Doctor in General Practice, Dr B

A Medical Centre

A Report by the

Health and Disability Commissioner

(Case 13HDC00158)

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Executive summary

1. Ms A, aged 34 years, had recently returned from a trip overseas. Ms A had become unwell while travelling. Her symptoms were general nausea, diarrhoea and extreme tiredness. Initially she had had abdominal pain, but that had abated by the time she returned to New Zealand.

2. On 26 January 2012, Ms A consulted Dr B at a medical centre. After asking some questions, Dr B examined Ms A's abdomen, groin, and labia, and inserted a finger or fingers into her vagina.

3. Apart from the abdominal examination, Dr B did not explain the reason for the examination or the nature of the proposed examination.

4. Dr B did not offer a chaperone, provide Ms A with a private space to disrobe and re-dress, or provide a cover for her. Dr B made no records at the time of the consultation of the nature of the examination he conducted, the reasons for it, or his findings.

Findings

5. Dr B's examination of Ms A (apart from the abdominal examination) was not clinically indicated in light of her reported symptoms. Dr B did not provide services to Ms A with reasonable care and skill and breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

6. Dr B had a duty to inform Ms A about the nature of the examination he proposed to undertake and the reasons for it. He also had a duty to inform her that she could have a chaperone or support person present. By failing to provide Ms A with the required information, Dr B breached Right 6(1)[2] of the Code. As Ms A did not receive sufficient information about the nature of, and the reasons for, the examination, or the option of having a chaperone present for the intimate parts of that examination, she was not in a position to make an informed choice and give informed consent to the examination. Accordingly, Dr B also breached Right 7(1)[3] of the Code.

7. By failing to make records at the time of the consultation, Dr B did not comply with the relevant professional standards and breached Right 4(2)[4] of the Code.

[1] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[2] 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 …"
[3] 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."
[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."

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8. The overall manner in which Dr B conducted the examination showed a lack of respect for Ms A and a lack of respect for her personal physical privacy. Accordingly, Dr B breached Right 1(1)[5] of the Code.

9. Adverse comment is made about the medical centre for failing to update Ms A regarding her complaint, and for not making a written record of her account.

Complaint and investigation

10. The Commissioner received a complaint from Ms A about the services provided by Dr B. The following issues were identified for investigation:

- *The appropriateness of the services provided to Ms A by Dr B in January 2012.*
- *The appropriateness of the services provided to Ms A by the medical centre between January and May 2012.*

11. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Dr B	Provider
The medical centre	Provider

12. Information was also obtained from:

Mr C	Complainant's partner
Ms D	Practice Manager
Dr E	Clinical Director
Ms F	Practice Nurse
Ms G	Practice Nurse

13. Expert advice was obtained from HDC's clinical advisor, Dr David Maplesden (**Appendix A**).

Information gathered during investigation

Ms A

14. Ms A and her partner, Mr C, had spent six weeks travelling overseas. During that time they both became unwell. Ms A stated that her symptoms were general nausea,

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

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diarrhoea and extreme tiredness. She said that initially she had had abdominal pain, but that had abated by the time she returned to New Zealand.

15. On 26 January 2012, Ms A made an appointment at the medical centre. Ms A advised that when she attends the medical centre she sees whoever is available, and does not have a preference for any particular doctor.

Consultation 26 January 2012

16. Ms A was first seen by a practice nurse, Ms F, who recorded that Ms A had been overseas for six weeks and had been back for ten days. The records also state that she had diarrhoea, which she developed four days before leaving, and that she was not able to sleep and had headaches, nausea and abdominal pain.

17. Ms A then saw Dr B.[6] She stated that while she was seated in a chair in the consultation room, Dr B discussed her symptoms with her and asked her several questions including, how often was she going to the toilet, was she having any stomach pains, were her faeces slimy, and did she have a loss of appetite?

18. Ms A told Dr B that her partner had also had diarrhoea since their return. Ms A stated that Dr B's behaviour was unlike the previous times she had seen him.[7] She said that he did not ask very many questions, and that he was "certainly a man of few words". Although Ms A had seen Dr B for prior appointments, she did not consider they had an established relationship.

Abdominal examination

19. Ms A said that Dr B stated that he wanted to feel her tummy, so she got onto the examination couch[8] and lowered her trousers down to her pelvic area. Dr B started to feel her stomach, starting high up and moving his way down.

20. Ms A told HDC: "He basically kept pushing areas and he would say to me, 'Does that hurt?' and I would say, 'No'." Ms A stated that she wasn't really looking at Dr B because she felt vulnerable and so avoided eye contact. She stated that she was looking at the ceiling rather than at him and did not take note of his expression, as she was just waiting for the examination to be over.

21. Ms A stated that she remembers telling Dr B that when he pushed on her stomach it was uncomfortable, but it did not hurt. Ms A does not recall any tenderness in her left

[6] Dr B has been registered in a general scope of practice since 2005. Dr B practises medicine under supervision in the General Practice Education Programme (GPEP) training programme. He qualified overseas with a Bachelor of Medicine and Bachelor of Surgery. Dr B is not a vocationally registered general practitioner.

[7] Ms A attended five consultations with Dr B between 11 January 2010 and 9 June 2011.

[8] The examination couch is another name used to describe the surgical bed in the consultation room.

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iliac fossa.[9] She stated: "I don't remember it hurting at all to be perfectly honest. I remember saying 'well that's uncomfortable but it doesn't really hurt'."

22. Dr B told HDC that he suspected Ms A might have contracted giardiasis,[10] and he was expecting to find some generalised tenderness, "because in Giardia inflammation of area in the gut so you get generalised marked sort of tenderness, you don't get any localised tenderness". Dr B stated that when he was checking Ms A's abdomen using deep palpation, there was tenderness on the left iliac fossa and, when he repeated the deep palpation, there was again mild to moderate tenderness. Dr B stated that he had not been expecting this tenderness so he asked Ms A questions such as, "have you got any urinary symptoms, have you got any discharge?" and she said "no". Dr B told HDC that he repeated the deep palpation and told Ms A he would probably have to look at her groin area, the lymph node, and the "hernia area orifices".[11]

Groin/genital examination

23. Ms A said that Dr B did not mention examining her groin but continued to examine her and his hands moved lower into the area of her groin. Ms A said that Dr B "got to my pants line and was pushing around it, he seemed nervous and uncomfortable, so I asked if he needed me to lower them". Dr B said "yes" so she moved her trousers and underwear down approximately 4–5 centimetres.

24. Ms A told HDC that "he started pushing around my pubic bone and clitoral area". She stated that she thought it was a little strange as she had consulted him about a diarrhoea complaint, but she assumed that Dr B must be looking for something specific. Ms A stated that Dr B started pushing "further down all around her pants line", again asking her whether it hurt, and she replied that it did not hurt but the pushing was not very comfortable.

25. Ms A said that when Dr B again got to the top of her pants he was clearly trying to push his hands underneath. She told HDC that she thought at the time he was uncomfortable and that perhaps women did not often come to male doctors for this kind of thing, so possibly he was having trouble with how to express to her what he needed to do. Ms A stated that she said to Dr B, "Do you need me to take off my pants?" and he said, "Yes".

26. Ms A told HDC that she then pushed her pants and knickers down to her ankles and sat back up, pulling her heels up to her bottom, then lay down on her back again with her legs apart. She said she did so "because when I've had vaginal examinations in the past that's kind of what they ask you to do so that was kind of what I did automatically". Ms A stated that Dr B did not tell her he was going to be doing a

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[9] The iliac fossa is a large, smooth, concave surface located on the internal surface of the ilium (part of the three fused bones making the hip bone).

[10] Giardiasis is a food- and water-borne disease that is caused by a parasite. Symptoms include abdominal pain, nausea and vomiting.

[11] A hernia is a condition in which part of an organ or tissue is displaced and protrudes through the muscle wall of the cavity containing it. A hernial orifice is a potential or actual deficiency in the muscle wall through which internal tissues or organs may protrude or have protruded.

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vaginal examination, but she inferred it from the fact he kept "going lower and lower" into that area.

27. Ms A stated that "he just started feeling down some more, and then he started putting his fingers in around my labia — he didn't put his finger inside me straight away, he pushed around in my labia". Ms A said that at that stage Dr B did not ask whether it hurt and she assumed he was looking for something different than previously. She stated that after feeling her labia on both sides he then put his fingers inside her. She stated that it was very brief and then he stopped. When asked by HDC how many fingers Dr B inserted into her, Ms A said she could not be 100% sure. She said, "I think it was two." Ms A said that Dr B then took off his gloves and washed his hands while she restored her clothing. Ms A recalls that Dr B was wearing gloves throughout the examination.

28. In contrast, Dr B said that after he told Ms A he needed to examine her groin area, she pushed her pants and underwear down. Dr B stated: "I was taken aback. I didn't have time to tell her it was not needed. It happened very quickly." Dr B stated that he thought that she lowered her clothing to her mid thigh or above her mid thigh and was lying flat.

29. Dr B told HDC:

> "Momentarily I thought, oh shall I stop her here and then I said, oh, [Ms A] knows me and probably she relied on me. If I do that, that would be more embarrassing for her, so let me check the lymph node and the hernial orifice quickly and finish it there. In retrospect I think I didn't do a good decision on that."

30. When interviewed by HDC, Dr B stated that he did not conduct an internal or genital examination of Ms A. He said that he has never done any internal examination on any woman while he has been a general practitioner (GP),[12] as he always asks his colleagues to do that. He stated that the only time he has performed an internal examination was in 2004, when he did a three-month gynaecology-obstetrics run during his training as, prior to coming to New Zealand, he was practising in a different area of medicine and so had no necessity to conduct internal examinations of women.

31. Dr B stated that the female doctors at the medical centre would conduct any internal examinations and give him the findings, and he would write them in his notes together with the name of the doctor who had carried out the examination.

32. In contrast, HDC spoke with Ms G, a practice nurse at the medical centre, who said that Dr B did conduct internal examinations on female patients. Ms G recalls at least two or three occasions on which Dr B asked her to be present as a chaperone while he conducted internal vaginal examinations. Ms G could not recall the identity of the patients concerned, as it was some time ago.

[12] As stated above, Dr B is not a vocationally registered general practitioner.

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33. When interviewed by HDC, Ms A stated that she had anticipated that Dr B would provide a reasonable explanation for the examination, and was very surprised when HDC staff advised her that he had denied to HDC having conducted a genital examination or having inserted his fingers into her vagina.

Privacy and chaperone

34. In Ms A's written complaint to the medical centre dated 5 September 2012, she stated that after she climbed onto the bed[13] Dr B put on gloves and pulled the curtain around the end of the bed. However, when interviewed by HDC she stated that "he didn't actually pull the curtain around at all, the beginning or the end or anything, there was no curtain". Ms A said that when she stood up and replaced her clothing after the examination there was no curtain drawn around the examination couch to preserve her privacy.

35. Both Dr B and Ms A agree that Ms A was not offered a sheet to cover her during the examination.

36. Both Dr B and Ms A also agree that Ms A was not offered a chaperone. The medical centre's Chaperone Policy states that "where an invasive or highly personal examination is to be conducted on the opposite sex 'a chaperone is always requested'". Dr B said that he did not offer Ms A a chaperone, as he did not consider that the examination he was going to conduct was an intimate examination. Dr B advised that if he has asked a patient if he or she would like a chaperone, he would usually record that in the notes. If the patient has declined a chaperone, he would also record that.

37. Dr B stated that he was provided with no training at the medical centre about the Chaperone Policy. In contrast, Dr E, the clinical director of the medical centre, advised that prior to this incident, there had been an informal complaint about Dr B's conduct in November 2011 regarding an alleged inappropriate breast examination. The medical centre "had iterated the need for chaperones to be used for breast or genital examinations" at that time to Dr B.

38. The medical centre provided a copy of a sign-off sheet on which Dr B had signed on 7 April 2011 that he had read and was aware of the content of the medical centre's policies.

39. The medical centre also stated that the Chaperone Policy is displayed above the examination couch in each room, and it is also displayed on the noticeboard in the waiting room. The notices were in place prior to Ms A's complaint to HDC about Dr B.

Records

40. Dr B made no record at the time of the consultation on 26 January 2012. Dr B stated that he is certain that he made contemporaneous notes on the patient management

[13] Examination couch — see above note 8.

system (PMS) but they cannot now be located. He stated that this is not the only time he has found notes logged into the system to be missing. Dr B advised that he does not normally make notes while he is talking to the patient, but makes the notes later. Dr B stated: "Sometimes you do typing and sometimes you push the wrong button everything is gone. So you have to do it again." Dr B said that if you do not save the notes they are deleted. He also said that it is possible that he forgot completely to make the notes. A computer audit indicates that the notes were never made.

41. Dr B stated that the lack of notes on 26 January 2012 was brought to his attention at his first meeting with Dr E on 3 February 2012, and she suggested that he complete the notes retrospectively. Dr B refused to do so, and instead completed some notes that day on a blank page in his personal diary. However, Dr E does not recall asking Dr B to make notes retrospectively. She stated that if doctors do have to add a note later, as sometimes happens, they should write something such as "notes omitted in error".

42. Dr B made records of a consultation with Ms A on 27 January 2012. Dr B's notes include: "[B]ack for r/v [review], been to lab for stool exam, still frequent bowel motions (6–7 times yesterday), no fever, o/e [on examination]; nil distress, systemically well, impr; likely ifective diarrhoea, discussed — will commence Abx [antibiotics] empercally, pl; ciprofloxacin; 500mg, po [orally], bd, 5/7, continue enerlyte as advised, r/v lab results [sic]." Dr B also noted that a prescription for ciprofloxacin was provided.

43. The content of this note implies that a face-to-face consultation took place between Ms A and Dr B on 27 January 2012. Ms A does not recall a further consultation with Dr B, but does recall attending the medical centre to pick up a prescription. When asked further by HDC, Ms A stated that she does not remember any further contact or communication with Dr B, but that:

> "… at that point I wasn't concerned, so if they had sent me in to get my script to him it wouldn't have bothered me in the slightest … I just felt like it had been handled badly and I felt better that I'd, you know, let them [the medical centre] know that that could be handled better next time."

44. In his initial response to HDC, Dr B also did not recall a consultation on 27 January 2012. However, when interviewed by HDC, Dr B advised that he did not have Ms A's medical records available to him at the time of his initial response. Dr B's legal advisor told HDC that after reviewing the clinical notes, Dr B had "been reminded that not only did he see [Ms A] on Thursday 26 January 2012 but again the following day. That was something which he [Dr B] had forgotten when he came to provide his response earlier."

Discussion with partner

45. Mr C told HDC that Ms A said to him that her appointment with Dr B had been "a little bit strange", and she had not expected to be examined in the manner she was. According to Mr C, Ms A told him that Dr B had conducted a vaginal examination.

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46. Mr C and Ms A discussed the fact that when Mr C went to the medical centre with the same problem later in the day on 26 January 2012 and saw a different doctor, he did not have the same type of examination. However, Mr C stated that they recognised they were not doctors and thought there must have been a reason for Ms A's examination.

Subsequent events

47. When Ms A returned to the medical centre on 27 January 2012, she spoke to Ms F. Ms F said that Ms A mentioned her concerns about the consultation with Dr B and said she had felt quite uncomfortable. Ms F made no record of the conversation but said that Ms A stated that the touching was quite inappropriate for an examination for diarrhoea, and that she was uncomfortable with the consultation for the following reasons:

- Dr B had not advised her before getting on the bed that he was intending to do a vaginal examination.
- Dr B had not asked her if she would like to have a female nurse present.
- Dr B had not explained why a vaginal examination was necessary given that she had come in with a bowel complaint.
- The process had seemed awkward and odd.

48. Ms F verbally notified Dr E of the above concerns. On 31 January 2012, Dr E spoke with Ms A, who reiterated the above concerns. Dr E said she understood from the conversation that the examination was an external genital examination. Dr E advised that when she spoke to Ms A she appeared to be concerned about Dr B having failed to explain the purpose of his examination. However, Dr E said that she did not ask for any detail about the examination and made no notes of the conversation.

49. Dr E stated that on 1 February 2012 she informed Dr B of Ms A's concerns about the consultation and asked him to take paid leave while the matter was investigated. Dr B met with Dr E and Ms D, the practice manager, on 3 February 2012 to respond to Ms A's concerns. Dr B was advised that this was a serious matter and reminded again of the Chaperone Policy. Dr B gave a verbal response stating that while he was examining Ms A's abdomen, she complained of pain "down below", and that was why he examined that area.

50. Dr E said that Ms A had been specific to her about having been examined in the clitoral area, and Dr E told HDC that she believes that on 3 February 2012 she asked Dr B specifically whether he had examined the external genitalia, and he confirmed that he had. She stated that she reiterated to Dr B that for any type of physical examination that could be construed as intimate, it was necessary to be conducted with a chaperone, and that he agreed.

51. Dr E said that she accepted Dr B's explanation for why he had examined Ms A's external genitalia. On 7 February 2012, Dr E informed Dr B that no further action

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would be taken on Ms A's complaint. Ms A's clinical records indicate that she was not advised of the outcome of her complaint until 25 May 2012. The notes state: "I have apologised for not getting back to her re the previous concerns. Explained we had spoken to the dr [doctor], and had no further concerns. Pt happy with this." However, when in September 2012 the medical centre received a further complaint from another female patient about Dr B's conduct during a chest examination, they sought advice from the Medical Council of New Zealand and were advised to get the complaint from Ms A in writing.

52. On 5 September 2012, Ms A provided a written complaint to the medical centre. In her complaint, Ms A stated that Dr B "started feeling around [her] labia and inside [her] labia on both sides and then inserted his fingers inside [her] for a few moments and felt around. He did not ask [her] if this hurt."

53. Dr E said that when they obtained Ms A's written complaint "it was apparent there was more to it than they had first thought", as she realised only at that point that there was an allegation of an internal examination. Dr E said that when Ms A was asked to provide a written complaint it was explained to her that the medical centre was taking the matter very seriously.

54. Dr B was subsequently dismissed.

Responses to provisional opinion

55. Responses were received from Ms A, Dr B, and the medical centre. The parties chose not to provide any comments other than the following:

    a. Dr B considers "the report contains a number of significant factual inaccuracies and that the findings of breach are seriously flawed". Dr B did not provide any further detail or comments about these statements.

    b. The medical centre acknowledged "the significant shortcomings in [its] initial management of [Ms A's] complaint".

Standards

56. The Medical Council of New Zealand's publication *Sexual Boundaries in the Doctor–Patient Relationship: A resource for doctors* (October 2009) provides:[14]

"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

[14] Available from http://www.mcnz.org.nz/support-for-doctors/resources/.

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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.

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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.”

57. The Medical Council of New Zealand’s publication *The Maintenance and Retention of Patient Records* (August 2008) states:[15]

“**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.”

58. The New Zealand Medical Association’s Code of Ethics (2008) recommends:[16]

“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: Dr B — Breach

Introduction

59. This opinion relates to the conduct of Dr B during a consultation with Ms A on 26 January 2012. The events that occurred during the consultation puzzled and concerned Ms A.

[15] Available from http://www.mcnz.org.nz/support-for-doctors/resources/.
[16] Available from http://www.nzma.org.nz/publications/other-nzma-publications/code-of-ethics.

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60. Ms A was unsure about the clinical necessity for the examination and what was reasonable in the circumstances. However, she trusted Dr B and permitted the examination to take place.

61. Patients look to their doctor as a person in whom they can place trust and impart confidences. In my view, Dr B took advantage of this trust and behaved in an inappropriate and unacceptable manner.

62. I am concerned about the nature of the examination and the manner in which it was conducted. I consider that Dr B'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 the patient intimately without the patient's consent. I am also concerned about Dr B's actions following the examination, in that he failed to respect Ms A's privacy, and he made no clinical records.

Factual findings

Lowering clothing

63. Ms A told HDC that when Dr B appeared to be having difficulty with the examination being obstructed by her clothing, she asked whether she needed to lower her clothing. When he indicated that she did, Ms A initially partially lowered her lower garments, then subsequently lowered them to her ankles and exposed her genital area. In contrast, Dr B told HDC that Ms A lowered her clothing to her mid-thigh or above her mid-thigh. For the purpose of this opinion, it is not necessary for me to make a finding as to whether Ms A lowered her clothing to her ankles or to her mid-thigh or above her mid-thigh. It is accepted that Ms A lowered her clothing at least to her thighs.

Examination

64. Ms A's account of the examination has been consistent. Immediately after the appointment on 26 January 2012, Ms A discussed with her partner having had a vaginal examination. Subsequently, Ms A was asked to give a detailed written account of events and, on 5 September 2012, she stated that Dr B "started feeling around [her] labia and inside [her] labia on both sides and then inserted his fingers inside [her] for a few moments and felt around. He did not ask [her] if this hurt." When interviewed by HDC staff on 3 April 2013, Ms A again stated that Dr B had put his fingers in and around her labia and then put his finger or fingers inside her.

65. Ms F and Dr E advised HDC that Ms A said that Dr B touched her around the clitoral area. Dr E advised that when she spoke to Ms A, Ms A's concern appeared to be Dr B having failed to explain the purpose of his examination. Dr E said that she understood that the examination was an external genital examination, but did not ask Ms A for any detail.

66. Dr E told HDC that she believes she asked Dr B specifically whether he had examined Ms A's external genitalia, and he confirmed that he had. However, when interviewed by HDC, Dr B stated that he checked the lymph nodes and the hernia orifices but did

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not conduct any internal or genital examination of Ms A. Dr B made no records of the nature of the examination he conducted at the time of the consultation.

67. Dr B told HDC that apart from during his training he has never conducted an internal examination on a female patient, including smear tests. However, Ms G advised HDC that she was a chaperone for Dr B on at least two or three occasions when he conducted internal vaginal examinations on female patients. Ms G could not recall the identity of the patients, as it was some time ago. I accept Ms G's evidence and note that Dr B's credibility is impaired by his incorrect evidence on this point.

68. I find it more likely than not that on 26 January 2012 Dr B examined Ms A's abdomen and groin, touched her labia, and inserted a finger or fingers into her vagina.

Extent of examination — Breach

69. Ms A told HDC that she presented to Dr B stating that she had diarrhoea and was feeling generally unwell. I have found that Dr B examined Ms A's abdomen and groin, touched her labia, and inserted a finger or fingers into her vagina.

70. Dr Maplesden advised me that given Ms A's history, "it was appropriate clinical practice to perform an abdominal examination to exclude any organomegaly,[17] abdominal masses or localised abdominal tenderness. Such an examination would involve the patient lying flat on the bed with their abdomen exposed from the epigastrium[18] to the pelvic brim[19]." Accordingly, I accept that it was appropriate for Dr B to perform the abdominal examination.

71. Ms A stated that she told Dr B that the abdominal palpation was uncomfortable but not painful. Dr Maplesden advised that he "would not expect routine examination of the groins, and certainly not a genital examination, in a patient whose abdominal findings were consistent with a history of bowel infection and in whom there was no suspicion of an acute abdomen".

72. Dr B stated that Ms A did indicate that she was experiencing pain in the left iliac fossa. Dr Maplesden advised that in that situation it might be clinically appropriate to examine the groins to exclude any herniae or local lymphadenopathy.[20]

73. I accept Ms A's account that the abdominal palpation was uncomfortable, but not painful, and that she did not indicate to Dr B that she was experiencing pain in her left iliac fossa. Dr Maplesden advised that "there was no clinical indication (based on [Ms A's] recollection of her 'pain') to palpate [Ms A's] external genitalia or perform an internal examination, and expected processes in this regard were not followed". Dr Maplesden stated that "this aspect of the examination, as reported by [Ms A], was a severe departure from expected standards".

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[17] Organomegaly is the abnormal enlargement of organs.
[18] The part of the upper abdomen immediately over the stomach.
[19] The upper edge of the pelvic inlet.
[20] Lymph nodes that are abnormal in size, number or consistency.

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74. I find that the external genital examination and the internal examination of Ms A undertaken by Dr B were not clearly indicated in light of her reported symptoms. In particular, that the abdominal examination, while uncomfortable at times, did not cause pain. Therefore, I find that Dr B did not provide services to Ms A with reasonable care and skill and, accordingly, Dr B breached Right 4(1) of the Code.

Required information — Breach

Nature of, and reasons for, examination

75. Dr B was employed by the medical centre. Ms A advised that she had previously seen Dr B but did not have an established relationship with him. She said she would see the first doctor available when she attended the medical centre.

76. Ms A stated that while she was seated in a chair in the consultation room, Dr B asked her a number of questions. He then said that he wanted to feel her stomach. Ms A stated that she was comfortable for him to do so, and she got onto the examination couch and lowered her trousers down to her pelvic area. Ms A said that Dr B did not explain the nature or extent of the examination, including that he would examine her groin and genitals, and did not explain what he was looking for, and there had been no discussion at that point of the possibility of her having giardiasis.

77. It is clear that during and after the consultation, Ms A was uncertain whether the examination conducted was clinically appropriate. Ms F advised HDC that Ms A told her that she was concerned about the appropriateness of the examination in relation to her presentation with diarrhoea, and that she had felt quite uncomfortable. Similarly, when interviewed by HDC, Ms A stated that she had anticipated that Dr B would provide a reasonable explanation for the examination, and was very surprised to discover that he denied to HDC having conducted a genital examination or having inserted his fingers into her vagina.

78. Right 6(1) of the Code provides that every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. In my view, a reasonable consumer in Ms A's circumstances, presenting with diarrhoea, inability to sleep, headaches, nausea and abdominal pain, 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. I find that Dr B did not provide Ms A with the information to which she was entitled.

79. 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 the applicable standard is the Medical Council of New Zealand's publication *Sexual Boundaries in the Doctor–Patient Relationship: A resource for doctors* (October 2009), 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 the patient must always be asked for his or her

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consent before the examination, and it should be clear that the patient has agreed to the examination before it is undertaken.

80. I find that Dr B had a duty to inform Ms A about the nature of the examination he proposed to undertake and the reasons for it. By failing to do so, he breached Right 6(1) of the Code.

Option to have a chaperone

81. The medical centre advised that following an earlier informal complaint about Dr B's conduct regarding an alleged inappropriate breast examination in November 2011, he had been reminded about the Chaperone Policy, which required practitioners to offer a chaperone for invasive or highly personal examinations conducted on the opposite sex.

82. Dr B did not offer Ms A a chaperone prior to examining her abdomen, groin, labia and vagina.

83. The Royal New Zealand College of General Practitioners' (RNZCGP) publication *Standard for New Zealand General Practice* (2011–2014) provides that informed consent may include routinely informing patients of their right to have a chaperone or support person present during consultations.[21] Despite Dr B not being vocationally registered as a GP, he was working as a doctor in general practice and, therefore, in my view, similar expectations apply. Whether or not a GP is vocationally registered does not change the information provision obligations the GP has to his or her patients.

84. Dr Maplesden advised me that the medical centre should have a notice visible to all patients stating that a patient can request a support person or chaperone at any time. However, he would not regard it as expected practice for a chaperone to be specifically offered as routine practice for the abdominal examination described. Dr Maplesden advised that if there was an expectation the examination might proceed beyond the abdomen and become more intimate in nature, a chaperone would be expected to be offered.

85. Dr Maplesden's advice is that the groin examination might be considered intimate by some patients, and best practice would be to offer a chaperone, although this might depend, to some degree, on the existing doctor–patient relationship and any perceived level of patient discomfort.

86. With regard to an examination of the genitals and the internal examination, Dr Maplesden advised that a chaperone should be offered routinely. Dr B advised that if he asks a patient if he or she would like a chaperone, he would usually record a patient's wish for, or refusal of, a chaperone. Dr B stated that he did not expect Ms A to pull down her clothing and, as he could have checked the lymph nodes and hernia orifices without her removing her underwear, he did not consider the groin examination to be an intimate examination.

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[21] Available at http://www.rnzcgp.org.nz/assets/documents/CORNERSTONE/Aiming-for-Excellence-2011.pdf.

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87. As noted above, the RNZCGP standards provide that informing patients about their right to have a chaperone may be part of the informed consent process. I consider that a consumer's rights under the Code in relation to informed consent appropriately include the provision of this information. 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 the examination. The provision of that information was therefore required under Right 6(1) of the Code.

Informed consent — Breach

88. As set out above, I do not consider that Ms A received sufficient information about the nature of the examination and the reasons for it, and so was not in a position to make an informed choice and give informed consent to the examination. My finding that Ms A was not offered a chaperone once it became evident that the examination was becoming intimate, also meant that she was not in a position to make an informed choice or give informed consent to the intimate part of the examination. Accordingly, for each of these reasons, I find that Dr B breached Right 7(1) of the Code.

Clinical records — Breach

89. 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. Furthermore, this Office has frequently emphasised the importance of record-keeping.[22]

90. In this case, Dr B made no record of the consultation on 26 January 2012. Dr B stated that he is certain that he made contemporaneous notes on the PMS but they cannot be located. He stated that this is not the only time he has found notes to be missing. Dr B stated that it is possible that he forgot completely to make the notes. A computer audit indicates that the notes were never made. Dr Maplesden advised that in his experience with the PMS used, in this case MedTech, it is difficult to lose notes unless the computer fails while the notes are being entered, which would be obvious to the operator. Once the notes have been entered, if the operator changes to another patient or closes the notes page, the notes are automatically saved.

91. Dr Maplesden stated that the most common reason for absent notes is the failure to record them which, in my view, is the most likely explanation for the lack of notes in this case. In not keeping records of the consultation on 26 January 2012 with Ms A, Dr B did not comply with the relevant professional standards and breached Right 4(2) of the Code.

Personal privacy — Breach

92. 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 "[e]very consumer

[22] See Opinions 10HDC00610 and 10HDC00509 (available from www.hdc.org.nz).
[23] Former Commissioner Robyn Stent, "Unravelling the Code" (29 April 1998).

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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, and the behaviour and attitude of the provider towards the consumer.[24]

93. 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.

94. Both Dr B and Ms A agree that Dr B did not supply a covering sheet. Dr Maplesden advised that if it were clinically appropriate to examine the groins, privacy should be maintained by positioning a coversheet over the patient's pelvic area and moving it as required. Similarly, once Ms A lowered her trousers and underwear and had exposed the genital area, Dr B should have used a sheet to preserve her modesty as far as possible.

95. Furthermore, when Ms A stood up and replaced her clothing, there was no curtain drawn around the examination couch to preserve her privacy. Ms A stated that Dr B was a man of few words and seemed very uncomfortable. She stated that when Dr B was feeling the top of her vaginal area, he became awkward and uncomfortable, which was why she pulled down her clothing.

96. In my view, the overall manner in which Dr B conducted the examination showed a lack of respect for Ms A's personal physical privacy. Accordingly, I find that Dr B breached Right 1(1) of the Code.

Opinion: The medical centre — Adverse comment

97. Ms A presented to the medical centre on 26 January 2012 with symptoms of diarrhoea. Dr B performed an examination of Ms A's abdomen, groins, genital area and vagina. As stated above, Ms A was not offered a chaperone.

98. The medical centre advised that in November 2011 there had been a previous informal complaint about Dr B concerning an alleged inappropriate breast examination, and that he had had the Chaperone Policy drawn to his attention at that time. Furthermore, on 7 April 2011, Dr B had signed a form indicating that he had read, and was aware of, the current the medical centre policies, which included the Chaperone Policy.

[24] See Opinion 11HDC00871 (available from www.hdc.org.nz).

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99. Given that when Ms A was triaged by a practice nurse on 26 January 2012 her symptoms would not normally have been indicative of a need for an intimate examination, I do not consider that the medical centre had an obligation to advise Ms A that she could request a chaperone. Furthermore, I accept that the Chaperone Policy was prominently displayed.

100. However, I am concerned about the process followed once Ms A alerted the medical centre to her concerns about the examination she had undergone.

101. On 27 January 2012, Ms A raised her concerns with Ms F. Ms F told HDC that Ms A told her that the touching was inappropriate, and that Dr B had touched her around the clitoral area. That day, Ms F reported the concerns to Dr E. On 31 January 2012, Dr E spoke to Ms A, who reiterated her concerns. Dr E said that Ms A told her about having been examined in the clitoral area, and that Ms A appeared to be concerned about Dr B having failed to explain the purpose of his examination.

102. On 1 February 2012, Dr E informed Dr B about the complaint and met with him on 3 February 2012. Dr E told HDC that Dr B gave a reasonably plausible explanation that when he examined Ms A's stomach she complained of pain "down below", and that was why he examined that area. The outcome was that Dr E reiterated to Dr B that it was necessary to have a chaperone for any type of physical examination that could be construed as intimate, and Dr B agreed.

103. Dr E told HDC that, in retrospect, they should have asked for the complaint in writing and gone into it in more detail at the time it was first made. Ms A's clinical records indicate that she was not advised of the outcome of her complaint until 25 May 2012, a gap of four months. The notes state "I have apologised for not getting back to her re the previous concerns. Explained we had spoken to the dr [sic], and had no further concerns. Pt happy with this."

104. The medical centre has acknowledged that Ms A should have been updated on the outcome of her complaint sooner and that a written record of her account should have been made. This was a missed opportunity by the medical centre to find out the specific details of the incident. However, following a further complaint from another patient, the medical centre requested a written complaint from Ms A which revealed the details of the examination.

105. The medical centre's failure to document both the complaint and the outcome properly meant that an opportunity to assess critically what was potentially a serious issue (whether or not the examination itself was appropriate) was missed. Mitigating factors here are that Dr E did discuss the complaint with both Ms A and Dr B within days of the complaint being made. Although the management of Ms A's complaint was suboptimal, I do not find that it amounted to a breach of the Code.

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Recommendations

106. I recommend that Dr B:

- provide a written apology to Ms A. The apology is to be forwarded to HDC within three weeks from the date of this opinion, for forwarding to her.
- review the Medical Council of New Zealand and RNZCGP's standards for intimate examinations, communications with patients, and the informed consent process, and review the standards in relation to informing patients about the right to have a chaperone present during intimate examinations. Dr B is to report to HDC, by three months from the date of this opinion, about any changes he has made to his practice as a result of reviewing these standards.
- arrange for the Medical Council of New Zealand to organise regular mentoring meetings with a senior colleague four times per year for the next two years. The mentor is to provide written information to the Medical Council of New Zealand by 1 December 2014 for year one, and by 1 December 2015 for year two, that the mentoring has occurred and that Dr B appears to be complying with professional standards and continuing to maintain professional boundaries. The Medical Council of New Zealand is to confirm to HDC by 19 December 2014 for year one, and 18 December 2015 for year two, that the mentoring has occurred and that Dr B appears to be complying with professional standards and continuing to maintain professional boundaries.

Follow-up actions

107.
- 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.
- 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 with a recommendation that it undertake a competency review of Dr B.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the district health board, and it will be advised of Dr B's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Royal New Zealand College of General Practitioners and will be placed on the HDC website, www.hdc.org.nz, for educational purposes.

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Addendum

The Director of Proceedings laid a charge before the Health Practitioners Disciplinary Tribunal. Professional misconduct was not made out.

http://www.hpdt.org.nz/Default.aspx?Tabid=423

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Appendix A — Independent expert advice to the Commissioner

The following expert advice was obtained from in-house vocationally registered general practitioner Dr David Maplesden:

"My name is David Maplesden. I am a vocationally registered general practitioner practicing 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 [Dr B]. To my knowledge, I have no personal or professional conflicts of interest. I have examined the available documentation: complaint and associated documentation including interview transcript from [Ms A]; response from [Dr B] including retrospective handwritten consultation notes; statements from various staff of [the medical centre]; [the medical centre's] clinical notes; relevant [medical centre] policy documents. I have been asked to provide advice on the clinical aspects of this complaint, primarily the appropriateness of the examination undertaken as recalled by [Ms A] and [Dr B]. I have not provided comment on the complaints process undertaken by [the medical centre]. As a reference for expected standards I have used the Medical Council of New Zealand publication *Sexual Boundaries In The Doctor–Patient Relationship*[25] and a relevant literature review service[26].

2. [Ms A] complains that [Dr B] performed an intimate examination (vaginal examination) on her on 26 January 2012: without informing her he was going to perform the examination; without requesting her permission for the examination; without offering her a chaperone; and when there was no clinical indication for the examination. There were no contemporaneous records completed for the consultation but [Dr B] completed a handwritten retrospective record of the examination, following his attention being drawn to concern by [Ms A] at the nature of the examination, on 2 or 3 February 2012 (response says 3 February 2012, record is diarised on 2 February 2012). [Dr B] denies performing a vaginal examination on [Ms A] and says there was no clinical indication for such an examination.

3. [Ms A's] written complaint (5 September 2012) and interview transcript (3 April 2013):

(i) [Ms A] and her partner had recently travelled [overseas] and both had persistent diarrhoea following their return. On 26 January 2012 [Ms A] attended the medical centre for this problem and was seen by [Dr B]. In the past [Ms A] would see whichever doctor was available at the medical centre and had seen [Dr B] in the past.

[25] Available on the MCNZ website: www.mcnz.org.nz

[26] Fishman M et Aronson M. History and physical examination in adults with abdominal pain. Uptodate. Last updated March 2012. www.uptodate.com

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(ii) [Dr B] questioned [Ms A] about the nature of her bowel symptoms including associated symptoms such as loss of appetite and abdominal pain. [Ms A] denied any current abdominal pain, and informed [Dr B] her partner had similar symptoms.

(iii) [Dr B] *then asked if he could feel my tummy, so I climbed onto the bed and* [I] *pushed my trousers down to hip level.* [Ms A] described [Dr B] pulling privacy curtains around the bed and putting on gloves. He did not discuss the reason for the examination, or offer a chaperone. He did not supply a covering sheet.

(iv) [Ms A] describes [Dr B] palpating her abdomen from the top down and asking her about tenderness on palpation. She denied any tenderness although on one occasions she stated *that's uncomfortable but doesn't hurt* referring to the general discomfort associated with someone pushing on the abdomen although not specifying this to [Dr B]. She describes [Dr B] then *pushing around…my pants line…he seemed nervous and uncomfortable so I asked if he needed me to lower them* [the pants]. *He said yes and I lowered my pants further to mid-vagina. He started pushing around my pubic bone and clitoral area.*

(v) [Ms A] describes feeling somewhat puzzled at the need for an examination of this sort given the nature of her complaint but assumed [Dr B] must have been *looking for something specific.* [Dr B] continued to palpate *further down all around my pants line again* and [Ms A] asked if she needed to remove her pants completely as [Dr B] appeared reluctant to make a request. [Dr B] responded 'yes' and [Ms A] sat up, pushed her pants to her ankles, and lay back down with knees up and legs apart as she was familiar with the requirement of this position for genital examinations. She assumed this was the requirement even though [Dr B] had not stated that he was going to perform an internal examination or why one might be required. She states that [Dr B] *then started feeling around my labia and inside my labia on both sides and then inserted his fingers inside me for a few moments and felt around. He did not ask me if this hurt.*

(vi) [Dr B] then removed his gloves and advised [Ms A] to get dressed. He supplied her with a lab form for a faeces sample and advised her she should collect a container from the nurse. [Ms A] did this then left the surgery. She later discussed the examination with her partner (conversation confirmed in a statement from the partner) who had seen his GP for the same problem but had not been comprehensively examined as [Ms A] had been.

(vii) [Ms A] states she returned to the surgery to pick up her results and discussed the examination with a nurse at that time. She expressed concern about the lack of communication from [Dr B] regarding the nature of the examination and lack of chaperone, but assumed there had been indications for such an examination. She does not recall seeing [Dr B] again.

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4. Comments based on [Ms A's] complaint and interview:

(i) [Ms A's] history of persisting diarrhoea since [an overseas trip] was consistent with a diagnosis of a bowel infection, possibly giardiasis, particularly as her travelling partner had similar symptoms. There was nothing in the history relating to genitourinary symptoms. [Ms A] was apparently otherwise well with no symptoms to suggest systemic toxicity and no current abdominal pain.

(ii) [Ms A] had seen [Dr B] on several previous occasions (see notes summary below). Given the history, I think it was appropriate clinical practice to perform an abdominal examination to exclude any organomegaly, abdominal masses or localised abdominal tenderness. Such an examination would involve the patient lying flat on the bed with abdomen exposed from the epigastrium to the pelvic brim. I would not generally regard a 'routine' abdominal examination on a patient I had seen on several previous occasions as an 'intimate' examination. While the practice should have a notice visible to all patients (usually in the waiting room) that a patient can request a support person or chaperone at any time, I would not regard it as expected practice for a chaperone to be specifically offered as routine practice in the situation described. My expectation would be that a chaperone would be offered if the patient was unfamiliar to the doctor or there was an expectation the examination might proceed beyond the abdomen and become more 'intimate' in nature.

(iii) The examination process as described by [Ms A] above started in an expected manner, with the doctor gaining permission for the examination and providing a private environment for the examination. There was evidently communication throughout the preliminary part of the examination with [Dr B] repeatedly asking if there was tenderness on palpation of the abdomen in various areas. Had there been no abnormal findings on basic palpation in the situation described, some doctors might auscultate the abdomen to determine the nature of bowel sounds but I would not expect routine examination of the groins, and certainly not a genital examination, in a patient whose abdominal findings were consistent with the history of bowel infection and in whom there was no suspicion of an acute abdomen.

(iv) [Ms A] states she admitted that palpation was 'uncomfortable' at one point even though she had no pain. This was apparently perceived by [Dr B] as being a pain response (see [Dr B's] response below) in the left iliac fossa. In this situation, it might be clinically appropriate to examine the groins to exclude any herniae or local lymphadenopathy, even though the history was still most characteristic of a bowel infection. I would expect an explanation to be given as to the nature of this aspect of the examination and reasons for it, consent to be gained for proceeding with the examination and privacy to be maintained by positioning a cover sheet over the patient's pelvic area and moving it as required. An examination of this type (groin area but not genital) might be considered intimate by some patients and best practice would be to offer a chaperone, although this might depend to

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some degree on the existing doctor/patient relationship and any perceived level of patient discomfort.

(v) I would not expect an examination of the groin area for herniae or lymphadenopathy to involve palpation of the genitals (labia, clitoris), and exposure of the genitals can be minimised by use of a sheet. I can see no clinical indication, based on the history obtained and examination findings to this point as described by [Ms A], to warrant palpation of the genitals or the internal examination described. Had there been clinical indications to proceed with such an examination (for example if there was suspicion of an acute abdomen or mass arising from the pelvis on abdominal examination) the expectation is that the reasons for and nature of such an examination are explained, permission for the examination sought (irrespective of whether permission for the abdominal examination had been given), a chaperone offered routinely, and the examination performed preserving the patient's modesty as much as possible with the use of a sheet cover. [Ms A's] statement indicates none of these expectations were met. Nor does the examination described constitute a competent bimanual pelvic examination if this was the intention.

(vi) In summary, I feel abdominal examination was indicated in this case and the process followed by [Dr B], to the point of detecting discomfort in [Ms A's] left iliac fossa, was largely consistent with expected standards. It could be argued that it was clinically appropriate to perform an examination of the groin area in the presence of apparent localised lower abdominal tenderness, but I am mildly critical there was no explanation of this process to [Ms A] and a sheet was not used to maintain modesty. There was no clinical indication (based on [Ms A's] recollection of her 'pain') to palpate [Ms A's] external genitalia or perform an internal examination, and expected processes in this regard were not followed. This aspect of the examination, as reported by [Ms A], was a severe departure from expected standards.

5. [Dr B's] response dated 11 December 2012

(i) [Dr B] is certain he made contemporaneous notes on the PMS but they cannot be located. He states this is not the only time he has found notes to be missing. A computer audit indicates the notes were never made (or never saved) but were not deleted or altered after the events in question. In my experience with the PMS used in this case (Medtech) it is difficult to 'lose' notes unless the computer fails while notes are being entered (which would be obvious to the operator). Once notes have been entered, if the operator changes to another patient or closes the notes page, the notes are automatically saved. The most common reason for absent notes is the failure to record them which, while being suboptimal practice, is not uncommon for a variety of reasons not necessarily related to the competence of the provider. As discussed further below, [Dr B's] previous consultations with [Ms A] were very well recorded and the absence of a record on this occasion appears to be an exception and a moderate departure from expected practice (the expectation being that all consultations will be adequately recorded).

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(ii) [Dr B] states he saw [Ms A] with a history [of recent travel] and persistent *diarrhoea, abdominal discomfort and reduced appetite* since then. Her partner had similar symptoms. [Dr B] examined [Ms A's] abdomen with gloved hands. *From the history given, he suspected Giardiasis, and was surprised therefore to find mild to moderate tenderness in the left iliac fossa area. [Ms A] acknowledged she had been worried about the tenderness. [Dr B] suspected an inflammatory condition (UTI, pelvic infection or possibly hernia).* [Ms A] denied any genitourinary symptoms or groin pain. [Dr B] advised he needed to examine [Ms A's] groin glands and *without being requested to do so, [Ms A] then pulled her pants and underwear down to the level of her upper thighs.* [Dr B] proceeded to check the hernia orifices and glands. *[Dr B] did not conduct an internal examination because it was not indicated. Had it been, he would certainly have arranged for a chaperone to be present.*

(iii) [Dr B] suspected [Ms A] had giardiasis and explained this. He asked her to provide a stool sample and advised her to maintain a good fluid intake. The stool sample was positive for Giardia and appropriate treatment was provided — a practice nurse being asked to provide the information to [Ms A]. On 3 February 2012 [Dr B] states he was informed by the clinical director of the medical centre that [Ms A] had made a verbal complaint about his examination of her. He conveyed to the medical director what the examination had entailed and, on finding his consultation notes had not been recorded, diarised retrospective notes on the advice of the medical director.

(iv) As discussed in section 4, there were sound clinical indications for the abdominal examination to be performed. There were reasonable clinical indications for an examination of the groin area given the presence of localised left lower quadrant pain. The examination processes followed (as described by [Dr B]) were largely consistent with expected standards although more of an effort could have been made to maintain [Ms A's] modesty during the examination, either by asking her to readjust her underwear or preferably by provision of a sheet. The failure to offer a chaperone for the groin examination described might be regarded as a mild departure from expected standards depending on the circumstances as discussed in section 4(iv). Clinical management, in terms of prescribing and investigations, was consistent with expected standards.

6. Clinical records

(i) [Dr B] had seen [Ms A] on five occasions prior to the consultation in question. These consultations were for upper respiratory symptoms and musculoskeletal complaints. Consultation dates were 11 January, 16 March, 6 April 4 May all 2010, and 9 June 2011. All consultations were very well documented.

(ii) The date of the consultation in question is 26 January 2012. Nurse triage notes include *was [overseas] for 6 weeks and has been back for 10 days, got diarrhoea 4 days before leaving and this is ongoing, not able to sleep, headaches, nausea and abdominal pain, needing to start back at work tonight. May need OWC. Temp*

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36.5, BP 108/78. [Dr B's] notes have only *p/c;* [presumably short for 'presenting complaint'] and record of prescription for Enerlyte, off work certificate and lab form for a stool sample.

(iii) [Dr B's] retrospective handwritten notes [on a diary page dated 2 February 2012] record the history of recent overseas travel and *loose motion → 2 wks, abdo discomfort, less appetite, partner has similar symptoms o/e systemically well, afebrile, normotensive, abdo: soft, nil distensions, mild to mod tender LIF, nil inguinal LN* [lymph nodes]*; hernial orifices — nad; BS-n. Imp: ?chr diarrhoea ?cause r/o giardiasis. Explained condition with Mx plan. Pl: stool for culture, parasite, r/v with report, adv: keep fluids up. F/u: stool positive for giardia — Rx given.* The standard of this note is similar to the standard of previous consultations recorded by [Dr B] (see 6(i)).

(iv) Despite no reference by either [Dr B] or [Ms A] to a subsequent consultation, there are consultation notes recorded on 27 January with [Dr B] identified as the provider. This consultation is preceded by a nurse triage note *pt here wanting to know if stool sample is back and wanting to commence treatment. Slept a little last night, but not really any better.* [Dr B's] notes include *back for r/v, been to lab for stool exam, still frequent bowel motions (6–7 times yesterday), no fever. o/e nil distress, systemically well Impr: likely infective diarrhoea. Discussed — will commence Abx empirically Pl: ciprofloxacin 500mg po bd 5/7, continue Enerlyte as advised, r/v lab results.* A prescription for ciprofloxacin was provided. The content of this note implies a face-to-face consultation took place between [Ms A] and [Dr B] on 27 January 2012. The consultation is well documented and the treatment and advice provided is consistent with expected standards. I cannot explain why this consultation was apparently not recalled by either subject.

(v) On 31 January 2012 [Dr B] has recorded *stool; giardia identified. Pl: MOH notification, metronidazole 2gm po od 3/7. R/v if still symptomatic in 1 wk; rpt stool in 2 wks.* Prescription and lab form were provided. Management on this occasion was consistent with expected standards.

7. Final comment: I note the discrepancies between [Ms A's] recall of the events of 26 January 2012 and those of [Dr B]. I have advised on the appropriateness of the examinations as recalled by each party, noting a severe departure from expected standards based on [Ms A's] recall, and mildly sub-optimal management based on [Dr B's] recall. Leaving aside the issue of the examination itself, [Dr B's] clinical management of [Ms A] was otherwise consistent with expected standards. [Dr B's] failure to provide contemporaneous documentation of his consultation with [Ms A] on 26 January 2012 was at most a moderate departure from expected standards noting this was apparently an oversight in the context of a very good standard of documentation for previous and subsequent consultations."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.