General Practitioner, Dr B

Natural Health Clinic

A Report by the

Health and Disability Commissioner

(Case 16HDC01577)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mrs A (aged 37 years at the time of these events) began consulting with Dr B at a natural health clinic in July 2015, regarding the management of her hypothyroidism. Dr B is a vocationally registered general practitioner (GP), but the natural health clinic is not a general practice, and Mrs A remained enrolled with GP Dr C at a medical centre while seeing Dr B.

2. Over the period of July 2015 to September 2016, Dr B ordered four sets of blood tests for Mrs A. On all occasions, abnormal HbA1c results were returned. HbA1c is the recommended screening test for diabetes.

3. Dr B advised Mrs A to make lifestyle changes following the elevated HbA1c result in August 2015, but did not take any action on the results from 3 December 2015 or 9 June 2016. Dr B did not send a copy of the results to Mrs A's GP at any point.

4. On 31 August 2016, the laboratory reported that there had been a "significant change" in Mrs A's HbA1c level. Dr B said that she did not review the blood test results on 1 or 2 September 2016, and that she was overseas over 3–5 September 2016.

5. On 5 September 2016, Mrs A complained to Dr B via email that she had "general ill-feeling", increased "cloudiness", perpetual thirst, and unexpected weight loss. Mrs A told HDC that, when she spoke with Dr B on 6 September 2016, she also mentioned that she had been passing excessive urine and had painful flanks. In a follow-up email on 6 September 2016, Dr B informed Mrs A of the significant change in HbA1c level and advised Mrs A to consult with her regular GP within the week.

6. On 7 September 2016, Mrs A was admitted to the public hospital, where she was diagnosed with type 1 diabetes.

Findings

7. Dr B failed to inform Mrs A about a series of abnormal HbA1c results and their significance, including advice about lifestyle changes. In doing so, Dr B breached Right 6(1)[1] of the Code.

8. By failing to communicate with Mrs A's GP in the time that she was providing care to Mrs A, Dr B failed to comply with professional standards, and, accordingly, breached Right 4(2)[2] of the Code.

9. Dr B's clinical management of Mrs A was deficient, in light of Mrs A's HbA1c results and her reported symptoms in September 2016. Dr B's email of 6 September 2016 did not convey any sense of urgency, despite Mrs A's symptoms of

[1] Right 6(1) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive."
[2] 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."

hyperglycaemia, and the risk of developing ketoacidosis. By failing to provide services with reasonable care and skill, Dr B breached Right 4(1) of the Code.[3]

10. Despite receiving a large influx of patients in 2016, the natural health clinic did not implement any measures to handle the increased workload. In addition, it did not arrange for another health professional to process test results over the period that Dr B was overseas, and there was no system in place to ensure that patients' GPs were advised of test results and the treatments provided. Accordingly, the natural health clinic breached Right 4(1) of the Code.

Recommendations

11. It is recommended that Dr B arrange for a peer to audit all blood test results received within the last month, with a focus on appropriate follow-up of abnormal results and communication with principal health providers; undertake further training on the diagnosis and management of diabetes; and apologise in writing to Mrs A.

12. It is recommended that the Medical Council of New Zealand consider whether a review of Dr B's competence is warranted.

13. It is recommended that the natural health clinic develop a written policy for the management of test results, and update the questionnaire provided to new patients to indicate that results and consultation notes (including prescriptions) will be provided to their usual GP unless the patient withholds consent.

Complaint and investigation

14. The Commissioner received a complaint from Mrs A about the services provided to her by Dr B. An investigation was commenced, and the following issues were identified for investigation:

- *Whether the natural health clinic provided Mrs A with an appropriate standard of care from July 2015 to September 2016.*
- *Whether Dr B provided Mrs A with an appropriate standard of care from July 2015 to September 2016.*

15. The parties directly involved in the investigation were:

Mrs A	Consumer
Dr B	Provider
Natural health clinic	Provider

Also mentioned in this report:

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

Dr D	General registrant

16. Information from Dr C, Mrs A's general practitioner (GP), was also reviewed.

17. In-house clinical advice was obtained from GP Dr David Maplesden (**Appendix A**).

Information gathered during investigation

Background

18. Mrs A (aged 37 years at the time) became a patient at the natural health clinic in July 2015, after Dr D, the doctor she had consulted previously for management of her hypothyroidism,[4] ceased practising in New Zealand.

19. Dr B is the owner-director of the natural health clinic, and is self-employed. Although Dr B[5] is vocationally registered as a general practitioner (GP), the natural health clinic is not a general practice clinic. The clinic advises patients that they should see Dr B for blood tests, general health review and health planning, but continue to see their regular GPs for any other needs, including urgent care issues.

20. At the time she was seeing Dr B, Mrs A was enrolled with GP Dr C[6] at a medical centre.

HbA1c results in 2015

21. On 30 July 2015, Mrs A presented to Dr B and requested a repeat prescription for the compounded thyroid medication Dr D had commenced her on. Dr B told HDC that she arranged for a blood test to check Mrs A's thyroid levels, and had included HbA1c[7] as a part of a health screening approach.

22. The test results were returned on 4 August 2015. At 44mmol/mol, Mrs A had an elevated HbA1c level,[8] which was accompanied by the following comment from the laboratory:

> "If used as a screening test, HbA1c result suggests impaired glucose tolerance; [cardiovascular disease] assessment and lifestyle changes recommended with annual follow-up. If known diabetic, this result suggests excellent control but if treated with insulin/sulphonylureas the risk of hypoglycaemia is increased."

[4] Hypothyroidism is the insufficient production of thyroid hormones, which help to regulate growth, development, and metabolism.
[5] Vocationally registered since 2003. Dr B is a Fellow of the Royal New Zealand College of General Practitioners.
[6] Vocationally registered in General Practice in New Zealand since 2006.
[7] HbA1c is the recommended screening test for diabetes.
[8] Individuals with HbA1c levels in the range 41–49mmol/mol are considered to have prediabetes, otherwise known as "intermediate hyperglycaemia".

23. As Mrs A lives an hour away from the natural health clinic, the HbA1c result was discussed over a telephone consultation on 16 September 2015. According to the consultation notes, Mrs A was advised by Dr B to limit her sugar intake.

24. Dr B said that she gave Mrs A another blood test form in December 2015 to recheck her HbA1c levels. The result, which was sent to Dr B and Mrs A on 3 December 2015, showed an HbA1c of 42mmol/mol. It was again accompanied by the comment that the result was suggestive of impaired glucose tolerance.

25. Dr B told HDC that the results "look[ed] fine" on review, and noted the "slight improvement" from the previous test. No further action was taken in relation to Mrs A's HbA1c level.

HbA1c results in 2016

26. On 8 June 2016, Mrs A emailed Dr B for another repeat prescription of thyroid medication, and queried whether it was time for another blood test. Dr B said that she emailed Mrs A a form to provide to the medical laboratory, with the comment "copy to patient, on synthetic T4/T3[9] capsule".

27. Mrs A could not recall being provided with a copy of the results from the medical laboratory. Dr B advised HDC that she did not send a copy of the results to Mrs A, and neither did the medical laboratory, despite her request.

28. The results were received by Dr B on 9 June 2016, and showed an HbA1c of 48mmol/mol. She did not discuss the result with Mrs A or arrange any follow-up for the elevated result. Dr B stated in her response to HDC:

> "I should have spoken to [Mrs A] and gotten her back or gotten [Mrs A] to see her GP or myself for more lifestyle measures or more active treatment for the raised HbA1c …".

29. On 29 August 2016, Mrs A emailed Dr B to report a one-week history of fuzzy eyesight, and recurrent thrush. Mrs A queried whether these symptoms might be related to her hypothyroidism, and asked about the results of her blood test in June 2016.

30. On the following day, Dr B informed Mrs A by return email that her thyroid was "sluggish", and gave her a form for further blood tests. There were no instructions on the form to send a copy of the results to Mrs A or Dr C.

31. The results, which were returned on 31 August 2016, showed a significantly elevated HbA1c of 91mmol/mol. The laboratory analysis stated:

> "The significant change in 11 weeks is noted. Has she had a blood transfusion? If this result does not fit with the clinical picture please contact the on call chemical pathologist to discuss."

[9] T4 (thyroxine) and T3 (triiodothyronine) are hormones produced by the thyroid gland, and are primarily responsible for regulation of metabolism.

32. Dr B said that she did not review the results on 1 or 2 September 2016, and that she was overseas over 3–5 September 2016.

Email correspondence — 2–5 September 2016

33. On 2 September 2016, Mrs A emailed Dr B's receptionist and enquired about the blood test results. The receptionist responded that they had been received, and said that she "had let [Dr B] know on the results". The receptionist clarified in her statement to HDC that she informed Dr B only that Mrs A wanted her results.

34. On Saturday (3 September 2016), Mrs A requested that copies of the results be sent to both herself and Dr C, and subsequently included Dr C's contact details. The receptionist said that she forwarded these two emails to Dr B when she saw them on Monday (5 September 2016), but warned Mrs A that Dr B was either still overseas or flying home, and might not receive the emails until the following day.

35. On the morning of 5 September 2016 (prior to the receptionist's return emails), Mrs A emailed Dr B and asked if she could give her a call regarding her blood test results and "general ill-feeling" over the weekend. Mrs A mentioned experiencing increased "cloudiness", perpetual thirst, and unexpected weight loss. She added that she had looked up her symptoms on the internet, which had raised the suspicion of diabetes.

36. Dr B responded that she was currently overseas and would check the results on her return the next day.

Communication of HbA1c result — 6 September 2016

37. Mrs A had a telephone consultation scheduled with Dr B at 3pm on 6 September 2016. Mrs A said that she missed Dr B's telephone call at 3.45pm, but managed to speak with her at 5pm. Mrs A stated that, when she described her symptoms to Dr B (general unwellness, excessive passage of urine, excessive thirst, weight loss, fuzzy/cloudy mental state, and painful flanks), Dr B did not suggest immediate medical treatment.

38. At 5.22pm, Dr B sent Mrs A a follow-up email. The email instructed Mrs A to consult with her regular GP within the week, as there was "a significant change" in her blood sugar levels. Dr B told Mrs A that her GP would organise more tests and possibly specialist review. Dr B also said that it was important to hydrate by taking drinks containing electrolytes.

Diagnosis of type 1 diabetes

39. Mrs A said that, at 8.30pm, she discussed her symptoms and elevated HbA1c with two nurses with whom she was acquainted, and was advised to attend the public hospital in the morning or immediately, in the event that her symptoms worsened or if she started vomiting.

40. On 7 September 2016, Mrs A was admitted to the public hospital, where she was diagnosed with type 1 diabetes.

41. On reflection, Dr B said:

> "Because this in essence was an acute Type 1 diabetes emergency presentation my advice should have been to see GP immediately within 24 hours and make sure a copy of results went to the GP that day and even called the GP myself to make sure [Mrs A] was seen and hospital or specialist review started asap for intravenous fluids and diabetes management."

Further information

Other factors

42. Dr B told HDC that she considers that the following factors led to the delay in the analysis of Mrs A's results on each occasion:

- She did not allow enough time at work each day for administrative tasks and results processing. Her usual schedule was 7.30am–5pm Monday to Friday with back-to-back patients, with occasional 30-minute breaks for emails and review of results.
- When Dr D left New Zealand in 2015, a large group of his clients approached her for help, leading to a marked and sudden increase in her prescription load and email requests. Many required review of section 29 prescriptions for specific compounded items.[10]
- Another practitioner stopped her practice in 2016, and Dr B took on some of her clients.

43. In relation to the care provided to Mrs A in early September, Dr B said that she had her cellphone with her when she was overseas over 3–5 September 2016 and was checking patient emails, but did not "set up or catch up on the results enough to respond in a timely and adequate manner to this evolving emergency".

Audit

44. Dr B said that she completed a self-audit of blood test email results over December 2015 to December 2016 to see whether any results had not been sent. Dr B stated that there were no other urgent or dangerous situations that developed, and, in all other cases, all routine results had been handled with follow-up consultations, and copies of routine blood test results were emailed to patients. Dr B made an undertaking to conduct additional audits and to keep a record of them.

Changes to practice

45. Dr B said:

> "I am disappointed that this outcome occurred for [Mrs A] and realise the lack of communication to the patient and GP in a timely manner led to a potentially dangerous situation."

[10] Section 29 of the Medicines Act 1981 permits the sale or supply of unapproved medicines to registered medical practitioners, but requires the supplier to notify the Director-General of Health. An unapproved medicine is a medicine for which consent has not been given by the Minister of Health for sale, distribution, or marketing in New Zealand. Such medications have not been through the Medsafe regulatory process.

46. Dr B told HDC that, since this incident, she has made changes to her routines and manner of handling results, including forming policies on handling the situations and results. In particular, Dr B stated that:

- All patients now receive routine pre-visit questionnaires so that she has their GP contact details on record as well as relevant history. This information is entered onto Medtech by her administrative assistant. She will routinely ask patients during their visit if they wish for their GP to be copied into the consultation information or blood test results.
- Patient contact now finishes by 3pm each day, which allows two hours for paperwork, telephone work, and review of results. In addition, she has freed up some personal commitments in the evenings and weekends, which will better enable her to deal with urgent patient emails and results.
- She has employed a part-time pharmacist experienced in compounding scripts to help process emails regarding compounded prescription requests.
- Another part-time staff member has been employed to assist with emailing results to patients once they have been assessed and commented on, as well as following up on patient service related emails.
- She has asked the two main compounding pharmacies in the region not to refer any new clients to her for compounded prescriptions as she is at personal work capacity. Similarly, she had asked the administrative assistant of the practitioner who ceased practising in 2016 not to send her any new clients.
- Her results policy from now on is for all results to be reviewed within 24 hours, and to send the results to the patient and also to the patient's GP where requested or if abnormal and needing action.
- If she knows she is going to be away, she will ask a medical colleague or allied health professional to check and receive a copy of the incoming results for her and take appropriate action such as advising patients to see their GP for urgent review and counsel them to attend their GP rather than wait for her return from leave.

Responses to provisional opinion

47. Dr B and the natural health clinic were provided with an opportunity to comment on my provisional opinion. Dr B and the natural health clinic accepted the recommendations as stated in my provisional opinion.

48. Mrs A was provided with an opportunity to comment on the "information gathered" section of my provisional opinion. She wrote:

> "I went to [Dr B] on the assumption that as a [doctor] who orders these tests, that I could trust her to be responsible for the outcome of them and informing me in a timely and effective manner … I am really pleased to note the changes that [Dr B] has made to her practice. I believe that the great number of systems upgrades can only be beneficial to patients in the future."

Relevant standards

Medical Council standards

49. The Medical Council of New Zealand's "Statement on complementary and alternative medicine"[11] stipulates:

> "If you are not the patient's general practitioner, then you should ensure continuity of medical care is being provided elsewhere. When you see a patient whose continuity of care is being provided by another general practitioner, you should be in regular contact with the general practitioner and should fully document [complementary and alternative medicine] and other treatments provided."

50. MCNZ's publication *Good prescribing practice* (issued in April 2010) states:

> "In most circumstances there should be timely and full information flow between general practitioners, hospital doctors and other relevant health practitioners about the indications and need for particular therapies. If you are the prescribing doctor and you make a change to treatment, you must notify your colleague(s) of the change and the rationale for it. If the change has significant implications for the patient and his or her care, you must also make sure that this information is received by your colleague(s)."[12]

51. Further relevant practice standards are outlined in the 2013 version of the MCNZ publication *Good Medical Practice*:

> "46. You should ensure that patients know how information is shared among those who provide their care.
>
> 47. You should seek the patient's permission to, and explain the benefits of, sharing relevant information with other health practitioners and agencies involved in their care, including their principal health provider (who will usually be their general practitioner).
>
> 48. Once you have the patient's permission to share information, you must provide your colleagues with the information they need to ensure that the patient receives appropriate care without delay."

[11] March 2011. See: https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Complementary-and-alternative-medicine.pdf.

[12] This statement was updated in September 2016, and now instructs prescribers to "[s]hare information about the prescribing with other health professionals involved in the patient's care to ensure continuity of care and patient safety. The sharing of information includes verbal communication with other health professionals and written communication such as providing another health professional with access to the patient's clinical records. Advise the patient that information about their care will be shared."

Opinion: Dr B — breach

52. The care Dr B provided to Mrs A was deficient in several respects. There was a pattern of poor communication of abnormal test results, a lack of coordination with Mrs A's GP, and a failure to provide appropriate advice to Mrs A regarding her significantly elevated HbA1c result of 31 August 2016.

Communication with patient

53. Over the period of July 2015 to September 2016, Dr B ordered four sets of blood tests for Mrs A. On all occasions, abnormal HbA1c results were returned:

4 August 2015	44mmol/mol
3 December 2015	42mmol/mol
9 June 2016	48mmol/mol
31 August 2016	91mmol/mol

54. The results of 4 August 2015, 3 December 2015, and 9 June 2016 included the following comment:

> "If used as a screening test, HbA1c result suggests impaired glucose tolerance; [cardiovascular disease] assessment and lifestyle changes recommended with annual follow-up. If known diabetic, this result suggests excellent control but if treated with insulin/sulphonylureas the risk of hypoglycaemia is increased."

55. There was a delay of more than one month in Dr B communicating Mrs A's initial HbA1c result, and Dr B did not advise Mrs A about the HbA1c results from December 2015 and June 2016.

56. My in-house clinical advisor, GP Dr David Maplesden, advised that he would have expected Dr B to have communicated the results, and their significance, to Mrs A promptly.

57. As this Office has stated previously, doctors owe patients a duty of care in handling patient test results, including advising patients of, and following up on, abnormal test results. The primary responsibility for following up abnormal test results rests with the clinician who ordered the tests.

58. Right 6(1) of the Code of Health and Disability Services Consumers' Rights (the Code) provides that "[e]very consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including an explanation of his or her condition; and … the results of tests". I consider that a reasonable consumer would expect to be informed of the series of abnormal HbA1c results and their significance, including advice about lifestyle changes.

59. As the clinician who ordered the tests, Dr B had a responsibility to communicate the results and their implications to Mrs A. Provision of this information would have enabled Mrs A to be a partner in her own treatment. Dr B failed to provide Mrs A with information that a reasonable consumer would expect to receive and, accordingly, breached Right 6(1) of the Code.

Communication with GP

60. Dr B did not, at any stage, share Mrs A's blood test results with Mrs A's enrolled GP.

61. Dr Maplesden commented:

> "Having ordered the [blood] tests, [Dr B] had a responsibility to ensure that appropriate ongoing management was facilitated, including provision of appropriate lifestyle advice and monitoring. If she was not prepared to undertake this aspect of patient management, it was her responsibility to ensure [Mrs A's] regular GP was kept fully informed of the results and for her to advise [Mrs A] she should see her regular GP for further management.
>
> …
>
> The absence of communication from [Dr B] to [Mrs A's] regular GP in relation to her thyroid prescribing as well as blood tests results is a significant omission."

62. MCNZ standards are clear on the need for timely communication of information to the consumer's principal health provider to ensure that the patient receives appropriate care.

63. There was no communication with Dr C in the time that Dr B was providing care to Mrs A, and I am particularly critical that Dr C was not informed of Mrs A's significantly elevated HbA1c result of 91mmol/mol, despite Mrs A's express requests and Dr B's own advice for Mrs A to consult with her GP for ongoing management. Dr B failed to comply with professional standards and, in doing so, compromised Mrs A's care. Accordingly, I find that Dr B breached Right 4(2) of the Code.

Clinical management

64. Dr B advised Mrs A to make lifestyle changes following the elevated HbA1c result in August 2015, but did not take any action on the results from 3 December 2015 or 9 June 2016.

65. Dr B provided Mrs A with a further form for blood tests in response to Mrs A's email of 29 August 2016, wherein she described symptoms of fuzzy eyesight and recurrent thrush.

66. On 31 August 2016, the laboratory reported that there had been a "significant change" in HbA1c level.

67. Mrs A emailed Dr B on 5 September 2016 and complained of "general ill-feeling", increased "cloudiness", perpetual thirst, and unexpected weight loss. Mrs A told HDC that, when she had her telephone consultation with Dr B on 6 September 2016, she also mentioned to Dr B that she had been feeling generally unwell, and had excessive passage of urine, excessive thirst, weight loss, fuzzy/cloudy mental state, and painful flanks.

68. Dr B, in a follow-up email, instructed Mrs A to consult with her regular GP within the week in relation to the "significant change" in her blood sugar levels. Dr B told Mrs A

that her GP would organise more tests and possibly specialist review, and encouraged Mrs A to hydrate by consuming drinks with electrolytes.

69. As mentioned above, Dr Maplesden advised that, having ordered the blood tests, Dr B had a responsibility to ensure that appropriate ongoing management was facilitated. Dr Maplesden also advised:

> "The advice provided to [Mrs A] by [Dr B] on 6 September 2016 was inadequate. [Mrs A] had presented symptoms and an HbA1c result diagnostic of diabetes, with the symptoms suggesting significant hyperglycaemia. There is a risk of ketoacidosis in this situation and I feel [Mrs A] should have been told (if she was not to be reviewed by [Dr B]) of her diagnosis and the need to seek prompt (within the next 24-hours) medical advice, with appropriate 'safety-netting' advice also provided, as was done by the after-hours service [Mrs A] contacted later that day. There was also a missed opportunity for appropriate handover to [Mrs A's] regular GP who [Dr B] could have contacted earlier on 6 September 2016 to discuss the result and [Mrs A's] management."

70. Overall, Dr Maplesden was concerned at the clinical decisions made by Dr B once she was aware of Mrs A's symptoms.

71. I accept Dr Maplesden's advice, and conclude that Dr B's clinical management of Mrs A in light of her HbA1c results and following her reported symptoms in September was deficient. Dr B's email of 6 September 2016 failed to convey any sense of urgency, despite the need for prompt medical assessment. Given Mrs A's reports of symptoms consistent with hyperglycaemia, and the risk of developing ketoacidosis, it was not appropriate to advise that Mrs A see her GP "within the week". In my view, Dr B failed to provide services with reasonable care and skill, and breached Right 4(1) of the Code.

Opinion: Natural health clinic — breach

72. Dr B is the sole director and one of the shareholders of the natural health clinic. Dr B is an employee of the natural health clinic and its sole doctor.

73. Dr B informed HDC that the natural health clinic accepted a large influx of patients in 2016, following Dr D's departure from New Zealand and another practitioner's cessation of practice. I am critical that no measures appear to have been put in place at the time to handle the increased number of patients. I note that the natural health clinic has now employed additional staff to handle the increased workload.

74. The natural health clinic lacked robust systems to ensure that appropriate care was provided to Mrs A. Although Mrs A's HbA1c result of 91mmol/mol was received on 31 August 2016, Dr B did not review the result prior to going on leave on 3 September 2016, and no arrangements were made for another health professional to process test results in her absence. Mrs A's HbA1c result was concerning and

required urgent follow-up, but was not reviewed until 6 September 2016. In my view, this was an unacceptable delay. Dr B said that it is now the natural health clinic's policy for all results to be reviewed within 24 hours, and that, in future, she will arrange for a health professional to handle results if she is away from the clinic.

75. Dr Maplesden commented: "I think these changes are all very reasonable although I am somewhat surprised such processes were not already in place."

76. I am also critical that, at the time of these events, the natural health clinic had no system in place to ensure that patients' GPs were advised of test results and the treatments provided. Dr B told HDC that she now elicits details of her patients' GPs through a questionnaire, and that this information is entered into Medtech by administrative staff. Dr Maplesden advised:

> "I think communication of results and consultation notes (which include prescriptions) to the patient's GP should be automatic (unless consent is withheld) as would be expected with any specialist consultation, whether or not the patient has self-referred. To aid such communication, I feel the wording of any new patient information sheet should indicate that such information will be provided to the patient's usual GP (in the interests of continuity of care and patient safety) unless the patient declines such consent (which should be recorded)."

77. Overall, I find that the natural health clinic failed to provide services to Mrs A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Recommendations

78. I recommend that Dr B:

a) Arrange for a peer to audit all blood test results received within the last month, with focus on appropriate follow-up of abnormal results and communication with principal health providers. The results should be provided to HDC within three months of the date of this report.

b) Undertake further training on the diagnosis and management of diabetes, and provide evidence that this has occurred, within three months of the date of this report.

c) Apologise in writing to Mrs A for the breaches of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

79. I recommend that the Medical Council of New Zealand consider whether a review of Dr B's competence is warranted.

80. I recommend that the natural health clinic:

a) Develop a written policy for the management of test results, following review of the principles set out in the Royal New Zealand College of General Practitioners' resource "Managing Patient Test Results". This should be sent to HDC within three months of the date of this report.

b) Update the questionnaire provided to new patients to indicate that results and consultation notes (including prescriptions) will be provided to their usual GP unless the patient withholds consent. A copy should be sent to HDC within three weeks of this report.

Follow-up actions

81. 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, and it will be advised of Dr B's name.

82. 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.

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

Appendix A: In-house clinical advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs A] about the care provided to her by [Dr B] of [the natural health clinic]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the information on file: complaint from [Mrs A]; response from [Dr B]; GP notes [the natural health clinic].

2. [Mrs A] complains about delays in the diagnosis of her type 1 diabetes. She had been attending [Dr B] since July 2015 for management of thyroid dysfunction secondary to Hashimoto's thyroiditis. [Dr B] had ordered blood tests on several occasions and these included glycosylated haemoglobin (HbA1c) levels which were abnormal on each occasion but this result was never conveyed to [Mrs A] or to her regular GP. [Mrs A] had consented to information being passed on to her regular GP. In late August 2016 [Mrs A] began to feel increasingly unwell with *fuzzy eyesight and recurrent thrush* and she contacted [Dr B] to query whether the results might be related to her thyroid, and also to query results from blood tests taken in June 2016, the results of which had not been notified to her. On 30 August 2016 an e-mail reply was received from [Dr B] notifying her the June results had shown her *thyroid was sluggish* (no other results disclosed) and a form was provided for further blood tests. [Mrs A] had the blood tests taken on 31 August 2016 (Wednesday). On 3 September 2016 (Saturday) she e-mailed [the natural health clinic] requesting a copy of the results and early on the morning of 5 September 2016 she e-mailed [Dr B] directly requesting the results and *relaying about general ill-feeling, thirst, weight loss, cloudiness and diagnosed myself with diabetes.* At 0900hrs that day she received an e-mail back from [Dr B] stating: *I'm [overseas] till tomorrow and can check as soon as back.* No further advice was given. Later that day [Mrs A] was notified she had an appointment with [Dr B] scheduled for 6 September 2016 (telephone consult). [Mrs A] missed the initial call from [Dr B] the following day (somewhat later than was scheduled) and she then e-mailed [the natural health clinic] again for contact regarding her blood test results. About 1700hrs [Mrs A] states [Dr B] called her back and asked about her symptoms (symptoms of weight loss, thirst, polyuria, general unwellness conveyed). [Dr B] conveyed to [Mrs A] the information her HbA1c was 'high' and provided her with contact details for ordering of an oral rehydration solution on-line. *At no stage did [Dr B] suggest any concern or suggest that I needed any immediate medical treatment. She suggested that I follow up with my GP within the week and that I may be referred to a specialist or given Metformin.* [Mrs A] then spoke with nursing colleagues and her regular practice (duty doctor at 2030hrs) and she was advised to attend ED the next morning or immediately should she develop any vomiting or worsening symptoms. [Mrs A] attended [the public hospital] the following morning where she was found to have a blood glucose level of 20mmol/L and she was admitted for further investigations, diagnosed with likely type-1 diabetes and commenced on insulin. [Mrs A] is

concerned at the lack of information provided to her and her own GP in regard to her blood results and general treatment provided by [Dr B], and the lack of urgency shown by [Dr B] in regard to the very abnormal blood test results from 31 August 2016.

3. I have reviewed the e-mail correspondence between [Mrs A] and [the natural health clinic] staff and this is consistent with [Mrs A's] complaint. In particular, there is an e-mail dated 2 September 2016 in which [Dr B's] administrative assistant confirms (in response to [Mrs A's] enquiries) that [Dr B] has been notified of [Mrs A's] blood results. An e-mail from [Dr B] to [Mrs A] dated 6 September 2016 (Tuesday) includes: *here are your blood results with comments. Please see you[r] local GP this week and get a review as this is a significant change in the blood sugar levels in 11 weeks. Your GP may want to swap you over to a T4 only medication for the thyroid as the T3 has gone up … to hydrate it is important you take a drink with electrolytes. You can use Elete electrolytes 120ml or 240mls order from Biotrace … and try 1 container of BASICA alkaline mineral drink … this has minerals and will help hydrate the body with the high glucose. Your GP will organise a blood glucose monitor an[d] more tests and perhaps even specialist review for the change in blood sugars. Please look them* [the results] *over and let me know any questions.*

4. The response from [Dr B] contains little additional information. [Dr B] states she provided a holistic service for patients with chronic medical issues but she does not provide care for acute problems and this is made clear to patients when they first attend her practice. [Dr B] states she was [overseas] on the weekend of 3 and 4 September 2015 and was not able to address [Mrs A's] abnormal results until her return to the surgery on 6 September 2016.

5. HbA1c results on file:

4 August 2015	44 mmol/mol
3 December 2015	42 mmol/mol
9 June 2016	48 mmol/mol
31 August 2016	91 mmol/mol

Reference range is recorded as <41 mmol/mol. A standard pathologist comment accompanies the first three results: *If used as a screening test, HbA1c results suggest impaired glucose tolerance; CVD assessment and lifestyle changes recommended with annual follow-up. If known diabetic, this result suggests excellent control but if treated with insulin/sulphonylureas the risk of hypoglycaemia is increased.* The result of 31 August 2016 was accompanied by the pathologist comment: *The significant change in 11 weeks is noted. Has she had a blood transfusion? If this result does not fit with the clinical picture please contact the on-call pathologist to discuss.* Further information on HbA1c and diagnosis of glucose impairment or diabetes is attached as Appendix 1.

6. [The natural health clinic's] consultation notes are available from 16 September 2015. The consultations relate primarily to management of [Mrs A's]

hypothyroidism using a prescribed T4/T3 combination. The blood test from 9 June 2016 showed, in addition to elevated HbA1c, a mild elevation in TSH and FT4 at the bottom of the normal range suggesting possible under-replacement. There is no suggestion from the notes that these results, or any of the previous elevated HbA1c results, were discussed with [Mrs A] or copied in to her GP. There is nothing in the response to indicate [Mrs A's] regular GP was kept informed by [Dr B] of the prescribing for thyroid dysfunction.

7. The Medical Council of New Zealand (MCNZ) includes the following information in its publication 'Cole's Medical Practice in New Zealand'[1]:

(i) If you request a clinical investigation, you should tell your patient why the clinical investigation is recommended and when and how they will learn the results.

(ii) All the relevant parties should understand their responsibilities clearly.

(iv) If you are responsible for conducting a clinical investigation you are also responsible for ensuring that the results are appropriately communicated to those in charge of conducting follow up and keeping the patient informed.

(v) If you are responsible for informing the patient, you should:

Inform the patient of the system for learning test and procedure results, and arranging follow up.

Ensure that staff and colleagues are aware of this system.

Inform patients if your standard practice is not to notify normal results and obtain their consent to not notifying.

If other arrangements have not been made, inform the patient when results are received. This is especially important if the results raise a clinical concern and need follow up.

(vi) If you order investigations it is your responsibility to review, interpret and act on the results. If you go off duty before the results are known, you should alert the incoming doctor that there are results outstanding. Further, you should check the results when you are next on duty.

8. The MCNZ states, in relation to prescribing practice[2], the prescribing doctor should: *share information about the prescribing with other health professionals involved in the patient's care to ensure continuity of care and patient safety. The sharing of information includes verbal communication with other health professionals and written communication such as providing another health*

[1] St George IM 2013. The management of clinical investigations. Chapter 14 in St George IM (ed.). Cole's medical practice in New Zealand, 12th edition. Medical Council of New Zealand, Wellington.
[2] MCNZ Good Prescribing Practice 2016. https://www.mcnz.org.nz/assets/News-and-Publications/Statement-on-good-prescribing-practice-June-2016.pdf

professional with access to the patient's clinical records. Advise the patient that information about their care will be shared.

9. Further relevant practice principles outlined in the MCNZ publication 'Good Medical Practice 2016'[3] include:

(i) You should ensure that patients know how information is shared among those who provide their care.

(ii) You should seek the patient's permission to, and explain the benefits of, sharing relevant information with other health practitioners and agencies involved in their care, including their principal health provider (who will usually be their general practitioner).

(iii) Once you have the patient's permission to share information, you must provide your colleagues with the information they need to ensure that the patient receives appropriate care without delay. Work collaboratively with colleagues to improve care, or maintain good care for patients, and to ensure continuity of care wherever possible.

(iv) Make sure that your patients and colleagues understand your responsibilities in the team and who is responsible for each aspect of patient care.

(v) If you are the patient's principal health provider, you are responsible for maintaining continuity of care.

10. The recommended management of patients following detection of an abnormal HbA1c result is outlined in Appendix 1.

11. Comments

(i) [Dr B] should be asked to provide the written policies her practice has in relation to management of test results as there appear to have been significant deficiencies in the management of [Mrs A's] results. In relation to the blood results of August and December 2015 and June 2016 I would expect the abnormal HbA1c results, and the significance of these results, to have been provided to [Mrs A] promptly following receipt of the results. Having ordered the tests, [Dr B] had a responsibility to ensure that appropriate ongoing management was facilitated, including provision of appropriate lifestyle advice and monitoring. If she was not prepared to undertaken this aspect of patient management, it was her responsibility to ensure [Mrs A's] regular GP was kept fully informed of the results and for her to advise [Mrs A] she should see her regular GP for further management. It does not appear that either [Mrs A] or her GP were notified of the results and [Mrs A] was denied the opportunity to make appropriate lifestyle changes that might perhaps have deferred her eventual diagnosis, or at least would have kept her alerted to the fact she was at increased risk of developing diabetes and to be alert for symptoms and signs of such progression.

[3] MCNZ Good Medical Practice. 2016. https://www.mcnz.org.nz/assets/News-and-Publications/good-medical-practice.pdf

(ii) The HbA1c result of 31 August 2016 was markedly abnormal and required prompt follow-up, particularly in a patient presenting symptoms suggestive of hyperglycaemia. The result should have been available to [Dr B] the same day (a Wednesday) or at latest by the Thursday morning. It is not clear when [Dr B] actually left her office [to go overseas] but it is apparent there was no robust process in place for reviewing of blood results in her absence (see section 7) resulting in almost a week before [Mrs A] was notified of the result, and in spite of reporting her unwellness to [Dr B] on 30 August 2016.

(iii) The advice provided to [Mrs A] by [Dr B] on 6 September 2016 was inadequate. [Mrs A] had presented symptoms and an HbA1c result diagnostic of diabetes, with the symptoms suggesting significant hyperglycaemia. There is a risk of ketoacidosis in this situation and I feel [Mrs A] should have been told (if she was not to be reviewed by [Dr B]) of her diagnosis and the need to seek prompt (within the next 24-hours) medical advice, with appropriate 'safety-netting' advice also provided, as was done by the after-hours service [Mrs A] contacted later that day. There was also a missed opportunity for appropriate handover to [Mrs A's] regular GP who [Dr B] could have contacted earlier on 6 September 2016 to discuss the result and [Mrs A's] management.

(iv) The absence of communication from [Dr B] to [Mrs A's] regular GP in relation to her thyroid prescribing as well as blood test results is a significant omission, noting [Mrs A] had not withheld consent for such communication.

(v) Taking into account the issues discussed above, I feel [Dr B's] management of [Mrs A] departed from expected standards of care to a **moderate** degree. To what extent this relates to inadequate practice policies and processes may need to be further determined."

On 4 May 2017, Dr Maplesden provided the following additional advice:

"I have reviewed further responses from [Dr B].

1. [Dr B] confirms the sequence of events provided by [Mrs A]. I note a statement from [Mrs A's] regular GP also confirms that at no stage did she receive information from [Dr B] regarding [Mrs A's] abnormal blood results, treatment for hypothyroidism, or her symptoms preceding the diagnosis of diabetes.

2. [Dr B] outlines her practice which appears to be extremely busy and, prior to the events in question, managed with some administrative, but no clinical, assistance. [Dr B] outlines the circumstances leading to this situation — predominantly increased patient numbers following departure or cessation of practice by some of her fellow holistic practitioners.

3. It is not apparent that [Dr B] had any formal written policy in place regarding management of results prior to the incident in question. I am familiar with the requirement for general practices which, with the introduction of RNZCGP

Foundation Standards[4], requires a large number of policies related to patient safety, access and experience. Prior to the events in question, I would expect a general practice to have had a robust results management policy in place. The difficulty here is how to define [Dr B's] practice. While she is a fellow of the RNZCGP, the patients she sees are not enrolled with her as their general practitioner and she receives no capitation payments. However, she does order blood tests and provide prescriptions and her practice might most closely equate to that of a specialist physician practising in private. [Dr B's] vocational scope is general practice and it may be worth clarifying with the Medical Council of New Zealand and/or RNZCGP whether [Dr B] would be expected to comply with, for example, the Foundation Standard requirements or whether there are other standards that might apply in her case.

4. [Dr B] has outlined the changes in her practice since the events in questions, including an increase in time dedicated to handling of results, additional staff (clinical (pharmacy) and non-clinical) to assist with processing of prescriptions and results, and efforts to reduce her overall workload with respect to patient contacts. With respect to the actual process of results management, [Dr B] states all results will be reviewed within 24-hours with copy of results and/or consultation notes to the GP where requested, and she will formally deputise handling of results to a colleague if she is absent from the practice. She is now using a new patient questionnaire which includes GP contact details. I think these changes are all very reasonable although I am somewhat surprised such processes were not already in place. I think communication of results and consultation notes (which include prescriptions) to the patient's GP should be automatic (unless consent is withheld) as would be expected with any specialist consultation, whether or not the patient has self-referred. To aid such communication, I feel the wording of any new patient information sheet should indicate that such information will be provided to the patient's usual GP (in the interests of continuity of care and patient safety) unless the patient declines such consent (which should be recorded). I note [Dr B] has undertaken an audit of patient results and has not found any other instances of significant results not being notified to the patient.

5. While the changes [Dr B] has made I think are reasonable, I remain concerned her workload (including out of work commitments) and the overall practice organization and standards might not be conducive to optimal patient safety. I remain concerned at the clinical decisions made by [Dr B] once she was aware of [Mrs A's] symptoms and blood results. I am not sure if a decision has been made for Medical Council referral for a formal review of [Dr B's] practice but I think this should be considered."

[4] https://www.rnzcgp.org.nz/RNZCGP/I_m_a_Practice/Quality_standards/Foundation_Standard/RNZCGP/Im_a_practice/Foundation_Standard.aspx?hkey=d20c8db4-d2b2-4b50-880f-ee2213049b27 Accessed 4 May 2017