Monitoring of thyroid function
(13HDC00619, 24 June 2015)

General practitioner ~ Whole thyroid ~ Monitoring ~ Information ~ Right 4(1)

A woman who had been enrolled with one medical practice since 1977 began consulting a GP at a different medical practice from 1998 specifically about her low bone density. Until mid-2011, the GP from the first practice was not aware that the woman had been consulting the second GP.

From 1998, the second GP (the GP) requested thyroid function tests for the woman and from September 2005 to December 2008 prescribed the woman Eltroxin (used to treat hypothyroidism).

On 16 May 2008, the GP recommended a change from Eltroxin to whole thyroid (a non-synthetic thyroid supplement which is not an approved medicine in New Zealand). The GP said that she gave the woman verbal and written information about hypothyroidism and whole thyroid. The woman said that she does not recall receiving the written information, and was not informed that whole thyroid is an unapproved medicine.

On 26 February 2009 two of the woman's thyroid tests were within the normal reference range, but the level of her thyroid-stimulating hormone (TSH) was low, indicating possible over-replacement of thyroxine. Following this, there was no review of the woman's thyroid symptoms until January 2011, but the medical practice continued to dispense repeat prescriptions of whole thyroid to the woman. The GP intended to follow up the woman in one year's time, but did not have in place a follow-up system to ensure that occurred.

On 20 January 2011, the GP increased the woman's dose of whole thyroid, without first testing the woman's thyroid levels. On 20 February 2011, the GP checked the woman's thyroid function but did not request TSH testing.

In April 2011, when the woman was overseas, she became clinically and biochemically hyperthyroid. The woman was admitted to an overseas hospital, and was found to have developed atrial fibrillation as a result of thyrotoxicosis which was caused by treatment.

On her return to New Zealand an endocrinologist placed the woman back on Eltroxin. In August 2013, the woman's thyroid function was assessed as stable and satisfactory, but she continued to experience episodes of atrial fibrillation.

It was held that the second GP did not provide services to the woman with reasonable care and skill and breached Right 4(1), for failing to sufficiently inform the woman about whole thyroid and failing to monitor the woman's thyroid function appropriately. The GP's documentation was suboptimal, and she failed to establish with the woman the first GP's role in her care and treatment, and to keep the first GP informed of her treatment of the woman.

It was also held that the medical practice breached Right 4(1) as it lacked robust systems to ensure that an adequate quality of care was provided to the woman.