General Practitioner, Dr C

After Hours Clinic

A Report by the

Health and Disability Commissioner

(Case 11HDC00871)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

TABLE OF CONTENTS

Executive summary

Background

1. Dr C was contracted to provide services at an after hours clinic (the clinic).

2. On 13 August 2011, Ms A presented with body aches and burning while urinating. Dr C performed an unchaperoned examination, including an examination of Ms A's upper and lower body with her lying on her back, and then examined her back with her lying on her front. The examination involved Dr C touching Ms A's legs, groin and back. Ms A said that Dr C also touched her breasts, vagina and clitoris during the examination.

3. Dr C examined Ms A's abdomen through her clothing, then with her clothing moved aside. Ms A was then asked to remove her lower clothing and was naked from the waist down. She was then asked to remove her upper garments. Dr C did not provide Ms A with privacy while she undressed, did not wear gloves during the examination, and did not cover Ms A while examining her. Dr C did not offer Ms A a chaperone.

4. Dr C said he recorded the clinical notes during the consultation. However, during the course of the afternoon he changed the records from initially describing the urinary symptoms to then emphasising that they were present. However, the final version stated that Ms A reported no urinary symptoms.

Decision

5. Dr C had a duty to inform Ms A about the nature and extent of the examination he proposed to undertake and, by failing to do so, he breached Right 6(1)(e)[1] of the Code of Health and Disability Services Consumers' Rights (the Code). As Ms A did not receive sufficient information, she was not in a position to make an informed choice and give informed consent to the examination. Accordingly, Dr C also breached Right 7(1)[2] of the Code.

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[1] Right 6(1) of the Code states:
"Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —
(a) An explanation of his or her condition; and
(b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and
(c) Advice of the estimated time within which the services will be provided; and
(d) Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and
(e) Any other information required by legal, professional, ethical, and other relevant standards; and
(f) The results of tests; and
(g) The results of procedures."

[2] Right 7(1) of the Code states: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."

6. Dr C's examination of Ms A was not clinically indicated and exceeded what was necessary in light of Ms A's presenting symptoms. He did not examine or record Ms A's vital signs. Accordingly, Dr C breached Right 4(1)[3] of the Code.

7. By failing to wear gloves while carrying out an intimate examination, Dr C breached legal and professional standards and, accordingly, breached Right 4(2)[4] of the Code.

8. By failing to advise Ms A that she could have a chaperone or support person present, Dr C breached Right 6(1) of the Code. Furthermore, as Ms A did not receive that information before the examination commenced, she was not in a position to make an informed choice or give informed consent to the examination. Accordingly, Dr C also breached Right 7(1) of the Code.

9. The overall manner in which Dr C conducted the consultation showed a lack of respect for Ms A, in terms of his dismissive response to her concerns, the manner in which he conducted the examination, and the lack of respect for her physical privacy. Accordingly, Dr C breached Right 1(1)[5] of the Code.

10. By changing the clinical records, Dr C breached professional standards and, accordingly, breached Right 4(2) of the Code. Dr C's actions may have impaired the ability of other providers to provide continuity of care to Ms A and, as a result, Dr C failed to minimise the potential for harm to Ms A. Accordingly, Dr C breached Rights 4(4)[6] and 4(5)[7] of the Code.

11. Dr C has been referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

12. The clinic was not on notice of any previous complaints about Dr C. When Ms A presented to the clinic on 13 August she was not triaged by the practice nurse, and her symptoms would not normally have been indicative of a need for an intimate examination. The clinic therefore did not have an obligation to advise Ms A that she could request a chaperone.

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

[4] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

[5] Right 1(1) of the Code states: "Every consumer has the right to be treated with respect."

[6] Right 4(4) of the Code states: "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer."

[7] Right 4(5) of the Code states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

Complaint and investigation

13. On 13 August 2011, the Commissioner received a complaint from Ms A about the services provided by Dr C, a general practitioner at an after hours clinic. An investigation was commenced on 4 November 2011 into the following issues:

- *The appropriateness of the care provided to Ms A by Dr C in August 2011.*
- *The appropriateness of the care provided to Ms A by the clinic in July and August 2011.*

14. Information was obtained from:

Ms A	Consumer/complainant
Mr B	Partner of consumer/complainant
Dr C	General practitioner
Ms D	Practice manager
Ms E	Clinical nurse manager

Also mentioned in this report:

Dr F	General practitioner

15. Independent expert advice was obtained from HDC's in-house clinical advisor, vocationally registered general practitioner Dr David Maplesden, and is set out in **Appendix A**.

Information gathered during investigation

Introduction

16. This report is about the standard of care Ms A received during the course of a consultation with Dr C at an after hours GP clinic.

17. The investigation into Ms A's complaint focused on the standard of care provided by Dr C to Ms A, as well as the clinic's responsibility to provide appropriate services to Ms A. The clinic advised HDC that it had not previously received any complaints about Dr C's conduct.

Chaperone policy

18. At the material time, the clinic had no chaperone policy in place. The clinic stated that each practitioner would be expected to follow their own professional obligations and the Royal New Zealand College of General Practitioners' guidelines.

19. On 17 November 2011, the clinic introduced a policy providing that patients must be offered a chaperone for all intimate examinations and where the patient is required to be in a state of undress. The policy provides that the offer of a chaperone can be made through a number of routes, including prominently placed posters and verbal

information prior to the actual consultation. The policy states that "where it is not always clear ahead of the consultation that an intimate examination or procedure is required, it is advisable to repeat the offer of a chaperone at the time of the examination". The policy provides that "if the patient is offered and does not want a chaperone, it is important to record that the offer was made and declined".

20. The policy requires staff, before conducting an intimate examination, to:

- Explain to the patient why an examination is necessary and give them an opportunity to ask questions.
- Explain what the examination will involve, in a way the patient can understand, so the patient has a clear idea of what to expect, including any potential pain or discomfort.
- Obtain the patient's permission before the examination and record that the permission has been obtained.
- Give the patient privacy to undress and dress and keep the patient covered as much as possible to maintain their dignity.
- Not assist the patient in removing clothing unless it has been clarified with them that assistance is required.

Ms A

21. Ms A is an overseas citizen and, at the time of these events, was working in New Zealand. She speaks English with an accent but is able to understand spoken English and be readily understood when speaking in English.[8] In response to my provisional opinion, Dr C said he believed Ms A was from South East Asia, which made him consider whether she had a serious infectious disease.

22. Ms A stated that, some six years prior to these events, she suffered a bladder infection and, despite taking antibiotics, developed a kidney infection two to three weeks after the bladder infection. In 2010, Ms A had a pelvic infection which again did not respond to antibiotics and resulted in her hospitalisation.

Appointment — 17 July 2011

23. On 17 July, Ms A went to the clinic, because she had symptoms suggestive of a urinary tract infection (UTI). Ms A was assessed by a triage nurse when she arrived and was found to be afebrile with white cells and blood in her urine. The nurse triage notes record Ms A's symptoms of one week of urinary frequency, dysuria,[9] left renal pain and abdominal discomfort. Ms A's temperature was 36.6˚C.

24. After a lengthy wait, Ms A saw GP Dr F. Ms A said that Dr F did not consider her previous failure to respond to antibiotics. Dr F stated that the wait was because the medical centre was very busy that day. He said he took Ms A's previous history into account and apologised if he appeared uncaring. He noted that "perhaps

[8] HDC staff interviewed Ms A on 25 January 2012. During the interview, when Ms A did not understand an expression she asked for clarification.
[9] Dysuria is pain during urination, or difficulty urinating.

communication difficulties may have played a part" in Ms A forming that impression. He examined Ms A and noted that she was afebrile and her abdomen was soft. He prescribed an antibiotic and advised Ms A to return if her symptoms did not settle after taking the antibiotics.

25. Ms A's symptoms resolved after taking the antibiotics, but recurred three weeks later.

Consultation — 13 August 2011

26. On 13 August 2011, Ms A again attended the clinic. She was accompanied by her partner, Mr B. On this occasion Ms A was not triaged by the practice nurse. At 12.19pm Ms A saw Dr C, whom she had not previously met, while Mr B remained in the waiting room.

27. Dr C is currently in the GPEP2[10] programme working towards his fellowship of the Royal New Zealand College of General Practitioners. Dr C qualified in 2000.

28. Dr C said that Ms A indicated that she had not seen a GP for this or other illnesses while she had been in New Zealand. He stated that he did not read the notes before seeing Ms A. At an interview with HDC on 24 February 2012, Dr C stated that, although it is his usual practice to look at the records to see what he had written last time in order to assist his memory, in this case as he had not seen Ms A before, there was no point in his reading her previous records. In response to the provisional opinion, Dr C clarified that it is his normal process to check previous records. However, he stated that "[m]ost of the patients who come to the after hours clinic come only for acute and emergency care as casual patients. Their 'notes' are not stored at the after hours clinic but rather with their regular GP." He stated: "Because we don't normally have notes and I understood she had never seen a GP, I wouldn't have initially looked for her previous records simply because there almost certainly wouldn't be any." He said: "Later in the consultation I found from our records that she was a patient that had seen [Dr F] of our practice previously."

Symptoms

29. Ms A stated that on 13 August 2011, her symptoms were similar to those she had experienced on 17 July 2011. She said that she told Dr C that she had generalised aching, but did not complain of a head or shoulder ache or of any vaginal pain. She stated that she told Dr C that she had pain and a burning feeling when urinating.

30. On 9 December 2011, Dr C made a written response to the complaint. In that response, Dr C refers to Ms A having poor communication skills, which he thought might have been due to a "language barrier" or might have been related to her "unwellness". Dr C stated that Ms A described tiredness and aches all over her body, including her arms, legs, back, shoulders, bladder, abdomen, vagina and knees. He stated that she described having strong head and neck aches, but reported no

[10] This is a training programme for doctors who have sat Primex, or have completed comparable training. This stage of the programme continues their preparation for Fellowship in order to practise as a vocationally registered general practitioner.

symptoms of burning micturition[11] or polyuria.[12] When interviewed by HDC on 24 February 2012, Dr C stated that Ms A did not talk much, was very tired and lethargic, not making eye contact, and said she had body aches everywhere, headaches, neck ache, pain in her lower abdomen, and pain in the kidney area, abdomen and vagina. He stated that Ms A did not say the word "vagina", but rather said that "it hurts down below". Dr C said that Ms A did not complain of urinary frequency or a burning sensation when passing urine. Dr C stated that Ms A said she thought she had a UTI but he thought her symptoms were not consistent with a UTI. In response to the provisional opinion, he added that Ms A "looked very tired dehydrated and weak unable to even make eye contact speak in full sentences, was looking down and sometimes using hands to show where it is hurting ".

Offer of chaperone and information provided

31. Ms A stated that she was not offered a chaperone or the presence of a third party at the consultation. She said that, at that time, she did not know what the word "chaperone" meant, and added that if Dr C had used that word she would have asked for an explanation, as that is her usual practice when she does not understand English words used in conversation with her. During a later telephone conversation with Dr C (discussed below), Ms A said to Dr C: "If I actually knew if I could bring someone in I would have done it 'cause I wasn't feeling comfortable", and, "You could have asked me if I wanted a nurse to be there 'cause I would have wanted that."

32. During that telephone conversation with Ms A, Dr C said he did ask Ms A about a chaperone. He said: "I asked as you entered the room actually." When Ms A said: "Every time I don't understand something I ask what that is. I always do that but I don't think I heard from you." Dr C replied: "I really apologise." In response to the provisional opinion, Dr C stated that his offer of an apology at that time was "really for if I could have asked louder and more clearly".

33. During an interview with HDC, Dr C stated that he explained to Ms A the nature of the examination and that she needed to remove her clothes. He said that at that time he asked whether Ms A "needs the chaperone" and she said she did not want one. Dr C stated: "Conscious of her low capacity to communicate, I recall taking more time than usual to carefully explain to the patient why I felt a physical examination was necessary, and that this would require some of her clothing to be removed. I noted my expectation that she would feel more comfortable having someone else in the room during my examination as a chaperone, and so I told her I could bring a nurse in for that purpose." Dr C asserted that Ms A was very clear that she would "get shy in the presence of a third person". He said he repeated this explanation at the time he showed Ms A the examination couch. In response to the provisional opinion, Dr C commented that he now believes that Ms A was too unwell, tired and distressed to have heard and understood what he said.

[11] Urination.
[12] Polyuria is the passage of large volumes of urine with an increase in urinary frequency.

34. Dr C stated that he recorded Ms A's decision about the chaperone in the notes and showed her the examination couch and the blanket that "we would use to cover her with, so that I had visible to me only the area of her body that I was examining". However, although Dr C asserted that the notes were made contemporaneously, the record in her notes — "Declined chaperone*"* — was made at 3.12pm, approximately 2.5 hours after the consultation had ended.

35. Dr C stated to HDC that he was concerned about possible serious pathology, including meningitis, and considered a comprehensive examination was required because Ms A could not give a good history and could be seriously ill. In response to the provisional opinion, Dr C stated: "I chose to use the look, feel, move approach while examining [Ms A]." He explained that this involved looking for obvious signs of rash, bruises, swelling, discharges and cysts, and feeling Ms A's lymph nodes and skin for raised rashes. During his interview, he stated that he told Ms A that he wanted to check her skin for rashes.

36. In contrast, Ms A stated that Dr C "just asked [her] to lie down" and did not explain the nature or extent of the examination. She said that there was no curtain around the examination couch.

Examination

Gloves

37. Ms A stated that Dr C was not wearing gloves while he examined her. During the telephone conversation with Ms A later on 13 August, Dr C stated that he was wearing a glove on his left hand but not on his right hand. However, when interviewed by HDC, Dr C agreed that he was not wearing gloves.

38. In response to the provisional opinion, Dr C said he now believes that he was wearing gloves on both hands and removed one while palpating the lymph nodes or checking the blanching of a rash. However, he is unable to remember exactly what happened.

Abdomen

39. Ms A said that she lay on the couch fully clothed and Dr C examined her abdomen through her clothing, by pressing on her belly. Dr C then asked her to pull up her upper clothing and lower her pants to expose her belly, and he continued to press and touch her belly. Dr C stated that he carried out an abdominal examination and found that Ms A was tender over her bladder and renal angles.

Legs

40. Dr C stated that after examining Ms A's abdomen he asked her to lower her pants, and he then examined her genital area, then he "asked the patient to cover up as [he] turned to an examination of her legs". However, he also said: "I wanted to see the leg part and then I said to lower the pants, then she lowered it … I was looking at her legs". Dr C explained that this was for the purposes of examining Ms A for rashes and muscle wasting. Dr C advised that he would have provided Ms A with a cover and that "I have used curtains while patient was undressing … This is what I normally do for any patient and I would have done the same with [Ms A] as well."

41. In contrast, Ms A said that after Dr C examined her abdomen, he asked her to take off her pants, and he stood and watched her while she took off her lower clothing, which included her trousers, thermal underwear and socks. She stated that Dr C did not at any stage provide a sheet or blanket for her to cover herself.

42. Ms A said that Dr C then "massaged" her legs, pressing and pushing on them. Dr C stated that he examined Ms A's legs because of her complaint of leg pain. He advised that he touched Ms A's legs to check for meningeal rash, did a visual comparative test for muscle wasting, and checked her calves for tenderness, DVTs, swelling or Kernig's sign.[13]

43. Ms A said that Dr C did not explain what he was looking for while he was massaging her legs and, when she asked, "Can you feel something by massaging me like that?" he mentioned something about her muscles. When Ms A spoke to Dr C later in the day she asked about the examination of her muscles. Dr C replied that if "the muscle was tender and the tone lax, or floppy, [he] would have referred her for an ultrasound scan of the particular muscle".

44. Dr C agreed that he touched Ms A's legs and said this was because there was "some redness around the area which [he] wanted to check if it [was] a rash which [he was] not able to see, [as he is] not used to the skin colour". In response to the provisional opinion, Dr C said: "I think I explained earlier that I was only looking for signs and symptoms of sinister diseases including by a blanching test but I was not 'massaging'." He stated: "I touched with 1–2 fingers in [a] couple of areas of doubt but not with the intention of massaging Ms A." Dr C added that he was checking for calf pains and boils.

Genital examination

45. Dr C stated: "At least a limited examination of the patient's genital area was warranted. I asked her to lower her pants for this purpose and she promptly did so without question. I did not see any obvious thrush, discharge, bartholins cyst[14] etc externally." In response to the provisional opinion, Dr C advised that it was not his intention to do an intimate examination. He stated that he "asked Ms A to lower her clothes to palpate the lymph nodes at the groin". Dr C also advised that this was just a "visual only examination" for the purposes of checking for a sexually transmitted infection (STI). He stated that he believed Ms A was from South East Asia, in which case, "a rule of thumb is to rule out STIs".

46. Dr C stated that Ms A was lying on her back with her legs straight, and he visualised her genital area but did not do a vaginal examination. Dr C was adamant that he did

[13] Kernig's sign is one of the physically demonstrable symptoms of meningitis. Severe stiffness of the hamstrings causes an inability to straighten the leg when the hip is flexed to 90 degrees.

[14] The Bartholin's glands are located at the entrance to a woman's vagina, one on each side. They are small and cannot be seen or felt when they are normal. Problems with the Bartholin's glands include cysts, which are relatively painless enlargements of the gland, and abscesses, which are infections of the gland.

not ask Ms A to bend her legs or pull her heels up towards her buttocks. He stated that he examined the lymph nodes in Ms A's groin, "and look[ed] to see if there was anything obvious" but did not touch her genital area. He stated that he did not undertake a per vagina (PV) examination. Ms A stated: "When he was close to my vagina he kind of like opened kind of so and then he touched the clitoris just once or twice. If it was longer than that I would have walked out but he was kind of careful and just touched and then he moved off and then asked me to take off my other clothes."

Upper body

47. Ms A stated that Dr C then asked her to take off her upper clothing and, when she queried whether she had to remove all her clothing, he told her that she did. Ms A said she removed her upper clothing, which included a shirt and a sports bra. Ms A said that she was then lying on her back on the couch, naked, with no covering. Ms A said that Dr C then massaged her breasts. She stated that Dr C did not examine her with a stethoscope.

48. In contrast, Dr C stated that he asked Ms A to lift up her shirt in order for him to check her skin for rashes, "but to [his] surprise she took her whole shirt off. She was not wearing a brassier (sic) which I did not know before, so I provided her with the blanket to cover herself." Conversely, Dr C also stated that, after he had examined Ms A's legs, she pulled her trousers back up and he then asked her to roll over so he could check for a rash on her back.

49. Dr C stated that he listened to Ms A's heart and lungs and recorded that they were strong dual heart sounds and that her lungs were clear. However, Ms A stated that Dr C did not examine her with a stethoscope. At 1.46pm Dr C recorded: "Heart and lungs normal abd soft no rebound tenderness."

Back

50. Ms A stated that after Dr C massaged her breasts he asked her to turn over. She said she was naked at that time, with no covering. Dr C advised that he checked "the lymph nodes in the Axilla" but he denies examining Ms A's breasts. He agreed that after he auscultated her heart and lungs he asked her to turn over, and said that that was so he could check her spine and paraspinal muscles. He said he "used the cloth to cover her breast area when she turned over". He stated that this was after he had examined Ms A's legs and she had re-dressed her lower body.

51. Ms A stated that she was feeling more and more uncomfortable, but when she asked Dr C whether he could see anything by doing this he responded: "Are you a nurse?" Ms A said that this response was made in an aggressive manner. Ms A stated that Dr C then massaged her back and legs. Ms A said that she kept asking, "Is it really necessary?" and Dr C then gave an explanation of why he was examining her, but she could not understand the medical terminology he used. Ms A said that, as she was feeling really uncomfortable, she did not ask for clarification until she had re-dressed.

52. In response to the provisional opinion, Dr C agreed that he asked Ms A whether she was a nurse, but stated that this was at the beginning of the consultation in response to her declining having a chaperone, and that he "was never aggressive with [Ms A]".

Re-dressing and urine test

53. Ms A said that, following the examination, Dr C told her that she could put her clothes back on, and stood watching her while she did so. Ms A advised that she felt uncomfortable and so did not replace her bra or socks.

54. Ms A said that Dr C then told her that she had a kidney infection. She asked him whether he could tell that she had a kidney infection by touching her body, and he said "yes". Ms A said that he pointed to a picture of a human body and showed her how the infection could move from the bladder to the kidneys.

55. Ms A said that Dr C then went back to his desk and said he needed her to take a urine test. Dr C showed her where to go to produce the urine sample.

56. In contrast, Dr C claimed that having completed the examination he left the room while Ms A re-dressed, and that she then came out of the room to do the urine test. Dr C stated: "This is what I normally do for any patient and I would have done the same with [Ms A] as well." Dr C advised that a dipstick procedure was carried out, which showed white blood cells and proteins in the urine, which suggested a UTI.

57. Ms A advised that her partner, Mr B, was waiting for her in the waiting room and, as she passed him, she handed him her bra and socks. Mr B has confirmed this. Ms A said that Dr C saw her do so and, when Ms A returned to the consultation room, Dr C asked her whether Mr B was her boyfriend. Ms A said that he was, and Dr C said, "I want your boyfriend to come in as well", and that after that Dr C spoke to Mr B, rather than to her.

58. Mr B stated that Dr C said he had had to feel Ms A's stomach and "her areas just to find something out".

59. Dr C stated that Mr B was invited into the consultation room with Ms A's consent, and additional history was obtained from him. Treatment and follow-up instructions were given to both Ms A and Mr B, and Ms A was given a prescription for Augmentin,[15] Ural sachets,[16] and paracetamol.

60. Dr C said that, when she went to pay, Ms A was concerned at the amount she had been charged, and there was "apparently a heated discussion at reception regarding this".

[15] Augmentin is an antibiotic used to treat bacterial infections.
[16] Ural granules are a urinary alkaliniser that provide fast relief from the symptoms of cystitis (inflammation of the bladder, usually caused by a bacterial infection; cystitis is also known as a urinary tract infection (UTI)).

Further contacts

61. At 3.01pm, Dr C telephoned Ms A and asked to speak to Mr B. Mr B said that Dr C asked him whether the couple would like to become his patients, which Mr B declined. Mr B said that there was no discussion of any need to enrol with the practice in order to have Ms A's tests processed.

62. Dr C stated that he realised Ms A did not have an NHI (National Health Index number)[17] when the MSU (mid-stream specimen of urine)[18] was to be sent off to the laboratory, which meant that she would have to pay for the test. He said that that was why he rang her to ask whether she would like to enrol with the practice.

63. Later in the day on 13 August 2011, Ms A telephoned Dr C to express concern about the consultation, and recorded the conversation without Dr C's knowledge. Ms A was unable to determine the time of this conversation from her Skype records. Dr C said that it was "later on that evening". The clinic has not been able to confirm the time of this telephone call.

64. A copy of the record of that conversation has been provided to HDC. During the conversation, Ms A asked why Dr C had had to touch her muscles. Dr C replied that it was because he thought that she might have had a kidney infection, she had not given a good history, and her whole body was aching. He also stated during the conversation that he thought Ms A might have a nervous weakness, that her muscles were sore, and that he was checking for glandular fever.

65. Dr C did not mention the additional symptoms of headaches, neck ache, pain in her lower abdomen, and pain in the kidney area, abdomen and vagina that he later related to HDC.

66. During the conversation, Dr C agreed that he asked Ms A to undress, and did not deny that Ms A was naked. Dr C said that he had asked Ms A to lower her clothing in order for him to look at her legs to check for a rash.

67. In response to the provisional opinion, Dr C said: "I was busy and engaged with other patients when I got the phone call. I could not explain things properly as I would in the presence of a 3rd party. … I was simply trying to respond to [Ms A's] specific questions as she put them to me, as best I could in the circumstances." He said that he was "intimidated by [Ms A's] repeated questions" and that he did not think it would have been "wise to pedantically argue with each statement I disagreed with, otherwise [Ms A] would have got very upset". Dr C also noted that the recording finishes before the completion of the conversation. Dr C recalls that the call ended with Ms A and Mr B thanking him.

[17] The National Health Index number (NHI number) is a unique identifier that is assigned to every person who uses health and disability support services in New Zealand.
[18] The purpose of an MSU test is to confirm the diagnosis of a urine infection and to help choose an appropriate antibiotic.

Clinical records

68. When HDC asked whether he made his notes contemporaneously and whether he subsequently changed them, Dr C stated: "I think I wrote during the consultation, I wrote during while she was sitting there, I wrote as it happened." He stated that he changed a part only where he "wrote about the altercation with the patient" that Ms A and Mr B had had with the receptionist about the amount they were charged. Dr C stated that he made no other amendments to the clinical records.

69. The consultation began at approximately 12.19pm, and Ms A was billed at 12.42pm (after the consultation had concluded).

70. There are three note entries for 13 August 2011, all with Dr C as the provider. The first relates to the medical consultation with Ms A. The second relates to the discussion about the MSU sample and telephone call to Ms A. The third relates to the call Dr C received from Ms A.

71. A number of changes were made to the notes during the course of the remainder of the day. The notes initially stated: "c/o body aches poly". During the course of the changes, Dr C added "declined chaperone". He changed "complained of body aches poly" to "complained of body aches plus flank pain, polyuria and dysuria" to "no symptoms of burning micturition or polyuria history".

72. The notes audit trail begins at 12.45pm on 13 August 2011. In the following presentation of the notes, for ease of reference, the comments that were added are in bold, and the comments that were deleted are in italics, with a line through the deleted words. The notes are recorded in two sections headed "subjective" and "objective".

73. The changes are as follows:

> "Subjective notes" c/o body aches poly **+ flank pain polyuria and dysuria**.
>
> "Objective Notes" were changed from being essentially blank to: **WBC+ Protein+ on dipstic Tender all over the abdomen and over the back c/o sore thigh and biceps and also paraspinal muscles ?flu+UTI/pyelonephritis oral abs given send urine to lab take it easy from [work] drink plenty of water.**

74. The notes were next altered at 1.46pm on 13 August 2011. In "Subjective notes" a "**+**" was added after "dysuria". In "Objective Notes", the changes are:

> WBC+ Protein+ on dipstic Tender all over the abdomen and over the back c/o sore thigh and biceps and also paraspinal muscles **Heart and lungs normal abd soft no rebound tenderness** ?flu+UTI/pyelonephritis oral abs given send urine to lab take it easy from [work] **until she gets better** drink plenty of water. **Explained to partner to keep a close eye and watch for signs of worsening and take her to ED if need be**.

75. The next alteration was at 2.12pm. The "Subjective notes" were unchanged. In "Objective Notes" the changes are:

> WBC+ Protein+ on dipstic Tender all over the abdomen and over the back c/o sore thigh and biceps and also paraspinal muscles Heart and lungs normal abd soft no rebound tenderness ?flu+UTI/pyelonephritis oral abs given send urine to lab take it easy from [work] until she gets better drink plenty of water. Explained to partner to keep a close eye and watch for signs of worsening and take her to ED if need be **(partner questioning about the high charge — [receptionist] explained to them the prices)**.

76. The next alteration was at 2.50pm with the addition of:

> **charged only $82 instead of $123.**

77. The next alteration at 3**.**12pm was as follows:

> In "Subjective notes" — "**very poor history communication difficult ?language barrier works in [workplace] will be here for an year ?PV discharge then c/o pelvic pain then** c/o body aches+flank pain polyuria and dysuria **+ no GP here**
>
> In "Objective Notes" — "**Declined chaperone** ~~*WBC + Protein +on dipstic*~~ Tender all over the abdomen and over the back c/o sore thigh and biceps and also paraspinal muscles **no enlarged LNs did not do PV** Heart and lungs normal abd soft no rebound tenderness ?flu+UTI/pyelonephritis oral abs given send urine to lab take it easy from [work] until she gets better drink plenty of water. Explained to partner to keep a close eye and watch for signs of worsening and take her to ED if need be **WBC+ Protein+ on dipstic done by RN Sent urine spec to lab rang pt and told them to f/u with after hrs as they do not have a GP in town** (partner questioning about the high charge — [receptionist] explained to them the prices) charged only $82 instead of $123.

78. The next alteration was at 3.44pm. There was no change in "Objective notes" but the following changes in "Subjective notes":

> very poor history communication difficult ?language barrier works in [workplace] will be here **in NZ** for an year ?PV discharge then c/o pelvic pain then c/o body aches+flank pain polyuria and dysuria **+ very vauge (sic) Has** no GP here **in NZ**.

79. The final version of the notes[19] supplied to HDC by Dr C are as follows:

> "Subjective notes" — very poor history communication difficult ?language barrier works in [workplace] will be here in NZ for an year **c/o tiredness and aches all over the body headache and neck aches+ no cough, thinks she has bladder infection no symptoms of burning micturition or polyuria history** ~~*?PV discharge then c/o pelvic pain then c/o body aches+flank pain polyuria and*~~

[19] The clinic was unable to provide the audit trail showing the time the final two notes were made.

~~*dysuria*~~ very vauge Has no GP here in NZ. **Haven't seen any GP before for this illness**

"Objective Notes" — Declined chaperone **o/e no neck rigidity, no rash on body, no stiffness of muscles no signs of meningism Heart dual hs+ Lungs clear no muscle wasting or weakness tender over the right flank c/o sore thigh and tender vastus muscles also tender calfs paraspinal muscles tender,** ~~*Tender all over the abdomen and over the back c/o sore thigh and biceps and also paraspinal muscles*~~ no enlarged LNs **in neck, axilla or groin, no glandular fever in past** did not do PV ~~*Heart and lungs normal*~~ abd soft **non tender bs+** ~~*no rebound tenderness*~~

Differential: Flu, unlikely glandular fever, unlikely meningitis. Muscle aches due to repetitive work at [workplace]. Oral abs given. Urine to lab dip stic showed WBC+ Protein++ done by RN. Take it easy from [work]. Encouraged lot of fluids. When pt went to give urine specimen, saw partner in the waiting room and invited him in to the consult.

~~*?flu+UTI/pyclonephritis oral abs given send urine to lab take it easy from [work] until she gets better drink plenty of water*~~

Explained to partner to keep a close eye and watch for signs of worsening and take her to ED if need be ~~*WBC + Protein + on dipstic done by RN Sent urine spec to lab rang pt and told them to f/u with after hrs as they do not have a GP in town (partner questioning about the high charge – [receptionist] explained to them the prices) charged only $82 instead of $123*~~.

80. The next consultation note states:

it would be a hassle to send urine spec to lab as pt has no NHI. Rang pt offered her to enrol with me — so that urine results could be followed up but pt's boyfriend declined…SO URINE RESULT NOT SENT. Boyfriend seems to be still unhappy about the cost, examination and treatment. Says he will find another doctor and another GP practice

81. The final consultation note states:

pt rang me and asks me why I had to examine her whole body for bladder inf — explained that since her history was very vaugue (sic) and since I did not know that her boyfriend was waiting outside during the first consult, I had to do a whole head to toe exam. Explained that I was ruling out various causes like meningitis and muscle wasting/bruising/swelling due to RSI. Apologised if I caused any discomfort. Pt said thanks for explaining and thanks for examining. I said if she wants to further discuss she could come and see me right now.

Vital records

82. Dr C made no record of basic observations of pulse, blood pressure and temperature or respiratory rate.

83. HDC contacted Ms A and asked whether Dr C measured her blood pressure or breathing rate, or took her pulse or temperature. Ms A responded that Dr C did not measure any of these observations, and the only test he carried out was a urine test after he had examined her.

84. In response to the provisional opinion, Dr C submitted that the vital signs were observed but not recorded. He advised that he is "absolutely sure" that he checked them, recalling that Ms A was afebrile, slightly tachycardic with normal oxygen saturations. He accepts that not recording these observations was a departure from accepted standards.

Response to provisional opinion

85. Dr C submitted that Ms A was very unwell when she presented at the consultation and, as such, he believes that she may have missed or not understood a lot of the information he provided her. He advised that she did not even understand the word GP, and he had to explain this word to her.

86. Dr C agrees that a simple urinary infection does not require a head-to-toe examination. However, in this case, because Ms A appeared so unwell and was unable to give a good history, Dr C advised that he was "anxious about her safety and had to do a comprehensive exam".

87. Dr C submitted that he gave Ms A all the relevant information about the examination, and proceeded only with Ms A's verbal consent. He stated that at no time did Ms A ask him to stop the examination.

88. In relation to the multiple changes to Ms A's consultation notes, Dr C advised that looking at the audit trail now he believes that he would have made an initial brief note at the time of the consultation. However, due to time pressure he left the notes incomplete. Then, because Mr B was "hostile" during his later telephone call to discuss enrolling with a GP, Dr C thought it wise to complete his notes.

89. In relation to why he initially wrote "polyuria and dysuria +" but later changed this to "no symptoms of burning micturition or polyuria history", Dr C stated that "this is just a simple correction just a clerical error on my part". He acknowledged that when asked about whether he had made any changes to the records he told the HDC investigator that the only change he had made was in relation to the charge for the consultation. However, he submitted that he made this statement without looking back at the audit trail and that his recollection had been incorrect.

90. Dr C acknowledged that he has been inconsistent with his recollection, but said that throughout the investigation various prompts such as the clinical records and the recording of his conversation with Ms A have enabled him to remember details of the consultation. He stated: "I know it looks like I am being inconsistent but all this is happening because I am unable to remember exactly what happened on that day."

91. Dr C advised that he regrets that Ms A was unable to understand the information he gave her, and said that he is enrolled to do the PRIMEX Clinical exam conducted by The Royal New Zealand College of General Practitioners to help improve his communication skills.

Standards

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

> "5. A breach of sexual boundaries comprises any words, behaviour or actions designed or intended to arouse or gratify sexual desires. It is not limited to genital or physical behaviour. It incorporates any words, actions or behaviour that could reasonably be interpreted as sexually inappropriate or unprofessional.
> …
>
> 8. Sexual impropriety means any behaviours, such as gestures or expressions, that are sexually demeaning to a patient, or that demonstrate a lack of respect for the patient's privacy. Such behaviours include, but not exclusively:
>
> - examining the patient intimately without his or her consent…
>
> 23. As the professional, the onus is always on you to behave in a professional manner. You must ensure that every interaction with a patient is conducted in an appropriate professional manner.
>
> 27. An important aspect of any consultation is communication with the patient. You must obtain informed consent before conducting a physical examination. This is not only a right of the patient but the discussion will also help to avoid miscommunication or misunderstanding about what you are asking or doing.
>
> 28. Your actions and how you communicate them to the patient influence the patient's perceptions about what you do and the treatment he or she receives. What may be an acceptable form of physical examination may appear suspicious behaviour to a patient if he or she does not understand what is happening and why it is necessary.
>
> Explain why you are asking questions or why the physical examination is necessary and what will happen in the examination. Remember that it may be obvious to you why these questions or examinations are necessary but it may not be obvious to the patient.
>
> 29. Make sure the patient is aware that he or she should voice any feelings of discomfort or pain and that he or she can ask you to stop at any time.

Disrobing facilities

30. If the consultation involves a physical examination that requires the patient to remove his or her clothes, you should provide an appropriate place to undress. This is an area where the patient can undress in private, out of view of anyone else, including you (although someone should be able to help if necessary).

31. Disrobing facilities may be provided by a curtain or a separate changing area.

32. You should not require a patient to undress unnecessarily or stay undressed for unnecessary lengths of time. For example, the patient only needs to uncover the part of the body that is being examined, and should be allowed to cover it again once you have finished.

33. If the physical examination includes several parts of the body, you should endeavour to allow the patient to cover as much of his or her body as possible before moving on."

93. The Medical Council of New Zealand publication *The Maintenance and Retention of Patient Records* (August 2008) states:

> **"Introduction**
> Records form an integral part of any medical practice; they help to ensure good care for patients and also become critical in any future dispute or investigation.
>
> 01. Maintaining patient records
> (a) You must keep clear and accurate patient records that report:
> - Relevant clinical findings.
> - Decisions made.
> - Information given to patients.
> - Any drugs or other treatment prescribed.
>
> (b) Make these records at the same time as the events you are recording or as soon as possible afterwards."

94. The New Zealand Medical Association's *Code of Ethics* (2008) recommends:

> 9. "Doctors should ensure that patients are involved, within the limits of their capacities, in understanding the nature of their problems, the range of possible solutions, as well as the likely benefits, risks, and costs, and should assist them in making informed choices".

Opinion — Breach: Dr C

Introduction

95. This opinion relates to the conduct of Dr C during and following a single consultation with Ms A. The events that occurred during the consultation concerned and distressed Ms A.

96. Ms A was unsure about what was reasonable in the circumstances, and so she complied with Dr C's requests to remove all her clothing and permitted him to touch most of her body. Trust is especially important in the doctor–patient relationship. Patients look to their doctor as a person in whom they place trust and impart confidences. In my view, Dr C took advantage of this trust and behaved in an inappropriate and unacceptable manner.

97. I am concerned about the nature of the examination and the manner in which it was conducted. I consider that Dr C's conduct amounts to sexual impropriety. The Medical Council of New Zealand's publication *Sexual Boundaries in the Doctor–Patient Relationship* specifies that sexual impropriety includes any behaviours that are sexually demeaning to a patient or that demonstrate a lack of respect for the patient's privacy, and include examining a patient intimately without the patient's consent. I am also concerned about Dr C's actions following the consultation, in that he altered the clinical records a number of times. Dr C's repeated alteration of the clinical records in the manner that occurred here also casts doubt on his credibility. Furthermore, it is notable that Dr C has provided a number of versions of the events that occurred at the consultation, whereas Ms A has consistently provided the same version of events.

98. I accept Ms A's account that Dr C examined her abdomen while she was clothed, then asked her to remove her lower clothing and massaged/touched her legs and groin and touched her vagina and clitoris. Following this, Dr C asked Ms A to remove her upper clothing and massaged/touched her breasts, then asked her to roll over and massaged/touched her legs and back.

Consultation information and consent — Breach

99. Dr C was working at the clinic. He had one consultation with Ms A on 13 August 2011. He stated that he did not read Ms A's records before seeing her. As a result, when the consultation began he was not aware of her previous UTI, which had been treated by Dr F. In my view, reading the notes is a fundamental aspect of appropriate care, particularly when seeing a patient for the first time. This would apply even if most patients were casual patients. I note that Dr C said that, notwithstanding his failure to read the notes, he became aware of the previous consultation during the course of his assessment of Ms A.

100. I have considered whether Ms A gave legally effective consent for Dr C to undertake a "top to toe" examination of her body. Dr C stated that he explained to Ms A in some detail about the need for her to undress, and stated: "I recall taking more time than usual to carefully explain to the patient why I felt a physical examination was necessary and that this would require some of her clothing to be removed." He said

that he repeated this explanation at the time he showed Ms A the examination couch. During his interview, he stated that he told Ms A that he wanted to check her skin for rashes.

101. In contrast, Ms A stated that Dr C "just asked [her] to lie down" and did not explain the nature or extent of the examination. Ms A stated that Dr C did not explain what he was looking for while he was massaging her legs and, when she asked, "Can you feel something by massaging me like that?" he mentioned something about her muscles.

102. It is clear that even after the completion of the consultation Ms A was uncertain about the purpose of the physical examination. When she telephoned Dr C later that day, she asked him to explain why a full body examination had been required, and he replied that the examination was needed because of her complaints about generalised aches and weakness. Dr C referred to generalised sepsis and said that he checked Ms A's glands for glandular fever. Ms A asked about the examination of her muscles, and Dr C replied that "if the muscle was tender and the tone lax, or floppy", he would have referred her for an ultrasound scan of the particular muscle.

103. HDC asked Dr C to describe the information he gave to Ms A before he examined her. He said that he explained that he wanted to check for meningitis and glandular fever and check her skin. Ms A stated that Dr C gave her no information about the proposed examination and, in particular, did not ask for consent to touch her groin area.

104. With regard to the genital examination, Dr C stated: "At least a limited examination of the patient's genital area was warranted. I asked her to lower her pants for this purpose and she promptly did so without question." He said he conducted a visual examination of her genital area but denies touching the area. However, Ms A stated that Dr C briefly touched her vagina and clitoris. She stated that she was given no information in advance that such touching would occur and, had the touching been prolonged, she would have walked out.

105. Right 6(1) of the Code provides that before making a choice and giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. I find that Dr C did not provide sufficient information to Ms A or obtain consent from her. In my view, a reasonable consumer in Ms A's circumstances — being a new patient to Dr C, presenting with symptoms of a UTI and about to undergo an extensive physical examination — would reasonably expect to receive information about the extent of the examination that was proposed, how the examination would be conducted, and the reason(s) why the examination was necessary.

106. Right 6(1)(e) provides specifically that the information that consumers have a right to receive includes any information required by legal, professional, ethical and other relevant standards. In this circumstance, I note that an applicable standard is the Medical Council of New Zealand's statement *You and Your Doctor — A Guide to your relationship with your doctor* (2008), which provides that doctors are to tell their patients why an intimate examination is needed, and how it will be performed. It also

provides that a patient must always be asked for his or her consent before the examination, and it should be clear that the patient has agreed to the examination before it is undertaken.

107. Dr C had a duty to inform Ms A about the nature of the examination he proposed to undertake and the reason(s) for it. By failing to do so, he breached Right 6(1) of the Code. As Ms A did not receive sufficient information, she was not in a position to make an informed choice and give informed consent to the examination. Accordingly, Dr C also breached Right 7(1) of the Code.

Extent of Examination — Breach

108. Ms A said that she presented to Dr C stating that she had generalised aching, and pain and burning when urinating. In contrast, Dr C said that Ms A did not complain of urinary frequency or a burning sensation when passing urine, and that he thought her symptoms were not consistent with a UTI. I note that Dr C initially recorded "c/o [complained of] body aches poly" and subsequently changed that to "c/o body aches+flank pain polyuria and dysuria". He later changed the notes to read "thinks she has bladder infection, no symptoms of burning micturition or polyuria history". However, he prescribed an antibiotic and Ural sachets, which are used to treat bladder inflammation.

109. I accept Ms A's statement that she complained to Dr C of frequency of urination and a burning sensation while urinating, plus aching of her body.

110. Dr C asked Ms A to move her clothing aside and expose her abdomen. My expert advisor, Dr Maplesden, advised that it was reasonable to exclude pyelonephritis,[20] which could have been done through an assessment of Ms A's vital signs for any indications of systemic sepsis, an abdominal examination to check for renal tenderness, and urinalysis. Accordingly, I accept that it was appropriate for Dr C to perform the abdominal examination.

111. Dr C said that he then proceeded to carry out what he described as a "top to toe" examination, including a visual inspection of Ms A's genitals, assessment of her muscle tone, inspection for muscle wasting, and a skin inspection. He stated that this was necessary because Ms A was a poor historian and could not localise her symptoms. However, three weeks earlier, when Ms A presented with similar symptoms, Dr F was able to diagnose a probable UTI by way of a urine test and examination of Ms A's abdomen. I note that Ms A maintains she was specific in describing her symptoms to Dr C, and that initially he recorded them as she described.

112. Dr Maplesden advised that "based on the history [Ms A] states she gave to [Dr C], and initially recorded by [Dr C] in his notes, and noting [Ms A] was apparently not sufficiently unwell to have warranted nurse triage or recording of vital signs or to have any objective evidence of significance unwellness, I feel there was no clinical

[20] A kidney infection.

indication for the physical examination to have extended beyond that discussed [an abdominal examination, assessment of vital signs and urinalysis]".

113. Dr C stated that he visualised Ms A's genital area while Ms A was lying on her back with her legs straight, and said he did not ask Ms A to bend her legs in order for him to see the genital area. When asked specifically, Dr C repeated that he did not ask Ms A to bend her legs or pull her heels up towards her buttocks. He stated that he did not see any obvious thrush, discharge or Bartholin's cyst.

114. I do not find credible Dr C's account that he could visualise Ms A's genital area sufficiently to assess whether she had thrush, discharge or a cyst while she was lying on her back with her legs straight.

115. Ms A stated: "When he was close to my vagina he kind of like opened kind of so and then he touched the clitoris just once or twice." Dr C stated that he did not touch Ms A's genital area, but only visualised it. I accept Ms A's statement that Dr C touched her vagina and clitoris.

116. Dr Maplesden advised that there was no clinical indication for the genital examination and, had there been a suspicion of underlying sexually transmitted infection, the appropriate process would have been to take vaginal swabs and/or a first catch urine sample, rather than the examination described by Dr C.

117. Dr Maplesden advised that "the circumstances of the physical examination, as described by Ms A, were clearly a severe departure from expected standards". I find that the examination of Ms A undertaken by Dr C (apart from the abdominal examination and urinalysis) was not clinically indicated in light of her reported symptoms. Therefore, I find that Dr C did not provide services with reasonable care and skill and, accordingly, Dr C breached Right 4(1) of the Code.

Vital signs — Breach

118. Dr C stated that Ms A was significantly unwell and that he was concerned that she might have sepsis, pyelonephritis or meningitis. However, he did not record the basic observations of pulse, blood pressure and temperature. He also did not record Ms A's respiratory rate. As stated by Dr Maplesden:

> "[T]hese observations, the 'vital signs', are fundamental to the process of determining degree of systemic unwellness and aiding appropriate triage categorisation. In combination with the patient history, they may determine the extent of examination required. To suspect serious illness as [Dr C] states he did, but failed to undertake these basic observations, is a severe departure from expected standards. To undertake but fail to record these observations in a very unwell patient would be a moderate departure from expected standards."

119. When asked whether Dr C measured her blood pressure, took her pulse or temperature, or measured her breathing rate at any stage during the consultation, Ms A responded that the doctor did not measure anything, and the only test conducted was the urine test he carried out "after he had examined [her] body".

120. HDC asked Dr C to describe the examinations he conducted. He said he listened to Ms A's heart and lungs and performed a urine test (although Ms A denies that he listened to her heart and lungs). Dr C's account did not include having taken the vital observations, nor did he make any record of them. It was not until he responded to the provisional opinion that Dr C advised that it is his usual practice to check the vital signs. He said he is "absolutely sure" that he checked them in this case, and was able to recall the details of the results.

I accept Ms A's statement that Dr C did not examine her vital signs. In my view this was a breach of her right to have services provided with reasonable care and skill. Accordingly, I find that Dr C breached Right 4(1) of the Code.

Use of gloves — Breach

121. Ms A stated that Dr C was not wearing gloves while he examined her. Dr C's account has been inconsistent. During his telephone conversation with Ms A on 13 August, Dr C stated that he was wearing a glove on his left hand but not on his right hand. However, when interviewed by HDC, Dr C accepted that he did not wear gloves. Dr C has since advised that, while he cannot be sure, he now believes that he was wearing gloves on both hands, but removed one of them while palpating Ms A's lymph nodes.

122. The Medical Council of New Zealand's publication *You and Your Doctor* states that the patient's health and safety are the doctor's first concern. Under the heading "Boundaries between Patients and Doctors" it states that a doctor may need to examine parts of the body that the patient might feel embarrassed or uncomfortable about, and when such personal examinations are needed the doctor will:

- leave the patient to undress in private unless the patient has asked for help
- keep the patient covered as much as possible during the examination
- use gloves where appropriate; and
- explain what is being done and why.

123. The Medical Practitioners' Disciplinary Tribunal considered the issue of doctors wearing gloves, and stated:[21]

> "To avoid doubt, the Tribunal states that a doctor performing an internal or intimate examination must always wear gloves."

124. In this case, the examination involved Dr C touching much of Ms A's body, including her legs, breasts, groin, and back. I note that in his latest account he advised that it is likely that he removed one of the gloves when touching Ms A's groin in order to assess her lymph nodes. I have accepted that Dr C also touched Ms A's vagina and clitoris. In my view, the touching of Ms A's genital area was an intimate examination,

[21] Decision 303/04/120C.

and it was inappropriate to carry out such an examination whilst not wearing gloves. I note Dr Maplesden's advice:

> "[I]f [Dr C] touched [Ms A's] genital area without gloves, I would regard this as a severe departure from expected standards. I would not expect gloves to be routinely worn for an examination that did not include the genital or anal area or digital examination of the oral cavity, although some of my colleagues might use gloves for examination of the groins and axillae as hygiene protection for themselves."

125. I find that by failing to wear gloves while carrying out an intimate examination, Dr C breached legal and professional standards and, accordingly, he breached Right 4(2) of the Code.

Chaperone — Breach

126. Dr C conducted an unchaperoned examination of Ms A's legs, groin, genital area, abdomen, breasts, and back.

127. Ms A is adamant that at no stage did Dr C offer her the opportunity of having a chaperone or support person present. Ms A asserted that at that time she did not understand the meaning of the word "chaperone" and, had it been used, she would have asked for an explanation. I note Dr C's submission that, in hindsight, he believes Ms A missed a lot of what he said, because of her "unwellness". He said that she did not even understand the word "GP" and he had to explain it to her, which is consistent with Ms A's account that she would question the meaning of a word she did not understand. Ms A commented that had she been offered the presence of a support person she would have asked for her partner, who was in the waiting room.

128. During the telephone conversation with Ms A, Dr C stated that he asked her about the chaperone as she entered the room. As stated, Dr C had not previously met Ms A, and she had not been triaged by the practice nurse. When Ms A entered the consultation room, Dr C had no knowledge of why she was there or whether a physical examination was required. I note Dr C's submission that he offered a chaperone at this time because Ms A was gravely unwell, and he considered that he might need someone else present to assist with communication. However, in my view, it is unlikely that Dr C would have asked Ms A whether she wished to have a chaperone as she entered the consultation room.

129. During his interview, Dr C stated that, later in the consultation, when he told Ms A that the examination would require some of her clothing to be removed, he "noted [his] expectation that [Ms A] would feel more comfortable having someone else in the room during [his] examination as a chaperone, and so [he] told her [he] could bring a nurse in for that purpose".

130. Dr C also stated that he made the notes during the consultation and specified the limited changes that he made later. However, in contrast to his account, the audit trail shows that at 3.12pm he changed the clinical records to include that Ms A had declined a chaperone.

131. I note the inconsistency of Dr C's accounts of events, and therefore accept Ms A's account that no chaperone was offered. The Royal New Zealand College of General Practitioners (RNZCGP) publication *Standard for New Zealand General Practice* provides that informed consent may include "routinely informing patients of their right to have a chaperone present during consultations".[22] The standard suggests that informing patients about their right to have a chaperone may be part of the informed consent process.

132. As stated, Ms A was a new patient to Dr C. In my view, a reasonable consumer in Ms A's circumstances would expect to be informed that she could have a chaperone or support person present during the course of her examination. The provision of that information was therefore required under Right 6(1) of the Code.

133. The RNZCGP standards also indicate that such information is relevant to the informed consent process. Those standards may be taken into account in my assessment of the adequacy of information under Right 6(1)(e) of the Code. In my view, Dr C failed to provide Ms A with information that a reasonable consumer in Ms A's circumstances would expect to receive. That information was that she could have a chaperone or support person present. I therefore find that Dr C breached Right 6(1) of the Code. Furthermore, as Ms A did not receive that information before the examination commenced, she was not in a position to make an informed choice or give informed consent to the examinations she underwent. Accordingly, I find that Dr C also breached Right 7(1) of the Code.

Clinical records— Breach

134. Ms A said that she presented to Dr C stating that she had generalised aching and pain and burning when urinating. In contrast, Dr C said that Ms A did not complain of urinary frequency or a burning sensation when passing urine, and that he thought her symptoms were not consistent with a UTI.

135. When asked whether he made his notes contemporaneously and whether he subsequently changed them, Dr C stated: "I think I wrote during the consultation, I wrote during while she was sitting there, I wrote as it happened." He stated that he changed a part only where he "wrote about the altercation with the patient" in relation to the amount they had been charged for the consultation. He stated that he made no other amendments to the clinical records. Dr C has since advised that he now believes that he added to the initial note following his telephone conversation with Ms A and Mr B about sending the urine sample for analysis. Dr C initially recorded "c/o [complained of] body aches poly". Dr Maplesden advised that the notes as recorded at 12.45pm were quite adequate for a patient who was not unduly unwell, and was presenting with UTI symptoms, as Ms A claims was the situation. Dr C subsequently changed the record to "c/o body aches+flank pain polyuria and dysuria". Later in the day he again changed the notes to read: "[T]hinks she has bladder infection, no

[22] Available from www.rnzcgp.org.nz.

symptoms of burning micturition or polyuria history." However, despite this, he prescribed an antibiotic and Ural sachets.

136. I note Dr Maplesden's comment with regard to the records:

> "The outstanding issue is the late alteration regarding the urinary symptoms which, having been initially described as being present, then emphasised as being present, then denied as being present, is a difficult sequence to explain (particularly in light of the history [Ms A] stated she gave). The only explanation I can see for this sequence of events is that [Dr C] has deliberately and retrospectively falsified the medical history to support his stated version of events and I would regard this as a severe departure from expected standards."

137. The audit log clearly establishes that Dr C made a number of changes to the clinical records on the afternoon of 13 August. I note his statement that he now believes that he added to the original note in response to his telephone conversation with Ms A and Mr B, to ensure his records were complete. However, this telephone conversation occurred at 3.01pm. Dr C made changes to the record at 1.46pm, 2.12pm, 2.50pm and then three more times following the telephone conversation.

138. I also note Dr C's submission that the change from "polyuria and dysuria +" to "no symptoms of burning micturition or polyuria history" was a typing error. I accept that it is not necessarily unusual for notes to be changed and added to retrospectively. However, the original note is consistent with Ms A's recollection.

139. I remain of the view that the nature of the changes to the clinical records is concerning, and that Dr C's conduct in this regard is unacceptable.

140. The Medical Council of New Zealand publication *The Maintenance and Retention of Patient Records* (August 2008) states that doctors must keep clear and accurate patient records that report relevant clinical findings, decisions made, information given to patients, and any drugs or other treatment prescribed.

141. In this case the records are not accurate; therefore, I find that Dr C did not comply with the relevant professional standards. Accordingly, I find that Dr C breached Right 4(2) of the Code.

142. The clinical record is essential to enable other providers to provide consistent and appropriate care. The records as amended by Dr C present a false picture of Ms A's symptoms. By changing the records in this manner Dr C potentially impaired the ability of other providers to provide continuity of care to Ms A and, as a result, Dr C failed to minimise the potential harm to her. Accordingly, I find that Dr C breached Rights 4(4) and 4(5) of the Code.

Personal privacy — Breach

143. Right 1, together with Rights 2 and 3, form the "attitudinal umbrella" under which all services must be delivered.[23] Right 1(1) of the Code provides that "every consumer has the right to be treated with respect". In the assessment of Right 1(1), the consumer's perception of the provider's manner may be taken into account, along with the overall circumstances of the complaint. I am also able to take into account the consumer's feelings[24] and the behaviour and attitude of the provider towards the consumer.[25]

144. The Medical Council of New Zealand's publication *Sexual Boundaries and the Doctor–Patient Relationship* requires a doctor to provide an appropriate place for a patient to undress in private, and states that a patient should not be required to undress unnecessarily or stay undressed for unnecessary lengths of time. It requires the doctor to endeavour to allow the patient to cover as much of his or her body as possible during the physical examination.

145. Ms A stated that when she was asked to remove her clothing there was no curtain drawn around the examination couch to preserve her privacy, and Dr C stood and watched her. Dr C's account suggests that he could see Ms A while she undressed, and he had not previously denied this. However, in his response to the provisional opinion he advised that "I have used curtains while patient was undressing and I stepped out of the room while patient was dressing. This is what I normally do for any patient and I would have done the same with [Ms A] as well." Dr C's advice as to what he "normally" does conflicts with his previous account of the consultation.

146. I note the expectation set out by the Medical Council that patients will be left to "undress in private" prior to intimate examinations. I consider that watching a patient undress, and not giving the patient the opportunity to disrobe and prepare herself for the examination, demonstrates a lack of respect.

147. Ms A also stated that she was not provided with a sheet or blanket with which to cover herself. In contrast, Dr C stated that after Ms A "took everything off" he put a white sheet on her to cover her.

148. Ms A was distressed about her symptoms and feeling unwell. She stated that she was feeling more and more uncomfortable as the examination progressed, and when she asked Dr C whether he could see anything by massaging and touching her, he responded in an aggressive manner, "Are you a nurse?" and then continued touching her back and legs.

149. In addition, Ms A said that Dr C also made her feel uncomfortable by standing and watching her while she re-dressed. She stated that she was so uncomfortable that she did not replace all of her clothing, and handed the items that she had not replaced to

[23] Former Commissioner Robyn Stent, "Unravelling the Code" (29 April 1998).
[24] Opinion 00HDC02637 (available at www.hdc.org.nz).
[25] Opinion 05HDC18417 (available at www.hdc.org.nz).

her partner when she went to provide the urine sample. Mr B has confirmed this account. In contrast, Dr C said that he left the room while Ms A re-dressed.

150. I accept Ms A's statement that she was not provided with any covering during the examination. However, even if Dr C's account were accepted, it is not acceptable to watch a patient undress and wait until everything has been taken off before providing any form of covering. I also accept that Ms A was not given privacy to re-dress, and that Dr C responded inappropriately when she asked whether it was necessary to continue to touch her.

151. In my view, the overall manner in which Dr C conducted the consultation showed a lack of respect for Ms A, in terms of his dismissive response to her concerns, the manner in which he conducted the examination, and the lack of respect for her physical privacy. Accordingly, I find that Dr C breached Right 1(1) of the Code.

The clinic — No Breach

152. Ms A first presented to the clinic on 17 July 2011 with symptoms suggestive of a urinary tract infection. She saw Dr F, who prescribed trimethoprim 300mg. I am advised by Dr Maplesden that Dr F's clinical documentation and that of the triaging nurse is quite reasonable and consistent with acceptable standards, although best practice might have been to include a record of the follow-up instructions given.

153. Ms A attended Dr C on 13 August 2011 with similar symptoms. An intimate examination was undertaken by Dr C and, as stated above, I have accepted that she was not offered a chaperone.

154. The clinic did not have a chaperone policy at that time. The clinic stated that "each practitioner would be expected to follow their own professional obligations" and adopt practices that also align with the Royal New Zealand College of General Practitioners' guidelines. The clinic has now instituted a policy that requires that patients be offered a chaperone for all intimate examinations and where the patient is required to be in a state of undress.

155. The clinic advised that prior to this complaint it had received no complaints about Dr C. I have not been provided with any evidence to suggest that the clinic was on notice of Dr C having previously failed to comply with professional standards.

156. In my view, it is good practice to have processes in place to ensure that all patients are made aware that they may request the presence of a chaperone. However, given that on 13 August Ms A was not triaged by the practice nurse and, in any event, her symptoms would not normally have been indicative of a need for an intimate examination, I do not consider that the clinic breached the Code.

Recommendations

157. I recommend that Dr C:

- Provide a written apology to Ms A. The apology is to be forwarded to HDC by **15 January 2013** for sending to her.

- Review the Medical Council of New Zealand's and the Royal New Zealand College of General Practitioners' standards for intimate examinations, communication with patients, and the informed consent process, and the Royal New Zealand College of General Practitioners' standards in relation to informing patients about their right to have a chaperone present during intimate examinations. Dr C is to report to HDC by **15 January 2013** about any changes he has made to his practice as a result of reviewing these standards.

- Arrange for the Royal New Zealand College of General Practitioners to organise regular mentoring from a senior colleague four times per year for the next two years until **15 December 2014**. The mentor is to provide written information to the Royal New Zealand College of General Practitioners by **15 December 2013** for year one and **15 December 2014** for year two that the mentoring has occurred and that Dr C appears to be continuing to maintain professional boundaries.

158. I recommend that the Royal New Zealand College of General Practitioners:

- confirm to HDC by **20 December 2013** for year one and **20 December 2014** for year two that the mentoring has occurred and that Dr C appears to be continuing to maintain professional boundaries.

Follow-up actions

- Dr C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, who will be advised of Dr C's name, with a recommendation that it undertake a competency review of Dr C.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the DHB and the Royal New Zealand College of General Practitioners, and they will be advised of Dr C's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the HDC website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings decided to institute a disciplinary proceeding, which is pending.

Appendix A — Independent advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden:

"My name is David Maplesden. I am a vocationally registered general practitioner practising in Hamilton, New Zealand. My qualifications are MB ChB (Auckland University 1983), Dip Obst (1984), FRNZCGP (2003).

1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms A] about the care provided to her by [a clinic] (the clinic) and [Dr C]. To my knowledge, I have no personal or professional conflicts of interest. I have examined the available documentation: complaint from [Ms A]; response from the clinic including their chaperone policy; statement from [Dr F]; statement from [Dr C]; various other documents obtained during this investigation, including interview and telephone transcripts.

2. Management on 17 July 2011 ([Dr F])

(i) [Ms A] presented to the clinic on 17 July 2011 with symptoms suggestive of a urinary tract infection (UTI). She saw [Dr F] and told him she had had a UTI six years previously that had not responded to the antibiotics prescribed and she had developed a kidney infection. She had also had a pelvic infection a year previously that was evidently slow to respond to antibiotics. [Dr F] examined her and determined from her mid-stream urine sample (MSU) that she had a likely UTI. He prescribed antibiotics but three weeks later her symptoms recurred. She is concerned her treatment was inadequate.

(ii) [Dr F] responds that [Ms A] had symptoms suggestive of a UTI, was afebrile, and dipstick urinalysis showed white cells and blood in her urine. There was no abdominal tenderness on examination. The MSU was not sent for culture as it was a Sunday. An appropriate antibiotic was prescribed (trimethoprim) and she was advised to return if her symptoms did not settle. [Dr F] did not feel that a single previous UTI six years previously, or a previous pelvic infection, were of particular significance in this presentation. He did not intend to appear dismissive of this information, but apologises if his manner was perceived this way.

(iii) Nurse triage notes record [Ms A's] symptoms of one week of frequency, dysuria, left renal pain and abdominal discomfort. Temperature 36.6°C. Urinalysis showed 3+leucocytes and 3+blood. Nitrites appear to have been negative. It is recorded [Ms A] has no known drug allergies. [Dr F] has assessed [Ms A's] abdomen to be soft, and noted her to be afebrile with urine results as recorded by the nurse. He has prescribed trimethoprim 300mg tabs, one BID for the first day then one daily for a further three days. Follow-up advice is not recorded.

(iv) Clinical documentation, when combining nurse and GP records, is quite reasonable and consistent with accepted standards. Best practice might include a record of the follow-up instructions given. The assessment undertaken is appropriate to the clinical presentation, including medical history, and is consistent with expected standards. Clinical management, including the type and dose of antibiotic prescribed

and the decision not to send the MSU for culture, is also consistent with recommended best practice. There were no objective findings to suggest systemic sepsis, pelvic infection or pyelonephritis. The clinical picture was one of an uncomplicated UTI.

(v) In making the comments above, [Dr F's] clinical management has been compared with recommendations contained in the Best Practice Advocacy Centre NZ (BPAC) publications *Laboratory Investigations of UTIs* June 2006[26] and *Antibiotics — choices for common infections* April 2011[27].

3. [Ms A] attended [Dr C] on 13 August 2011 again complaining of urinary symptoms. (At later interview [Ms A] clarified that the symptoms had resolved after her previous treatment then recurred). In her complaint, [Ms A] states [Dr C] first examined her in what she felt was an inappropriate manner (details on file) including examination of her upper body, with her lying on her back and front, and with her completely naked by the end of the examination. She states he did not wear gloves, and her vagina was touched as part of the examination. She states he then performed a urine test, told her she had a 'kidney infection' and prescribed her antibiotics.

4. I have viewed a transcript of an interview undertaken by an HDC investigator and [Ms A] on 25 January 2012. The following information is based on her statements. She states her symptoms were similar in nature to those of 17 July 2011 and had recurred since her course of antibiotics. She also complained to [Dr C] of generalised aching. She denies complaining of head or shoulder ache, or of any vaginal pain. She states she was not offered a chaperone or the presence of a third party. She was asked to lie on the examination couch and [Dr C] examined her abdomen through her clothing and then asked her to remove her lower body garments. She was not given a covering blanket. [Ms A] states [Dr C] then massaged her lower and upper legs and around the vaginal area, touching her clitoris briefly on two occasions. He did not explain the reason for his examination although may have talked about 'muscles' in response to [Ms A] questioning him. He then asked her to remove her upper body clothing so she was lying supine on the examination couch, completely naked and with no cover. He massaged around [Ms A's] breasts and then asked her to turn over, which she did. At this stage he asked her if she was a nurse to which she replied in the negative. He then explained the need for the examination he was performing (details of his explanation apparently medical jargon and not understood by [Ms A]). [Dr C] massaged [Ms A's] back and legs and then asked her to put on her clothes. The examination took in excess of 10 minutes. [Ms A] states [Dr C] watched her dress and, in answer to her query as to what was wrong with her he explained, using an anatomical diagram, that she had a kidney infection. [Ms A] was then asked to provide a urine sample which she did elsewhere. [Dr C] then invited [Ms A] and her partner back into the consultation room and explained to the partner he had needed to examine [Ms A] and implied [Ms A] was very unwell and *she doesn't know what to say…* He prescribed antibiotics and painkillers and instructed [Ms A] to return to ED

[26] Available at http://www.bpac.org.nz/resources/campaign/uti/uti_poem.asp
[27] Available at http://www.bpac.org.nz/resources/handbook/antibiotics/antibiotics_guide.asp

if her condition worsened, and that results would become available but to start the antibiotics immediately. [Dr C] called [Ms A] later that day and asked to speak with her partner. The partner states that [Dr C] asked if the couple would like to become his patients, which the partner declined. He is adamant there was no discussion of the need to enrol with a practice in order to have [Ms A's] tests processed.

5. I have viewed a transcript of a telephone call to [Dr C] initiated by [Ms A] (and recorded by her) later on 13 August 2011. [Ms A] asks [Dr C] to elaborate on why the full body examination was required. [Dr C] appears to agree that he had asked [Ms A] to undress. He implies he asked her as she entered the room if she wanted a chaperone but apologises if he did not. He explains the need for the examination because of her complaints of generalised (especially leg) ache and weakness, possibility of generalised sepsis, and refers to checking glands for glandular fever. He talks about needing to assess muscle tone and referring for an ultrasound scan if there is muscle weakness. He states he was wearing a glove on his left hand but not on his right hand, having removed the right hand glove during the examination (he later admitted not wearing gloves at all).

6. In his written response to the complaint dated 9 December 2011 [Dr C] notes [Ms A] did not communicate well which may have been partly a language barrier but also related to her unwellness. *She described tiredness and aches all over her body, including her arms, legs, back, shoulders, bladder, abdomen, vagina and knees…she also described strong head and neck aches...she did have a mild fever, she indicated that she thought she had a bladder infection. When prompted she reported no symptoms of burning micturition or polyuria history. She indicated…that she had not seen a GP for this or other illnesses.* Given the vagueness of the symptoms, [Dr C] was concerned about possible serious pathology including meningitis, and was of the opinion that a comprehensive examination was required rapidly because the patient could be seriously ill and could not give a good history. He states he explained to her in some detail about the need to undress and then offered a nurse chaperone, to which she replied *that she would get shy in the presence of a third person.* The declining of a chaperone was recorded in the notes. [Dr C's] description of the examination is recorded in sections 14–22 of his response and will not be reiterated in detail here. There are significant differences between his account and that provided by [Ms A], including that a blanket was provided at all times, and [Ms A] took off her shirt rather than lifting it as requested, and was not wearing a bra. Following the examination, [Ms A] was instructed how to perform a MSU and dipstick suggested a UTI. [Ms A's] partner was invited into the consultation room with the patient's consent and additional history obtained from him. Treatment and follow-up instructions were given to both of them. A prescription was provided for Augmentin, Ural sachets and paracetamol. [Ms A] was concerned at the amount she had been charged when she went to pay and there was apparently a heated discussion at reception regarding this. [Dr C] clarifies [Ms A] was *an unenrolled visitor to New Zealand who is not eligible for health subsidies.* He describes realising [Ms A] did not have an NHI when the MSU was to be sent off (which meant she would have to pay for the test) and this was the basis for him ringing her to ask if she would like to enrol with the practice. He describes receiving a call from [Ms A] later that day in which he answered in detail her query regarding the need for such a comprehensive examination that day.

7. I have reviewed the clinical notes and notes audit:

(i) There are three note entries provided for 13 August 2011, all having [Dr C] as provider. The first relates to the medical consultation with [Ms A]. The second relates to discussion around the MSU sample and call to [Ms A]. The third relates to the call [Dr C] received from [Ms A]. I could not see any nurse triage entry and presume [Ms A] had not seen a nurse before the medical consultation on this occasion.

(ii) It is not entirely clear at what time the consultation commenced, or the duration of the consultation. The notes audit trail (all changes made by provider [initials] — presumably [Dr C]) begins at 1245hrs on 13 August 2011 with 'Subjective notes' changed from *c/o body aches poly* to *c/o body aches+flank pain polyuria and dysuria.* 'Notes' were changed from essentially blank as *[ ]* to *WBC+ Protein+ on dipstic Tender all over the abdomen and over the back c/o sore thigh and biceps and also paraspinal muscles ?flu+UTI/pyelonephritis oral abs given send urine to lab take it easy from [work] drink plenty of water.* This entry appears to have been made at the conclusion of the consultation.

(iii) The notes have been altered next at 1346hrs on 13 August 2011 (an hour after the previous entries). In 'Subjective notes' a '+' has been added after 'dysuria'. In 'Notes' the changes are as tracked in [**bold**] below:

WBC+ Protein+ on dipstic Tender all over the abdomen and over the back c/o sore thigh and biceps and also paraspinal muscles ***Heart and lungs normal abd soft no rebound tenderness*** *?flu+UTI/pyelonephritis oral abs given send urine to lab take it easy from [work]* ***until she gets better*** *drink plenty of water.* ***Explained to partner to keep a close eye and watch for signs of worsening and take her to ED if need be.***

(iv) The next alteration is at 1412hrs: 'Subjective notes' unchanged. 'Notes' as below:

WBC+ Protein+ on dipstic Tender all over the abdomen and over the back c/o sore thigh and biceps and also paraspinal muscles Heart and lungs normal abd soft no rebound tenderness ?flu+UTI/pyelonephritis oral abs given send urine to lab take it easy from [work] until she gets better drink plenty of water. Explained to partner to keep a close eye and watch for signs of worsening and take her to ED if need be ***(partner questioning about the high charge — [receptionist] explained to them the prices)***

(v) Next alteration at 1450hrs is the addition *charged only $82 instead of $123.*

(vi) Next alteration 1512hrs:

In 'Subjective notes' — ***very poor history communication difficult ?language barrier works in [workplace] will be here for an year ?PV discharge then c/o pelvic pain then*** *c/o body aches+flank pain polyuria and dysuria* ***+ no GP here***

In 'Notes' – ***Declined chaperone*** ~~***WBC+ Protein+ on dipstic***~~ *Tender all over the abdomen and over the back c/o sore thigh and biceps and also paraspinal muscles* ***no enlarged LNs did not do PV*** *Heart and lungs normal abd soft no rebound tenderness*

?flu+UTI/pyelonephritis oral abs given send urine to lab take it easy from [work] until she gets better drink plenty of water. Explained to partner to keep a close eye and watch for signs of worsening and take her to ED if need be ***WBC+ Protein+on dipstic done by RN Sent urine spec to lab rang pt and told them to f/u with after hrs as they do not have a GP in town*** *(partner questioning about the high charge — [receptionist] explained to them the prices) charged only $82 instead of $123.*

(vii) Next alteration is 1544hrs in 'Subjective notes' (no change to 'Notes' recorded):

very poor history communication difficult ?language barrier works in [workplace] will be here ***in NZ*** *for an year ?PV discharge then c/o pelvic pain then c/o body aches+flank pain polyuria and dysuria +* ***very vauge Has*** *no GP here* ***in NZ.***

(viii) I note the final version of the notes supplied (see below) is significantly different to the version recorded in the last audit entry above. I cannot explain this discrepancy unless some of the audit information has not been supplied.

(ix) Notes as supplied by [Dr C] with changes from the 1544hrs audit version tracked in red:

'Subjective notes' — *very poor history communication difficult ?language barrier works in [workplace] will be here in NZ for an year* ***c/o tiredness and aches all over the body headache and neck aches+ no cough, thinks she has bladder infection no symptoms of burning micturition or polyuria history*** ~~***?PV discharge then c/o pelvic pain then c/o body aches+flank pain polyuria and dysuria +***~~ *very vauge Has no GP here in NZ.* ***Haven't seen any GP before for this illness****.*

'Notes' — *Declined chaperon* ***o/e no neck rigidity, no rash on body, no stiffness of muscles no signs meningism Heart dual hs+ Lungs clear no muscle wasting or weakness tender over the right flank c/o sore thigh and tender vastus muscles also tender calfs paraspinal muscles tender,*** ~~***Tender all over the abdomen and over the back c/o sore thigh and biceps and also paraspinal muscles***~~ *no enlarged LNs* ***in neck, axilla or groin, no glandular fever in past*** *did not do PV* ~~***Heart and lungs normal***~~ *abd soft* ***non tender bs+***~~***no rebound tenderness***~~

Differential: Flu, unlikely glandular fever, unlikely meningitis. Muscle aches due to repetitive work at [workplace]. Oral abs given. Urine to lab dip stic showed WBC+Protein++ done by RN.

Take it easy from [work]. Encouraged lot of fluids. When pt went to give urine specimen, saw partner in the waiting room and invited him in to the consult. ~~***?flu+UTI/pyelonephritis oral abs given send urine to lab take it easy from [work] until she gets better drink plenty of water.***~~ *Explained to partner to keep a close eye and watch for signs of worsening and take her to ED if need be* ~~***WBC+ Protein+ on dipstic done by RN Sent urine spec to lab rang pt and told them to f/u with after hrs as they do not have a GP in town (partner questioning about the high charge — [receptionist] explained to them the prices) charged on $82 instead of $123.***~~

(x) Next separate consult note (audit trail for this not supplied) notes the RN stating *it would be a hassle to send urine spec to lab as pt has no NHI. Rang pt offered her to enrol with me — so that urine results could be followed up but pt's boy friend declined…SO URINE RESULT NOT SENT. Boyfriend seems to be still unhappy about the cost, examination and treatment. Says he will find another doctor and another GP practice.*

(xi) Final consultation note is *pt rang me and asks me why I had to examine her whole body for bladder inf — explained that since her history was very vaugue and since I did not know that her boyfriend was waiting outside during the first consult, I had to do a whole head to toe exam. Explained that I was ruling out various causes like meningitis and muscle wasting/bruising/swelling due to RSI. Apologised if I caused any discomfort. Pt said thanks for explaining and thanks for examining. I said if she want to further discuss she could come and see me right now.*

8. I have viewed a transcript of the interview undertaken by an HDC investigator and [Dr C] on 24 February 2012. [Dr C] explains that the nurse on duty with him on 13 August 2011 did not triage [Ms A] but does triage patients presenting who appear very unwell, or with chest pain, trauma etc. Such patients may be seen in ED which is next door. He reiterated that [Ms A] denied complaints of dysuria or polyuria and *looked too unwell for a simple UTI.* He did not determine she had been seen previously although notes from the consultation the previous month were on the computer. He states a priority was to check [Ms A's] skin and this required exposure of all her skin. He states he asked her if she wanted a chaperone (using that expression) and she declined. He states he *just visualised* the lower part of [Ms A's] body but in a later letter confirmed he had palpated her lower body. He denies touching the genital area but did a visual inspection. He maintains he used a sheet to cover [Ms A] and, as far as he can recall, her lower garments were replaced before he examined her upper body. He states he left the room when [Ms A] was dressing. He confirms he was not wearing gloves during the examination. He states he recalls writing the consultation notes during the consultation. On further questioning about whether the notes might have been altered later, he states *I changed a bit where I wrote about the altercation with the patient…I wanted to mention that it has to be one week of it instead of 88 but I erased that…that's all I can remember.*

9. The [clinic] Chaperone Policy has been examined and is robust and consistent with expected standards. According to the policy, [Dr C] must offer [Ms A] a chaperone for the type of examination undertaken and *If the patient is offered and does not want a chaperone it is important to record that the offer was made and declined.*

10. Observations and comments

(i) [Ms A] presented to the clinic on 13 August 2011. It would be helpful to have a precise timeline including her arrival time, start and conclusion of consultation, and timing of the two telephone calls referred to, in order to relate these to the timing of alterations made to the clinical notes.

(ii) In his responses, [Dr C] has emphasised how unwell [Ms A] was, and this was the basis for the extensive examination undertaken. Despite her apparent unwellness, she was not triaged by a nurse as would be expected for a significantly unwell patient presenting at an after-hours clinic, and as had been undertaken the previous month when [Ms A] presented to the clinic with similar symptoms.

(iii) [Ms A] was familiar with the symptoms of a UTI having had one a month prior to her consultation with [Dr C]. She described symptoms of urinary frequency and burning to [Dr C] and he recorded this in his notes, emphasising the dysuria symptom with a '+' (see 7(iii)). However, some hours after the consultation he altered the notes to specifically exclude such symptoms. I note he also listed, in the final version of the notes, a frank denial by [Ms A] that she had ever had similar symptoms which appears somewhat unusual.

(iv) Despite [Ms A's] apparent significant unwellness, and [Dr C's] stated concerns about sepsis including pyelonephritis and meningitis, I can see no record of the basic observations of pulse, blood pressure and temperature. Respiratory rate might also be recorded when a patient is non-specifically very unwell. These observations, the 'vital signs', are fundamental to the process of determining degree of systemic unwellness and aiding appropriate triage categorisation. In combination with the patient history, they may determine the extent of examination required. To suspect serious illness, as [Dr C] states he did, but fail to undertake these basic observations, is a severe departure from expected standards. To undertake, but fail to record these observations in a very unwell patient would be a moderate departure from expected standards.

(v) The patient history will generally direct the nature and extent of examination required. [Dr C's] rationale for what he described as a 'top to toe' examination, including visual inspection of the genitalia, assessment of muscle tone, muscle wasting and skin inspection, is that [Ms A] was a poor historian and could not localise her symptoms. There was no such problem encountered in her previous consultation, and [Ms A] maintains she was quite specific in describing her symptoms, which were suggestive of recurrent UTI, although accompanied by myalgia. As noted above, [Dr C] had initially recorded the urinary symptoms. It was certainly reasonable to exclude pyelonephritis which could have been done through assessment of vital signs for any indication of systemic sepsis, an abdominal examination to check for renal tenderness, and urinalysis. [Dr C] did perform an abdominal examination and urinalysis.

(vi) Based on the history [Ms A] states she gave [Dr C], and initially recorded by [Dr C] in his notes, and noting [Ms A] was apparently not sufficiently unwell to have warranted nurse triage or recording of vital signs or to have any objective evidence of significant unwellness, I feel there was no clinical indication for the physical examination to have extended beyond that discussed in section (v) above. If there was suspicion of an underlying sexually transmitted infection (STI), appropriate samples (vaginal swabs and/or first catch urine sample) would have been undertaken and empiric treatment different to the treatment prescribed by [Dr C].

(vii) Relevant in this case is that [Ms A] was not chronically unwell, and [Dr C] had not established any medical history to suggest she had other than an acute problem

she wanted addressed. Had she had a long history of myalgia or chronic fatigue without localising symptoms, there may have been grounds to undertake an examination of the lymph and musculoskeletal systems and aspects of [Dr C's] examination, as reported by him, might have been regarded as conscientious in that context. It is not clear whether [Ms A] recalls [Dr C] auscultating her heart, lungs and abdomen with his stethoscope as he has recorded. I could see nothing in the initially recorded history to make one particularly suspicious of meningitis requiring the need for an examination of the entire skin surface, reiterating that [Ms A] presented with urinary symptoms.

(viii) The circumstances of the physical examination, as described by [Ms A], were clearly a severe departure from expected standards[28]. [Ms A] states she was not offered a chaperone. If [Dr C] touched [Ms A's] genital area without gloves, I would regard this as a severe departure from expected standards. I would not expect gloves to be routinely worn for an examination that did not include the genital or anal area or digital examination of the oral cavity, although some of my colleagues might use gloves for examination of the groins and axillae as hygiene protection for themselves. The examination as reported by [Dr C], notwithstanding my impression that there was no particular clinical indication for the extent of the examination, was consistent with expected standards apart from the failure to provide privacy to [Ms A] when she was disrobing. [Dr C] states he offered [Ms A] a chaperone and she refused one. This was documented in the clinical notes as an addition at least two hours after the

[28] The Medical Council of New Zealand publication 'Sexual Boundaries in the Doctor–Patient Relationship' states:

- *You should be told why the doctor's questions or a physical examination is needed, and what will happen in the examination or treatment. If you do not understand something, or do not know why you are being asked something, ask your doctor to explain it so that you understand. If you are unhappy about the consultation, the suggested treatment or the examination, say so.*
- *If the consultation involves a physical examination that requires the patient to remove his or her clothes, you should provide an appropriate place to undress. This is an area where the patient can undress in private, out of view of anyone else, including you (although someone should be able to help if necessary).*
- *Disrobing facilities may be provided by a curtain or a separate changing area.*
- *You should not require a patient to undress unnecessarily or stay undressed for unnecessary lengths of time. For example, the patient only needs to uncover the part of the body that is being examined, and should be allowed to cover it again once you have finished.*
- *If the physical examination includes several parts of the body, you should endeavour to allow the patient to cover as much of his or her body as possible before moving on.*
- *For some physical examinations it may be appropriate for you to provide a robe if the patient's own clothing makes examination difficult.*

The publication 'You and Your Doctor' advises the patient to expect, for 'personal' examinations, the doctor will

- *leave you to undress in private unless you have asked for help*
- *keep you covered as much as possible during the examination*
- *use gloves where appropriate*
- *explain what is being done and why*

consultation and I am not certain when this was in relation to the various telephone calls.

(ix) The clinical notes were comprehensive but some significant changes were made to their content as they evolved. Some GPs will complete their notes during a consultation, while others complete notes immediately after, or even several hours after, the consultation (eg after a morning or afternoon clinic). It is not necessarily unusual for the notes to be amended or added to following a consultation if the GP becomes aware he or she has omitted some clinically significant information. What is unusual in this case is the number of times the notes were amended and the nature of the amendments, and this is clearly outlined in section 7, although the audit trail may be incomplete. My overall impression is that the notes, including patient history, may have been altered and embellished retrospectively to justify the examination [Dr C] had performed. I am not sure why he felt this was necessary, or what his justification was for altering the patient history to specifically exclude UTI symptoms. He took pains to point out that [Ms A] was a poor and vague historian, yet listed very specific musculoskeletal symptoms and employment history. The initial notes, recorded in 7(ii), were in fact quite adequate for a patient presenting with UTI symptoms and not unduly unwell, as [Ms A] claims was the situation. I note [Dr C] could not recall his frequent alterations of the notes in the hours following [Ms A's] consultation. To deliberately provide false information in the clinical record would be a severe departure from expected standards.

(x) Clinical management, in terms of treatment of UTI and follow-up, was adequate. Augmentin is not a first-line treatment for UTI but given the rapid recurrence of symptoms after trimethoprim treatment (although it is not apparent [Dr C] was aware of this at the time of the consultation, despite the previous notes being on file), and the intention to send the MSU off for culture and sensitivities, it was probably not unreasonable. Follow-up advice as documented and confirmed by [Ms A's] partner was very reasonable.

(xi) It is unclear what [Ms A's] residency status was. If she had a current work visa, she would have been eligible for funding of the lab test without an NHI required[29]. If she was eligible for health subsidies, I am not aware that enrolling with a practice would have altered her eligibility for funding of lab tests although it would eventually have made doctors' fees and prescriptions less costly. If she was not eligible for health subsidies (eg visitor rather than work permit) I am not aware there was any advantage in her enrolling in [Dr C's] practice. The precise reason for [Dr C] ringing [Ms A] is difficult to clarify from the various responses.

11. Summary

(i) If [Ms A] presented with UTI symptoms and body ache of a moderate nature as she claims, I would regard her initial management, including only the abdominal examination undertaken initially by [Dr C], and in terms of clinical documentation up

[29] Personal communication with medical laboratory

to the version of the notes outlined in section 5 (ii), and prescribing and follow-up, as being consistent with expected standards.

(ii) If [Ms A] was as unwell as [Dr C] claims, and he was suspicious of systemic sepsis including meningitis or pyelonephritis as he claims he was, I would regard his failure to record [Ms A's] vital signs of temperature, pulse and blood pressure as a severe departure from expected standards. If he took these readings but did not record them, I would regard that as a moderate departure.

(iii) If [Ms A] presented with UTI symptoms and body ache of a moderate nature as she claims, I would regard the extent and nature of the examination undertaken by [Dr C] as not being appropriate to the clinical situation. If she was as unwell as [Dr C] claims, the extent of the examination could be regarded as being conscientious apart from the notable absence of recording of vital signs.

(iv) There are marked differences between [Ms A] and [Dr C] in the recollection of the manner in which the examination was undertaken and in whether or not a chaperone was offered. I am unable to prefer either version. If [Ms A's] version is accurate, this would be a severe departure from expected standards. The examination as described by [Dr C], leaving aside the issue of whether or not it was clinically indicated, could be consistent with accepted standards.

(v) The clinical notes, regarding the final version in isolation, are comprehensive and of a good standard apart from the absence of vital signs recorded. However, the number of times the notes were edited in the period following the consultation, and the nature of the edits (including a change to a denial of previously emphasised symptoms), is unusual and must be regarded as irregular and perhaps suspicious.

(vi) It would be helpful to establish an accurate timeline of events as recommended in section 10(i). The issue of the clinical notes audit trail needs to be revisited, perhaps by an independent person familiar with the PMS, confirming HDC has all relevant data related to changes to the three separate consultation notes completed on the date in question."

Dr Maplesden was asked to comment on the level of departure from expected standards with regard to the alteration of the clinical records. He replied:

"In a general sense adding to or refining the notes retrospectively (within a few hours of the consultation) I would not regard as unusual practice — I think this was discussed in my advice. In [Dr C's] case, I think the elaboration of his notes could be perceived as justifying retrospectively the nature of his interaction with [Ms A] and giving it some clinical validity. This is certainly the impression I got. However, for the most part he could explain these actions (and I am sure they could be defensible) as being a conscientious clinician ensuring his documentation met expected standards by refining his entries over several hours. The outstanding issue is the late alteration regarding the urinary symptoms which, having been initially described as being present, then emphasised as being present, then denied as being present, is a difficult sequence to explain (particularly in light of the history [Ms A] stated she gave). The only explanation I can see for this sequence of events is that [Dr C] has deliberately and retrospectively falsified the medical history to support his stated version of events and I would regard this as a severe departure from expected standards."