General Practitioner, Dr B

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC01892)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman in 2020 by a locum general practitioner (GP) at a medical centre.

2. The woman requested an appointment as she had discovered a lump under her ribcage and was also experiencing severe anxiety. She complained that the GP performed a breast examination instead of listening to her about her symptoms of anxiety.

3. The GP provided inadequate responses to the complaint and made accusatory statements about the woman.

Findings

4. The Deputy Health and Disability Commissioner found that the GP failed to confirm the purpose of the woman's appointment and did not explain the rationale for the breast examination, breaching Right 6(2) of the Code. By performing the breast examination without explaining the purpose of it, he also breached Right 7(1) of the Code.

5. The Deputy Health and Disability Commissioner also found that the GP failed to provide an adequate response to the woman's complaint, and made inappropriate comments about her character, veracity, and mental health. The doctor acted unprofessionally and in breach of Right 10(3) of the Code.

Recommendations

6. The Deputy Commissioner recommended that the GP provide a formal apology to the woman and reflect on his appointment with her. The Deputy Commissioner also recommended that should he return to New Zealand, he undertake professional training in clinical communication, complaint management, record-keeping, informed consent, and his obligations as a healthcare provider under the Code.

7. The Deputy Commissioner recommended that Te Whatu Ora use this report as an educational tool for its staff on how to deal with complaints from consumers.

8. The Deputy Commissioner recommended that the Medical Council of New Zealand conduct a review of the GP's competence and conduct should he return to New Zealand and re-apply for a practising certificate.

Complaint and investigation

9. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her by Dr B. The following issue was identified for investigation:

- *Whether Dr B provided Mrs A with an appropriate standard of care in June 2020.*

10. This report is the opinion of Deputy Commissioner Deborah James and is made in accordance with the power delegated to her by the Commissioner.

11. The parties directly involved in the investigation were:

Mrs A	Consumer
Dr B	Provider

12. Further information was received from:

Te Whatu Ora|Health New Zealand	Operator of the medical centre
RN D	Practice nurse at the medical centre

13. General practitioner Dr E is also mentioned in this report.

14. In-house clinical advice was obtained from general practitioner (GP) Dr David Maplesden (Appendix A).

Information gathered during investigation

Background

15. At the time of events, Mrs A was a patient at the medical centre, a primary healthcare service. The medical centre was operated by the district health board (now Te Whatu Ora).[1] Mrs A was experiencing anxiety and depression during the public health restrictions in 2020 as a result of the COVID-19 pandemic.[2]

16. Dr B was a locum GP at the medical centre. Mrs A saw Dr B for a GP consultation on 9 June 2020. She complained about the care she received that day and at a follow-up appointment on 15 July 2020.

Appointment and breast examination on 9 June 2020

Mrs A's account

17. In a complaint to the district health board, Mrs A stated:

> '[On 9 June 2020] I came in with severe anxiety and depression. I was not able to communicate this to the doctor as he didn't ask what was wrong. He gave me a breast examination which I did not come in for …'

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, resulting in all district health boards being disestablished. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to the district health board now refer to Te Whatu Ora.
[2] New Zealand imposed restrictions on gathering during the COVID-19 pandemic.

18. In her complaint to HDC through the Nationwide Health and Disability Advocacy Service, Mrs A said that she 'had been experiencing anxiety and depression during Covid 19 lockdown restrictions, so made an appointment to be seen …'

19. When Mrs A arrived at the district health board, she saw Dr B. Mrs A told HDC that she gave him information, including her full name and details, which was printed at reception. Dr B looked up a file on the computer and told Mrs A that he would complete a breast examination. Mrs A said that she was upset and crying, and tried to tell Dr B that she was not there for a breast examination.

20. Dr B then left the room and returned with RN D, a practice nurse. Mrs A stated that Dr B told her to get on the examination table, and he began examining her breasts. Mrs A said in her complaint to the district health board that she 'cried non stop as he did this and [she] kept telling him [she] wasn't there for that'. Mrs A told HDC that she told Dr B three times that she '[did not] want a breast exam' and was crying throughout the appointment, but he chose to ignore this and completed the breast examination. Dr B then advised her that there was nothing wrong with her and she left.

21. Mrs A said that she was not given the opportunity to tell Dr B about the anxiety and depression for which she had come to the district health board. She said that after seeing Dr B, a nurse made an appointment for her to be seen the following morning.

22. Mrs A told HDC that she was 'visibly upset and discussed this with [RN D] in the waiting room, who made another appointment the following day to be seen by an alternative General Practitioner'. In her complaint to the district health board, Mrs A stated: '[T]hankfully the nurse could see how distraught I was. She came after me and got me an appointment first thing the following morning.'

Clinical notes

23. The district health board provided HDC with clinical notes that recorded a telephone call from Mrs A to a nurse on 9 June 2020. The notes state that Mrs A had found a lump 'under [her] ribcage' and was scheduled for a breast ultrasound scan (USS) the following week for a different, previously identified breast lump. The notes also state that Mrs A had lost weight, lost appetite and was very anxious. The district health board gave Mrs A an appointment with a GP that day.

24. In his clinical notes for 9 June 2020, Dr B recorded that Mrs A presented as an urgent walk-in. He noted that he explained to her that she had had a normal mammogram in 2019. He recorded that she was 'quite anxious', 'states low appetite — discussed anxiety', and that his impression was that Mrs A suffered from anxiety. However, Dr B did not record any specific reason(s) for her anxiety. Dr B documented, 'breasts both sides normal', and that he explained to Mrs A that there was no sign of malignancy. He also recorded that a chaperone was present and that Mrs A had requested liver function tests.

25. In response to the provisional opinion, Mrs A said that Dr B did not acknowledge or discuss her anxiety with her during the appointment, despite recording in his notes that she was anxious.

26. RN D recorded in the clinical notes on 9 June 2020 that Mrs A had been waiting in the waiting area prior to being seen by Dr B. RN D noted that after the appointment, she apologised to Mrs A for the fact that she had had to wait (at reception, as she had been confused with a different patient with the same first name). RN D documented that Mrs A was still very anxious after the appointment, and she tried to reassure her by reinforcing what Dr B had said — that on examination there were no signs of malignancy in her breasts.

27. On 10 June 2020, Dr B recorded: 'Discussed [patient] with [Clinical Nurse Manager] today.'

28. Dr E saw Mrs A on 10 June 2020 and noted that she presented with a list of symptoms she had been experiencing over the previous eight weeks, the main concerns being anxiety, depression, loss of appetite and weight loss, trouble sleeping, dark thoughts and frustration. Dr E discussed depression and anxiety with Mrs A, and also explained that a painful lump on the right anterior of her chest was likely to be a tender sternocostal joint.

29. In Mrs A's clinical notes of 12 June 2020, a nurse noted that during a 'call from health line re [a person with Mrs A's first name]', Mrs A had said that she did 'not want to see [Dr B] again', and that she was 'requesting [a] female doctor'.

Appointment on 15 July 2020

30. Mrs A told HDC that one month after her 9 June appointment, she made a follow-up appointment on 15 July 2020 and asked not to be seen by Dr B. However, when she arrived and went to the consultation room, Dr B was in the room, and she advised him that she would like to be seen by another doctor. She stated that 'he grabbed the paper provided by reception out of her hands, wrote no charge and threw it back at her'. Mrs A said that Dr B told her to 'get out and make an appointment with someone else'.

31. On 15 July 2020, Dr B recorded in Mrs A's clinical notes: '[P]refers different GP — will rebook = sure; no charge.' Dr B told HDC:

> '[Mrs A] requested to be seen from a different GP, what I did agree on: I did not prescribe Diazepam in the first place, so my impression was if she was drug seeking again, she was doctor shopping for another GP and would say whatever to not paying the consultation fee. Here one point is actually correct: I marked on her appointment slip a "No charge consultation".'

Complaint by Mrs A to the district health board

32. On 15 July 2020, Mrs A submitted a complaint to the district health board. The district health board discussed the complaint with RN D, who was the chaperone, and reviewed the clinical notes. The district health board provided HDC with the results of its internal enquiries into Mrs A's complaint.

33. The district health board said that it was 'unable to get a response from [Dr B]', and that it had had difficulty contacting Dr B after requesting that he respond to HDC's concerns.

34. In a letter from the district health board to Mrs A on 18 August 2020, the district health board advised Mrs A to 'discuss with medical council' since Dr B was not able to be contacted regarding the incident.

35. The district health board recorded a discussion with RN D on 30 October 2020. The record states:

a) RN D understood that Mrs A had presented with a new lump on the right side of the chest wall beneath the right breast, and a few weeks prior (26 May 2020) had presented for a different breast lump in the right breast.

b) RN D was present throughout the examination. The district health board recorded that RN D did not at any time hear Mrs A say that she did not want the examination, and at the time, she was seated with her arm raised for the examination.

c) Following the examination, Mrs A requested a number of blood tests, which Dr B considered were not required, but he did order a test for liver function. RN D said that it seemed that Mrs A thought she had cancer, and Dr B did not think this was the case. Further, there was an understanding that an ultrasound scan had been scheduled.

d) When leaving the consultation room, Mrs A appeared anxious but not extremely upset at that time.

36. HDC approached RN D to confirm the accuracy of this record of the 30 October 2020 discussion. She made the following comments and corrections and agreed with the rest of the record:

a) RN D clarified that it was Dr B who told her that Mrs A had presented with a breast lump. She had not discussed with Mrs A the reason for her appointment or reviewed any notes. RN D stated that this was normal practice for chaperoning patients.

b) RN D clarified that '[Mrs A] had her right arm raised during the examination time only'.

c) When Mrs A requested a number of different blood tests, Dr B declined her request and said that the mammogram would be a better diagnostic tool for her. Mrs A did not agree and requested blood tests, especially liver function, which Dr B agreed to.

d) Mrs A was upset when leaving the consultation room and was crying. She said that she did not think that Dr B had listened to her enough, and she felt that he should have ordered more tests. She also stated that she did not think she really needed to have another breast examination that day and wondered why Dr B had thought she needed one.

e) RN D said that Mrs A 'appeared to be having a cascade of concerns about her health in general'. RN D stated that she sat with Mrs A while she was crying and listened to her and tried to reassure her. She explained the rationale for the breast examination and waiting for the mammogram rather than ordering more tests. RN D offered to take Mrs

A to the ward to have a sit down and to speak to someone else, as the clinic was closing, but Mrs A declined and said that she wanted to go home. RN D offered to call her the next morning and Mrs A agreed to this.

f) Dr B did discuss Mrs A with RN D and the Clinical Nurse Manager the next morning as he was concerned that Mrs A was unhappy with the consultation. It was agreed that RN D would make contact with Mrs A as arranged.

g) When RN D telephoned Mrs A the following day, Mrs A still appeared to be upset about the consultation with Dr B, and her health and her life in general, and felt that she was not coping. She accepted an offer of a further consultation with a female GP, Dr E.

37. As a result of its internal enquiries into Mrs A's complaint, the district health board recommended:

- An internal discussion with all clinicians regarding confirming with patients who they are and why they are presenting.
- Patients with similar names on a schedule should be highlighted as a duplicate name or otherwise marked to ensure that name confusion does not occur.

Response from Dr B and engagement with HDC

38. HDC initially contacted Dr B on 22 October 2020 requesting a response to Mrs A's complaint by 12 November 2020. On 13 January 2021, Dr B told HDC that he was not currently living in New Zealand and would need legal advice to finalise his answer to the complaint when he was back in New Zealand. However, through email he made some comments about the complaint:

- He said that Mrs A presented on 9 June 2020 with a suspicious lump with pain that might have been an abscess and received an emergency appointment on the same day she requested it. He said that 'the procedures were explained through the triage nurse and the nurse on the phone'.
- He said that he told Mrs A that she did not have an abscess or any other abnormal clinical findings. Her most recent mammogram was printed and explained to her.
- He said that Mrs A had multiple other issues but did not consult him because of her anxiety.
- He told HDC that 'on another presentation, also as emergency consultation, on a different day she then requested a female GP'.
- He did not charge Mrs A for this later appointment, and he explained to her that she could have another appointment with a doctor of her choice.
- He told HDC that Mrs A did not complain at the time of either consultation.

39. After some discussions about clinical information, and with the clinical information being made available to Dr B, on 12 March 2021, HDC extended the due date for Dr B's formalised response to 2 April 2021.

40. On 16 March 2021, Dr B emailed HDC saying that he did not agree with the complaint but providing no substantive response. He said that Mrs A 'would need to testify in a court'. He stated that 'because her statements are incorrect, her case [would] get dismissed and she would also need to cover the legal costs'.

41. On 22 March 2021, HDC sent a letter to Dr B saying that HDC had 'made several attempts to seek a response from [him] to [Mrs A's] complaint' but had received no response. HDC reminded Dr B that he was 'expected to use [his] best endeavours to assist this Office in facilitating the fair, simple, speedy and efficient resolution of complaints by responding promptly to [HDC's] requests for information', and that he had all the necessary information to provide a response, including Mrs A's complaint and clinical notes. HDC requested an urgent response by 8 April 2021. Dr B disagreed that he had not provided a response, and said:

> 'Because of the withholding of information, the need of legal advice for the court case and an external expert opinion in this case, your client has to witness in court. I do not think that without an objective examination and a court case we will find a solution.'

42. On 9 May 2022, HDC sent Dr B a letter notifying him of HDC's intention to undertake an investigation under section 40 of the Health and Disability Commissioner Act 1994 (HDC Act). In the same letter, HDC required that Dr B provide information by 30 May 2022 under section 62(1) of the HDC Act, including a response to Mrs A's complaint, and a response to the issues raised by my in-house clinical advisor.

43. On 8 June 2022, Dr B forwarded to HDC his email response to the Medical Council of New Zealand (MCNZ) sent on 23 May 2022.[3] Dr B stated that Mrs A presented with a possible painful lump in her right breast or chest wall, and that all her clinical findings were normal. Dr B said that Mrs A's 'frequent consultations' would 'show her mental state clearly for any courtroom' and suggested that she had 'drug seeking behaviour'. Dr B made the following further comments:

- He was always overbooked.
- There was a longstanding shortage of GPs and nurses in the region.
- 'Most of the complaints [in the region] and in NZ were mainly because of financial reasons, if they would complain about whatever, they would request a refund of the consultation fees.'

44. On 20 June 2022, HDC followed up with Dr B asking him to provide a response to my in-house clinical advisor's comments by 1 July 2022.

[3] MCNZ asked Dr B to respond to information about Mrs A's complaint, which it had received from HDC.

45. On 1 July 2022, Dr B emailed HDC saying:

> 'I never ever examined any patient in my whole life without consent. She even requested a Liver function test — how would this have happened without consent? A whole team of nurses was present too.'

46. In response to the provisional opinion, Mrs A said that only one nurse was present during the examination.

47. To date, Dr B has not responded to HDC's three requests for comment on my in-house clinical advisor's comments, nor has he provided a formal response to Mrs A's complaint, despite multiple opportunities, reminders and requests to do so. He has provided a number of reasons for not engaging or responding to requests from HDC, including family issues, COVID-19, his inability to return to New Zealand, and not having information that he believed to be relevant, but which HDC did not hold.

Responses to provisional opinion

Mrs A

48. Mrs A was provided with the 'information gathered' part of the provisional opinion.

49. Mrs A said that she is not sure what Dr B meant when he said that 'the procedures were explained through the triage nurse and nurse on the phone'. She said that instead of examining and discussing with her the lump on her lower rib cage, Dr B performed a breast examination. Mrs A also said that Dr B did not appear to notice the 'emotional meltdown' she was having during the appointment.

50. Mrs A was distressed to read that Dr B told HDC that she was 'drug seeking', and strongly rejects this. She stated that she was suffering with anxiety and reached out for help. Mrs A stated:

> 'I feel [Dr B's] "reasons" for not responding to HDC's requests are weak and show no responsibility nor recognition to the seriousness of his actions towards someone who was clearly struggling mentally. To label me a "drug seeker" is really disappointing coming from someone in the medical profession who should be helping not labelling.'

Dr B

51. Dr B was provided with a copy of the provisional opinion, and he disagreed with the Deputy Commissioner's findings. He said that Mrs A 'requested a breast examination, she agreed to the examination, [and] she was informed from several persons [including] the triage nurse and the on call nurse …' He described Mrs A as 'friendly and cooperative' and said she did not have any concerns or questions, did not cry, and a chaperone was present during the consultation.

52. Dr B said that following the examination, Mrs A requested a blood test and received a form for this. He said that the previous results were explained and printed out for her, along with the planned ultrasound referral.

Opinion: Dr B — breach

Introduction

53. When seeing Dr B, Mrs A had a right to have services provided with reasonable care and skill, and to be provided with information that a reasonable consumer in Mrs A's circumstances would need to give informed consent. Dr B could provide services to Mrs A only if she made an informed choice and gave informed consent to those services. Dr B also had a duty to facilitate the fair, simple, speedy, and efficient resolution of Mrs A's complaint. To assist with my consideration of the care provided by Dr B, I sought advice from my in-house clinical advisor, GP Dr David Maplesden.

Failure to ascertain reason for consultation

54. Dr B saw Mrs A for a GP consultation on 9 June 2020. Mrs A says that she came in for depression and anxiety.

55. The clinical notes show that Mrs A came into the clinic after she had called a nurse on the same day complaining of a lump 'under [her] ribcage', weight loss and low appetite and feeling very anxious. During this consultation, Dr B conducted a breast examination on Mrs A.

56. My in-house clinical advisor stated that it is 'accepted practice for the GP to ask the patient the reason for their attendance prior to proceeding with an examination'. Dr Maplesden said that 'to proceed with an examination without confirming with the patient this was (at least in part) the purpose of the consultation and gaining consent for the examination would be a significant departure from accepted practice'.

57. Mrs A told HDC that she expressed to Dr B that she did not want a breast examination. Dr B's clinical notes state that Mrs A was 'here quite anxious' and then describe the findings of the breast examination. Dr B's clinical notes do not indicate whether or not there was a discussion about the purpose of the consultation before the examination occurred, or whether informed consent for the examination was obtained.

58. In response to my provisional opinion, Dr B said that Mrs A requested and agreed to a breast examination. However, he has not provided any further information about what discussions, if any, took place, regarding ascertaining the purpose of Mrs A's attendance and explaining the breast examination. I have considered Mrs A's evidence, the clinical notes, and the fact that RN D told HDC that Mrs A said to her after the appointment that she did not understand why Dr B had felt that a breast examination was necessary — none of which support Dr B's statement that Mrs A requested and agreed to a breast examination. I conclude that Dr B did not confirm with Mrs A the purpose of her visit or the purpose of the examination.

Informed consent and documentation of consent

59. According to Mrs A, Dr B informed her that he would be performing a breast examination, left the room, returned with RN D to chaperone, and then began the breast examination after asking Mrs A to lie on the table. Mrs A says that she did not want or request a breast

examination during her 9 June 2020 appointment and told Dr B three times that she did not want a breast examination.

60. RN D told HDC that Mrs A had her right arm raised during the breast examination, and that she did not hear Mrs A say that she did not want the examination. However, RN D told HDC that after the consultation, Mrs A said that she did not think she needed a breast examination and wondered why Dr B thought it was needed.

61. Although I find that Mrs A did not actively request a breast examination, because of these differing recollections I cannot be certain that Mrs A expressed to Dr B that she did not want a breast examination. However, I must emphasise the fact that if a consumer does not object to an examination, that does not mean that the consumer has provided informed consent in line with Right 7 of the Code of Health and Disability Services Consumers' Rights (the Code).

62. It is clear to me that while Mrs A presented with a lump under her ribcage along with her anxiety symptoms, it was not explained to her why a breast examination was necessary. There is no evidence in the clinical records or from Dr B, Mrs A or RN D to indicate that Dr B explained to Mrs A the indications for, and nature and purpose of, a breast examination and obtained Mrs A's informed consent.

63. The MCNZ's statement on informed consent[4] says that effective communication is critical in the consent process. It states that 'the doctor undertaking the treatment or procedure is responsible for the overall informed consent process'. While Dr B states that a triage nurse and a nurse on the phone 'explained [the procedures]' (a statement that Mrs A refutes), it was his responsibility to communicate with Mrs A effectively to ascertain the reason for her attendance and obtain consent for the breast examination. From the evidence available to me, I find that Dr B did not take the steps required to obtain informed consent from Mrs A.

64. I emphasise the importance of documenting discussions about consent in the clinical notes. The MCNZ's statement on 'Maintaining Patient Records'[5] states that doctors must maintain clear and accurate patient records that note decisions made and the reasons for them. There may be significant knowledge gaps between doctors and patients. A patient may not understand why certain procedures are being proposed, whereas the reasons may be obvious to a doctor. It is important that patients understand the reasons for their treatment, and that doctors communicate with their patients.

65. This is especially important for sensitive procedures such as breast examinations. HDC has previously emphasised the need for providers to obtain explicit, unambiguous consent when

[4] https://www.mcnz.org.nz/assets/standards/55f15c65af/Statement-on-informed-consent.pdf accessed 17 March 2023. The 2019 statement, which applied at the time of the events, contained the same wording.
[5] https://www.mcnz.org.nz/assets/standards/0c24a75f7b/Maintenance-patient-records.pdf. Accessed 19 January 2023.

intimate or sensitive areas of the body are involved.[6] Consent must never be assumed in such circumstances and should be documented appropriately.

Conclusion about 9 June appointment

66. I accept my in-house clinical advisor's comment that if Dr B did not confirm with Mrs A the purpose for her consultation on 9 June 2020, and gain consent before proceeding with an examination, it would be a significant departure from accepted practice. I find on the balance of probabilities that Dr B proceeded with a breast examination without confirming the purpose of Mrs A's visit and did not explain the rationale for the examination.

67. By failing to confirm the purpose of Mrs A's presentation, and by not explaining the rationale for, and nature of, the breast examination, Dr B failed to provide the information that Mrs A required to give informed consent to the breast examination, breaching Right 6(2) of the Code.

68. By proceeding with the breast examination without having provided appropriate information, Dr B provided a service to Mrs A without her informed consent. Accordingly, Dr B breached Right 7(1) of the Code.

Failure to facilitate resolution of complaint

69. Right 10(3) of the Code requires providers to facilitate the fair, simple, speedy, and efficient resolution of complaints.

70. While I acknowledge that Dr B has undergone difficult personal circumstances, throughout the HDC complaint process and investigation, he has provided only brief information in response to the complaint and has made inappropriate comments about Mrs A's general mental health. He has accused her of '[d]rug seeking behaviour' and made insinuations about Mrs A's veracity by saying that she 'would say whatever to not paying the consultation fee [sic]' and by saying that complaints made in the region 'were mainly because of financial reasons'. Dr B has failed to provide an adequate response addressing all of the issues in the complaint, despite multiple opportunities and reminders from HDC to do so.

71. The MCNZ's standard *Good Medical Practice*[7] states at paragraphs 59 and 60:

> '59. You must cooperate fully with any formal inquiry or inquest (although you have the right not to give evidence that may lead to criminal proceedings being taken against you). When you provide information you must be honest, accurate, objective and the information provided must be based on clear and relevant clinical evidence.

[6] See https://www.hdc.org.nz/decisions/search-decisions/2020/19hdc00788/. The Commissioner emphasised that '[i]t is not sufficient to assume that a client has given informed consent because the client does not object to specific actions'.

[7] https://www.mcnz.org.nz/assets/standards/b3ad8bfba4/Good-Medical-Practice.pdf. Accessed 19 January 2023.

> 60. You must not withhold relevant information from any formal inquiry or inquest, or attempt to contact or influence complainants or witnesses except where directed by the relevant authority.'

72. Dr B has not provided his formal response to Mrs A's complaint. Dr B has failed to comply with HDC's request under s 62(1) of the HDC Act for a response to my in-house clinical advisor's comments.

73. I find that the communications described in paragraphs 38 to 45 above are not compliant with the standard *Good Medical Practice* set by the MCNZ.

74. In a previous investigation [8] (20HDC01793), HDC attempted four times to contact a counsellor to provide a response to a complaint, and to obtain session notes, amongst other information. The counsellor did not provide such information and told HDC that he was unable to access the records from his clinic due to COVID-19. However, further attempts to contact the counsellor were also unsuccessful. HDC found that the counsellor breached Right 10(3) of the Code. Dr B's behaviour in this investigation is comparable to the counsellor's behaviour in the previous investigation.

75. HDC investigations are impartial and fair processes. The correspondence sent to Dr B by HDC were opportunities for him not only to clarify and resolve the issues raised by Mrs A, but also to provide information to support his assertions that the care provided to Mrs A was appropriate. Dr B did not take these opportunities and, in doing so, unnecessarily delayed Mrs A's right to have her complaint handled in a speedy, efficient, and satisfactory manner.

76. Dr B's communications with HDC as described above, and in particular his comment that Mrs A 'would need to testify in a court … because her statements are incorrect, her case will get dismissed and she would also need to cover the legal costs' have hindered the fair resolution of Mrs A's complaint.

77. In response to the provisional opinion, Dr B again asserted that '[Mrs A] was under the mental health team' and said that he did not receive the clinical notes. He said: '[H]er mental health status is evident for this case. I think without reviewing this, this case is incomplete.' HDC provided Dr B with Mrs A's clinical notes on 21 December 2020. HDC confirmed with the district health board on 9 February 2021 that Mrs A was not registered with the mental health service. The district health board told HDC that it had emailed Dr B advising that it did not hold any mental health service clinical notes regarding Mrs A and that none of Mrs A's prescriptions were from mental health practitioners. HDC told Dr B on 15 February 2021 that there were no mental health records for Mrs A.

78. Dr B further said that 'the notes of the triage nurses and the documentation of the phone calls were not provided'. HDC provided Dr B with this information, which was contained in Mrs A's clinical notes on 21 December 2020.

[8] 20HDC01793. Available on www.hdc.org.nz

79. Dr B also said: '[T]he case was discussed with our management team directly afterwards too, the evidence for this was not provided.' The only reference to this discussion is a note in Mrs A's clinical notes written by Dr B, which reads, 'discussed pat[ient]/with [Clinical Nurse Manager] today'.

80. Accordingly, I find that by failing to provide an adequate response to HDC and making inappropriate comments about Mrs A's character, veracity, and mental health, Dr B acted unprofessionally and in breach of Right 10(3) of the Code.

15 July 2020 appointment — adverse comment

81. Mrs A says that at a subsequent appointment on 15 July 2020, she advised Dr B that she would like to be seen by another doctor. She stated that in response, 'he grabbed the paper provided by reception out of her hands, wrote no charge and threw it back at her'. Mrs A says that Dr B told her to 'get out and make an appointment with someone else'.

82. In his clinical notes from this appointment, Dr B noted: '[P]refers different GP — will rebook = sure; no charge.' Dr B commented:

> '[Mrs A] requested to be seen from a different GP, what I did agree on: I did not prescribe Diazepam in the first place, so my impression was if she was drug seeking again, she was doctor shopping for another GP and would say whatever to not paying the consultation fee. Here one point is actually correct: I marked on her appointment slip a "No charge consultation"'.'

83. From Mrs A's account, the way in which Dr B conducted himself during this appointment, in particular throwing a piece of paper at her, was, from her perspective, disrespectful. Dr B, from the limited comment he provided to HDC regarding this appointment, assumed that Mrs A's reason for asking for a different GP was that she was 'drug seeking' and 'doctor shopping'. He has made this comment despite a note on 12 June 2020 by a nurse that states: '[Mrs A] does not want to see [Dr B] again. [R]equesting female doctor.'

84. I am unable to find objectively on the facts whether Dr B was intentionally dismissive and disrespectful to Mrs A. However, she clearly perceived it as such, and Dr B's subsequent comments show a lack of appreciation of Mrs A's feelings, and an assumption about drug-seeking behaviour that is not supported by the clinical notes or preceding events. I am critical of Dr B's poor reflection on both appointments and how his actions were perceived by Mrs A.

Recommendations

85. I recommend that Dr B:

a) Provide a formal apology to Mrs A for failing to check the purpose of her visit and explain the rationale for a breast examination before proceeding with one, failing to obtain

informed consent, his manner during the 15 July 2020 appointment, as well as failing to facilitate the resolution of her complaint. This apology is to be sent to HDC within one month from the date of this report, for forwarding to Mrs A.

b) Reflect on the appointment of 15 July 2020 in light of this report and provide HDC with evidence of his reflection within one month of the date of this report.

86. Dr B is no longer residing or practising in New Zealand. I recommend that should he return to New Zealand and intend to resume practice here, he undertake professional training in clinical communication, complaint management, record-keeping, informed consent, and his obligations as a healthcare provider under the Code, and report back to HDC on his reflections from the training undertaken.

87. I recommend that Te Whatu Ora use this investigation report as an educational tool for its staff on how to deal with complaints from consumers and report back to HDC with evidence that this has been done within three months of the date of this report.

88. I recommend that MCNZ conduct a review of Dr B's competence and conduct should he return to New Zealand and re-apply for a practising certificate.

Follow-up actions

89. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to MCNZ and the medical association in Dr B's home country, and it will be advised of Dr B's name.

90. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to Te Whatu Ora|Health New Zealand and the Royal New Zealand College of General Practitioners, and they will be advised of Dr B's name.

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

92. Dr B 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.

Addendum

93. Dr B did not comply with the recommendations made for him within the timeframes set out in the report.

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from GP Dr David Maplesden:

'1. Thank you for the request that I provide a file steer in relation to the complaint from [Mrs A] about the care provided to her by [Dr B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have done short term locums at [the medical centre] but I do not recognise any of the personnel named in the communication related to this file. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the following information:

- Complaint from [Mrs A]
- Response from [the DHB]
- Response and GP notes [medical centre]
- Limited e-mail communication from [Dr B]

2. [Mrs A] states she developed anxiety and depression during the Covid lockdown period and presented to [the medical centre] on 9 June 2020 to discuss management of her anxiety. She saw [Dr B] who did not seek to establish why she was presenting but informed [Mrs A] she required a breast examination and then left the room to obtain a nurse chaperone. He returned with the nurse and despite [Mrs A] attempting to explain she was not presenting for a breast examination, the examination was undertaken. [Dr B] informed [Mrs A] the examination was normal and the consultation concluded without her having her anxiety symptom addressed. [Mrs A] was extremely upset and the nurse chaperone arranged an appointment with another GP for the next morning to enable [Mrs A] to discuss her mental health issues. [Mrs A] complained to [the DHB] and they responded they were unable to contact [Dr B] but it appears he thought [Mrs A] was a different patient with a similar name who was booked for a breast examination.

3. Review of GP notes

(i) Nurse notes dated 26 May 2020 refer to [Mrs A] reporting a new lump in her right breast with routine screening mammogram due in July 2020. An appointment was made with GP [initials] who saw her the same day. History of recently self-detected right parasternal lump is noted and: *After informed consent, doesn't want chaperone. Inspection breast; scar left breast laterally. Otherwise skin nad, nipples nad. Palpation dense tissue, no lumps felt. Above breast right side 2 x3 soft lesion between 3rd and fourth rib next to sternum, mobile axillae: nad.* Management plan was for ultrasound (referral made) although the lump was felt to be most likely benign.

(ii) Nurse notes dated 9 June 2020 are: *Ph. call from pt. Found a lump under ribcage today. Not painful. Is scheduled for breast uss next week for new breast lump. Has lost wt, lost appetite & now very anxious. Appt. given w' GP for review.*

(iii) [Dr B's] notes dated 9 June 2020 are:

[P]resented here as urgent walk in: has app. for sono pending, had normal mammogramme in 2019 — explained, here quite anxious

breasts both sides normal nipples axilla normal no induration palpl. — explained;

resp. nad afebrrile & abdo otherwise nad

no sign for malign. here today — explained, reassured, states low appetite — discussed anxiety

chaperone present

requests liver function tests — form done, normal labs prevsly — explained

imp: anxiety plan: review after lab & sono

(iv) Further nurse notes dated 9 June 2020 read: *Apologies to patient who had been waiting due to misunderstanding with appt. Patient very anxious still. Tried to reassure her by reinforcing what Gp said. Will followup tomorrow with pc.*

(v) Provider [initials] reviewed [Mrs A] on 10 June 2020 noting she presented with a written list of symptoms including *anxiety and depression, loss of appetite and weight loss, trouble sleeping, dark thoughts, frustration …* A well-documented mental health consultation is presented (GAD score 17/21) and there is also reference to the right breast lump as: *painful lump R anterior chest is likely a tender sternocostal joint, does not feel like soft tissue lump, pt is booked for urgent breast US.* Trial of citalopram was commenced with short term use of sedatives. Several additional consultations were undertaken in June 2020 in relation to the anxiety symptoms.

4. Provider responses: the district health board response to HDC includes the comment: *[RN D] accompanied and was present throughout [Mrs A's] appointment with [Dr B]. [RN D] is fully aware of the responsibility of advocacy as a chaperone and would have intervened if there had been any indication that [Mrs A] did not agree to have her breast examined. At no point during the appointment did [RN D] gain the impression that [Mrs A] did not want her breast examined, as she was seated with her arm raised for the examination.*

5. [The medical centre's] internal report includes information from [RN D] with additional information contained in an affidavit from [RN D]:

(i) *There had been a slight confusion with the patient as she had just seen another patient named [Mrs A's first name] and thought she had left the practice. Once that was sorted, [Dr B] asked her to chaperone the breast examination.* [RN D] provided further information that she had rescheduled the breast exam for another patient [with the same first name] just before [Dr B] approached her to chaperone a breast examination for [Mrs A]) [RN D] informed [Dr B] the assessment had been rescheduled but he

approached her about 30 minutes later stating '[the person]' was still in the waiting room. [RN D] realised then that [Mrs A] was a different [person with the same first name] and she apologised to [Mrs A] for the delay. She realises this may have increased [Mrs A's] anxiety.

(ii) *The practice Nurse understood that [Mrs A] had presented with a lump on the right side of the chest wall beneath the R) breast. Only a few weeks ago she had presented for a breast lump in the R) breast. With this information, [RN D] considered it professionally appropriate to re-examine the breast site in order for the Doctor to make a comparison.* [RN D] notes the medical file notes referred to anxiety about a new breast lump.

(iii) *[RN D] acknowledged that the patient was anxious but not extremely. She did follow up with her after the consult. [RN D] commented that [Mrs A] considered she had cancer which was contrary to [Dr B's] diagnosis of the situation.* [RN D] notes [Mrs A] requested several blood tests which [Dr B] did not necessarily endorse but a referral was made for some tests. She notes: *Leaving the consultation room, [Mrs A] was anxious but did not appear to be extremely upset at that time.* [Dr B] subsequently (10 June 2020) discussed the appointment with [RN D] and the associate clinical nurse manager because of concerns about the level of [Mrs A's] anxiety and an appointment was arranged with [Dr E] (see above).

(iv) I note [Dr B] has not yet provided a formal response but denies the allegations of [Mrs A] and he believes the observations of [RN D] and the contemporaneous notes support this.

6. Comments

(i) As far as I can determine from the available documentation [Mrs A] contacted [the medical centre] on 9 June 2020 expressing concern about a new breast lump and anxiety symptoms — the two apparently related (based on the nurse note). She was given an appointment with [Dr B] whom she had seen previously in March 2020 for a lip lesion. While not entirely clear, based on [RN D's] statement it appears [Dr B] may have read the notes and assumed a breast examination would be required (quite a reasonable assumption based on the nurse note) and proactively sought [RN D's] assistance as a chaperone prior to taking [Mrs A] from the waiting room — however, I cannot be certain of this sequence of events. The misidentification issue relates to [RN D] assuming [Dr B] was talking about another patient requiring breast examination when he asked for her assistance as a chaperone which meant she gave [Dr B] erroneous information that the examination had been rescheduled. However, [Dr B] recognised this error when he saw [Mrs A] still in the waiting room and questioned [RN D]. In essence, if does not appear [Dr B] mistook [Mrs A] for another patient when he saw her for a consultation, and he had consulted with her less than three months previously.

(ii) There is quite a marked contrast between the clinical notes of 9 June 2020, [RN D's] recollections and the content of the complaint. It is accepted practice for the GP to ask

the patient the reason for their attendance prior to proceeding with an examination and, to proceed with an examination without confirming with the patient this was (at least in part) the purpose of the consultation and gaining consent for the examination would be a significant departure from accepted practice. The impression I have gained from the notes and [RN D] is that [Mrs A] was anxious about her breast lumps and the feeling they could be cancer, although it does not appear any other reasons for her anxiety were explored during the consultation. If [Mrs A] had found a new breast lump and was anxious about this (as the clinical notes suggest) I believe it was clinically appropriate to undertake a breast examination provided the patient consented to the examination and presence of a chaperone. Best practice would be to document verbal consent for the examination although in practice I see such documentation relatively infrequently.

(iii) If [Mrs A's] major presenting symptoms were primarily anxiety related, I would expect these to be explored with management dependent on the history obtained. A breast examination (with consent) may still have been appropriate if the breast lump was a major source of anxiety, but best practice would be to have explored the anxiety symptoms in more detail than is evident from [Dr B's] notes but is illustrated in [Dr E's] notes the following day. However, I cannot exclude the possibility that [Mrs A] presented to [Dr B] the new breast lump as the source of her anxiety rather than more longstanding generalised anxiety being her outstanding issue.

(iv) Whatever the sequence of events, there was apparently significant miscommunication between [Dr B] and [Mrs A], and it would be appropriate for [Dr B] to reflect on the possible reasons for this. However, if the consultation proceeded as described by [Mrs A] ie [Dr B] proceeded with a breast examination without establishing the reason for [Mrs A's] attendance and without gaining verbal consent, and with her expressing distress during the examination, this would be cause for serious concern.'