Decision 21HDC02614
30 July 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

GP care for termination of pregnancy

1. The Health and Disability Commissioner (HDC) received a referral of a complaint from the Nationwide Health and Disability Advocacy Service that raised concerns from Ms A about the care provided to her by general practitioner (GP) Dr B at Provider1 (GP's centre).

Care provided by Dr B

2. On 9 August 2021, Ms A consulted with Dr B regarding an unexpected first trimester pregnancy (7 weeks + 3 days' gestation). Ms A requested a referral for a termination of pregnancy (ToP). This first consultation focused on arranging pre-ToP investigations and providing anti-nausea medication. Dr B said that he also briefly discussed the options of medical vs surgical ToP, and that Ms A's visa status meant the relevant services would not be publicly funded. Ms A was advised to return for a second consultation once the investigations had been completed, and a ToP referral was not completed on this date.

3. Dr B stated that he has always managed ToP patients through two consultations — the first for the workup and the second to manage other medical or pregnancy-related issues and to provide further explanation about the ToP options and procedures. He considers that the second consultation provides an opportunity to ascertain the patient's wishes whether to continue or terminate the pregnancy. Provider1 confirmed that this was the practice's process and that, as it sees patients from a wide variety of cultures, the routine advice of a second consultation helps to ensure that many culture-specific and other issues are addressed adequately prior to referral.

4. Ms A is concerned that Dr B continued to consult with her about abortion services while in the reception waiting area in front of other patients, which caused her embarrassment and anxiety. Dr B said that he did not continue the consultation, but he acknowledged that he took Ms A to the front desk and told staff in English that 'she needed a "TOP" workout' in the full reception and waiting area, although he stated that this information was necessary for the reception staff to coordinate the next steps.

5. On 18 August 2021, after the results of the investigations had returned, Dr B telephoned Ms A. Dr B did not document this telephone conversation. Ms A was advised to return to the clinic for the second consultation after the COVID-19 lockdown. She was told that no services were available during the COVID-19 alert level 4 lockdown (which had commenced in Auckland the previous evening). Again, a ToP referral was not completed on this date.

6. Dr B acknowledged his mistake in not knowing that the private sector ToP service (Provider2) was always available, even during level 4 lockdown. He said that, had he known, he would have asked Ms A to come straight to the clinic after the workup, and he would have referred her to the service with all the investigation results. Dr B noted that Ms A presented during an 'unprecedented and chaotic time' of the COVID-19 pandemic, and, as a working GP, he had limited information about which hospital or specialist services were available during COVID-19 lockdown levels.

7. In response to the provisional opinion, Ms A stated that this was a 'deeply painful and personal memory for her', and she hopes that 'the findings from this case will help improve the care and experience for others in the future'.

8. My in-house clinical advisor, Dr David Maplesden, advised that the relevant HealthPathways guidance recommends immediate referral once tests have been organised, meaning that the most appropriate management would have been for Dr B to have referred Ms A to Provider2 or to have advised her to self-refer on 9 August 2021 while awaiting the investigation results. Dr Maplesden noted that, if the dating scan result was imminent, it would also have been reasonable to wait for this, and appropriate management would then be to refer Ms A to Provider2 immediately or advise her to self-refer on receipt of the dating scan. However, he considered that, for the reasons Dr B described, Dr B's intention to have a second consultation with Ms A prior to formalising the referral was probably reasonable at the time the decision was made (9 August 2021), although he would expect her current gestation to be taken into account to ensure that delays did not impact access to medical ToP if that was her preference.

9. However, Dr Maplesden advised that it was unreasonable and inconsistent with accepted practice for Dr B to advise Ms A on 18 August 2021 to make an appointment 'after lockdown' when the duration of lockdown could not be anticipated, there was no particular need for a further consultation from a clinical perspective, and referral was time critical if Ms A wished to consider medical ToP as opposed to surgical ToP. Dr Maplesden advised that Dr B's care was not consistent with accepted practice and would be met with moderate disapproval.

10. In response to the provisional opinion, Dr B stated:

> '[I agree] to some extent as there was no further clinical work for [me to do apart from the referral itself to the ToP clinic]. However, given this particular context of this ToP consultation, that her being an international student, with very limited English [and] the need to explain about the referral process to [a] private ToP clinic, it was reasonable to have a second consultation with Ms A so that she can understand fully about the process.'[1]

11. Dr B said that he 'never had any intention of delaying her ToP services'. He stated:

> 'The episode of COVID lockdown was a complicating factor for this particular ToP consultation, as I was not aware of the fact that private ToP clinic (Provider2) was always available during level 4 COVID lockdown.'

12. In my view, Dr B failed to refer Ms A for her ToP in a timely manner. I accept that, in general, it is reasonable to offer a second consultation to people who remain unsure or who indicate that further time is needed to consider options. However, I agree with my advisor that the

[1] That is, '(explaining bloods/investigation results, [and] giving the contact details of [the] private ToP clinic), the clinic nursing staffs/doctor make a referral with confirmed date of ToP specialist consultation, a doctor has an opportunity to deal with any medical issues from bloods/STD swabs/USS results (e.g. treating anaemia for low [haemoglobin], treating any vaginal infections, [and] making acute referral to Gynae on-call admission in case of ectopic pregnancy), a doctor can reconfirm her wish for ToP (as I often see women who attend an initial ToP consultation later change their minds and decide to continue the pregnancy).'

second consultation was unnecessary from a clinical perspective, and I am critical of Dr B for delaying the second consultation and referral when this was a time-critical matter. I acknowledge the unprecedented time of COVID-19 lockdowns but consider that to postpone the second consultation during the uncertain lockdown period potentially hindered Ms A's ability to exercise autonomy in her health care. I note that a virtual or telephone consultation could also have been considered.

13. In my opinion, the referral should have been made at the latest once the results were available. I do not accept Dr B's submission that he was not aware that Provider2 was open during COVID-19 lockdown as reasonable, and I agree with Dr Maplesden that this would have been a simple query for Dr B or a practice staff member to resolve.

14. I consider that Dr B did not provide services to Ms A with reasonable care and skill and find him in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

15. I am also critical of Dr B for taking Ms A to the front desk and discussing the ToP with the receptionist (stating that Ms A needed a 'TOP' workout) in the busy waiting area. Ms A understandably perceived this as a continuation of the consultation, and I consider that more suitable options were available to maintain her privacy in this scenario, for example by writing a brief note to the receptionist as to what was required for Ms A, or going to the reception area first without Ms A to discuss next steps with the reception staff. In response to the provisional opinion, Dr B stated that his actions in going to the reception area with Ms A after consultation, as outlined in paragraph 4 above, was 'purely an act of doing a favour for Ms A, as she seemed unsure what to do next after the initial ToP consultation [and] was unable to speak in English at the time'. Regardless of the intent, in my view, Dr B had a responsibility to consider the sensitivity of the matter and respect the privacy of Ms A, and I remain critical that other options available for having this conversation more privately were not utilised.

Complaint management by Provider1

16. Initially, Ms A tried to raise her concerns with Provider1 with the help of an advocate. The complaint was referred to HDC as Provider1 would not engage in the advocacy process, despite five attempts to obtain a response to Ms A's concerns (2 September 2021, 16 September 2021, 1 October 2021, 5 October 2021, 12 October 2021).[2]

17. After many attempts by HDC to seek a response, Provider1 responded to HDC's request for information on 19 June 2023 (approximately 1.5 years after HDC received the complaint and HDC's initial request for information).[3] There was a further seven-month delay in HDC receiving Provider1's response to HDC and commencing its investigation.

[2] As part of its response in June 2023, Provider1 forwarded to HDC an email that appears to have been sent to the Advocacy Service on 27 September 2021, which primarily discussed issues not central to the complaint, and a further email that appears to have been sent to the Advocacy Service on 7 February 2022 (after the matter had been referred to HDC), which responded to the concerns in the complaint, but these were not received by the Advocacy Service, nor HDC, until June 2023.

[3] HDC sent an information request on 19 November 2021, which was followed up on 15 December 2021, 24 December 2021, and 18 February 2022. HDC then sent two further letters following up on the overdue

18. Provider1 was given an opportunity to respond to the provisional decision. However, as has been demonstrated in previous attempts to engage with the practice, it failed to respond to HDC despite numerous opportunities to do so.[4]

19. I find Provider1 in breach of Right 10 of the Code for failing to provide a response to Ms A's HDC complaint for 18 months.

20. I am also critical of the delays in engaging with the Advocacy Service in relation to the complaint process it attempted to facilitate on Ms A's behalf, and the further delays in providing responses to HDC during this investigation.

Recommendations

21. I recommend that Dr B and Provider1 each separately provide a written apology to Ms A for their breaches of the Code, as identified in this report. The apologies should be provided to HDC within three weeks of the date of this report, for forwarding to Ms A.

22. I recommend that Dr B undertake training related to privacy and management of patients requesting termination of pregnancy and reflect further on whether his usual practice aligns with sector expectations. Evidence of attendance at training and a written report of his reflections and any changes implemented to his practice going forward should be provided to HDC within three months of the date of this report.

23. I recommend that Provider1 review its complaints management process/policy, ensuring that it aligns with HDC's Code of Rights, and make changes as appropriate. A copy of the updated policy should be provided to HDC within three months of the date of this report, and an evaluation of the effectiveness of changes made to its process should be made by conducting an audit of compliance (of any complaints made in the subsequent six months). Provider1 is to provide HDC with the outcome report and any corrective actions, within 12 months of the date of this report.

24. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Medical Council of New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner

information and reminding Provider1 of the right to complain and its obligations under the Code — on 1 March 2022 and 24 March 2022. Further follow-up requests were sent on 1 June 2022 and 13 April 2023, and on 14 June 2023 the initial request was re-sent after a telephone conversation with Provider1.

[4] The provisional decision was sent to Provider1 on 9 May 2025 with a date for any response to be provided by 30 May 2025. Follow-up reminder emails were sent by HDC on 4 June 2025, with an extension to 13 June 2025. No response was received, and on 16 July Provider1 was given a final opportunity to respond by 18 July 2025, which it failed to do.

Appendix A: Clinical advice to Commissioner

'CLINICAL ADVICE — MEDICAL + Addendum

TO	**:**	INV
FROM	**:**	David Maplesden
CONSUMER	**:**	Ms A
PROVIDER	**:**	Dr B; Provider1
FILE NUMBER	**:**	C21HDC02614
DATE	**:**	27 June 2023; Addendum 19 March 2024 (s10–12)

---

1. My name is David Maplesden. I am a graduate of Auckland University Medical School, and I am a vocationally registered general practitioner holding a current APC. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide clinical advice in relation to the complaint from Ms A (per NHDAS) about the care provided to her by Dr B of Provider1. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following documentation:

- Complaint from Ms A per NHDAS
- Response from Dr C on behalf of Dr B
- GP notes Provider1

3. Ms A attended Dr B at Provider1 on 9 August 2021 in relation to an unplanned pregnancy. She wished to consider termination of pregnancy (TOP). She states Dr B advised her to return to the clinic after the current COVID lockdown ended and Dr B stated *no services were available during level 4 lockdown.* Ms A states Dr B continued a conversation about abortion services with Ms A's partner while in the waiting room within earshot of other patients. The complaint notes: *On the 16th August 2021, Ms A re-contacted Provider1 concerned about her unplanned pregnancy and the available options; as she was still awaiting the prescription for the discussed procedure. Ms A stated the receptionist told her in an abrupt manner to come back to clinic and the charge would be $80.00 to collect the prescription; and then abruptly ended the conversation. Throughout this process, Ms A described feeling powerless; and found the whole situation extremely distressing.*

The key issues for Ms A are listed in the complaint as:

- *Doctor did not provide full information or options*
- *Lack of professional behaviour expected of a clinician*
- *Medications were not prescribed within a timely manner*
- *Services were not of an appropriate standard with a delay in coordinated timely medical care*

- *Her dignity and privacy was not respected; causing Ms A embarrassment and anxiety. She felt she should not have to protect her personal privacy and medical needs when seeking support.*

4. The response from Dr C includes the following points:

(i) A consultation was undertaken with Dr B on 9 August 2021 with Ms A and her partner. Ms A is not eligible for funded health care in New Zealand. Ms A appeared sad and anxious in relation to her unplanned pregnancy. A standard first antenatal/pre-TOP consultation was undertaken. Metoclopramide and ondansetron were prescribed for nausea. Ultrasound and blood tests were organised. Staff in reception were advised by Dr B that Ms A *needed a TOP workout* and Ms A was advised she would require another consultation for referral for termination of pregnancy.

(ii) Ultrasound was performed on 17 August 2021 and revealed a singleton pregnancy dated at 8 weeks+5 days [result indicates 7 weeks+2 days]. New Zealand entered COVID level 4 lockdown at midnight the same day and Auckland remained at level 4 until midnight 21 September 2021. Dr B phoned Ms A on 18 August 2021 to discuss the scan result and: *as it was just the first day of the lockdown, Dr B admitted that he did tell her to come back after the lockdown as he himself did not expect the lockdown could last for that long at the time. Moreover, she still has time based on her ultrasound scan report.*

(iii) A few days later Ms A's partner contacted Provider1 requesting further anti-emetic medication for Ms A. He was advised that Ms A needed to attend for review and there would be a charge for any prescription. Ms A's partner then apparently contacted the practice on several occasions verbally abusing staff. The response includes: *That then spelled the end of the relationship between* [Ms A] *and the clinic. We called later and confirmed that* [Ms A] *has been to another clinic for ongoing care.*

5. Ms A was known to Dr B, having attended for review in January 2021 for matters unrelated to pregnancy. It is not clear if she regarded Dr B as her 'registered' GP. She was not eligible to be enrolled at the practice because of her visa status. GP notes record the consultation with Dr B on 9 August 2021. Date of last period (LMP) and estimated gestation recorded (7 weeks+3 days based on LMP) and *feels very nauseated and vomited daily.* Ms A's desire to terminate the pregnancy is noted. Blood pressure and pulse recorded and positive urine hcg. Documented plan is: *Antenatal bloods, STD swabs and USS pregnancy, antiemetic for hyperemesis, oral fluids encouraged, Med Cert.* Blood tests and swab results were unremarkable. Prescription for metoclopramide and ondansetron is recorded. Ultrasound result dated 17 August 2021 confirmed a singleton pregnancy of 7 weeks+2 days gestation. There are no notes referring to discussion of the result with Ms A or subsequent management plan. The next note is from another staff member and dated 23 August 2021: *received a call from the patient, requested medication for nausea, I informed there will be a charge for dr consultation, she started swearing F words, said dr told her to come back after lockdown.* There are no additional clinical notes.

6. Recommendations for management of patients requesting TOP are available on the Auckland Region HealthPathways[1] although the reference there to the DECIDE website[2] (which went live in July 2022) is not applicable to the events in question. The physical assessment of Ms A undertaken by Dr B appears appropriate and is adequately documented. The investigations ordered were appropriate and management of hyperemesis was reasonable. There is no reference to discussion of TOP options (medical versus surgical termination) although based on Ms A's initial estimated gestation (8 weeks 5 days) it is unlikely all investigations would have been completed within the time frame for consideration of medical termination (usually up to nine weeks' gestation although some providers will consider the method up to 10 weeks). As far as I can determine, Ms A required a private referral (as she was not eligible for publicly funded health care) which limited her provider option to Provider2 which performs medical abortions up to 10 weeks' gestation. Patients are able to self-refer to Provider2.

7. I am unable to determine why Dr B felt it was necessary to consult with Ms A a second time prior to making a referral for TOP before all results were available (noting the cited HealthPathways guidance states: *If the patient is considering an abortion, arrange investigations as indicated* [which was done], *including (if possible) for patients who plan to self-refer. There is no need to wait for results of blood tests, swabs, or cervical screening before referral*) or promptly on receiving the ultrasound result. Based on the revised estimated gestation of 7 weeks 2 days per ultrasound report, Ms A may have been able to access a medical termination if she was promptly referred to Provider2 or was advised she could self-refer. While the sudden level 4 lockdown was a complicating matter, there was no withdrawal of services by Provider2 as a consequence of the lockdown. I believe the most appropriate management of Ms A by Dr B would be for him to have referred her to Provider2 (or advised her to self-refer) while awaiting the investigation results although it was probably not unreasonable to wait for the dating scan result if this was imminent. On receipt of the dating scan result which dated the pregnancy somewhat earlier than anticipated, I believe appropriate management was to immediately refer Ms A to Provider2 or advise her to self-refer. I believe it was unreasonable and inconsistent with accepted practice for Dr B to advise her to make an appointment 'after lockdown' when the duration of lockdown could not be anticipated, there was no particular need for a further consultation from a clinical perspective, and referral was time critical if Ms A wished to consider medical termination as opposed to surgical termination. I note Dr B did not document his discussion with Ms A on 18 August 2021, and best practice would be to have done so.

8. The events of 23 August 2021 are somewhat unclear with the response referring to Ms A's partner being abusive in phone calls while there is a single note referring to Ms A being abusive. I can understand Ms A's distress at knowing she required a time critical procedure (TOP) but without being given any certainty over when her second pre-referral consultation would take place (after lockdown) or why a second consultation was required. While I do not believe practice staff should be required to tolerate verbal abuse, I do not believe abuse from the partner (if this was the case) should have resulted in the professional relationship being terminated with Ms A, and certainly not without ensuring she had timely access to

[1] Auckland Region/Te rohe o Tamaki Makaurau Community HealthPathways. Section: *Abortion.* https://aucklandregion.communityhealthpathways.org/ Accessed 27 June 2023
[2] https://www.decide.org.nz/ Accessed 27 June 2023

the procedure she required. I note also the failure of the practice to respond to Ms A's complaint in a timely manner.

9. I believe Dr B's management of Ms A would be met with moderate disapproval by my peers, relating mainly to his failure to refer Ms A for her termination in a timely manner following an appropriate initial consultation. The circumstances surrounding the termination of the professional relationship are probably not sufficiently clear to enable specific comment. It appears the practice may require further education regarding the responsibility to respond to patient complaints in a timely manner. There may be a privacy issue with respect to discussion of Ms A's TOP related matters in a non-private area.

Addendum 19 March 2024

10. I have reviewed a further response from Dr B dated 29 August 2023 and a response from medical director of Provider1. There is no new information provided regarding the decisions made by Dr B with respect to management of Ms A's TOP request, but the basis for some of his management decisions has been clarified in both responses. Dr B felt Ms A was somewhat overwhelmed by all the information he attempted to provide her at the first visit on 9 August 2021 (complicated by the fact she needed to be made aware of the cost of the various options provided) and part of the reason for organising a follow-up visit once all results were available was to revisit her management options and how the NZ 'system' worked, confirm her desire for TOP and to address any medical issues revealed by the test results. Provider1 response notes the wide variety of cultures seen in the clinic and routine advice of a second appointment prior to TOP referral helps to ensure many culture-specific and other issues (including language barriers) are adequately addressed prior to referral. While noting the cited HealthPathways guidance recommends immediate referral once tests have been organised, I believe Dr B's intention to review Ms A prior to formalising the referral was probably reasonable at the time the decision was made, for the reasons presented by Dr B and in the Provider1 response. However, I would expect the patient's current gestation to be taken into account when organising such follow-up to ensure delays do not prevent the patient from accessing medical TOP if that is their preference.

11. Dr B acknowledges he was not aware that Provider2 would continue to provide TOP services during level 4 lockdown. He states had he been aware of this, he would have asked Ms A to attend once her ultrasound results were available and would have referred her to Provider2 at this time. I believe it would have been a fairly simple process for Dr B or a Provider1 staff member to have contacted Provider2 to clarify what service they were offering during lockdown. Dr B states Ms A knew that Provider1 *is a walk-in clinic as opposed to an appointment-based GP clinic* and could have attended the planned follow-up appointment at any time. However, he restates that in the phone call of 18 August 2021 I *told her to come back for ToP referral 2nd consultation once Level 4 Lockdown was lifted.* I remain of the view that this advice was not consistent with accepted practice for the reasons previously discussed, including that referral for TOP was time critical if Ms A wished to consider a medical termination (Dr B states Ms A had not expressed a preference for a medical versus surgical procedure at this time) and the length of lockdown was uncertain. Furthermore, it was recommended that patients that could be safely managed via a telephone or video consultation (as I believe was the case with Ms A) be preferentially managed in that way during level 4 lockdown. The Provider1 response does indicate

telephone consultations were undertaken over this period and PPE requirements were followed for face-to-face appointments. Nevertheless, Ms A required certainty regarding the process for proceeding with her TOP and this was not provided by Dr B. I remain of the view that the advice provided to Ms A by Dr B on 18 August 2021 (to come back after lockdown) would be met with moderate disapproval by my peers in the circumstances described. The additional stresses imposed on primary care by the level 4 lockdown might be given consideration as a mitigating factor in Dr B's management decisions and in the inadequate documentation of Dr B's telephone contact with Ms A on 18 August 2021. The fact the clinic was 'walk-in' and a formal appointment was not required might also be considered as a mitigating factor.

12. With respect to the events of 23 August 2021, I am puzzled that Ms A was advised to attend the medical centre for review during level 4 lockdown for what was in effect a repeat prescription, but I cannot state this was a departure from accepted practice as recommendations provided by RNZCGP in relation to patient contact during the various stages of COVID lockdowns were advisory rather than prescriptive. It appears Ms A was verbally abusive to Provider1 staff on 23 August 2021 and as she was not a registered patient with the practice the requirements for formal termination of the professional relationship may not apply. The Provider1 response notes a staff member did contact Ms A after 23 August 2021 (date uncertain) to confirm she had received attention regarding her TOP and this seems a reasonable action. I have no further comments or recommendations.'