General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 01HDC04864)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Complainant / Consumer
Dr B	Provider / General Practitioner
Dr C	Surgeon
Dr D	Medical Oncologist
Professor E	ACC advisor

Complaint

On 3 May 2001 the Commissioner received a complaint from Mrs A about treatment provided by Dr B at her surgery. The complaint was summarised as follows:

- *From May 1999 until March 2000, general practitioner Dr B failed to diagnose Mrs A's breast cancer despite clinical signs being present.*
- *Given Mrs A's presenting symptoms, Dr B should have managed her case with greater urgency.*

An investigation was commenced on 23 July 2001.

Information reviewed

- Relevant medical records
- Information from the Accident Compensation Corporation (ACC)

Expert advice was obtained from Dr Ian St George, an independent general practitioner.

Information gathered during investigation

On 12 May 1999 Mrs A consulted her general practitioner, Dr B. Mrs A was concerned about the "changing" nature of a swelling under her left arm. The swelling had begun to spread into the side of her left breast, creating a "thickness". Mrs A informed Dr B that her sister had been diagnosed that week with breast cancer. Mrs A stated that after Dr B examined her, she told her that the swelling was probably the result of a "blocked gland".

Dr B denied telling Mrs A that a blocked gland was the likely cause of the swelling. There is no note of discussion about a "blocked gland" in Dr B's records.

Dr B said that the primary focus of the initial consultation was the difficulties Mrs A had been experiencing with her menstrual cycle.

Dr B's clinical records note that Mrs A's period had been regular until one month prior, and that she had been bleeding for two weeks prior to the consultation.

Dr B's clinical records also note that Mrs A had complained of being increasingly tired over the last two years. Mrs A was under stress at home and at work. Mrs A did not present with any cough, cold or chest problems.

Dr B recalled that she undertook a "breast check" because it is her practice to do so when carrying out a smear test. Dr B's clinical records note:

> "Breasts – [? axillary] nodes – lesion [right] ? axilla. ? [old] infected lesion."

There is an arrow in the notes pointing from "breasts" to the letters "NAD" (no abnormality detected).

Dr B arranged for Mrs A to have a mammogram, which took place on 26 May 1999. The radiologist's report stated:

> "The breast tissue is dense throughout. No discrete mass, distortion or micro-calcification is seen. There has been no significant change from the previous mammogram in 1990.
>
> Impression: no evidence of malignancy."

Dr B did not seek a needle biopsy (removal of tissue for microscopic examination) in addition to the mammogram.

On 27 May 1999 Dr B's medical notes record an attendance with Mrs A. The notes record that Mrs A had a "cough/cold". There is nothing in the records to show that any changes in Mrs A's breast were discussed at that appointment. Dr B advised that had the issue been discussed, it "would have been recorded in the notes".

Mrs A recalled that in late June or early July 1999 she returned to see Dr B and was told that the mammogram was clear. Mrs A recalled that Dr B offered no further treatment, and reassured Mrs A that there were no problems. Dr B has no record of an attendance at this time and disputes that it occurred. Dr B has provided no documentary evidence confirming when the results of the mammogram were discussed with Mrs A.

Mrs A consulted Dr B again on 15 September 1999 as the swelling had become "a lot worse", to the degree that it restricted her left arm movements. Dr B suggested that Mrs A consult a specialist at a public hospital. Mrs A recalled that Dr B did not appear to consider this specialist consultation to be urgent.

Dr B's account of the September consultation differs. She notes that the September consultation was a "follow-up" appointment to the initial consultation regarding Mrs A's periods and that concerns about Mrs A's left breast were "not the presenting complaint".

Dr B advised that Mrs A's menstruation problems had settled down on treatment and that she was waiting for the results of a pelvic ultrasound. She also recalled that Mrs A presented to her with ear problems.

Dr B recalled that Mrs A pointed out the restriction in her arm movement, which Dr B attributed to the "scar" under her left axilla. Dr B is unable to recall whether she examined Mrs A's breast.

It is agreed that Dr B then arranged a referral for Mrs A to a public hospital for a surgical review in relation to her complaint about her restricted arm movement.

On 16 September 1999 Dr B wrote to the Surgical Outpatients Clinic of the public hospital as follows:

> "Please could you review and assist this lady who has a large scar in her (L) axilla [armpit] following an infected gland ?cyst some years ago. This is causing her problems with tethering and restriction of arm movements. Previous medical history – nil, she has no allergies and is on no medication."

There is nothing in the referral letter of 16 September 1999 to denote urgency. The public hospital therefore marked the referral with the lowest priority, "routine".

In December 1999 the public hospital notified Mrs A that the date for her appointment was 5 May 2000.

Mrs A stated that by January 2000 her breast was "greatly out of shape" and that her nipple was inverted. As a result, Mrs A visited Dr B on 21 January 2000.

Dr B recalled that Mrs A presented with multiple problems at this consultation, including changes in her left breast over the previous month. Dr B's clinical notes record that the left nipple was retracted, and the breasts irregular to the feel and moderately oedematous (swollen). The breast was also observed to have been "dimpling" over the nipple. Dr B assessed the changes as having arisen from "the scar in the axilla [armpit]". Dr B informed Mrs A that she would try to get the appointment with the public hospital brought forward.

Mrs A recalled that at this consultation Dr B gave her the impression that she was "panicking unnecessarily" and that her breast symptoms were not serious.

A few days later, in a letter dated 27 January 2000, Dr B wrote to a second public hospital (instead of the first public hospital) asking that Mrs A's appointment be expedited and noting the changes in Mrs A's condition. She also noted:

> "We wonder if this is secondary to scarring and tethering [sic] from left axilla, but are concerned about the rapid change in the left breast."

In relation to the issue of urgency, Dr B advised me that the hospital required referrals to be in writing, and that it was her understanding that these would be sent to the appropriate clinic to be "assessed for priority by the specialist". She noted that "urgent cases to the surgical clinic specifically are seen within two weeks".

Dr B explained that the six-day delay in preparing the letter was due (in part) to her attending three clinics at that time. This meant she had to work from a "distance".

Dr B's letter of 27 January was not forwarded to the correct hospital as it was mistakenly addressed to the second public hospital.

In February 2000 Mrs A telephoned Dr B to express her concern that she had yet to receive an "earlier appointment" with the first public hospital. By this stage she was very concerned and scared.

In early March 2000 Mrs A contacted the Breast Screening Unit at the first public hospital for assistance but was told that they could not help her as she was already in the "system", having seen a doctor and awaiting an appointment.

On 8 March 2000 Mrs A telephoned Dr B to enquire about the progress made in organising an earlier appointment with the first public hospital. She was becoming increasingly concerned. Mrs A states that she did not attend in person with Dr B that day.

Dr B stated that according to her computer records Mrs A did attend that day. Dr B's clinical notes record that on 8 March 2000 Mrs A "represented with further changes noted in the breast having not yet been seen at clinic". Dr B went on to record an increase in "swelling" to the left breast and "aching", which was "worse at the end of the day. Seems to [reduce] a bit at night."

The clinical notes also record that it was not until 8 March that Dr B discovered that she had mistakenly sent her request for an earlier appointment (dated 27 January 2000) to the wrong hospital.

Dr B stated that, having discovered the error, she ensured that the referral letter was faxed immediately to the first public hospital's Surgical Clinic. There is, however, conflicting evidence about this matter. Dr C, a surgeon in private practice who Mrs A subsequently consulted, advised:

> "I have reviewed her hospital files and I note that … the letter dated 27 January 2000 to [the first public hospital] … was received at the hospital on the 30 March 2000 …"

Dr B contended that the date of "30 March" was in fact the date of Mrs A's scheduled appointment at the hospital. Dr B submitted a further letter from Dr C dated 27 November 2002 (some two years after the event) in which he confirms that he "has been informed" that an appointment was set for 30 March 2000.

The first public hospital has, however, confirmed that it did not receive Dr B's letter of 27 January 2000 until 30 March 2000.

It is clear that no follow-up action was taken by Dr B until March 2000, with regard to securing an urgent appointment for Mrs A with the first public hospital – either by way of follow-up letter (to that of 27 January 2000) or telephone call.

Dr B advised that on 13 March 2000, Mrs A telephoned her and informed her that she still had not heard from the first public hospital. Dr B suggested that Mrs A telephone the hospital to confirm an appointment date. Dr B recalled that she suggested that, as Mrs A had medical insurance, it might be faster to go to a private surgeon. Dr B recommended Dr C, and a referral was faxed to his surgery.

This account is not accepted by Mrs A, who stated that she made no contact with Dr B on 13 March 2000, and that Dr B did not recommend Dr C to her. Mrs A stated that it was her husband who thought to contact a private surgeon. This was as a result of the delays, and Mrs A's growing concern and stress levels. In discussing matters with her husband, Mr A suggested that "he would find someone else" for Mrs A to see. Mrs A's husband then selected Dr C's name from the telephone book.

On 13 March 2000 Mr A contacted Dr C, and requested a consultation for his wife. Dr C saw Mrs A the following day, 14 March 2000.

Dr C advised that his nurse contacted Dr B's receptionist to request a referral on 14 March 2000. Dr B in turn forwarded a letter dated 3 March 2000 to Dr C. The letter was, in substance, the same letter of referral made to the first public hospital. Dr C, in commenting on the referral letter, noted that Dr B's letter described "clinical findings of advanced breast cancer".

Dr C described Mrs A's condition on examination on 14 March 2000:

> "On examination her left breast was distorted and swollen and in the centre of this was an inverted nipple. There was a 4cm mass in the axilla with skin tethered into it. These changes indicated an advanced breast cancer."

Dr C took core biopsies of the axillary mass and breast mass that evening, which both showed infiltrating lobular carcinoma.

On 15 March 2000 a mammography and a chest x-ray were undertaken at a radiology clinic. The radiology results state:

> "Impression: the appearance is of a carcinoma in the left axillary tail with lymphatic obstruction causing skin thickening."

Mrs A and her husband met with Dr C later on 15 March and he told them that Mrs A had inoperable breast cancer. Dr C suggested a course of chemotherapy and referred Mrs A to Dr D, a medical oncologist at the first public hospital.

Mrs A consulted Dr D on 27 and 29 March 2000. Dr D assessed Mrs A to have locally advanced inflammatory breast cancer which was inoperable at that time. Dr D recommended two to three cycles of chemotherapy before surgery could be considered.

On 26 May 2000 Mrs A was admitted to a private hospital, where she underwent a mastectomy.

On 13 June 2000 Dr C wrote to Dr D and noted that Mrs A had made a very "pleasing recovery" after her left mastectomy and axillary dissection. Dr C also noted:

> "… The histology indicated that she had a wide spread infiltrating lobular carcinoma and the nodule in the axilla had invaded latissimus dorsi. There was extensive intra-lymphatic and intra-vascular emboli and six of the ten apical nodes were involved. Unfortunately the pathologists did not look for any nodes around the deposit in the axilla and I would have expected that there would have been about ten nodes in this area.
>
> She is now waiting to hear from you with respect to her next course of chemotherapy."

Mrs A received a further three doses of chemotherapy at a second private hospital.

Following this treatment, Mrs A was referred to the Radiotherapy Department at the first public hospital, where she underwent six weeks of radiotherapy treatment under the care of a doctor.

On 19 July 2000 the doctor noted that he had examined Mrs A and that on examination, she was "generally well" and that the surgical scar had healed up nicely.

Mrs A subsequently lodged a claim with the Accident Compensation Corporation (ACC). Mrs A's claim was initially accepted on the basis of "medical error" in March 2001, but that decision was overturned on review in April 2002, on the basis that Dr B "cannot be held responsible for the actions of the hospital/specialist who … made the decision on how the referral should be managed".

Independent advice to Commissioner

The following independent expert advice was received from Dr Ian St George, a general practitioner:

> "**Introduction**
>
> I respond to your letter of 17 December seeking advice in relation to [Mrs A's] complaints against [Dr B]. I am asked to advise the Commissioner whether [Dr B] provided services to [Mrs A] that complied with appropriate standards. Thank you for your reply of 12 March to my request of 19 December for further information.
>
> [Mrs A] complains that
> 1. From May 1999 to March 2000 [Dr B] failed to diagnose [Mrs A's] breast cancer despite clinical signs.

2. Given her presenting symptoms [Dr B] should have managed her case with greater urgency.

You ask me to advise on whether [Dr B] provided services with reasonable care and skill, and on

1. The specific standards and whether they were met.
2. [Dr B's] overall clinical management of [Mrs A] and whether it was in accordance with good practice.
3. Whether [Dr B] should or could have been alerted earlier that [Mrs A's] symptoms might indicate cancer, and if so by what and how.
4. Whether failure to detect the cancer earlier was reasonable.
5. [Dr B's] record-keeping.
6. [Dr B's] referrals on 15 September 1999 and 21 January 2000; whether [Dr B] could or should have expedited the referrals.
7. Whether undue delay was caused by the misdirection of the 21 January 2000 letter to [the second public hospital] rather than [the first public hospital].
8. Any other relevant matters.

I have read

- Your letters to me.
- Documents labelled 'A': [Mrs A's] letter to you of 30 April 2001, the ACC 'accepted claim' letter of 18 March 2001, [Dr …'s] letter to ACC of 30 January 2001, [Mrs A's] notes of 14 August 2000.
- Documents labelled 'B': [Dr B's] letter to you of 14 August 2001, her letter to ACC of 26 September 2000, her letter to Surgical OPD [of the first public hospital] of 16 September 1999, hers to [the second public hospital] of 27 January 2000, a copy of the same letter and same date but addressed to [the first public hospital], [Dr B's] letter to [Dr C] of 13 March 2000, a mammogram result of 2 Feb 90, another of 26 May 99, another of 15 March 2000, biopsy result of 14 March 2000, supplementary results of markers, a report from [Prof E] to ACC undated, [Prof …'s] letter to [Prof E] of 30 May 2001.
- Documents labelled 'C': a record of a telephone conversation between [Mrs A] and [the Investigation Officer] of 12 July 2001.
- Documents labelled 'D' and headed 'Submission to the Disputes Resolution Council': a timeline of events compiled by [Mrs A], some 'further information', 'Matters which we wish to bring to the attention of this Disputes Tribunal', copies of [Dr B's] clinical notes, [Dr B's] letter to [Mrs A] of 27 June 2000, the mammography results of 2 Feb 90 and 26 May 99, [the first private hospital's] account with [Mrs A] of 13 June 2000, [Dr B's] letters to [the first public hospital], [Dr C] as above, a letter from [Dr C's] '[…] to [Mrs A] of 26 June 2000, the mammogram result of 15 March 2000, subsequent correspondence, reports and accounts, and some documents from ACC: the treatment details sheet, [Dr B's] letter to ACC of 26 September 2000, [Dr C's] letter to ACC of 5 October 2000, [Dr …'s] opinion with attached papers.
- Documents labelled 'E': [Mrs A's] handwritten letter to you of 26 July 2001, [Dr …'s] report to ACC of 4 July 2001, [Prof …'s] and [Prof E's] reports, some further

comments by [Prof E] of 14 July 2001, comments by [Mrs A] of 16 July, report of a telephone conversation with [Mrs A] by [the Investigation Officer] of 20 July 2001.
- Documents labelled 'F': [Dr C's] letter to you of 20 November 2001, with further copies of some of the above.
- Documents labelled 'G': [Dr D's] letter to [Dr …] of 26 June 2000 and other correspondence from him.
- Documents sent at my request dated 12 March 2002 – a letter from [Dr B] and all her case notes on [Mrs A].

I have assessed whether [Dr B's] actions were reasonable in the circumstances by the standards of the profession, as far as they have been stated or previously judged, at the time of the incidents. I state here I have no personal, financial or professional connection with any party that could bias my assessment.

The facts

The facts relating to [Dr B's] contacts with [Mrs A] have been repeated several times in the above documents, but briefly [Dr B's] clinical notes read –

2 Feb 1990: the card reads 'Tenderness and thickening tail L breast. Mammogram nad'.
12 May 99: 'Breasts – axillary nodes – lesion R axilla ?old infected lesion – nad. Mammogram screening.'
[Mrs A] writes, '… swelling … was beginning to spread further… my sister had been diagnosed with breast cancer…'
27 May 99: no comment on breasts
15 Sep 99: 'Scar under L axilla; (increased) pulling; Surgical clinic ref.'
[Mrs A] writes, 'The swelling a lot worse and was now restricting my arm movement …'
? Jan 00: 'Breast noticed (increased) dimpling over nipple and oedematous looking, 1/12 on L. Breast L nipple retracted, moderately oedematous looking, irreg to feel, ++. ? secondary to scar L axilla – note to Surg appt. Speed up appt.'
8 Mar 00: 'Increased swelling L breast & aching. Worse at end of day. Seems to decrease a bit at night. No ???? lesion/swelling + lower ½ breast. Letter went to [the second public hospital]. Appt not sent to her from [the second public hospital]. To ref [the first public hospital] faxed 8/3/00 urgent. Phoned by [Mrs A] requests referral in private, not heard from [the first public hospital]. Suggest phoning. Will go private. Ref [Dr C]. 14/3/00.'

My opinion

1. The specific standards and whether they were met: [Prof E] refers several times to 'best practice' – a spuriously collective or objective term for what is a matter of clinical judgement. [Dr B] did not make any diagnosis on 12 May 1999 – she accepted a normal mammogram for a lesion in the breast tail, a difficult area to assess mammographically. She appears to have believed this was the result of previous infection (and subsequently [Prof E] appears to have thought there had been surgery there), but she recorded no

actual diagnosis. This was despite [Mrs A] informing her the swelling was beginning to spread further, and that her sister had just been diagnosed with breast cancer. Mammography was not enough: I think she should at that point have asked for a needle biopsy of the breast tail lesion.

2. [Dr B's] overall clinical management of [Mrs A] and whether it was in accordance with good practice: She saw [Mrs A] again on 27 May 99 for another matter but did not look at the breast. On 15 September she became concerned and referred [Mrs A] to the surgical clinic, but she did not intimate any urgency. One must assume (one would hope) she was concerned about the possibility of breast cancer at that point, and if so she should have told the surgical clinic she wanted an urgent appointment. In January there were clear signs of cancer, and she noted 'speed up appt', but sent the letter to [the second public hospital] in error; in my opinion she had a responsibility to make that urgent referral by telephone and to follow up to ensure it had been acted on. By March [Mrs A] was desperate, it was obvious she had cancer, and she was referred privately.

3. Whether [Dr B] should or could have been alerted earlier that [Mrs A's] symptoms might indicate cancer, and if so by what and how: In May 99 [Dr B] did not make a diagnosis but assumed a negative mammogram was all that was needed – I think she should have ordered needle biopsy then. On 15 September [Dr B] noted the lesion was 'causing problems with tethering and restricting arm movements'; this would be most unusual for axillary scarring, and indeed should have alerted her and the recipient of the referral letter at [the first public hospital] to the possibility of cancer. In January she knew the situation was urgent ('speed up appt') but failed to ensure her referral was successful. In such a situation most general practitioners would phone the surgeon for an early appointment. The same is true of 8 March.

4. Whether failure to detect the cancer earlier was reasonable: I do not believe so. By September 1999 (only 4 months after the May consultation) there was increased pulling (casenotes) and tethering and restriction of arm movements (referral letter). That signifies a quite rapid change in the lesion – after an interval of nine years of apparent quiescence – and should have alerted her in September to the likelihood of cancer. I believe she should have ordered needle biopsy in May, and certainly by September.

5. [Dr B's] record-keeping: Her record-keeping is regarded by [Prof E] as 'exemplary', yet there is little clear separation of subjective symptoms from objective findings, no clear diagnosis or assessment of the exact nature of the illness, and no clear plan recorded. I cannot discern clearly from her notes exactly what the lesion was in the tail of the breast in 1990. There are no records of the consultations where [Dr B] told [Mrs A] the results of her mammogram. Her records are at best adequate: they are far from exemplary.

6. [Dr B's] referrals on 15 September 1999 and 21 January 2000; whether [Dr B] could or should have expedited the referrals: I believe so; in January her letter indicating urgency went to the wrong hospital – that is a mistake but mistakes do happen – nonetheless it did cause further delay. A copy faxed to [the first public hospital] also went astray – and that caused further delay again. Certainly by January she must have

been aware her patient had cancer, and she should have discussed it with her patient and made direct contact with a surgeon.

7. Whether undue delay was caused by the misdirection of the 21 January 2000 letter to [the second public hospital] rather than [the first public hospital]: Yes – see above.

[8]. Any other relevant matters: It is very easy to be wise after the event, but [Mrs A] was not well managed by [Dr B]."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

Opinion: Breach – Dr B

Summary
Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights state that every consumer has the right to have services provided with "reasonable care and skill" and in compliance with professional standards. There are several aspects of the care Dr B provided Mrs A that give me cause for concern, and that lead me to the conclusion that she failed to meet the standard expected of a responsible general practitioner.

Diagnosis
I accept my expert advisor's advice that Dr B should have ordered a needle biopsy of the breast tail lesion in May 1999, and "certainly by September 1999". Dr B failed to arrange this basic diagnostic step.

It was not sufficient for Dr B to rely solely upon the results of the mammogram in May. This is especially so, given that Mrs A's sister had been diagnosed with breast cancer, and in light of the changes in Mrs A's breast both at the May examination and in the intervening period before the September examination.

This view is further supported by the Royal New Zealand College of General Practitioners' "Guidelines for Primary Care Providers: Early Detection of Breast Cancer" dated 1999. The Guidelines note that no single test is sufficient to exclude the possibility of cancer, and state that a "triple test" is the most "appropriate clinical examination technique" for diagnosing breast cancer. The "triple test" consists of:

i) A clinical breast examination;

ii) Diagnostic mammography; and

iii) Fine needle aspiration.

According to the Guidelines, all three of the above are to be conducted (in the stated order) to ensure more accurate results.

I also note my expert advisor's concern about Dr B's apparent failure to form any clear diagnosis of cancer. I accept his advice that Dr B should have been alerted to the possibility of cancer by September 1999. Although Dr B has noted that Mrs A presented with other concerns at the consultations in May 1999 and September 1999, it does not excuse her failure.

It is of further concern that by January 2000 Dr B had still failed to make a diagnosis of cancer, even though (as noted by Dr C) Dr B's letter of referral to the first public hospital described "clinical findings of advanced breast cancer". I accept my expert advice that by January 2000 Dr B should certainly have been in a position to tell Mrs A that she had cancer, especially given the rapid changes in the lesion.

Case management

Dr B also failed to manage Mrs A's care with the urgency it required. As my expert advisor has noted, Dr B should have been alerted to the possibility of breast cancer by September 1999, and certainly by January 2000, when clear clinical signs of breast cancer were present.

The letter of referral made in September 1999 was unsatisfactory in that it did not denote any urgency.

Dr B's letter of referral of 27 January 2000 was written some six days following her attendance on Mrs A. This was despite Dr B's own clinical notes recording that some "speed" was required. Dr B mistakenly sent the letter to the wrong hospital (the second public hospital, instead of the first public hospital).

During the two-month period from 27 January to 30 March 2000, Dr B appeared to take no further steps to follow up her referral. She seems to have assumed that putting a letter in the mail was all that was required to fulfil her professional responsibility as GP to respond to a potentially life-threatening condition. Dr B sent no follow-up letter, and made no telephone contact with a surgeon or the hospital, despite Mrs A's worsening condition and growing concern.

I accept my expert advice that by January 2000 Dr B must have been aware that Mrs A had breast cancer, and should have telephoned a surgeon for an early appointment.

Note taking
I accept my expert advisor's comments that Dr B's clinical notes show "little clear separation of subjective symptoms from objective findings, no clear diagnosis or assessment of the exact nature of illness, and no clear plan recorded". I further note that there is no record of the consultation where Mrs A was advised of the outcome of the mammogram.

Conclusion
Dr B failed to diagnose Mrs A's breast cancer in a timely manner and did not manage her care with appropriate urgency or comply with professional standards of record keeping. In my opinion Dr B failed to provide services of an appropriate standard to Mrs A and breached Rights 4(1) and 4(2) of the Code.

Actions

I recommend that Dr B take the following actions:

- Apologise in writing to Mrs A for breaching the Code. This apology is to be sent to my Office and will be forwarded to Mrs A.
- Review her practice in the light of this report.
- Contact the Royal New Zealand College of General Practitioners to discuss appropriate training or a refresher course in light of this report.

Further actions

- In accordance with Section 45 of the Health and Disability Commissioner Act 1994, I will refer this matter to the Director of Proceedings to determine whether any further action should be taken.
- A copy of this report will also be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners.
- A copy of this report, with details identifying the parties removed, will be sent to the Royal New Zealand College of General Practitioners, Women's Health Action, and the Federation of Women's Health Councils, Aotearoa, and placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings considered this matter and decided not to issue proceedings before the Medical Practitioners Disciplinary Tribunal or the Human Rights Review Tribunal.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.