General Practitioner, Dr C

A Report by the

Health and Disability Commissioner

(Case 03HDC13895)

Parties involved

Mrs A	Consumer
Ms B	Complainant / Mrs A's granddaughter
Dr C	Provider / general practitioner
Dr D	Geriatrician

Complaint

On 17 September 2003 the Commissioner received a complaint from Ms B about the care provided to her grandmother, Mrs A. The following issues were identified for investigation:

Whether Dr C provided Mrs A with services of an appropriate standard in June 2003. In particular, whether he:

- *adequately assessed, monitored and treated Mrs A's deteriorating condition prior to her admission to a public hospital on 30 June 2003;*
- *referred Mrs A to hospital in a timely fashion.*

Information reviewed

- Information from Dr C (letters dated 3 December 2003, 3 June 2004, 10 June 2004).
- Information from the rest home (letters dated 12 December 2003, 15 June 2004, 10 February 2004, 8 December 2004).[1]
- Mrs A's clinical records from the rest home.
- Independent expert advice was obtained from Dr Keith A Carey-Smith, general practitioner.

[1] The rest home has not been able to disclose a number of documents (progress notes, observation charts) which have been lost in the intervening period.

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Information gathered during investigation

Mrs A, a resident of the rest home, was admitted to a public hospital suffering from expressive dysphasia,[2] right-sided weakness, and confusion. She was discharged back to the rest home on 6 June. The discharge letter to Dr C stated that Mrs A's diagnoses were reversible ischaemic neurological deficit secondary to low blood pressure, severe postural hypotension,[3] nocturia[4] (for which she was prescribed tolterodine), recurrent urinary tract infections (for which she was prescribed nitrofurantoin), mild cognitive impairment, hypothyroidism,[5] episodic neutropenia,[6] glaucoma,[7] hyperlipidaemia[8] and nocturnal hallucinations (for which she was prescribed haloperidol). Mrs A was also noted to have had falls due to her postural hypotension or vasovagal episodes.[9] The discharge letter requested that Dr C monitor Mrs A's urinary tract infections and her blood pressure.

On her return to the rest home, Mrs A's health appeared satisfactory until 14 June, when her speech and walking were noted to be very slow. On 19 June Mrs A was assessed by the house doctor, because of deterioration in her general health. The house doctor took blood tests, which showed that Mrs A was anaemic. The following day, because Mrs A's condition had not improved, she was seen by Dr C, her general practitioner, who ordered a urine test, which showed no infection.

Dr C telephoned the rest home on 23 June to check on Mrs A's condition. On being told that she was confused and drowsy, Dr C instructed staff by telephone to withhold her tolterodine and nitrofurantoin.

Dr C telephoned again on 24 June and, as he was told Mrs A was still drowsy, he stopped her haloperidol. Over the next few days, the rest home nursing staff documented that Mrs A was experiencing increasing unsteadiness and confusion, resulting in falls.

Dr C assessed Mrs A on 27 June and recorded that she was still very confused. He decided to refer her to Dr D, a geriatrician at the public hospital, for assessment. Dr C stated:

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[2] Dysphasia: A disorder of language affecting the generation and content of speech and its understanding.

[3] Postural hypotension: low blood pressure on standing, which may cause falls.

[4] Nocturia: Passage of urine at night.

[5] Hypothyroidism: Subnormal activity of the thyroid gland.

[6] Neutropenia: Reduced white cells in the blood, which can increase susceptibility to infections.

[7] Glaucoma: Poor eyesight as a result of increased pressure within the eye.

[8] Hyperlipidaemia: High cholesterol level in the blood.

[9] Vasovagal episode: Fainting caused by slowing of the heart and fall in blood pressure as a result of the action of the vagus nerve.

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> "As [Mrs A] was not improving I decided to refer her urgently back to the [Aged Care service] at [the public hospital]. … Later that day [27 June] I was told the [Aged Care team] would admit her on Monday 30 June and this was confirmed by fax, (this was entered into my notes on Monday.)"

Dr C wrote in the referral letter:

> "[The rest home] are managing [Mrs A] at present and I would prefer your opinion rather than send her into an acute medical ward."

Dr D confirmed that Dr C's referral was received by administration staff on 27 June. However, in contrast to Dr C's recollection, Dr D advised that the referral was first considered at the staff clinical meeting on 30 June 2003 as "there was nothing in the letter to indicate urgency". Dr D said that if the referral had been important, Dr C could have followed up his facsimile by phone. She did not know whether this had occurred, although she believes that, if so, it would have been documented.

There is no record of any fax being sent to Dr C by the Aged Care team on 27 June. However, it has been confirmed that on 30 June, following the clinical meeting, a fax was sent to Dr C informing him that a bed was available.

During the weekend of 28 and 29 June Mrs A's condition deteriorated. She had difficulty swallowing, her fluid intake was very poor, and she required subcutaneous fluids, which were ordered by the After-Hours Service doctor. During the night of 29/30 June Mrs A became unresponsive.

On the morning of 30 June the nursing staff at the rest home contacted Dr C, who faxed a referral to the Emergency Department (ED) at the public hospital. Mrs A was taken by ambulance to the ED and assessed. The ED doctor recorded that Mrs A's temperature was 35.2°C (normal is 36-37°C), blood glucose level 1.5mmol/l (normal is above 4mmol/l), Glasgow Coma Score 10 (fully conscious is a score of 15), pulse 84 and blood pressure 127/72.

The ED doctor also recorded that Mrs A had a bulla[10] on the sole of her left foot, an old purplish rash on her legs, stiffness in her neck, a soft systolic heart murmur at the left upper sternal edge, and a cough with dull and decreased air entry in the left base and crepitations.[11] Mrs A also had an abnormal ECG,[12] globally increased muscle tone with an equally reduced reflex in her legs and left arm, and "Plantars -?upgoing on L[eft]".

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[10] Bulla: Blister.

[11] Crepitations: An abnormal "crackling" sound heard through a stethoscope.

[12] ECG: Electrocardiograph. An investigation of the function of the heart, measuring electrical activity.

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An X-ray indicated that Mrs A had a very large left pleural effusion[13] from an unknown cause.

Mrs A's primary diagnosis was recorded as pneumonia, and she was admitted to the public hospital. The hospital nursing staff recorded that Mrs A's heels appeared red and she had a large fluid-filled blister on the sole of her right foot and a small blister on her left foot.

Mrs A was treated for pneumonia and a urinary tract infection prior to discharge on 17 July to another public hospital.

Independent advice to Commissioner

The following expert advice was obtained from Dr Keith A Carey-Smith, general practitioner:

"**Introduction**

In order to provide an opinion to the Commissioner on case number 03/13895, I have read and agree to follow the Commissioner's Guidelines.

My opinion is based on my training in medicine and general practice, and my experience and ongoing CME [Continuing Medical Education] as a rural general practitioner in Taranaki for over 30 years. This includes general practice care of patients in three rest homes, including hospital level beds.

My qualifications are FRNZCGP, Dip Obstet (NZ) and DA(UK).

Purpose

To obtain independent advice on whether general practitioner [Dr C] provided care of an appropriate standard to [Mrs A].

Background

The events surrounding the case are summarised in the Expert Advice notice. The summary relating to the days involving [Dr C] are repeated below as relevant.

[13] Pleural effusion: Fluid collected in the membrane covering of the lungs.

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Issues under investigation

Whether [Dr C] provided [Mrs A] with services of an appropriate standard in June 2003. In particular, whether he:

- Adequately assessed, monitored and treated [Mrs A's] deteriorating condition prior to her admission to [the public hospital] on 30 June 2003
- Referred [Mrs A] to hospital in a timely fashion

Documents and records reviewed

Information from:

- Complainant (pages 1-13)
- [The rest home] (pages 14-553)
- [Dr C] (pages 554-566)
- [The District Health Board] (pages 567-720)

Expert advice requested:

1. Did [Dr C], general practitioner, provide services of an appropriate standard to [Mrs A] in June 2003?

Consultation on 20 June

2. What investigations (for example, blood pressure, pulse, temperature, abdomen examination) should [Dr C] have undertaken at this consultation?
3. Should [Dr C] have considered other causes for [Mrs A's] confusion? If so, please specify.
4. What further action, if any, was warranted?

23 and 24 June

[Dr C] stated that on 23 June he thought [Mrs A's] drowsiness, ongoing confusion and low blood pressure could be caused by her tolterodine and nitrofurantoin. Dr C also stated that on 24 June he instructed staff to withhold [Mrs A's] haloperidol as her condition had not improved.

5. Was [Dr C's] conclusion that the side effects from [Mrs A's] medications could be the cause of her condition reasonable?
6. Should [Dr C] have considered other causes for [Mrs A's] condition? If so, please specify.
7. Should [Dr C] have stopped [Mrs A's] tolterodine, nitrofurantoin and haliperidol?
8. Should [Dr C] have physically examined [Mrs A] on either 23 or 24 June?
9. What further action (including further investigation), if any, was warranted?

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10. Should [Dr C] have assessed or followed up [Mrs A's] condition on 25 or 26 June?

Consultation on 27 June

11. What investigations (for example, blood pressure, temperature, abdomen examination) should [Dr C] have undertaken at his consultation with [Mrs A] on 27 June?
12. Should [Dr C] have arranged for [Mrs A] to be admitted to hospital acutely? In your response please include comment on [Dr C's] statement that he was happy if [Mrs A] remained at [the rest home]until 30 June 'with the proviso that if she got worse over the weekend [of 28 and 29 June] the Home would call the after-hours service and get her reassessed by a doctor.
13. Should [Dr C] have followed up his fax to the [Aged Care service] at [the public hospital] on 27 June? If so, when?

General

14. Are there any aspects of the care provided by [Dr C] to [Mrs A] that you consider warrant additional comment?

15. If, in answering any questions, you believe that [Dr C] did not provide a reasonable standard of care, please indicate the severity of his departure from that standard.

    To assist you in this last point we note that some experts approach this sort of question by considering whether the provider's peers would view the conduct with mild, moderate or severe disapproval.

16. Are there any aspects of the care provided by [Dr C] that you consider warrants additional comment?

General comments:

The loss of rest-home progress notes, summary of issues (written by […] for [Dr C] on 27 June), and vital signs limit accurate review of this case. Apart from this, the rest-home records and procedures in relation to medical care appear satisfactory.

It should be noted that diagnosis of pneumonia and other infections in the elderly is difficult. Features such as abnormal chest signs, fever and elevated white cell count are often absent (as in this case). Onset is often insidious. The only indicators in this case were the altered cognition and raised ESR.

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Specific advice requested:

Consultation on 20 June

> *2. What investigations (for example, blood pressure, pulse, temperature, abdomen examination) should [Dr C] have undertaken at this consultation?*

[Dr C] states (supported by notes made at the time) that he 'saw [Mrs A] ... and ordered a urine test'. The implication is that no physical examination was carried out. Two days before [the house doctor] had examined [Mrs A], including chest, abdomen and blood pressure. He found nothing specifically wrong, and ordered blood tests.

There is no evidence of major change reported by the nurses to warrant a further full examination. The confusion reported on the evening of 19 June was not a new feature. Although ideally a further examination should have been performed, I consider it reasonable for [Dr C] to have accepted [the house doctor's] report of two days before. Because of the rather low BP on the 18th, [Dr C] should have rechecked this, or requested a recent BP result from the nursing staff, along with enquiring about pulse and temperature. (I could find no records of blood pressure, pulse or temperature recordings taken by [the rest home] nursing staff over this period, though the letter from the Manager (p 325) suggests that vital signs were taken but the records lost).

> *3. Should [Dr C] have considered other causes for [Mrs A's] confusion? If so, please specify.*

The list of possible causes of confusion is long, but the main likely causes in such a patient as [Mrs A] are:

- Dehydration
- Infection especially urinary, respiratory or systemic (septicaemia)
- Metabolic – uraemia, electrolyte disturbance
- Drug side effects
- Cerebrovascular insufficiency or CVA

It would appear that [Dr C] considered urinary infection (urine ordered – no significant infection), and was aware that [the house doctor] had checked for chest infection and had ordered blood tests to determine electrolytes and renal function. These were also normal, although the ESR was elevated and anaemia present. The white cell count (often elevated in bacterial infection such as pneumonia) was normal. It would appear the results of these tests were available to [Dr C]. There is no record of whether [Dr C] considered the other diagnoses such as drug side effects or CVA at this stage.

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4. What further action, if any, was warranted?

I consider that ideally [Dr C] should have rechecked the pulse and blood pressure and performed a brief general examination to confirm [the house doctor's] negative findings. [Mrs A] was at high risk for chest infection (age, debility, and previous pneumonia). Therefore even in the absence of symptoms and signs of pneumonia, a chest X-ray was probably indicated at this stage. However, this would have required transporting the patient. Taking all these factors into account, I consider care in this respect was mildly sub-standard.

23 & 24 June

5. Was [Dr C's] conclusion that the side effects from [Mrs A's] medications could be the cause of her condition reasonable?

Medication side effects are a common cause of confusion and drowsiness in the elderly. Tolterodine and haloperidol have drowsiness and dizziness listed as side effects, nitrofurantoin does not normally cause such symptoms. Haloperidol can also cause confusion and agitation. [Dr C's] conclusion is therefore reasonable.

6. Should [Dr C] have considered other causes for [Mrs A's] condition? If so, please specify.

[Dr C] states that he had excluded electrolyte disturbance and urinary infection from the tests done, and pneumonia because of [the house doctor's] negative findings. Progressively considering other diagnoses such as drug side effects is appropriate. As before, the possibility of chest infection should have been considered.

7. Should [Dr C] have stopped [Mrs A's] tolterodine, nitrofurantoin and haloperidol?

I consider it reasonable to have withdrawn tolterodine and nitrofurantoin in the first instance, since both are non-essential drugs. Stopping haloperidol the next day is also reasonable. She was prescribed this in hospital for the listed nocturnal hallucinations or nightmares and the decision to stop risked a worsening of her confusion. However with the increased drowsiness and worsening speech and cognitive state, withdrawal was appropriate.

8. Should [Dr C] have physically examined [Mrs A] on either 23 or 24 June?

[Dr C] phoned to discuss [Mrs A] on both days and would have been aware of her gradual deterioration. However reports suggested no major change in her condition. It appears that he considered that a further examination was not indicated. In retrospect, it is possible that he could have detected the pneumonia at this stage. However since no major change in recordings or clinical status was reported by the nursing staff, I consider it reasonable not to have examined [Mrs A] on these days.

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9. *What further action (including further investigation), if any, was warranted?*

Continued observation including temperature, pulse and blood pressure was indicated, and probably carried out by the rest home staff (though full records have been lost). It was reasonable to take no further action whilst waiting for the effects of stopping the medication.

10. *Should [Dr C] have assessed or followed up [Mrs A's] condition on 25 or 26 June?*

[Dr C] states that her condition improved on these days. It was noted that she was eating and drinking well on 24th; and on 25th (am): '[Mrs A] a little better tonight', and 'seems much better today' (p 5). On 26$^{th:}$ 'weak … but fully orientated'. She remained confused and needed a lot of help. On the 26th (evening) notes include: 'fluid intake good' and 'speech hard to understand … but seems OK". As before, there were no symptoms to alert [Dr C] to the possibility of pneumonia. None of these features indicate a reason for a further urgent assessment. In is reasonable for a sick older person to be reviewed medically every 3-4 days if there is no major change in their condition, and they are under nursing observation and care.

Consultation on 27 June

11. *What investigations (for example, blood pressure, temperature, abdomen examination) should [Dr C] have undertaken at his consultation with [Mrs A] on 27 June?*

On 27th June following [Mrs A's] fall in the night and further confused behaviour, [Dr C] reviewed [Mrs A]. He had available nurses' records which included satisfactory blood pressure and temperature levels. He found her 'physically unchanged', and checked her cognition by talking to her. He also states that he checked her pulse, and examined her chest (heart and lungs) (p 566), but his notes do not record any physical examination findings, and his letter (p 556) does not mention such examination (apart from 'check for injuries'. [Ms B] (p 3) implies an examination by [Dr C] on 27th, and his referral letter (27th June – p 715) has an added note 'PS No sign heart failure or chest infection'.

All this suggests an examination but does not indicate how extensive it was. A brief physical examination would certainly have been appropriate at this time, including chest (front and back), neurological, and abdominal examination, but it is not clear whether all these actually occurred. Note however that detection of pleural effusion or pneumonia in elderly people in a rest home situation is difficult, and the condition may not have been detected even if [Dr C] had examined [Mrs A's] chest. (It is noted in the hospital admission record that the house surgeon had the benefit of the X-ray findings before examining her and finding left basal chest signs).

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Ideally, management at this stage should have included exclusion of pneumonia by arranging a chest X-ray. As discussed previously this decision in a community setting is complex, and would have involved logistical problems. Again, I would consider this omission to be a mild departure from appropriate standards in this particular case.

12. *Should [Dr C] have arranged for [Mrs A] to be admitted to hospital acutely? In your response please include comment on [Dr C's] statement that he was happy if [Mrs A] remained at [the rest home] until 30 June 'with the proviso that if she got worse over the weekend [of 28 and 29 June] the Home would call the after-hours service and get her reassessed' by a doctor.*

[Dr C] was clearly concerned about the lack of response to stopping her medications, and referred her for further investigation at the hospital. Having determined that she would be admitted on the Monday three days later, and found no major change in her condition, his explanation for not admitting her acutely is reasonable. However if he had discovered the pleural effusion on examination or by X-ray, his decision is likely to have been different. The advice for the after-hours service to see her over the weekend if she got worse is likely to be the standard arrangement. Apparently [Mrs A's daughter] was informed that the staff had told [Dr C] that they could cope with her mother over the weekend.

13. *Should [Dr C] have followed up his fax to the [Aged Care service] at [the public hospital] on 27 June? If so, when?*

Having arranged the referral, and determined later on 27th that she was to be admitted on Monday, I do not consider any further arrangements were necessary.

General

14. *Are there any aspects of the care provided by [Dr C] to [Mrs A] that you consider warrants additional comment?*

The medical notes written by [Dr C], both those made at the rest home, and in his own records, give insufficient information both for a locum/associate, and for me to confirm and assess what history, examination and management plan had been performed. In particular I consider the absence of a record of examination findings on 27th June to be unsatisfactory, and to be viewed with mild disapproval.

Conclusion:

Did [Dr C], general practitioner, provide services of an appropriate standard to [Mrs A] in June 2003?

Ideally [Dr C] should have re-examined [Mrs A] some time between 20th and 26th June, but I would not consider this to be significantly substandard care. The lack of

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recording of examination findings on 27th June is a deficiency I would view with mild disapproval. The extent of this examination is in doubt. The omission of a chest X-ray between 20th and 27th June also constitutes mildly substandard care. In other respects (consideration of causes of [Mrs A's] condition, and overall management), I do not find any serious deficits."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

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

Other relevant standards

"Good Medical Practice – A Guide for Doctors" (Medical Council of New Zealand, February 2000 and December 2003):

"Domains of competence: …

2. Good clinical care must include:
   - an adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination
   - providing or arranging investigations or treatment when necessary
   - taking suitable and prompt action when necessary.

3. In providing care you must: …
   - keep clear, accurate, and contemporaneous patient records that report the relevant clinical findings, the decision made, the information given to patients and any drugs or other treatment prescribed."

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Opinion: Breach – Dr C

Under Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Mrs A had the right to have services provided by Dr C with reasonable care and skill and in accordance with professional standards. Ms B, Mrs A's granddaughter, complained that the services provided to Mrs A were not of an appropriate standard and there had been a failure to respond appropriately to her deteriorating condition.

20 to 26 June 2003
On 19 June the house doctor saw Mrs A because of a general deterioration in her health, and she was found to be dehydrated and anaemic. Dr C reviewed Mrs A the following day because, as he stated, "she was no better". On 23 and 24 June Dr C telephoned the rest home, and was told that Mrs A was drowsy and confused. Dr C discontinued two of her prescription drugs but did not reassess Mrs A until 27 June.

Dr Carey-Smith, in advising me, stated:

> "Ideally [Dr C] should have re-examined [Mrs A] some time between 20th and 26th June, but I would not consider this to be significantly substandard care."

I agree with Dr Carey-Smith. In my opinion, at some stage between 20 and 27 June, it would have been prudent for Dr C to formally assess Mrs A, since he was aware of her deteriorating condition, and should have been aware of her susceptibility to infection.

27 June 2003
On 27 June, Dr C reviewed and examined Mrs A because of a fall and her continuing confusion. Dr Carey-Smith is critical of the way in which Dr C recorded this consultation. The information available suggests that Dr C examined Mrs A, but does not indicate the extent of the examination. Dr Carey-Smith advised:

> "A brief physical examination would certainly have been appropriate at this time, including chest (front and back), neurological, and abdominal examination, but it is not clear whether all these actually occurred."

It was clear to Dr C that Mrs A's condition was deteriorating on 27 June, as evidenced by his decision to send a referral to the Aged Care service in the public hospital. Commenting on Dr C's assessment on 27 June, Dr Carey-Smith stated:

> "Ideally, management at this stage should have included exclusion of pneumonia by arranging a chest x-ray. … I would consider this omission to be a mild departure from appropriate standards in this particular case."

I agree with Dr Carey-Smith. It is my opinion that Dr C should have arranged for a chest X-ray on or before 27 June. He was aware of the deterioration in Mrs A's condition since 23 June and, as Dr Carey-Smith stated, Mrs A "was at high risk for chest infection" because of her age, debility and having previously had pneumonia.

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Dr C sent a facsimile referring Mrs A to the Aged Care team after the consultation on 27 June. He stated that he received a facsimile from the Aged Care team in response that same day, saying that Mrs A was to be admitted on 30 June. However, there is no record, either in Dr C's clinical notes, or in Dr D's records, of any facsimile being sent to, or received by, Dr C that day. Dr D is clear in her recollection that the decision to admit Mrs A was made at the clinical meeting on 30 June, after which the facsimile confirming that decision was sent to Dr C.

Dr Carey-Smith also stated:

> "The medical notes written by [Dr C] … give insufficient information both for a locum/associate, and for me to confirm and assess what history, examination and management plan had been performed. In particular I consider the absence of a record of examination findings on 27th June to be unsatisfactory, and to be viewed with mild disapproval."

Professional standards set by the New Zealand Medical Council require doctors to keep clear, accurate and contemporaneous records, and in my opinion Dr C failed to achieve this standard. The medical staff who were responsible for Mrs A on the weekend of 28 and 29 June would have been reliant on the clinical record maintained by Dr C, particularly as Mrs A's referral to the public hospital's Aged Care service was not to take effect until 30 June. In these circumstances Dr C's record was, in my opinion, inadequate.

Summary

Dr Carey-Smith has indicated three areas of substandard care in Dr C's treatment of Mrs A: that Dr C should have re-examined Mrs A between 20 and 26 June; that he did not adequately record the full examination he performed on 27 June; and that a chest X-ray should have been performed on or before 27 June. Individually, these are relatively mild departures from appropriate standards, and somewhat understandable in the context of a busy general practitioner caring for an elderly resident of a rest home. However, in my opinion the failures compound themselves. Therefore, it is my opinion that Dr C failed to fully discharge his duty of care to Mrs A because he did not adequately and appropriately assess, monitor and treat her deteriorating condition between 20 and 27 June. He also failed to make a clear and accurate record of his examination on 27 June. As a consequence, he breached Rights 4(1) and 4(2) of the Code.

No further action

Dr Carey-Smith, in advising me, assumed from Dr C's statement that he knew on Friday 27 June that Mrs A was to be admitted to the public hospital on 30 June. Consequently, Dr Carey-Smith considered that Dr C's decision not to follow up his referral with the Aged Care service on 27 June was reasonable. However, based on the evidence available to me, I cannot conclude that Dr C did know on Friday 27 June that Mrs A was to be admitted on

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Monday 30 June. However, I note that Dr C gave staff advice on whom to contact if Mrs A deteriorated over the weekend, and was advised by fax on Monday 30 June that the Aged Care service had a bed for Mrs A.

Dr Carey-Smith's advice on the standard of care Dr C provided to Mrs A is predicated on the fact that Dr C decided it was appropriate for Mrs A to remain at the rest home over the weekend, unless her condition deteriorated. It is not possible to know what follow-up actions Dr C would have taken on Monday 30 June had Mrs A's condition either not deteriorated to the point that she required immediate admission or he had not heard from the Aged Care service. Accordingly I intend to take no further action on this issue.

Recommendation

I recommend that Dr C take the following action:

- Apologise to Mrs A for his breaches of the Code. This written apology should be sent to the Commissioner, for forwarding to Mrs A and Ms B.

Follow-up actions

- A copy of this report will be sent to the New Zealand Medical Council.
- A copy of this report will be sent to the Royal New Zealand College of General Practitioners.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.

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