching a decision.'

16. Mx B did not hear from Dr A after sending the additional pages of information and emailed him again on 13 April 2021 and asked when a report from the appointment could be expected. Dr A responded to this email on 14 April 2021 setting up a second appointment with Mx B. On 19 April 2021, Dr A emailed Mx B again. Dr A thanked Mx B for the additional documentation and advised that it had been useful and that he continued to deliberate on the question of an ADHD diagnosis, noting that many of Mx B's 'symptoms could also be explained by a mood disorder'.

17. Dr A arranged a second 60-minute video-call appointment with Mx B free of charge on 29 April 2021. In response to my provisional opinion, Mx B said: 'I was happy for the offer of an additional assessment session and open to explore "mood disorders" as Dr A indicated was needed in his email.' Dr A told HDC that he offered to see Mx B again free of charge because of the likelihood of conflict and advised that their partner could attend the appointment to assist with gathering a collateral history. Mx B told HDC that their partner was not questioned and involved in this appointment and 'was only able to share some information after I insisted'. However, Dr A responded to this concern saying: 'This interview was difficult, but [Mx B's partner] did participate in a useful discussion of the causes of the lack of motivation.'

18. Mx B said that during this appointment, Dr A said, 'I think you have depression.' Mx B told HDC: 'I stated my unhappiness of the quality of the assessment [and] stressed that I wanted him to conduct a comprehensive assessment.' During the appointment, they also discussed Mx B's perceived benefits from the anti-depressant Efexor (prolonged-release venlafaxine). Mx B said that when replaced by the generic venlafaxine, the effects of this could no longer be felt. Dr A told HDC that this observation strongly supported a diagnosis of anxiety and depression, although Mx B still felt that an ADHD diagnosis was likely.

19. During this appointment, Mx B expressed unhappiness about how Dr A had conducted the first video-call appointment. Mx B said that another psychiatrist had been contacted for a new assessment. Dr A stated that during this appointment, Mx B did not engage with his attempts to focus on mood disorder. Dr A told HDC that after the second appointment, he still maintained the belief that Mx B was suffering from anxiety and depression, and he stated that he 'felt pressured into diagnosing ADHD'. Dr A said: 'I do not agree with [Mx B's] suggestion that I didn't do a thorough assessment.' Further, Dr A stated:

> '[Mx B] believed [they] had ADHD, and had effectively self-diagnosed [themself] with ADHD prior to our consultation and was resistant to enquiry in directions other than ADHD which made a standard psychiatric assessment difficult, if not impossible to perform.'

20. Dr A told HDC that their 'disagreement over diagnosis led to a breakdown of the therapeutic alliance'.

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21. Following this second appointment, Dr A emailed Mx B on 29 April 2021 with a copy of the initial letter that had been sent to Dr C. In the covering email to Mx B, Dr A stated briefly: '[T]he antidepressant we talked about was bupropion and the migraine treatment was Imigran.[11] The anti-anxiety treatment was pregabalin.' Dr A also wrote another letter to Dr C regarding the medication information discussed (pregabalin and sumatriptan) and his recommendations.

22. The letter to Dr C dated 6 May 2021[12] summarised the second appointment with Mx B and Mx B's partner and said that Dr A 'felt that [Mx B's] problems were more likely to be due to either depression or anxiety'. This letter also outlined that Mx B 'might respond well to' pregabalin [13] and suggested sumatriptan [14] for migraine, although the reason, dose, expected effect, and side effects of these medications are not detailed in the letter. Dr A advised Dr C that he had discharged Mx B from follow-up.

23. In response to my provisional opinion, Mx B told HDC that during the first assessment, pregabalin was suggested as migraine prophylaxis. Mx B said that it was only in the email of 29 April 2021 that pregabalin was mentioned to treat anxiety, and throughout the session anxiety was not mentioned, rather the focus was on depression. Mx B stated that they did not receive a copy of the letter to Dr C and is unaware of Dr A's rationale for considering that depression/anxiety was the 'more likely' diagnosis.

24. In relation to the notes taken throughout the two consultations, Dr A told HDC that they are more of an 'aide-memoire[15]' being handwritten and are different to what might be seen in the public sector. Dr A stated that his notes are reflective of the fact that he operates in a private capacity.

25. Dr A told HDC that Mx B presented with a complex scenario that would have required several consultations to fully explore different diagnoses. He stated that he was not given the opportunity, as 'discussion during [their] second appointment was unproductive' as Mx B was resistant to any line of enquiry unrelated to ADHD. Dr A said that 'a formulation was impossible under these circumstances', which is the prerequisite to forming a plan. Dr A stated: '[M]y suggestions to the GP were just that, suggestions for the GP to consider rather than a management plan.'

26. Dr A told HDC that in advance of seeing a consumer, 'usually [he] use[s] the Conners forms [as a diagnostic tool for ADHD] although this is a little time consuming'. After the second appointment, on 6 May 2021 Dr A emailed Mx B stating that he was sending a self-assessment form (the Conners form) for screening of ADHD and advising that Mx B would

[11] Imigran is a brand name for sumatriptan.

[12] Dr A told HDC that this letter was written on 6 May 2021, but there was an administration error with a new staff member, and the second letter was not posted until late July 2021. Despite noting that this letter was posted in late July 2021, Mx B told HDC that as of 26 November 2021, the letter had not been received. Dr C's practice provided HDC with a copy of Dr A's letter of 6 May 2021 stamped with 5 August 2021 as the date received.

[13] A medication used to treat epilepsy, anxiety, and nerve pain.

[14] A medication used to treat acute migraine in adults.

[15] A written summary or outline used to aid the memory and serve as a reminder.

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be provided with a copy of the final letter to Dr C once completed. However, Mx B did not return the Conners form, as Mx B had lost faith in the process.

27. In response to Dr A's email, on 6 May 2021 Mx B wrote to Dr A outlining their experience with the assessment and lack of communication and advising that another psychiatrist had been engaged as Mx B did not agree with the diagnosis of anxiety and depression. In this letter, Mx B also invited Dr A to reflect on the feedback provided and share his thoughts on this.

28. Dr A responded to this email thanking Mx B for the feedback. He told HDC that he did not respond to the concerns raised by Mx B as he did not agree with the views and did not see the benefit in doing so. He also said that he did not consider this email to be a formal complaint.

Responses to provisional opinion

Mx B

29. Mx B was given the opportunity to comment on the 'Information gathered' section of the provisional report. Mx B stressed that their concern was over the standard of the assessment and that they received no written or verbal information about the diagnostic criteria Dr A used in his assessment.

30. Mx B also told HDC:

> 'I wanted to be able to discuss and better understand my symptoms. I was not attached to being diagnosed or any diagnosis, but as ADHD can only be assessed and diagnosed by a psychiatrist, a psychiatrist was sought. It's a real "catch 22" as an adult wondering if you might have ADHD. To get an assessment to include consideration of ADHD, you first need to request that and see the appropriate professional. By requesting for ADHD to be considered, you then get accused of self-diagnosing.'

31. Additional comments made by Mx B have been incorporated into this report where relevant.

Dr A

32. Dr A was provided with a copy of my provisional decision for comment; however, he had no further comments to make.

Opinion: Dr A — breach

Introduction

33. Dr A has a responsibility to provide his patients with healthcare services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code). I have carefully considered all the information gathered, including independent psychiatric advice from Associate Professor Newton-Howes and responses from Dr A, and I set out my decision and the reasons for it below.

34. At the outset, I acknowledge the lack of clinical documentation in this case, which has notably affected my ability to obtain clarity on Dr A's assessment during the two

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appointments. This is further complicated by the different recollection of events between the parties.

Adequacy of psychiatry assessment

35. Mx B believed that a comprehensive assessment was to be undertaken, rather than an assessment solely to determine a diagnosis of ADHD. Mx B's view is that Dr A did not explore their concerns adequately, particularly in the second assessment.

36. First, I will comment on the purpose of the referral. The referring clinician wrote to Dr A requesting a 'psychiatric assessment' and noting Mx B's current functional challenges, medical and mental health history, and recent medication changes. The referral noted that Mx B thought 'they may have ADHD' and 'would be most grateful if [Dr A] could assess [Mx B]'. My in-house clinical advisor noted that as the referral set out Mx B's symptoms and provided a psychiatric background, the intention appears to have been for Dr A to conduct a full mental health psychiatric assessment, with consideration given to ADHD.

37. This is supported by my independent advisor, Associate Professor Newton-Howes, who stated that based on the referral information provided to Dr A, he would be examining 'the possibility of a depression and anxiety diagnosis, a trauma-based diagnosis (on the basis of early life experience), and neurodiversity including both attention deficits/hyperactivity and autistic traits'.

38. I agree with the above advice. Taking into consideration the detail of the referral, it would be reasonable to conclude that the expectation was that a comprehensive psychiatric assessment would be undertaken with additional consideration of ADHD within the overall assessment.

Gathering of information

39. This section considers whether Dr A gathered all the appropriate information from Mx B during the assessments, and collateral information from Mx B's partner.

40. Associate Professor Newton-Howes noted that the standard features of a comprehensive psychiatric assessment include details of medical or past psychiatric history, alcohol and drug history, and family history of mental disorder. It is also standard practice for a collateral history to be gathered from those close to the patient to help the psychiatrist gain an understanding of how the patient was functioning before the assessment.

41. The 'Adult Attention Deficit Hyperactivity Disorder Practice Guidelines' in place at the time of these events state that '[a] discussion with partners and family members about problems specifically related to ADHD symptomatology should also form part of the assessment process'.

42. Dr A told HDC that in the first appointment, Mx B provided a clear history and was fully cooperative. The handwritten notes from the initial appointment stated: '[Mx B] to write down any symptoms that [they] found difficult to discuss.' After the initial appointment, Mx B sent an email to Dr A stating: '[T]here is a lot of stuff I did not get to say about the struggles I continue to have today and are the priority for me to find a way to better manage.'

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43. The clinical notes show that on 18 March 2021 Mx B sent further information to Dr A and asked whether he wanted 'the contact details of those close to [Mx B] to corroborate what's going on'. Mx B emailed Dr A again on 21 March following up on the previous email and sending an updated version of the notes written previously, as Mx B felt that the assessment interview had not provided a full opportunity for this. This email again stated that Mx B's family and partner were happy to talk to Dr A as part of the assessment, and contact details were provided. I am critical that there is no evidence to suggest that Dr A contacted either Mx B's partner or father at this stage, despite being provided with the opportunity to do so.

44. Dr A told HDC that a second appointment was arranged with Mx B 'in view of the likelihood of conflict', but given the breakdown of the therapeutic relationship, much of the second appointment was unproductive. Dr A told HDC that Mx B's partner was present at the second appointment to provide collateral information, although there is a difference regarding the degree and purpose of their participation. Dr A stated that '[Mx B's partner] did participate in the second appointment' and 'participate[d] in a useful discussion of the causes of a lack of motivation'. However, in contrast, Mx B told HDC: '[Dr A] did not ask my partner any questions even when I stated [they were there] for that purpose.' Nor did Dr A contact Mx B's father, although Mx B had provided his phone number.

45. Associate Professor Newton-Howes noted that it was 'good practice' to have arranged the second appointment and invited Mx B's partner. I agree that this was appropriate so that Mx B's partner could help to resolve Mx B's concerns and provide further information.

46. However, it appears that the second appointment was unsuccessful in its aims, particularly regarding the gathering of relevant collateral information from Mx B's partner. Associate Professor Newton-Howes advised that it was 'unusual that [Dr A] did not interview the patient's partner', nor was there any effort made to contact previous mental health providers or look into whether Mx B had a sensitive ACC claim. Associate Professor Newton-Howes considers this to be a moderate departure from the acceptable standard of care.

47. I am concerned at the lack of clinical documentation relating to the second appointment and the significant difference in recollections as to how much Mx B's partner contributed to discussions. I acknowledge the difficulties faced by psychiatrists when obtaining information, particularly if the relationship breaks down, as Dr A has noted was the case. Accordingly, whilst I recognise my advisor's view, I consider that I am not in a position to make a finding of fact on the extent to which Dr A explored Mx B's concerns, and how much Mx B's partner participated in the second appointment. However, if Mx B's partner was present and was not asked to provide collateral information, I would be critical of this.

Formulation and diagnosis

48. This section examines the formulation of the diagnosis given to Mx B, including the consideration given to ADHD and Dr A's conclusions about anxiety and depression.

49. I acknowledge Dr A's response that he did not provide a formal diagnosis for Mx B and that diagnosis would have required some time and several appointments. However, as identified by Associate Professor Newton-Howes, I am concerned that Dr A did not use classifiers such

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as 'possible' or 'probable' in relation to Mx B's diagnosis, which would have had a significant impact on what was understood by Mx B. Mx B told HDC that it was a shock to view the final report that provided a diagnosis of anxiety and depression, as they felt it was a hasty conclusion without adequate consideration of Mx B's history. In response to the provisional decision, Mx B told HDC that it was only in the email of 29 April 2021 that pregabalin was mentioned to treat anxiety, and that throughout the session anxiety was not mentioned, rather the focus was on depression. I accept Associate Professor Newton-Howes' advice that the use of classifiers would have been useful for Mx B and Dr C to ascertain the probable diagnosis while also appreciating that it was not a definitive diagnosis.

50. Given the dispute over the diagnosis of anxiety and depression, I consider it important to review the adequacy of the formulation, including the consideration given to a diagnosis of ADHD. Mx B's stated 'expectation was to receive a detailed report outlining the tools used during the assessment and all conclusions reached that formed [Dr A's] end diagnosis'.

51. Mx B expressed concern that a comprehensive ADHD evaluation did not occur, as there was no structured or semi-structured interview or a review of diagnostic criteria. Mx B felt that much of the first appointment inappropriately focused on Mx B's difficult childhood and migraines.

52. Dr A told HDC that Mx B returned a 'positive' result on the ADHD screening questionnaire (ASRS-V1.1) completed prior to their first appointment.[16] However, Mx B disputes this and told HDC that this questionnaire was provided by their GP. I acknowledge Dr A's comment that this tool is not diagnostic, and, although a psychiatrist may not rely solely on the results of self-assessments, I consider that they are useful in aiding the overall diagnostic picture of the patient.

53. Dr A's clinical documentation refers to ADHD several times, including the notes from the first appointment, which state, '? Possible ADHD', and, at the end '? ADHD school reports requested'. Dr A told HDC that he requested school reports because often the symptoms of ADHD are more prevalent in childhood.

54. Dr A's consideration of ADHD is also outlined in his correspondence with the referrer, Dr C. After the initial appointment, Dr A wrote to Dr C saying, '[Mx B] complains mainly of symptoms that could be ADD[17]' and that '[Mx B's] case is complex … [Mx B] clearly described problems concentrating that could be caused by ADHD but also could be the result of depression.' After this appointment, Dr A also emailed Mx B stating: 'I continue to deliberate on the question of ADD. One problem is that many of your symptoms could also be explained by a mood disorder.'

[16] For this assessment, Mx B scored 66 out of 72, and the assessment states that 'the higher the point total, the greater the likelihood that [the person] show[s] signs of attention deficit disorder'. Dr A told HDC that 'the results were suggestive of ADHD' but noted that this is a screening test, and the authors do not claim it is diagnostic.

[17] Attention deficit disorder is used to denote inattention as the primary feature of the disorder without features of hyperactivity.

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55. In his final letter to Dr C, Dr A concluded:

> '[Mx B's] school reports were not entirely consistent with that diagnosis [of ADHD]. One or two comments could be interpreted as being part of Attention Deficit Disorder, but my greater impression was of an adolescent [child] who was working diligently and getting reasonable results despite a very difficult background situation.'

56. At this time, Dr A provided Mx B with the Conners questionnaire. Dr A told HDC that he uses this questionnaire to assess ADHD, but it was sent after the second appointment, after which Mx B wanted no further contact, and the forms were not returned. Dr A said that as the forms were not completed, he was 'unable to provide any further clarity on the possible diagnosis of ADHD'.

57. It is unclear why Dr A did not follow his usual process in this case and send the Conners questionnaire to Mx B prior to the initial appointment, and instead sent this after the second appointment. Mx B told HDC that the questionnaire was not returned to Dr A because trust in the assessment process had been lost, and Mx B believes the questionnaire should have been provided at the first session. I am critical that Dr A did not adhere to his usual process and provide the Conners questionnaire to Mx B prior to the initial appointment to act as a further tool in considering a potential ADHD diagnosis.

58. Dr A told HDC that 'the background information leading to a diagnosis of anxiety and depression was self-evident'. He noted that Mx B's use and discontinuation of antidepressant medication 'strongly suggest[ed] that depression and/or anxiety was a consideration'. He stated: 'Many of [Mx B's] problems appear to be due to a lack of motivation but anxiety, depression and temperament can all contribute to a lack of motivation.'

59. Associate Professor Newton-Howes considers that notwithstanding Dr A's diagnosis,[18] the formulation that explains how the diagnosis is reached is absent, and he 'cannot follow the logic Dr A uses to generate his thoughts in regard to the diagnosis of anxiety/depression'. Associate Professor Newton-Howes noted that Dr A did not screen for ADHD psychopathology, his conceptualisation of functioning is brief, no medical or past psychiatric history is provided, no alcohol or other drug history is provided, no family history of mental disorder is provided, no formulation is given, and the mental state examination is brief. It is also unclear how Dr A used the ASRA-V1.1 assessment tool, although the screen was positive. Associate Professor Newton-Howes considers this to be a severe departure from accepted practice. I accept this advice.

60. I acknowledge Dr A's perspective that Mx B 'had effectively self-diagnosed … ADHD and was resistant to enquiry in directions other than ADHD which made a standard psychiatric assessment difficult, if not impossible to perform'. This is shown in the letter Dr A wrote to Dr C following the second appointment, in which Dr A stated: '[Mx B] said that "I felt I wasn't being heard" but was, perhaps, annoyed that I was reluctant to make a diagnosis of

[18] Associate Professor Newton-Howes understands Dr A to have diagnosed Mx B with anxiety and depression and therefore refers to it as the 'diagnosis' throughout his report.

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Attention Deficit Disorder.' In contrast to this, in response to the provisional opinion Mx B told HDC:

> 'I was not attached to being diagnosed or any diagnosis, but as ADHD can only be assessed and diagnosed by a psychiatrist, a psychiatrist was sought. It's a real "catch 22" as an adult wondering if you might have ADHD. To get an assessment to include consideration of ADHD, you first need to request that and see the appropriate professional. By requesting for ADHD to be considered, you then get accused of self-diagnosing.'

61. I also acknowledge Mx B's perspective that school reports and ADHD screening test results were not discussed at the first appointment, and collateral information was not elicited from their partner at the second appointment. Mx B told HDC that the conclusion they had depression 'came out of left field' and they were not informed of Dr A's rationale for this diagnosis.

62. Regardless of whether the patient is likely to agree or dispute the decision-making of the psychiatrist, I consider it pertinent that formulation and reasoning is both well documented and communicated with the patient. I accept Associate Professor Newton-Howes' advice and agree that it is difficult to follow how Dr A arrived at a diagnosis of anxiety and depression. Given the focus of the referral, I would have expected Dr A to have recorded his rationale for ruling out the ADHD diagnosis clearly. I consider it reasonable that Mx B expected the final report to include a rationale as to any diagnosis formed, or the formulation and decision-making that Dr A employed while considering Mx B's symptoms.

63. If, as Dr A has stated, this case was complex and required multiple appointments, then I would have considered it appropriate for Dr A to communicate his formulation to Mx B clearly, in that it appeared that Mx B was suffering from anxiety and depression, and further, to inform Mx B that more information would be needed to assess the ADHD aspect of the referral. I note that Dr A's final letter to Dr C fails to explain why this diagnosis was formulated and how the assessments undertaken, or lack thereof, support this.

64. Lastly, although I acknowledge that Mx B is concerned that the appointments with Dr A did not follow any form of structure, in the absence of clinical documentation I am unable to ascertain the format in which the questioning and structure was arranged. However, if the appointments did lack clear structure, I would remind Dr A to be mindful of this to ensure that the patient has a clear understanding of what is going to happen in the sessions.

Whether a comprehensive assessment was undertaken

65. Based on the information above, I will now consider whether overall a comprehensive assessment was undertaken, having determined that this was the purpose of Mx B's referral.

66. Associate Professor Newton-Howes noted that a comprehensive psychiatric assessment is not possible in two appointments. However, he would expect consideration to be given to 'the wide array of psychiatric problems and possibilities', and that the diagnoses and formulations would be clear.

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67. Due to the limited clinical documentation, I am unable to identify what topics were discussed during these appointments and therefore determine the breadth of the assessment. However, I do note the length of the appointments, approximately 90 minutes and 60 minutes respectively, and the documented comments about Mx B's life history, trauma, and current symptoms.

68. Dr A told HDC that '[t]he assessment was also as comprehensive as circumstances allowed', and he considers that 'nearly all the usual information is present and where there are gaps it is often because [Mx B] did not provide sufficient information despite enquiry'. I acknowledge that there was a breakdown in the relationship, which may have hindered the thoroughness of the assessment. Dr A told HDC that a second appointment was arranged with Mx B 'in view of the likelihood of conflict', but given the breakdown of the therapeutic relationship, much of the second appointment was unproductive.

69. Associate Professor Newton-Howes advised that he found it very difficult to determine the assessments undertaken due to the poor documentation, particularly as there are no notes from the second appointment. Notwithstanding this, Associate Professor Newton-Howes advised that the documentation for both assessments, and that sent to Dr C, indicates that Dr A did not screen for psychopathology,[19] his conceptualisation of functioning is brief, no medical or past psychiatric history is provided, no alcohol or other drug history is provided, no family history of mental disorder is provided, no formulation is given, and the mental state examination is brief. Associate Professor Newton-Howes considers that in the circumstances, the assessment, care, and management undertaken by Dr A was a severe departure from acceptable standards.

70. I accept this advice and consider that the failings demonstrated by Dr A fall short of what would be expected of a psychiatrist in the circumstances and based on what was included in the initial referral.

Conclusion — adequacy of assessment

71. Based on the information available to me, I do not consider that a comprehensive assessment occurred over the two sessions that took place. I acknowledge my independent advisor's advice that a comprehensive assessment would take multiple appointments. However, it is evident on the information provided that Dr A did not undertake the necessary considerations and screenings that would have been expected in the two appointments, and I am concerned that he considers that 'nearly all the usual information is present'.

Documentation

72. Dr A's clinical documentation for this case includes 1.5 pages of handwritten notes from the first appointment, the results from the initial ASRS-V1.1 self-assessment, correspondence between the parties, and the two letters sent to Dr C following each appointment. Importantly, there were no clinical notes for the second appointment.

[19] Psychopathology is the scientific study of mental illness or disorders.

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73. The Medical Council of New Zealand (MCNZ) documentation guidelines, 'Managing Patient Records' (December 2020), state:

> 'Patient records reflect a doctor's reasoning and are an important source of information about a patients care'; and

> 'Patient records are a crucial part of medical practice. They help ensure good care of patients and clear communication between doctors and other health practitioners.'

74. Both Dr A and Associate Professor Newton-Howes identified that the notes taken during the consultations with Mx B are written in the style of being an 'aide-memoire' rather than clinical notes. Dr A said that things are done differently in private practice, and his letter to Dr C was 'sufficient' and provided a 'good account of the patient's previous life'. Furthermore, Dr A told HDC that 'nearly all the usual information is present and where there are gaps it is often because Mx B did not provide sufficient information despite enquiry'.

75. Associate Professor Newton-Howes advised that Dr A's documentation style has inherent content deficiencies, and 'the notes taken and letters to the GP are notable for a lack of description of psychopathology, and various other histories'. He considers that the documentation is moderately below the expected standard for a specific ADHD assessment and severely below the expected standard for a comprehensive assessment. I accept this advice and am critical that Dr A's documentation fell below expected standards.

76. I also disagree with Dr A regarding the approach to notes in the private sector. The MCNZ standards apply to both private and public practice. Dr A's documentation appears to be lacking 'relevant clinical findings', 'information given to, and options discussed with, patients (and their family or whānau where appropriate)', 'decisons made and the reasons for them', 'requests or concerns discussed during the consultation', 'the proposed management plan including any follow-up', and 'medication or treatment prescribed including adverse reactions'. Therefore, I consider that Dr A did not comply with the requirements of MCNZ's 'Managing Patient Records' statement.

Communication with GP

77. This section of the report will assess the adequacy of Dr A's communication of medication recommendations. At the outset, I acknowledge Dr A's comment that he made 'recommendations' for medications as opposed to making a formal management plan for Mx B.

78. MCNZ's 'Managing Patient Records' states that 'medication or treatment prescribed including adverse reactions' should be clearly and accurately stated on the patient's records.

79. On 29 April 2021, Dr A emailed Mx B attaching the initial letter that was sent to Dr C on 21 April 2021. In this email, Dr A stated, 'The antidepressant we talked about was bupropion and the migraine treatment was Imigran. The anti-anxiety treatment was pregabalin,' with no further context. In his letter dated 6 May 2021, written following discussion with Mx B in their second appointment, Dr A suggested that Dr C prescribe pregabalin and sumatriptan

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(Imigran) for migraine. Associate Professor Newton-Howes commented that 'none of these notes detail the psychopathology of migraine, depression or anxiety'.

80. Associate Professor Newton-Howes considers that the communication between Dr A and the referring GP (Dr C) fell severely below the standard of care required, as '[t]here is no clear management plan provided to the GP and the recommendations in respect of pharmacology are entirely unclear'. I accept this advice.

81. I am also concerned that the medication 'bupropion' was mentioned in the email Dr A sent to Mx B but there is no record of this information/recommendation having been sent Dr C directly in either of the letters.

82. Having accepted that Dr A made medication recommendations (as opposed to formal prescriptions) to both the GP and to Mx B, I would expect clear communication between providers, as outlined in the MCNZ guidance above. In making medication recommendations for the GP to prescribe, there is an underlying assumption that medication options, including risks and benefits, would have been discussed with Mx B. However, this discussion is not documented. I consider that Dr A should have clearly articulated his reasoning for Mx B's diagnosis and rationale for medication recommendations, including his discussion with Mx B.

83. Associate Professor Newton-Howes was critical that the medication Dr A suggested in his final letter to Dr C lacks content as to expected effects, side effects, length of timing dose, review, or when to seek support. I agree that this information is lacking. Furthermore, Dr A did not complete a risk assessment for Mx B when considering what medication to prescribe. I accept Associate Professor Newton-Howes' advice that this was a moderate departure from expected standards, as this is considered necessary to understand how much medication to prescribe at a time. From the information presented to me, it was reasonable for both Mx B and Dr C to interpret these medications as recommendations, and therefore associated comments relating to this should have followed. This is regardless of the fact that this was not a formal management plan.

Conclusion

84. I accept that psychiatric assessments can be complex and require multiple appointments to gain a clear diagnostic picture. Further, I acknowledge that in this case the referral notes that Mx B requested a psychiatry assessment as '[they] think [they] may have ADHD', and that there were difficulties in maintaining a therapeutic alliance between the parties, which hindered further assessment.

85. As stated within this report, the lack of documentation has affected my assessment significantly, and I am critical that this fell below the expected professional standards. Therefore, I find that this was a breach of Right 4(2) of the Code.

86. While there is evidence that Dr A considered alternative diagnoses to a certain extent, I am critical that there were various deficiencies in the overall adequacy of the assessment in the context of consideration of ADHD. Furthermore, I am concerned about Dr A's level of

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communication with both Mx B and Dr C in explaining the rationale and diagnostic reasoning for the consideration of Mx B's symptoms, and also in relation to the recommended medications. In my view, the overall standard of care Dr A provided to Mx B when completing his assessment and communicating with both Mx B and Dr C fell below the expected standard. Therefore, in my opinion, Dr A breached Right 4(1) of the Code.

Changes made since events

87. Dr A told HDC that with the benefit of hindsight, he could have chased Mx B's school reports so that they were provided earlier, or he could have consulted Mx B's father if further school reports were not available. However, other than this change, Dr A stated that he considers that in the circumstances and based on the information he had at hand, he did the best he could.

Recommendations

88. I recommend that Dr A:

a) Provide a written apology to Mx B for the breaches of the Code found in this investigation. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mx B.

b) Provide evidence that he continues to engage in professional supervision, as stated in his response dated 8 December 2023.

c) Review his practice in light of the overall assessment completed, including formulation, documentation, and communication and report back to HDC on his learning, within three months of the date of this report.

Follow-up actions

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

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

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Associate Professor Giles Newton-Howes:

'Associate Professor Giles Newton-Howes
BA, BSc, MBChB, PhD
MRCPsych, FRANZCP
CCT Adult Psychiatry and Substance Misuse Psychiatry (UK)
Consultant Psychiatrist

[HDC]

Complaint: [Dr A] & [Mx B]

Our ref: C21HDC01771

1. Introduction

1.1 This report is prepared by Associate Professor Giles Newton-Howes, Consultant Psychiatrist. I have a Bachelor of Medicine and Bachelor of Surgery awarded in 1998 and PhD awarded in 2018 from the University of Otago. I have a Bachelor of Science awarded in 1993 Bachelor of Arts awarded in 1999 awarded from Victoria University (Wellington, New Zealand). I have a postgraduate diploma in Cognitive Behavioural Therapy from Royal Holloway, University of London, awarded in 2006. I am a member of the Royal College of Psychiatrists (UK), obtaining membership in 2004 and a Fellow of the Royal Australian and New Zealand College of Psychiatrists. I have my Certificate of Completion of Training (CCT) in General Adult Psychiatry and a Certificate of Sub-Specialty Training in Substance Misuse Psychiatry awarded by The Postgraduate Medical Education and Training Board in the United Kingdom in 2007. I am vocationally registered in Psychiatry by the New Zealand Medical Council. Other than my clinical work I am the deputy Clinical Leader, Community, Mental Health Addictions & Intellectual Disabilty Service, Te-Upoko-Me-Te-Whatu-O-Ika and Associate Professor at University of Otago, Wellington.

1.2 I have been asked to prepare a report to the Commissioner on case number C21HDC01771. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors accessed through the link in the letter of instruction.

1.3 I am unaware of any conflicts of interest.

1.4 I have been asked to, "provide expert advice to the Health and Disability Commissioner … seeking your opinion on the care provided by [Dr A] to [Mx B] between March to May 2021."

1.4 In completing this report I have had access to the following relevant information:

1. Letter of complaint dated 30 July 2021.

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2. [Dr A's] response dated 25 August 2021 including clinical notes and correspondence between the parties.
3. Health and Disability Advocacy Service mid-referral dated 18 November 2021. This clarifies the consumer's concerns.
4. Original referral document sent to [Dr A] dated 12 January 2021.
5. Copies of [Mx B's] school reports

2. Observations and Preamble

2.1 The complaint of [Mx B] (document 1) identifies the type of service provided as "Midwife" although I have assumed this is an error as [Dr A], the service provider, is correctly identified as a psychiatrist and it is as a psychiatrist alone that I provide this expert advice. I note [Mx B] identifies themselves as [occupation]. The concern to the Health and Disability Commissioner (HDC) appears to be made on 30 July 2021. [Mx B] states they are escalating the complaint due to the failure of [Dr A] to communicate with their GP and requests an apology and a refund of the cost of the assessment.

3. Summary of documents sent

3.1 A series of email correspondence is included in the document bundle. This is from 18 March 2021 to 6 May 2021. Essentially this verifies the comments in respect of timeline in the complaint. The email of 6 May lays out clearly [Mx B's] concerns in respect of the assessment. In this they make clear their motivations are altruistic, "… to help you [Dr A] improve for future clients."

3.2 The letter of response to the HDC from [Dr A] dated 25 August 2021 is included in the bundle. It notes two zoom assessments on 18 March and 29 April 2021. It notes a clinical impression of "anxiety and depression", although [Dr A] states, "… I gained the overall impression that [Mx B] had decided on the diagnosis of ADHD and was dismissive of other possible diagnoses." [Dr A] arranged a second private appointment, free of charge, with the implication being this was to manage the likely mismatch between his clinical impression and his view of [Mx B's] considerations. [Dr A] acknowledges the delay in the second letter to the GP and describes addressing the issue that led to the delay. [Dr A] notes that the communication from [Mx B] on 6 May was for his reflection and notes he did that.

3.3 36 pages of clinical notes are included in the document bundle.

3.3.1 Two pages of handwritten notes dated 18 March are included. These are very brief notes, amounting more to an "aide-mémoire" than clinical notes. They conclude with, "?ADHD School reports requested." No mention of depression or anxiety are made in the conclusion[1]. A one-page typed note dated 29 April is included. It is a note describing the content of the interview with [Dr A] identifying his view that ADHD was unlikely, and their problems were, in his view, more likely related to anxiety and depression. He

[1] The note is somewhat difficult to decipher however I do not think internalising psychopathology is identified at all other than the comment "tends to be sad" under mental state.

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identifies a past positive response to venlafaxine, an antidepressant, as what appears to be the rationale for this view. He describes making "treatment suggestions" including pregabalin (reason, dose, expected effect, and side effects are not detailed) and sumatriptan for migraine (again the reasoning and effects are not documented). None of these notes detail the psychopathology of migraine, depression or anxiety. The handwritten notes comment on impulsivity.

3.3.2 The referral of Dr C dated 12 Jan 2021 in included. In it he notes the withdrawal from amitriptyline, prescribed for migraine, with no migraines occurring for over a month. It notes withdrawal from venlafaxine, after ten years, without an increase in anxiety (suggesting this is what it was prescribed for). It notes difficulty in study, procrastination, sleep problems (chronic), impulsive spending, reduced concentration, and frustration with their [child]. It notes [Mx B's] wondering that they may have ADHD. It notes the prior history of generalized anxiety disorder, and "mood-affective" disorder, and migraine.

3.3.3 A variety of school and university work is included in the notes. Under personal qualities and work habits it describes [Mx B] as "well organized" with "excellent independent study skills" in a note dated 22 November 2022.

3.3.4 Written material from [Mx B] to [Dr A] is included.

3.3.5 The letter from [Dr A] to Dr C dated 22 March 2021 is included. It lays out a personal history and the view of [Mx B] complaining of symptoms, "… that could be ADD." No psychopathology is described, either cross sectionally or longitudinally. Conceptualization of functioning is brief. No medical or past psychiatric history is provided. No alcohol or other drug history is provided. No forensic or familial history of mental disorder is provided. No formulation is given although conclusions are stated. The mental state exam is very brief. No clear outcome is described. The further letter dated 6 May outlines the second appointment. It notes [Mx B's] "displeasure" with the process of assessment. The content reflects that of the letter in 3.2 to the HDC.

3.4 A letter from … is included.

4. Questions asked and opinion, with a focus on:

4.1 The overall adequacy of assessments, tools used and diagnostic formulation/ management plan produced by [Dr A].

4.1.1 This is very difficult to assess on the basis of the notes provided. Clearly [Mx B] was unhappy with the process …[2]. I note that the notes taken and letters to the GP are notable for a lack of description of psychopathology, and various other histories as laid out in 3.3.5. No formulation is made and how [Dr A] used the ASRS-V1.1 assessment tool is unclear[3]. No diagnostic tool for ADHD is used, although I note [Dr A] did not

[2] Removed for privacy reasons.

[3] I note this tool is a screening tool that itemises the 18 symptoms of ADHD with an expectation of completion of part A, and then part B only if part A screens positive. The tool is not diagnostic.

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consider this diagnosis to be correct and so potentially saw no purpose for doing this. The ASRS-V1.1 does, however, screen positive. There is no clear management plan provided to the GP and the recommendations in respect of pharmacology are entirely unclear. No consideration of psychology or social interventions are made. Overall, I find the assessment to be severely different from an acceptable standard of care and the formulation/management to be severely different from an acceptable standard of care. I would expect my peers to find the notes and letters to be lacking as I have described in 3.3.5.

4.2 Whether [Dr A] obtained and considered all appropriate information from [Mx B] during the assessment process.

4.2.1 This is difficult to be clear of as the notes are absent of many of the standard features of a psychiatric assessment. These includes: no psychopathology being described (or obviously screened for), either cross sectionally or longitudinally, a poor conceptualization of functional problems, no medical or past psychiatric history, no alcohol or other drug history, no forensic or familial history of mental disorder is provided, and the mental state exam is very brief. No clear formulation/summary is detailed. This is severely below the standard of accepted practice and would, I expect, be negatively commented on by my peers.

4.2.2 Usually collateral history would be collected, and I note an academic history was sought and provided. It is unusual that [Dr A] did not interview the patient's partner who was present for the second interview and did not contact either partner or father whose numbers were provided. No mention is made of other past mental health providers who may have been involved[4] and no effort is made to access other notes. No comment is made as to whether [Mx B] has an ACC sensitive claim as may be the case (and a source of possible useful information)[5]. This is a moderate departure from a usual standard of care. I note there was ample opportunity to collect at least some collateral information including during the second interview.

4.3 The adequacy of the documentation and communication with the patient and [Dr A][6].

4.3.1 The documentation to the GP and patient has content deficiencies as described above but the timing of this appears to be adequate noting the clerical error with the second GP letter that [Dr A] has taken steps to rectify and has apologized for.

[4] This seems likely as the diagnosis of generalised anxiety disorder appears to have been made by a mental health professional.

[5] There is mention in the notes of an event of a sensitive nature that may have led to such a referral.

[6] Although this is what is asked for in the letter of referral I have presumed this is an error and what is questioned is communication with the patient and their GP, as it makes no sense for [Dr A] to communicate with himself.

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4.3.2 The handwritten notes and one-page typed note are more of an aide-mémoire to my mind as opposed to clinical notes. The problems with these relate to the content issues described above.

4.4 [Mx B] is concerned that they did not receive a full report explaining [Dr A's] assessment and the rationale for the overall diagnosis. Please comment on this.

4.4.1 I agree. I cannot follow the logic [Dr A] uses to generate his thoughts in regard to the diagnosis of anxiety/depression. I can understand his reluctance to diagnose ADHD and agree with him that his understanding of [Mx B's] academic achievements would not support a diagnosis of ADHD generally. Nonetheless a formulation that explains how the diagnosis is reached, in this case in the depression/anxiety realm, is absent and there is no rationale given to rule out the diagnosis of ADHD, that appears to have prompted the referral. This does, to my mind, fall severely below the standard of accepted practice. I note if this was solely an ADHD assessment then some of the errors and omissions would be moderate, however there is emphasis in the notes of this as a "comprehensive assessment", which it is not in my opinion.

4.5 Whether [Dr A's] diagnosis of anxiety and depression were reasonable in the circumstances. When answering this question, please comment on whether you consider consideration should have been given to an ADHD diagnosis.

4.5.1 To the latter question first any comprehensive psychiatric assessment should consider the wide array of psychiatrist problems and possibilities and not be shuttered to a single diagnosis. This could potentially take some time, however the classifiers "possible" and "probable" exist in the taxonomic lexicon to enable a provisional diagnosis to be expressed. In this regard, on the basis of the referral information alone, I would be examining closely for the possibility of a depression and anxiety diagnosis, a trauma-based diagnosis (on the basis of early life experience), and neurodiversity including both attention deficits/hyperactivity and autistic traits. I note the history of bacterial meningitis and would also be considering consequences of this including possible cognitive or executive difficulties. I note the likelihood of an alcohol or other use disorder in life circumstances as laid out in the referral and would be screening for these too. As [Dr A] notes, the diagnostic picture, *on the basis of the referral information alone*, is complex and in a private setting I would make clear the likely requirement for a number of sessions to develop the diagnostic picture to ensure a patient was aware of the likely cost. As such, and as described above, the assessment as described in the notes fails to clearly address any of these possibilities. I would consider this a severe departure from the expected standard of care.

4.5.2 As I have described I am unable to follow the logic used by [Dr A] to reach a diagnosis of anxiety and depression[7] however on the basis of the referral document, with a ten-year history of treatment with venlafaxine recently stopped, and the withdrawal of amitriptyline, also an antidepressant, my highest concerns would be to

[7] As an aside "anxiety and depression" is not formally a diagnosis, rather a description of two affective states. The various anxiety and depressive disorders have formal criteria.

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rule out the return of a mood state at review. As such it is reasonable for this to be at the forefront of an assessing psychiatrist's mind with the referral documentation as provided. I would therefore consider a focus on mood disorder to be good practice, within the confines of the other comments made. I do not, however, consider the formulation of "anxiety and depression" to be clear and consider this to fall severely below the standard of care required.

4.6 Please comment on the overall reasonableness of care provided to [Mx B] by [Dr A].

4.6.1 Overall I find the timing of the assessment from receipt of referral, timing of the appointments and second appointment and letters to the GP to be adequate, noting the clerical error that occurred.

4.6.2 Overall I find the documentation to be moderately to severely below the standard expected. It is moderately below for a specific ADHD assessment and severely below for a comprehensive assessment. I note that a comprehensive assessment with the background as described is not really possible in two one-hour appointments, with no collateral history, however I would expect clear diagnoses and a formulation to be made, with the likely "possible" or "probable" classifier.

4.6.3 Overall I am unable to comment on the communication with the patient in the clinic and what standard this reached. I note the difference of opinion in regard to diagnosis and [Dr A] is clearly both cogent of this and appears to have worked hard to provide a space in the second appointment to discuss this, with [Mx B's] partner present for support. This is good practice. I note [Mx B's] unhappiness at the assessments; however, this appears to relate to content, and these concerns appear reasonable.

4.6.4 Overall I find the communication to the GP with a clear plan to fall severely below the standard required. No clear diagnosis is made, no consideration is given to anything other than pharmacotherapy and the medication suggested entirely lacks content as to expected effects, side effects, length of timing dose, review or when to seek support. I note too there is no risk assessment, and this is possibly appropriate, however a failure to assess of a history of overdose makes knowing how much medication to prescribe at a time very difficult and this too falls moderately below the standard of care expected.

5. Recommendations for improvement

5.1 I would recommend [Dr A] engage a supervisor to oversee his practice. I would recommend he ensure that he is up to date with how to take an adequate psychiatric history and to formulate a patient. These are basic psychiatric skills that appear, on this occasion, to be absent. It is difficult to understand how [Dr A] is practising on the basis of this review and I would recommend an audit of a wider array of patients to understand if this is an outlier in his practice, or if these problems are more generalized.

5.2 I would recommend [Dr A] focus on his continuing medical education, examining his skills to ensure he remains up to date.

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5.3 I note [Mx B] expressed considerable disappointment with [Dr A's] communication and style. I acknowledge this … however on the basis of the notes there is no other indication of concern with respect to communication.

I trust this report has been of assistance to you.

Yours truly,

Dr Giles Newton-Howes
Consultant Psychiatrist

The above report is based on the information available to me. It is based on the history and records as provided. If other information becomes available at a later date this may alter or change both the content of the report and the opinions provided. This may require an amendment or new report to be prepared. This report is conducted as an independent psychiatric evaluation at the request of a third party. Decisions regarding further management and interventions are at the prerogative of the referrer. Any legal actions taken as a consequence of this report are solely at the discretion of the referrer. The referring party is responsible to ensure that the report and any detailed documents are dealt with in a confidential manner in keeping with the Health Information Privacy Code. The referring party is responsible for safe keeping of these documents as required by the Health Information Privacy Code.'

Further comment

On 8 April 2024 Associate Professor Newton-Howes noted that he had read Dr A's comments and stated: 'I am happy with the contents of my report and do not think [Dr A's] replies address the issues I have concerns with on the basis of a file review … I think the HDC has sufficient [information] to go on from my perspective at least.'

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