General Practitioner, Dr B

Integrative Health Clinic

A Report by the

Health and Disability Commissioner

(Case 17HDC01144)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary ... 1
Complaint and investigation ... 3
Information gathered during investigation ... 3
Relevant standards ... 10
Opinion: Dr B — breach ... 10
Opinion: Medical centre — other comment ... 15
Recommendations ... 16
Follow-up actions ... 16
Appendix A: Independent advice to the Commissioner ... 17
Appendix B: In-house advice to the Commissioner ... 39

Executive summary

1. In October 2016, Ms A, aged 54 years at the time of events, was referred to Dr B, a general practitioner (GP) who specialises in natural health solutions.

2. Ms A had a total of five consultations with Dr B over a period of approximately six months. This report discusses Dr B's management of Ms A's thyroid and diabetes concerns during that time.

3. Ms A had been prescribed 20u[1] insulin twice daily. On 1 November 2016, having obtained an HbA1c[2] result of 50mmol/mol,[3] Dr B agreed to a trial of reducing Ms A's insulin owing to concerns that she might be allergic to it. Dr B did not document her discussions with Ms A regarding the risks and benefits of reducing insulin, or lifestyle management of Ms A's diabetes in those circumstances.

4. On 15 November 2016, Dr B prescribed a 25ml bottle of Lugol's iodine to address Ms A's hypothyroid[4] concerns, and noted that Ms A should start with one drop daily and increase as directed to a maximum of six drops daily on the skin. Dr B acknowledged that this was a high dose, but said she felt that it was appropriate in Ms A's case.

5. On the same day, Ms A reported that her blood sugar levels (BSLs) were "between 6 and 7". Dr B documented a plan for Ms A to reduce her insulin to 8 units twice daily.

6. On 21 December 2016, Dr B recorded a plan to reduce Ms A's insulin to 6 units twice daily.

7. On 10 January 2017, Dr B prescribed Ms A T3.[5] A thyroid function test (TFT) from the previous day showed Ms A's thyroid stimulating hormone (TSH) level at 4.8.[6]

8. On 3 February 2017, Ms A requested an endocrinology referral. Dr B stated that she explained to Ms A that she did not meet the guidelines for a referral to an endocrinologist regarding her thyroid or pituitary. Dr B did not document this discussion, and did not inform Ms A of the option of seeking endocrinology care privately.

9. On 5 April 2017, Ms A had her final consultation with Dr B owing to elevated BSLs, and a further HbA1c test was carried out. On 27 June 2017, Ms A emailed Dr B's clinic to cancel all future appointments.

[1] 20 units, equal to 0.2 milliliters.
[2] A test that measures average blood glucose over the previous 8 to 12 weeks and gives an indication of longer-term blood glucose control.
[3] Millimoles per mole.
[4] Underactive thyroid gland.
[5] Triiodothyronine — an iodine-containing hormone that is an amino acid derived from thyroxine.
[6] The normal range of TSH levels is 0.4–4.0. When TSH is 4–6, monitoring is recommended, and when TSH is 6–10, testing should be repeated in two months' time and treatment considered.

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Findings

10. Dr B was found to have breached Right 4(1)[7] of the Code of Health and Disability Services Consumers' Rights (the Code) for the following reasons:

a) She prescribed reduced insulin when Ms A's BSLs were above a level wherein insulin could be reduced safely.

b) She did not order a repeat HbA1c three months after the first test for the monitoring of Ms A's BSL levels in the context of relatively rapid insulin reduction.

c) She prescribed Ms A T3 when her TSH was not at a level that clinically indicated that treatment.

d) She prescribed a high dose of iodine despite the extent of Ms A's potential iodine deficiency being unclear.

e) She did not inform Ms A of the option of seeking endocrinology care privately.

11. Dr B was also found to have breached Right 4(2)[8] of the Code, as she did not document (a) her discussions with Ms A regarding the risks and benefits of reducing insulin, and lifestyle management of diabetes during insulin reduction; or (b) that she explained to Ms A that she did not meet the guidelines for an endocrinology referral.

12. Other comment was made in relation to the integrative health clinic (the clinic). It was found that the errors that occurred did not indicate broader systems issues.

Recommendations

13. It was recommended that Dr B provide a written apology to Ms A, and undertake the following actions:

a) Provide an update on the plan to employ another doctor at the clinic.

b) Conduct an audit of daily notes for a period of two months, and report to HDC on the outcome of the audit.

c) Consider adopting the Medical Council of New Zealand's recommendation in relation to a written consultation protocol, and report her decision to HDC.

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

[8] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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Complaint and investigation

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

- *Whether Dr B provided Ms A with an appropriate standard of care between 2016 and 2017.*
- *Whether the clinic provided Ms A with an appropriate standard of care between 2016 and 2017.*

15. The parties directly involved in the investigation were:

Ms A	Consumer
Integrative health clinic	Group provider
Dr B	Provider/general practitioner (GP)

Also mentioned in this report:

Ms C	Nurse
Ms D	Nurse
Ms E	Naturopath

16. Independent expert advice was obtained from GP Dr Tracy Chandler, and is included as **Appendix A**. In-house clinical advice was obtained from GP Dr David Maplesden, and is included as **Appendix B**.

Information gathered during investigation

Background

17. This report discusses the care provided to Ms A (54 years old at the time of the events) in relation to thyroid and diabetes management. Ms A's medical history included coronary artery disease with ischaemic cardiomyopathy,[9] and obesity. In 2012, she had a heart attack and was diagnosed with Type 2 diabetes, after which she was started on insulin. Ms A's regular medications included metoprolol[10] and aspirin.

18. In October 2016, due to the complex nature of Ms A's health issues, she was referred by naturopath Ms E to Dr B, a GP who specialises in natural health solutions.

19. Over the course of about six months, Ms A had a total of seven consultations at Dr B's clinic — five with Dr B, and two with other clinic staff. During this time, Ms A self-recorded her own BSLs using home monitoring equipment.

[9] A weakened heart muscle as a result of a heart attack or coronary artery disease.
[10] A medication used to treat many heart-related conditions.

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Thyroid management

Introduction

20. This section of the report discusses issues relating to the treatment of Ms A's thyroid stimulating hormone (TSH) levels.

31 October 2016 to 3 February 2017

21. At the first consultation on 31 October 2016, Dr B noted that Ms A had concerns that she might have hypothyroidism, and that she requested a prescription for thyroid hormone. Dr B's records show that in response to this, she prescribed iodine.[11] A thyroid function test (TFT) was performed the following day, and again on 14 November 2016.

22. At the second consultation on 15 November 2016, Dr B recommended that Ms A take "tyrosine[12] to help thyroid", and she gave Ms A a laboratory form to check her TSH in a month's time. Dr B prescribed a 25ml bottle of Lugol's iodine to address Ms A's hypothyroid concerns, noting: "[S]tart with one drop daily, increase as directed to a maximum of 6 drops/day on skin and/or diluted in food or drink." Dr B told HDC that one drop is equivalent to about 6.25mg.[13]

23. In relation to the prescription of iodine, Dr B told HDC that she adheres to a standard, as recommended by a holistic medical practitioner, for doses of up to 50mg or more per day when there is a great need. Dr B stated that she was aware that what she prescribed was a high dose, but felt it was appropriate in Ms A's case. Dr B explained that Ms A's skin absorbed iodine at an abnormally fast rate, and her poor diet had resulted in an "increasingly severe iodine deficiency", and, in addition, Ms A's weight was approximately 200kg.[14]

24. In response to my provisional opinion, Ms A stated that she did not have a poor diet, and that she has always led a healthy lifestyle and eaten healthy foods.

25. In relation to the assessment of a possible iodine deficiency, Dr B stated in response to my provisional decision:

> "This is a clinical decision to be made, it is not something that can easily be determined by testing. A 24-hour urine test for iodine costs $150. Testing is more appropriate for population assessment rather than being accurate regarding an individual. What is known is that after the use of iodine (amongst other things), the weeping inflamed skin on [Ms A's] legs healed without serious infection."

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[11] Iodine is needed for the production of thyroid hormones.

[12] Tyrosine is an amino acid that is naturally present within blood and nervous system tissues. Tyrosine combines with iodine in thyroid cells to make the thyroid hormones thyroxine and triiodothyronine.

[13] Six drops is equivalent to about 38mg.

[14] Dr B stated that this final reason was based on a guide to appropriate iodine dosing of "0.25mg/kg/day".

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26. At the fourth consultation on 10 January 2017, Dr B recorded Ms A's blood pressure as approximately 118/86mmHg,[15] and "not as good as last time". Dr B did not mention a plan in relation to this finding, but prescribed frusemide[16] and documented "hypothyroidism … suspected". Dr B recorded that a TFT from the previous day showed Ms A's TSH level at 4.8. Dr B told HDC that although Ms A's T3 was not below the normal range, it was proportionately lower than her T4.[17] Therefore, she prescribed 30mcg[18] T3 capsules, noting that Ms A was to take "one capsule on rising".

27. Regarding the prescription of T3, Dr B told HDC that she felt it was reasonable to give Ms A a trial of slow-release T3, as potentially it could support Ms A to lose weight, increase her energy, and improve her BSLs.

28. Dr B acknowledged that the dose of T3 prescribed was "moderately high". However, she reasoned that a significant cost associated with slow-release T3 capsules is that they require compounding.[19] Therefore, in order to save costs for Ms A, Dr B made one prescription for the 30mcg strength rather than starting with a low-dose prescription.

29. In response to my provisional opinion, Dr B stated that "[h]aving started thyroid hormone, Ms A did her own trial of stopping it and found that she felt better when she was on it".

30. On 3 February 2017, Ms A attended a consultation with the clinic's anthroposophic[20] nurse, Ms C, who recorded that Ms A had requested a referral to an endocrinologist, and that Ms A wanted further discussion with Dr B regarding this.

31. Dr B told HDC that Ms C called her through "at the end of that consultation to deal with the doctor-specific matters", and she had a brief discussion with Ms A. Dr B said that at that time she explained to Ms A that "she did not meet the referral guidelines for a referral to endocrinology regarding her thyroid or pituitary", and that endocrinology "could be willing to see her regarding her diabetes and regarding obesity but that she did not have any other disorder recognised by conventional endocrinology". Dr B stated: "[Ms A] chose for me to not make a referral to endocrinology at that point." Dr B told HDC that she did not suggest the option of seeing a private endocrinologist, as she did not believe that a private endocrinologist would agree to treat Ms A regarding her health concerns at the time.

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[15] Dr B noted: "[Blood pressure with] large cuff held with a crepe bandage [not] tight enough for the Velcro to hold so not sure of systolic but it was at least 118, diastolic became difficult to hear but may have been about 86."
[16] A diuretic medication (used to increase the amount of salt and water expelled by the body as urine). It is also used to treat high blood pressure.
[17] Thyroxine — a hormone produced in the thyroid gland.
[18] Microgram — one millionth of a gram.
[19] Preparing medication that is specially tailored to a patient.
[20] Anthroposophic medicine has ties to homeopathy, and looks at the physical, mental, emotional, and spiritual aspects of an individual when prescribing therapies, medicines, or treatments.

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32. In response to my provisional opinion, Dr B stated:

> "I … believe it would be unethical to encourage [Ms A] to see an endocrinologist privately when that would not meet her desires and particularly when she had constrained financial circumstances. I explained to her that I did not know of any endocrinologist who was interested in [Ms A's] perspectives on her endocrine problems."

33. However, Ms A told HDC:

> "I did not change my mind about wanting a [referral] to an endocrinologist. I said at the time if I [don't] have [Cushing's][21] or hypothyroidism then at least a thorough check by a specialist will rule those disorders out."

34. Dr B acknowledged that she failed to document the above discussions in her notes.

Diabetes management

Introduction

35. This section outlines issues regarding the reduction of Ms A's insulin dose for treatment of Type 2 diabetes, and testing to monitor her BSLs.

31 October 2016 to 5 April 2017

36. On 31 October 2016, Ms A's prescription of insulin was 20u twice daily. Dr B told HDC that Ms A had a desire to "come off all [conventional] medication", including insulin. Ms A had reported to Dr B that when she was first commenced on insulin, she suffered an allergic reaction, and some of the symptoms continued despite a change in the type of insulin. Dr B also stated that Ms A had reported that since being on insulin, her weight had increased to over 200kg, and that she was "highly susceptible to adverse effects from medications". Under these circumstances, Dr B queried whether Ms A might be allergic to insulin. Dr B's management plan included requesting blood tests, which were sent to the laboratory that day, and incorporating additional naturopathic support when needed, to ensure that Ms A's BSLs were maintained. Dr B told HDC that she discussed with Ms A the aim of weaning off insulin, but said that she wanted to see the blood results before instituting the care plan.

37. Dr B told HDC that "discussion of lifestyle factors such as food, activity, sleep and stress management was always a significant component" of her discussions with Ms A in relation to decreasing insulin. There is no record of advice being given for lifestyle management of Ms A's diabetes. Dr B stated that Ms A was informed of the potential risks in relation to reducing her insulin dose, and that if her BSLs could not be managed adequately through other means, insulin would need to be reinstated. Dr B told HDC that the potential benefits discussed included that if they identified that Ms A had an allergy to insulin, by stopping it she could have fewer symptoms, and that less insulin had the potential to make it easier for Ms A to lose weight. However, Ms A told HDC that she differs in her

[21] A condition caused by excess levels of corticosteroids and especially cortisol in the body due to either hyperfunction of the adrenal gland or to prolonged use of corticosteroid medications.

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recollection, and stated that the risks and benefits were "not discussed with [her] in any detail at all".

38. On 1 November 2016, blood tests showed that Ms A's HbA1c reading was 50mmol/mol, and it was noted: "In the setting of confirmed diabetes, this result indicates very good control. … Suggest repeat in 6–12 months."

39. In response to my provisional opinion, Dr B stated that she waited until she had Ms A's HbA1c result of 50mmol/mol before she agreed to a trial for weaning off insulin.

40. On 15 November 2016, Dr B recorded that Ms A had reported that there was no difference in her health, that her BSLs were "between 6 and 7", and that since she had reduced her insulin dose her skin sensitivity was "not as bad". The clinical notes state that the management plan was to "reduce insulin to 8 units twice daily so long as most [BSL] readings less than 7[mmol/L]",[22] and Dr B recommended Pure Innovation Glucolin[23] for treating Type 2 diabetes.

41. Dr B stated that at the third consultation on 21 December 2016, Ms A "reported that she was consistently getting good [BSL] readings with her home monitoring", and recorded in the notes for that consultation that Ms A had reduced her insulin intake to 10 units twice daily. Dr B also recorded the plan to "reduce insulin down to 6 units twice daily and if the BSLs remain[ed] good [to] recommend stopping insulin".

42. On 10 January 2017, Dr B documented the reason for the visit as "[Follow up] on less insulin". It was documented that Ms A advised that she had cut her insulin dose "down to 6 [units twice daily]" but that she had noticed that her BSLs were up sometimes to "10, 13". The clinical record makes no mention of Dr B's impression or plan for diabetes and insulin management in light of this information.

43. Dr B told HDC that on this date she also generated a laboratory request form for a mid-stream urinalysis[24] because Ms A had complained of feverish symptoms. Dr B told HDC:

> "There was no need to check an HbA1c at that time as it gives an indication of how blood sugars have been over a three month period."

44. In response to my provisional opinion, Dr B stated:

> "Our laboratory guidelines recommended [Ms A's] November HbA1c be repeated within 6 to 12 months … [Ms A's] late January appointment with me had to be cancelled because of [a bereavement]. That was the appointment where I would have reassessed the appropriate timing for the next HbA1c. In the interests of not wasting health dollars we are encouraged to not repeat HbA1c tests until there has been 3 months of a new intervention, which is what I did. … In order to do my best for [Ms A]

[22] BSLs are measured in mmol/L (millimoles per litre). Targets for self-monitoring of BSLs are 6–8mmol/L while fasting and before eating, and 6–10mmol/L for two hours after eating.

[23] Medication aimed at assisting with maintenance of normal, healthy blood glucose levels.

[24] A test for a range of conditions such as infection, kidney problems, or glucose in the urine.

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> it was important to me to obtain a urine specimen and I was able to achieve that in January because [she] had mentioned feverish symptoms so was willing to provide a specimen for that reason. … On that occasion it was confirmatory of [Ms A's] report that her blood sugars were generally good but it is not a replacement for an HbA1c."

45. On 22 February 2017, Ms A visited the practice for a consultation with the clinic's homeopath and practice nurse.

46. On 5 April 2017 — Ms A's fifth and final consultation with Dr B — the documented reason for the visit was that Ms A was having issues with her BSLs, with levels of 19 to 21.[25] An HbA1c test was carried out. Dr B documented her management plan that naturopath Ms E would work with Ms A on blood-sugar-lowering nutrients and herbs, and that insulin could be reintroduced if sufficient progress was not made with restoring blood sugars to healthy levels.

47. Dr B told HDC that she was significantly concerned that Ms A's BSLs had risen, and that this had not been communicated with her sooner, "as had been the plan". Dr B further stated:

> "I did my best to hide my shock and calmly explained that checking for allergy to insulin was a short-term trial and whatever we do, the aim is to have blood sugar levels well managed overall."

Subsequent events

48. On 1 May 2017, Ms A emailed Dr B advising that her health had deteriorated, and that her BSLs had been in the 30s, and said: "I really think I need a referral to an endocrinologist asap." Dr B's reply email on the same day stated:

> "I'm happy to refer you to an endocrinologist but … so far, we haven't found anything to suggest any … disorders that endocrinologist[s] treat, apart from diabetes and their solution to that is more insulin. What supplements have you added to help address your type II diabetes? How are you finding them?"

49. Ms A did not address Dr B's questions in her subsequent reply, and asked again for an endocrinology referral.

50. On 3 May 2017, an email from Ms A to Dr B stated: "[A]s far as the thyroid issue is concerned I would prefer to let the endocrinologist deal with that … nothing is working." In her reply email, Dr B wrote: "If you have not been taking any thyroid hormone for a month then it would be a good idea to do a blood test now so that we can make a more useful referral to the endocrinologist."

51. In a further email on 4 May 2017, which was copied to Ms A's naturopath, Dr B sought clarification about Ms A's current thyroid status, and on the amount of carbohydrates Ms A had been consuming, and said that the information was important for an endocrinology referral. On the same day, Ms A responded: "no thanks".

[25] Levels above 10 are considered abnormal.

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52. On 6 May 2017, Dr B made a referral to an endocrinologist. On 27 June 2017, Ms A emailed Dr B's clinic asking for cancellation of all her future appointments.

Further information

53. Dr B told HDC:

> "I am very sorry that there was this lapse in communication between [Ms A] and me over a few weeks with regards to her continuing off insulin despite no improvement in her health and rising blood sugars."

54. Dr B added:

> "I have been very conscious of the need to address workload issues … My practice manager and I have been actively looking to recruit another doctor with experience in integrative care to reduce the workload on our team … I am currently in the process of taking on an international medical graduate with a background in integrative medicine. … Once she is able to work with me that will reduce the workload."

55. Dr B also stated that in regard to her role in Ms A's appointment with Ms C on 3 February 2017, and since the events in question: "[W]hen I join a nurse consultation I generally change the MedTech login to my own to facilitate me writing my own notes at the time in such situations."

Responses to provisional opinion

56. Ms A and Dr B were given the opportunity to respond to sections of my provisional opinion. Where relevant, their comments have been incorporated into the report.

57. Ms A reiterated the issues she raised in her complaint, and stated that she disagreed with several of Dr B's statements regarding her diabetes management.

58. Dr B accepted that her note taking should have been better in Ms A's case, but emphasised the complexity and challenging components of Ms A's presentations. Dr B told HDC that in this case, strict adherence to clinical guidelines would not have been effective. Dr B further stated:

> "The reason there are guidelines for care of patients rather than mandatory rules is to take into account the variations that may be the best solution for the circumstances of individual patients. … I recognised that working with [Ms A] would take enormous care to foster the therapeutic relationship and that was my top priority, because without that I would have no chance … If I were to have taken the approach of following the guidelines strictly as though they are inflexible rules, I may not have been able to help her at all."

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Relevant standards

59. The Medical Council of New Zealand (MCNZ) publication *Good Medical Practice* current at the time of events states that doctors must keep clear and accurate patient records that report:

a) Relevant clinical information;
b) Options discussed;
c) Decisions made and the reasons for them;
d) Information given to patients;
e) The proposed management plan; and
f) Any medication and other treatment prescribed.

Opinion: Dr B — breach

Thyroid management

60. As discussed above, during Dr B's management of Ms A, her TSH level returned a result of 4.8. Dr B reasoned that because Ms A's T3 was proportionately lower than her T4, it was reasonable to commence Ms A on 30mcg of T3. Dr B explained that she prescribed this moderately high dose because she wanted to save costs for Ms A by writing only one prescription. When Ms A later requested a referral to an endocrinologist, Dr B did not inform Ms A of the option to see a private endocrinologist, as Dr B did not believe that a private endocrinologist would agree to treat Ms A regarding her health concerns at the time.

61. My expert advisor, Dr Tracy Chandler, stated:

> "If [Dr B] was suspicious of or treating subclinical hypothyroidism my local Health Pathways[26] states …:
>
> a) TSH > 10, treat with thyroxine.
> b) TSH 6 to 10, repeat TSH in 2 months, consider treatment.
> c) TSH 4 to 6, monitor every 6 to 12 months, or treat with thyroxine if autoantibody positive or goitre.
> d) If results do not indicate hypothyroidism or subclinical hypothyroidism, consider the clinical picture and repeating TSTs at regular intervals e.g., every 3 months. If the diagnosis remains uncertain, consider discussing with a thyroid physician."

62. Dr Chandler advised that in regard to thyroid management and prescription of T3, Ms A's clinical records and results "do not indicate a diagnosis of thyroid disease". Dr Chandler added:

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[26] A web-based information portal that supports primary care clinicians to plan patient care through primary, community, and secondary healthcare systems.

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"[I]t would be deemed a moderate departure from accepted practice to treat TSH of [Ms A's] levels. This is based on the above guidelines with acknowledgement that there is evidence that lower (than accepted by conventional medicine) [TSH] reduces [coronary artery disease] risk …"

63. Similarly, my in-house clinical advisor, Dr David Maplesden, advised that the management of Ms A's thyroid function departed from accepted standards of care to a moderate degree in relation to the administration of T3 when there was no clinical indication.

64. Dr Chandler also advised that Dr B departed from accepted practice by not explaining to Ms A that she had the option of pursuing endocrinology assessment privately.

65. I accept my experts' advice that Ms A's TSH levels did not indicate a prescription of the thyroid hormone T3, and am therefore critical of Dr B's actions in this regard. In addition, although Dr B considered that a referral through the public system was not appropriate, Ms A may have benefited from being made aware that she could attempt to pursue endocrinology care privately, and I find the omission to inform Ms A of her options in this regard to be sub-optimal.

Diabetes management

66. As discussed above, Ms A self-recorded her own BSLs. Dr B queried whether Ms A was allergic to insulin, and on that basis trialled weaning her off it after having obtained an initial HbA1c result of 50mmol/mol on 1 November 2016. When insulin reduction occurred, Ms A's BSL was between 6 and 7. Another HbA1c test was not carried out until April 2017.

67. Dr Chandler referred to the Diabetes Australia (DA) best practice guidelines, which state that it is reasonable to assess diabetes control with self-reported BSL readings, but advised that lowering insulin when BSL readings were above 6 would be considered a mild to moderate departure from current Royal Australasian College of General Practitioners guidelines, which suggest reducing insulin if the lowest BSL of the previous three days is below 5.9. Dr Chandler added: "It is only a mild to moderate departure as it would be reasonable if [Ms A] were having side effects from insulin to try alternative ways of managing her diabetes."

68. In relation to HbA1c testing, Dr Chandler referred again to the above DA guidelines, which recommend that before advancing through additional BSL-lowering combinations, clinicians evaluate the patient's HbA1c response after three to six months. She noted that Ms A's second HbA1c test, five months after the initial test, was therefore performed within accepted timeframes, as long as there were no mitigating factors. However, Dr Chandler advised that in Ms A's case, there was evidence of a need for an HbA1c to be performed sooner than five months. Dr Chandler advised:

"With the relatively rapid reduction in insulin it would be accepted practice to perform an HbA1c at 3 months after the first HbA1c performed by [Dr B] (on 1/11/16) and so this should have been performed around early February."

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69. Dr Chandler further advised that as it appears that Dr B was aware of the need to monitor glucose levels, she considers the omission of a further HbA1c test in early February to be a mild departure from accepted practice.

70. I am mindful that it was reported that Ms A wished to come off insulin owing to the adverse effects experienced, and that Dr B considered weaning her off insulin as a trial in case Ms A was allergic to it. However, I accept my expert's advice, and I am critical that Dr B enabled the reduction of insulin when Ms A's BSLs were above 6.

71. I note Dr B's submission that she had planned to reassess the appropriate timing for Ms A's next HbA1c test at their scheduled appointment in late January 2017, and that this was cancelled owing to a bereavement. Dr B further stated that doctors are not encouraged to repeat HbA1c tests until there has been three months of a new intervention, for financial reasons. I am nonetheless of the opinion that given the relatively swift reduction of insulin and the need for careful management of Ms A's BSLs, the failure to order a repeat HbA1c test three months after the initial test was sub-optimal in these circumstances. I accept my expert's view in this regard.

Iodine

72. At the consultation on 15 November 2016, Dr B prescribed a 25ml bottle of Lugol's iodine to address Ms A's hypothyroid concerns, with instructions to start with one drop on the skin daily, and increase as directed to a maximum of 6 drops per day, which is about 38mg.

73. Dr B told HDC that she follows the recommendation of a holistic medical practitioner for doses of 50mg or more of iodine per day "when there is a great need", and that an approximate guide to appropriate iodine dosing is "0.25mg/kg/day". She further stated that she felt that Ms A had an increased need for iodine, owing to the speed at which Ms A's skin absorbed iodine, a potential iodine deficiency caused by malnutrition prior to her heart attack, and because Ms A's weight of 200kg meant that a higher dose of iodine was indicated.

74. Dr Chandler advised:

> "[W]hilst it is reasonable to give ... iodine this needs to be done carefully … The use of iodine at the doses referred to in the clinical records would be deemed a high dose and would be deemed by my peers as a severe departure from accepted practice."

75. In regard to the dose of iodine prescribed, Dr Maplesden advised: "[T]his is not a conventional approach to management of thyroid dysfunction and … it may be difficult to establish any consistent local or international recommendation in this regard." However, further oral advice from Dr Maplesden was that because Ms A had thyroid function tests within the normal range, and she did not have any investigation results confirming iodine deficiency, there was no clinical indication to provide iodine treatment at a high dose (even if that dose was within a range accepted by some practitioners), and a more cautious approach to treatment would have been safer for the patient.

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76. It is a concern that Dr Chandler has identified a potentially serious over-prescription of iodine. I am also mindful of Dr Maplesden's comments that the dose prescribed was in the context of unconventional approaches, and that widely accepted guidelines on the dose of such medication within alternative treatment methods may not exist. Dr Maplesden also advised that a more cautious approach to treatment would have been safer for the patient. Guided by my experts' comments, I am critical that iodine was prescribed in the manner it was.

Documentation

77. There are several instances where Dr B advised HDC that key discussions around Ms A's thyroid and diabetes management took place, but that the discussions were not documented.

78. Dr B stated that "the risks and benefits of meeting [Ms A's] request to lower insulin were discussed with her at her first visit, and subsequently". However, Ms A told HDC that the risks and benefits were not discussed "in any detail at all". Dr B also stated that "discussion of lifestyle factors such as food, activity, sleep and stress management was always a significant component" of consultations, but Dr B did not document these discussions.

79. On 3 February 2017, Ms A requested an endocrinology referral. Dr B told HDC that she explained to Ms A that she did not meet the referral guidelines regarding her thyroid. Dr B stated that Ms A chose not to be referred at that point. However, Ms A told HDC that she "did not change her mind" about wanting a referral. Again, this discussion was not documented.

80. Dr Chandler noted the "immense complexity" of Ms A's case, and Dr B's statement that "routine consultations with [Ms A] were of at least an hour in duration". Dr Chandler advised that "[l]engthy and challenging consultations make it nearly impossible to record all the information discussed with the patient". Dr Chandler concluded:

> "To proceed with reducing insulin and implementing complimentary management without documenting informed consent would be deemed by my peers to be a mild departure from accepted practice."

81. Dr Chandler further advised that although reversing Type 2 diabetes and reducing insulin is possible, "reducing insulin needs to be done slowly and carefully and is only possible if intensive nutrition and lifestyle management is implemented". There was no record in any of Dr B's consultations that she had advised Ms A on lifestyle management of her diabetes. Dr Chandler stated that if this advice was given but not recorded, this would be considered a mild departure from accepted practice.

82. Dr Chandler also advised that Dr B departed from accepted practice by not documenting that she had explained to Ms A that she did not meet the guidelines for an endocrinology referral.

83. MCNZ's publication *Good Medical Practice* requires doctors to keep clear and accurate patient records that report, among other things, the options discussed, the information

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given to patients, and the decisions made and the reasons for them. It is clear from the issues my expert has identified that Dr B failed to comply with this requirement in regard to some important clinical discussions with Ms A.

Other matters for consideration

84. In response to my provisional opinion, Dr B submitted that in her view, insufficient weight has been given to the complexity and challenging components of Ms A's presentations. Dr B told HDC that in this case it was not appropriate to follow guidelines strictly, owing to the complex nature of Ms A's presentation, which she felt required a more tailored approach to care, as strict adherence to clinical guidelines would not have been effective.

85. Dr Chandler advised that the series of consultations that Dr B had with Ms A would rank among the most difficult any GP would ever have to experience. Dr Chandler further stated that she commends Dr B for the changes she has made to her practice since these events, and for "the clear intention she has to do the best she can for the patient especially in this case which was clearly a very challenging one". During the process of my decision-making, I have taken into consideration these comments from Dr Chandler, and I acknowledge the difficulties in Ms A's presentation.

Conclusion

86. It is clear that although Ms A's presentation was complex, and while Dr B appears to have made extensive efforts to understand Ms A's needs by communicating with her via email in addition to consultations, there have been several departures from accepted practice. To summarise:

- Dr B prescribed reduced insulin when Ms A's BSLs were above a level wherein insulin could be reduced safely.

- Dr B did not order a repeat of the HbA1c test at three months after the initial test performed on 1 November 2016 despite major changes being made to Ms A's diabetes treatment regimen.

- Dr B prescribed Ms A T3 when her TSH was not at a level that clinically indicated that treatment.

- Dr B prescribed Ms A iodine at an objectively high dose despite the extent of Ms A's potential iodine deficiency being unclear, when it would have been safer to take a more cautious approach to treatment with iodine.

- Dr B did not inform Ms A of the option to seek endocrinology care privately.

87. For these reasons, I am of the view that Dr B failed to provide services to Ms A with reasonable care and skill, and therefore breached Right 4(1) of the Code.

88. I am also concerned that there were several instances where material issues regarding Ms A's health care were not documented. These were:

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- Discussions regarding the risks and benefits of reducing insulin.
- Discussions regarding lifestyle management of Ms A's diabetes in the context of insulin reduction.
- That Dr B had explained to Ms A that she did not meet the guidelines for an endocrinology referral.

89. Dr B did not document the above matters adequately and, as such, did not adhere to MCNZ standards for record-keeping. It follows that Dr B failed to comply with relevant professional standards, and therefore breached Right 4(2) of the Code.

Opinion: Medical centre — other comment

90. As a healthcare provider, the clinic is responsible for providing services in accordance with the Code. Dr B stated that she is the sole GP, majority shareholder, and director of the company.

91. In giving her advice on these events, Dr Chandler noted MCNZ's recommendation for clinicians to "adopt written consultation protocols that specify what information in the form of discussion, publications and questions will be given in a specific type of consultation", so that clinicians need not spend unnecessary time writing extensive notes, but instead "note in the patient record that the protocols were fulfilled and only outline any exceptions to the protocol".

92. Dr Chandler also recommended that the clinic adopt a practice of asking patients for a copy of their BSL readings, to ensure the accuracy of information on which clinical decisions are based.

93. However, overall Dr Chandler found that the clinic's practice systems appeared to be adequate. I accept Dr Chandler's advice. I consider that the errors that occurred did not indicate broader systems or organisational issues at the clinic. However, it would be prudent for the clinic to consider MCNZ's recommendation for written consultation protocols.

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Recommendations

94. I recommend that Dr B:

a) Provide a written apology to Ms A. The apology is to be sent to HDC within four weeks of the date of this report, for forwarding to Ms A.

b) Provide an update on the plan to employ another doctor with experience in integrative care in order to address workload concerns, and report to HDC within four weeks of the date of this report.

c) Conduct an audit of daily notes for a period of two months, to ensure that all notes have been entered for any given day, and report to HDC on the analysis of the audit (and action taken where non-compliance is identified), within three months of the date of this report.

d) Consider adopting MCNZ's recommendation in relation to a written consultation protocol, and report to HDC on the outcome of this consideration within four weeks of the date of this report.

Follow-up actions

95. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to MCNZ, and it will be advised of Dr B's name.

96. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Royal New Zealand College of General Practitioners, and it will be advised of Dr B's name.

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

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from GP Dr Tracy Chandler:

"**Introduction**

Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice.

My qualifications, training, experience and my area of expertise which are relevant to the case — BSc (HONS) — *4 year Biochemistry Degree*, MB ChB — *5 year Medical Degree*, FRNZCGP — *Fellowship of the Royal NZ College of General [Practitioners]*, PGDipSEM — *3 years Post-Graduate Diploma in Sports and Exercise Medicine*, Cert Dermoscopy, Homeopathy Certificate (Introductory), MACNEM Member — *Member of the Australasian College of Nutritional and Environmental Medicine*, Member of Australian Integrative Medicine Association.

The instructions I have been given are to provide comment on the following:

1. The adequacy of [Dr B's] management and monitoring of [Ms A's] insulin dosages and blood sugar levels.
2. The appropriateness of the decision not to refer [Ms A] to an endocrinologist.
3. The appropriateness of the tests and examinations undertaken by [Dr B].
4. The appropriateness of [Dr B's] management of [Ms A's] symptoms.
5. Any other matters in this case that you consider warrant comment.

Due to the complexity of the case and the integrative nature of the complaints and question I have elected to answer each question in a flowing format in this one document but have numbered the answer to each of the questions above in the body of each answer below.

Key:

BSL = Blood sugar level (recorded by finger-prick testing)

PMS = Patient Management System

HDC = Health and Disability Commissioner

MCNZ = Medical Council of New Zealand

RNZCGP = Royal New Zealand College of General [Practitioners]

CAM = Complementary and Alternative Medicine

TSH = Thyroid Stimulating Hormone

CAD = Coronary artery disease

CVD = Cardiovascular disease

PMS = Patient management system

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I have been provided with the following information to base my review on:

I have reviewed the available information: complaint from [Ms A]; response from [Dr B], and the Clinical Notes from [the clinic] from October 31, 2016 to June 27, 2017.

I have also consulted with [my mentor] regarding specific issues about this case which I will refer to in the body of my answer. He is a Fellow of the Australasian College of Nutritional and Environmental Medicine and of the Royal NZ College of General [Practitioners].

Background of complaint

[Ms A's] complaints are as follows:

Regarding [Dr B]

a. There was resistance to her request for blood tests.

b. She requested [Dr B] write a referral to an endocrinologist but this was not done.

c. Her request for a definitive diagnosis was refused.

d. She felt offended at [Dr B's] comments regarding [a personal pursuit].

e. She discovered that [Dr B] had communicated with her naturopath but had not given her permission to do so.

Clinical timeline

1. Her first appointment was on 31/10/16. The reason for visit (as stated by [Dr B]) was '? hypothyroid, weight gain since started on insulin & other drugs after heart attack 4 years ago; fluid seeping from legs'.

   1.1. [Ms A] states that [Dr B] 'took me off my insulin and said that this was causing my illness so I went off my insulin and my blood sugars went through the roof'. [Dr B's] notes from the first appointment on 31/10/16 state that 'the aim is to wean off insulin'. No further clarification was given but [Dr B] states in her reply to the complaint that 'I discussed the aim of weaning off insulin, but wished to see the blood results before instituting that care plan.'

   1.2. There is no mention in the clinical record of this date of [Ms A] requesting a referral at this visit and [Ms A] does not specifically cite which appointments she asked for the referral at but in her complaint, states she asked 5 times.

   1.3. An examination was performed and [Dr B] records among other findings 'myxoedema'. There is no record of an examination of her thyroid gland or of a weight and height measurement. [Dr B] also states that she 'applied iodine'.

   1.4. [Dr B's] management plan includes 'recommend personal cares [for legs] … increasing EFA … add extra vit D … restart R-alpha lipoic acid … refer for

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personal cares … stop aspirin … do fasting blood tests … do 24 hour urine collection for cortisol'. In her notes dated 2/11/16 and in her reply to the complaint [Dr B] also states she 'phoned Med Reg' for advice 'including the creatinine levels and the lymphoedema'.

2. A prescription was generated on 2/11/16 which includes a prescription for insulin at 20u/day. It is unclear if this was the dose [Ms A] had been on prior to her first visit with [Dr B] and this would be important information to elicit. This would require access either to her previous GP's notes or to [Ms A's] pharmacy records.

3. A message to [Ms A] from [Dr B] (presumably by text, this information is unclear) includes '... insulin, reduces ability to make glutathione'.

4. At the next appointment on 15/11/16 the 'reason for visit' was recorded by [Dr B] as 'F/U after additional supplements'. [Ms A] states that 'I find when I eat nuts, that paleo granola for breakfast I don't need a lot of insulin. I take 10 twice a day'. [Dr B] records her home blood sugar readings as 'probably between 6 and 7'. There is no record of the relationship of these readings to meals. [Dr B] records in her notes of 15/11/16 that [Ms A] had 'noticed since I cut down that insulin (skin sensitivity) not as bad'. It is unclear if [Ms A] initiated the insulin reduction herself or under guidance from [Dr B]. However in that same consult of 15/11/16 there is no comment from [Dr B] regarding that insulin reduction but she does comment in her management plan to 'reduce insulin to 8 units twice daily so long as most blood sugar readings less than 7'. [Dr B] also 'recommended pure innovation Glucolin to address the type II diabetes'.

5. There is no mention in the clinical record of this date of [Ms A] requesting a referral at this visit and [Ms A] does not specifically cite which appointments she asked for the referral at but in her complaint, states she asked 5 times.

6. The examination findings include pulse (including kidney pulse) and temperature recordings. There is no record of a leg or thyroid examination.

7. In her management, among other management [Dr B] records 'I recommend adding in Solgar tyrosine to help thyroid … gave a lab form to recheck thyroid after at least a month on new regime'. On 15/11/16 [Dr B's] notes also record 'Dulc 1M, two pillules' but does not state what the indication is. A patient handout regarding The Dulc 1M also does not state what the indication is. [Dr B] also prescribed Iodine on 15/11/16 but does not state what the indication is. It also does not state how long this was used for but only 1 prescription was given on 15/11/16 with an amount of '25' recorded (presumably mls though this is not clear from the notes).

8. In the notes at the next appointment on 21/12/16 the 'reason for visit' was recorded by [Dr B] as 'health' and [Ms A] stating that 'the legs is my biggest issue'.

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8.1. [Ms A] states 'BSLs? — they've been between 6,7,7.5' and 'insulin taking now? — 10 twice a day'. [Dr B's] management of the insulin dosages and BSLs was recorded by [Dr B] as 'Reduce insulin down to 6 units twice daily and if BSLs remain good I recommend stopping insulin'.

8.2. There is no mention of [Ms A] requesting a referral at this visit and [Ms A] does not specifically cite which appointments she asked for the referral at but in her complaint, states she asked 5 times.

8.3. At the visit on 21/12/16 [Dr B] records her 'p88, reg' … and the BP reading records the systolic reading only, there is no evidence of a diastolic reading.

8.4. [Dr B] records in this visit notes that 'doesn't need metoprolol' and 'reduce losartan as BP still on the low side despite having stopped metoprolol' and the notes from that visit record a rx for losartan 12.5mg once daily (previous dose was 25mg once daily). On this day [Dr B] also records in her notes 'Stram 1m [homeopathic remedy], two pillules' but does not state what the indication is.

9. On 10/1/17 [Dr B] records the reason for visit as 'f/u on less insulin'. [Dr B] asks [Ms A] 'What taking for thyroid? — iodine. One drop? — yeah, every day, I started taking it on my skin. How quickly absorbed? 20 minutes. Now it's 6 in a glass of water every day. When got up to the 6? — the 6th day'.

9.1. [Dr B] also records asking [Ms A] 'what have you been able to achieve with insulin?' — 'I cut it down to 6 but I did notice it (BSL's) was up a couple of times 10, 13'. There is no mention of the impression of or plan for the insulin management in light of this information.

9.2. There is no mention of [Ms A] requesting a referral at this visit and [Ms A] does not specifically cite which appointments she asked for the referral at but in her complaint, states she asked 5 times.

9.3. Among other examinations there was no mention of a thyroid examination, weight or height.

9.4. [Dr B] records that 'BP not as good as last time'. She does not mention her plan for the BP but generates a repeat prescription for frusemide. [Dr B] also adds a new diagnosis to [Ms A's] classifications of 'hypothyroidism … suspected'.

9.5. Impression and Plan notes from this visit do not include information about what [Dr B's] impression is of [Ms A's] diabetes control or plan for management is. [Dr B] also records a prescription for 'T3 30mcg SR caps Take one capsule on rising'. It does not say what the indication was. A TFT from this time shows TSH 4.8, FT4 17.5 and FT3 4.1.

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10. On 3/2/17 during a consult [Ms A] had with [the clinic's anthroposophic nurse, Ms C] who stated 're requesting referral to endocrinologist, would like further discussion with [Dr B] about this'.

11. On 8/2/17 [Ms A] emails [Ms C …] with a list of symptoms including 'increased blood sugar levels' and asks at the end of the email 'let me know your thoughts'. There is no record of a reply to this or whether or not [Ms C] handed over this information to [Dr B]. There is also no record of any comment from any clinic practitioner regarding this email in any subsequent clinical notes.

12. In an email from [Ms A] to [the clinic's homeopath and practice nurse Ms D] dated 22/2/17 [Ms A] mentions 'We will talk about what to do when I come for my appointment tomorrow …' but there is no record of this visit or of a reply to this email from the clinic, and indeed it is not until 5/4/17 that there is record of [Ms A] visiting [Dr B]. However, on 20/2/17 [Dr B] records 'I phoned to give her appointment details and get an update on how she is … "up and down, hot and cold"' and '… salivary cortisol testing is the cortisol information we haven't checked so far' and a lab form was generated. There is no information in this record of whether or not [Dr B] had seen or planned management regarding the email from [Ms A] to [Ms C] dated 8/2/17.

13. On 22/2/17 [Ms A] visits [nurse Ms D …]. She records that [Ms A] told her 'used to feel I was being poisoned on meds. [Dr B] has got me off them'. A follow up email from [Ms D] to [Ms A] contains nutrition advice.

14. There is record on 13/3/17 of an email from [Ms A] to [Dr B] stating 'I stopped the insulin after the last visit, seem to not had any adverse effects'. In [Dr B's] reply to this email she states 'that's great news if you've got free of insulin. Now you actually have a chance of addressing the type II diabetes and overcoming it … what sort of blood glucose readings have you been getting?' There is no reply from [Ms A] to this question recorded in the notes.

15. On 28/3/17 [Dr B] emailed [Ms A]. In this email [Dr B] asks 'your salivary cortisol results … shall I forward them onto [Ms E] and have a preliminary chat about them too? It would also be good for me to have a chat with [Ms E] about some of the extra insights gained from [you]'. In the reply from [Ms A] to [Dr B] dated 29/3/17 [Ms A] mentions 'I have forwarded your email to [Ms E]' (naturopath).

16. At the visit on 5/4/17 [Dr B] recorded that [Ms A] reported the reason for visit as 'I'm having an issue with blood sugar …' and that 'best blood sugars?' — '19, it seems to sit at 19 all the time, the highest it's been is 21'. [Dr B] mentions in her management plan that [naturopath Ms E] will work on blood sugar lowering nutrients and herbs with [Ms A], if necessary can then add insulin back in'.

    16.1. There is no mention of [Ms A] requesting a referral at this visit and [Ms A] does not specifically cite which appointments she asked for the referral at but in her complaint, states she asked 5 times.

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16.2. In the examination findings there is a pulse of '88, reg' and a 'BP … 128–88' recorded but no other examination findings.

16.3. The previous thyroid function test that is available in the notes provided was on 9/1/17 which showed a TSH of 4.8, FT4 17.5 and FT3 4.1. If there is a further thyroid function test between 9/1/17 and the visit on 5/4/17 this would be important to know. Also, in the notes from this day [Dr B] records her plan of [Ms A] 'Take a break from T3 and see if feeling worse in which case restart and I will do another prescription.'

Additionally, in these visit notes [Dr B] records, 'Rhus-t Q3 was made up' but does not state what the indication is.

17. Email from [Ms A] to [Dr B] dated 1/5/17 stating 'my health has deteriorated … my blood sugars have been up in the 30's … I really think I need a referral to an endocrinologist asap'. In her reply to this email on the same day [Dr B] states 'as discussed previously, I'm happy to refer you to an endocrinologist but in my experience they don't deal in pituitarys or thyroids that are under stress — only recognised pathologies such as hypo or hyperthyroidism or pituitary tumours or necrosis, etc. So far, we haven't found anything to suggest any of these disorders that endocrinologist treat, apart from diabetes and their solution to that is more insulin. What supplements have you added to help address your type II diabetes? How are you finding them …?'

18. 3/5/17 Reply email from [Ms A] to [Dr B] stating 'Yes please can you do the referral to the endocrinologist for [the public hospital] if possible please'. [Dr B] reply email on the same day to [Ms A] states 'I need your answers to my questions so I can write a referral'.

19. 3/5/17 Further email from [Ms A] to [Dr B] stating 'as far as the thyroid issue is concerned I would prefer to let the endocrinologist deal with that I have found the Rhus-t Q3 drops to be of no use as my health has deteriorated. So, nothing is working'. In her reply to this email from [Ms A] on the same day [Dr B] states 'If you have not been taking any thyroid hormone for a month then it would be a good idea to do a blood test now so that we can make a more useful referral to the endocrinologist (giving them your April result which is when you were taking a pill is not helpful because that's not telling them about whats going on in your body'.

An entry in the notes on 4/5/17 states 'forwarded yesterday's email again with the addition: Hi [Ms A] 'Looking forward to receiving more info from you as you are able. Clarification about carbohydrates is particularly important so I can write a referral to endocrinologist, and getting a blood test for thyroid' … 'Also copied to [Ms E] and another email on the same date states 'I need to have the current information about your thyroid status in order to send the referral to the endocrinologist. I can arrange for a housecall for the blood to be taken.' There is

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then an entry on the same [day] which appears to be a reply email from [Ms A] to [Dr B] … 'I eat it twice a week quinoa and brown rice about a cup. And I would prefer to leave any further blood testing to the endocrinologist. Thanks …'

21. 4/5/17 email from [Ms A] to [Dr B] stating 'no thanks'. On the same day [Dr B] replies (? by email) to [Ms A] 'Hi [Ms A] This doesn't make sense.'

22. [Dr B] made a referral to the local endocrinologist on 6/5/17. This was 2 days after the last correspondence from [Ms A] to [Dr B]. This email dated 4/5/17 was a reply from [Ms A] to [Dr B] who had requested information for a referral. I agree that recent blood tests would be helpful for a referral but not essential as referrals can be made based on symptoms alone. It is unclear from the notes at what point a referral was requested by [Ms A] and also it is unclear whether or not this and subsequent requests from [Ms A] for an endocrinology referral were refused but supporting evidence from [Ms E] would be helpful for this. The only mention is in a visit [Ms A] had with Ms C […] who stated 're requesting referral to endocrinologist, would like further discussion with [Dr B] about this'. It is unclear whether or not the 're' in this sentence refers to regarding or re-requesting. This is an important distinction to understand as it helps clarify the confusion that [Dr B] has regarding when [Ms A] first requested a referral to an endocrinologist. Again, a report from the naturopath [Ms E] may help to confirm this.

23. 30/5/17 Email from [Ms A] to [Dr B] 'Please cancel my appointment I will not be able to attend'. On the same day [Dr B] send a reply (? by email) '… Please let me know how you want to arrange your blood test so I can make the referral you want'.

24. 27/6/17 Email from [Ms A] to clinic 'Please cancel all future appointments for me'.

a. What is the standard of care/accepted practice?

1. The NICE guidelines for managing type 2 diabetes in adults (https://www.nice.org.uk/guidance/ng28/resources) does not specifically state how to reduce or stop insulin except for the following 'Monitor people on insulin for the need to change the regimen'.

[Local] Health Pathways in regards to reducing or stopping insulin states 'Correct any hypoglycaemia by reducing insulin doses by 20%'.

In the Royal Australasian 'General Practice Management of type 2 diabetes' (https://www.diabetesaustralia.com.au/best-practice-guidelines) there is mention of a dose titration protocol for basal and pre-mixed insulin that suggests reducing insulin if the lowest blood glucose level of the previous three days is below 5.9 and 'Targets for self-monitoring of blood glucose levels are 6–8 mmol/L for fasting and pre-prandial, and 6–10 mmol/L for two hours postprandial'. These guidelines also state 'The general HbA1c target in people with type 2 diabetes is HbA1c ≤53 mmol/mol (≤7%). Due to the natural variation of HbA1c test results, a target HbA1c of 53

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mmol/mol would be achieved by laboratory results being in a range of 48–58 mmol/mol (6.5–7.5%).' These guidelines also state that all patients with diabetes need to 'optimise their blood glucose control to improve short-term and long-term health outcomes'. However, what is 'optimal' will vary depending on the balance between benefits and risks, and the patient's priorities (Figure 3). 'Given the range of diabetes presentations to general practice, there is no single glycaemic target that suits all patients. Targets need be individualised and balanced against patient capabilities and the risk of severe hypoglycaemia, especially among older people … Unfortunately, a simple stepwise algorithm cannot match all individual patient's needs. The insulin dosage may need to be reduced if the person adopts a healthier lifestyle and/or loses weight.'

In regard to the use of supplements Pure innovation Glucolin (containing chromium, biotin and manganese is not listed as an agent for lowering BSL in the diabetes management guideline referred to above there is evidence that these active ingredients do help to lower blood sugar. If the patient were wanting to come off insulin then providing the patient was told of the potential risks/benefits then this would be deemed as accepted practice.

In regard to other pertinent insulin and BSL management issues the [local] Health Pathways states in its guidelines on management that GPs should 'reinforce healthy lifestyle advice — healthy weight, smoking cessation, exercise' [website reference]

2. If a patient asks to be referred then to determine whether this is accepted practice depends on the clinical presentation at the time, in particular whether or not the patient meets the Health Pathways referral guidelines. According to the Health Pathways referral guidelines the following conditions are the only ones that will currently be accepted for referral to an Endocrinologist:

a. Gonadal disorders in women including amenorrhoea, delayed puberty, hyperandrogenism in women (including hirsutism and PCOS), galactorrhoea, menopause
b. Gonadal disorders in men including primary hypogonadism and gynaecomastia
c. Hypercalcaemia, hypocalcaemia and disorders of the parathyroid gland
d. Hypernatremia and hyponatraemia
e. Endocrine hypertension including Conn's syndrome, pheochromocytoma and Cushing's syndrome
f. Disorders of the adrenal glands
g. Pituitary disorders
h. Polydipsia and polyuria
i. Confirmed hypoglycaemia in the absence of diabetes medications (laboratory glucose < 2.5mmol/L with appropriate symptoms)
j. Endocrine tumour syndromes
k. Turner's syndrome, Klinefelter's syndrome, Kallmann's syndrome
l. Gender dysphoria after psychological evaluation

3. The appropriateness of tests and examinations depends on the clinical problem being addressed.

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a. For insulin management, a 'review of Glycated haemoglobin (HbA1c) measurement should be used to assess long-term blood glucose control', and 'Self-monitoring of blood glucose is recommended for patients with type 2 diabetes who are using insulin where patients have been educated in appropriate alterations in insulin dose' (https://www.diabetesaustralia.com.au/best-practice-guidelines). The 'Stop rule' emphasises that before advancing through additional glycaemic-lowering combinations, after evaluating each patient's HbA1c response after three to six months, support the patient to engage in healthy lifestyle choices, assess for comorbidities and complications (eg CVD risk or distress) and then evaluate the need for additional or altered medication/combination therapy' … and … 'It is reasonable to assess diabetes control with self-reported BSL readings.'

b. For thyroid examination [local] Health Pathways were accessed. The following passage re assessment applies. 'Clinical assessment including: clinical thyroid hormone status e.g., weight gain, bradycardia, constipation, dry skin … palpate for thyroid nodules and lymph nodes' [website reference] For thyroid testing there are no clear guidelines regarding testing thyroid function when using complementary management. However accepted practice among my peers would be to follow the guidelines for thyroid function testing that apply to the treatment of clinical hypothyroidism which state that 'If for any reason a dose adjustment takes place, TSH testing will be required after approximately six to eight weeks' (https://bpac.org.nz/BPJ/2010/December/thyroid.aspx)

4. In regard to management of [Ms A's] symptoms:

a. In regard to insulin and BSL management. This is addressed above in Q1.

b. In regard to thyroid management. [Ms A's] clinical records and results do not indicate a diagnosis of thyroid disease. From my knowledge of Integrative Medicine, I assume that [Dr B] was suspicious of subclinical hypothyroidism but this is unclear from the clinical records. If [Dr B] was suspicious of or treating subclinical hypothyroidism my local Health Pathways states 'For **subclinical hypothyroidism**, (high TSH, normal FT4):

- TSH > 10, treat with thyroxine.
- TSH 6 to 10, repeat TSH in 2 months, consider treatment.
- TSH 4 to 6, monitor every 6 to 12 months, or treat with thyroxine if autoantibody positive or goitre.
- If results do not indicate hypothyroidism or subclinical hypothyroidism, consider the clinical picture and repeating TFTs at regular intervals e.g., every 3 months. If the diagnosis remains uncertain, consider discussing with a thyroid physician.
- Manage any goitre, thyroid nodule, or lymphadenopathy.

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However there is evidence that TSH linearly associated with CAD and that those patients with a TSH of 1.5–2.4 were 41% more likely to die over next 8 years compared to TSH below 1.5 and those with TSH of 2.25–3.34 were 69% more likely to die (Arch Intern Med 2008 Apr 28;168(8):855–60).

c. In regard to the use of homeopathics. There are multiple indications for most homeopathics and it is unclear from the clinical records what the indication/s were. Of note in its statement on Homeopathy the (USA) National Centre for Complementary and Integrative Health (NIH) states that 'a 2007 systematic review found that highly diluted homeopathic remedies, taken under the supervision of trained professionals, are generally safe and unlikely to cause severe adverse reactions.' *(https://nccih.nih.gov/health/homeopathy).* Again, providing the patient was told of the potential risks/benefits of homeopathy and the practitioner had received some formal training in appropriately prescribing homeopathics then the use of homeopathy would be deemed as accepted practice.

d. In regard to the use of email and telephone consultations. In the MCNZ's statement on Internet and Electronic Communication the following passages apply 'If a doctor chooses to use email to communicate with a patient, they should advise the patient of any limits they would like to place on its use. For example the patient should be advised not to use email if urgent advice is required … Doctors must maintain a clear, accurate and contemporaneous record of all communication concerning their medical practice, especially anything regarding a patient' *(https://www.mcnz.org.nz/assets/News.../Internet-and-electronic-communication.pdf).* In the MCNZ statement of Telehealth the following passages apply. 'In using telehealth, you should be aware of its limits and ensure that you do not attempt to provide a service which puts patient safety at risk … If you treat a patient, you are responsible for gathering and assessing the information used to form a diagnosis, irrespective of its source.' *(https://www.mcnz.org.nz/assets/News-and.../Statement-on-telehealthv3.pdf)*

e. In regard to any other matters the issue of informed consent needs discussion. In general, there is no record of informed consent with the use of supplements and/or with reducing/stopping of medications, however this discussion is not often recorded in doctors notes and so would not be deemed to be outside accepted practice. This is clarified in both the HDC 'RIGHT 7. Right to Make an Informed Choice and Give Informed Consent … 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.' The MCNZ guidelines on informed consent which state that 'You must keep clear and accurate patient records that report information given to patients and decisions made … The Medical Council recognises that every aspect of a consultation cannot realistically be noted in the patient's record. As a result,

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we recommend that you adopt written consultation protocols that specify what information in the form of discussion, publications and questions will be given in a specific type of consultation (e.g. all patients experiencing migraines). You do not need to spend unnecessary time writing extensive notes. Instead, you can note in the patient record that the protocols were fulfilled and only outline any exceptions to the protocol' (https://www.mcnz.org.nz/.../Information-choice-of-treatment-and-informed-consent.pdf).

f. In regard to informed consent for complementary medicine the MCNZ states 'When complementary and alternative medicines (CAM) have demonstrated benefits for the patient and have minimal risks, and patients have made an informed choice and given their informed consent, Council does not oppose their use … Where a patient is making a choice between conventional medicine or CAM, you should present the patient with the information that a reasonable patient, in that patient's circumstances, would expect to receive about the options available. This information includes an assessment of the expected risks, side effects, benefits and cost of each option. This allows competent patients to make an informed choice … In advancing knowledge, and providing treatments in areas of uncertainty where no treatment has proven efficacy you must: (a) ensure that your patients are told the degree to which tests, treatments or remedies have been evaluated, and the degree of certainty and predictability that exists about their efficacy and safety' (https://www.mcnz.org.nz/assets/News.../Complementary-and-alternative-medicine.pdf).

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) do you consider this to be? Please explain.

c. How would it be viewed by your peers?

I have answered these two questions together as this is the best format for answering these questions.

1. In regard to the lowering of insulin:

   a. Lowering insulin when BSL readings were above 6 would be viewed as a mild to moderate departure from current guidelines. This is because of the information in the current guidelines above. It is only a mild to moderate departure as it would be reasonable if [Ms A] were having side effects from insulin to try alternative ways of managing her diabetes and she mentioned in her consult. [My mentor] concurs with this assessment. Also, HbA1c on 1/11/16 was 50. This was below the level at which insulin management is deemed acceptable, i.e. this HbA1c level was not a barrier to reducing insulin. The next HbA1c was on 5/4/17 and was 77. The time difference was slightly over 5 months. The guidelines referred to in a above state 'evaluating each patient's HbA1c response after three to six months'. The 2nd HbA1c was

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therefore performed within accepted guidelines as long as there were no mitigating factors. However, in [Ms A's] case there is evidence of a need for an HbA1c to be performed sooner than 5 months as discussed in the following paragraphs.

b. If [Dr B] had seen the email from [Ms A] to [Ms C] dated 8/2/17 and not actioned the comment from [Ms A] 'increased blood sugar levels' this would be viewed by my peers as a moderate departure from accepted practice. With the relatively rapid reduction in insulin it would be accepted practice to perform an HbA1c at 3 months after the first HbA1c performed by [Dr B] (on 1/11/16) and so this should have been performed around early February. The email from [Ms A] on 8/2/17 should have triggered a request from [Dr B] to perform an HbA1c. At the very least an HbA1c request form should have been given to [Ms A] at her visit with [Dr B] on 5/4/17. It is not until [Ms A's] visit with [Dr B] on 5/4/17 that [Dr B] asks the question about BSLs again. This constitutes a delay of 2 months from when [Ms A] first mentioned 'increased blood sugars' to receiving some form of management for her raised BSLs. This would be deemed by my peers as a mild to moderate departure from accepted practice based on the guidelines above.

c. There is also no record on 13/3/17 of an email from [Ms A] to [Dr B] stating 'I stopped the insulin after the last visit, seem to not had any adverse effects'. In [Dr B's] reply to the email from [Ms A] to [Dr B] on 13/3/17 [Dr B] asks [Ms A] the question '… what sort of blood glucose readings have you been getting?' There is no reply from [Ms A] to this question recorded in the notes. If there was no reply and the clinic did not have a policy in place regarding follow up of queries to questions from clinical staff this would be deemed by my colleagues a mild to moderate departure from accepted practice depending on the severity of the clinical problem.

d. It is unclear when the self-reported BSL readings were taken in relation to food but it would be reasonable to assume that [Ms A] had been instructed on how to perform BSLs by the doctor starting the insulin management (which was prior to [Ms A] joining [Dr B's] practice). My peers would therefore view [Dr B's] lack of recording where these BSLs were taken in relation to food as acceptable practice.

e. Reversing type 2 diabetes and reducing insulin is possible. However, reducing insulin needs to be done slowly and carefully and is only possible if intensive nutrition and lifestyle management is implemented. This nutrition and lifestyle implementation usually takes 6–12 months, depending on the individual patient. Whilst I am aware that [Ms A] was also consulting with a naturopath [Ms E] there is no record in any of [Dr B's] consultations regarding whether or not [Dr B] advised [Ms A] on lifestyle management of her diabetes. If this advice was given but not recorded this would be considered a mild departure from accepted practice. If the advice was not given, in the context of the quick

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reduction in insulin, this would be deemed a moderate departure from accepted practice. Of note, there is record in [Dr B's] clinical notes from 21/12/16 that she advised [Ms A] to 'soak nuts before using'. This suggests that a nutrition discussion to some extent was made. There is also record in the notes on 23/2/17 of an email from Ms G to [Ms A] which contains relevant nutrition advice.

f. There is no mention in any consult of whether or not [Ms A] was consulted about the risks and benefits of lowering her insulin and using alternative management. To proceed with reducing insulin and implementing alternative management without informed consent would be deemed by my peers to be a moderate departure from accepted practice. However it would be reasonable to assume that this discussion took place during the first visit that the reduction of insulin occurred in.

2. The appropriateness of the decision not to refer [Ms A] to an endocrinologist.

a. In our [local Health Pathways] [Ms A] did not meet the referral guidelines to an endocrinologist at any stage of her clinical presentation, based on the notes provided. I do not have the Health Pathways guidelines for [Dr B's] local area. This would be important information to have but it is likely to be the same as for my [local Health Pathways]. The clinical records do not record whether or not [Ms A] was offered private Endocrinology referral.

b. [Dr B] made a referral to the local endocrinologist on 6/5/17. This was 2 days after the last correspondence from [Ms A] to [Dr B]. This email dated 4/5/17 was a reply from [Ms A] to [Dr B] who had requested information for a referral. If a referral was appropriate (and in this case it was not under the public referral guidelines) I agree that recent blood tests would be helpful for a referral but not essential as referrals can be made based on symptoms alone.

c. Also of note it is unclear from the notes at what point a referral was requested by [Ms A] and also it is unclear whether or not this and subsequent requests from [Ms A] for an endocrinology referral were refused but supporting evidence from [Ms E] would be helpful for this. The only mention is in a visit [Ms A] had with [Ms C] on 3/2/17 who stated 're requesting referral to endocrinologist, would like further discussion with [Dr B] about this'. It is unclear whether or not the 're' in this sentence refers to regarding or re-requesting. This is an important distinction to understand as it helps clarify the confusion that [Dr B] has regarding when [Ms A] first requested a referral to an endocrinologist. Clarification from [Ms C] regarding her notes on 3/2/17 would be helpful here. Also, a report from the naturopath [Ms E] regarding her impression of her visits with [Ms A] to the various clinic providers may help to confirm this.

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d. If a referral were requested and this request was not recorded my peers would deem this a mild departure from accepted practice. If a referral was requested and the patient did not meet referral guidelines (as in this case) and this was not explained to the patient and alternative referral options (i.e. private referral) was not offered my peers would deem this a mild departure from accepted practice.

3. In regard to the appropriateness of tests and examinations.

   a. Diabetes testing and examination is covered in part 1 of this section.

   b. There is no record of an examination focussed on thyroid disease (except for pulse, temperature and blood pressure) in any of the visits. If a thyroid exam was not performed this would be considered a mild to moderate departure from accepted practice. This is due to mitigating circumstances of the complexity of [Ms A's] problems and the need for management of the more pressing medical problem which in this case was the diabetes management.

   c. Thyroid function testing was performed immediately after the initial visit 1/11/16, on 14/11/16, on 9/1/17, and on 5/4/17. [Ms A] had increased her iodine up to 6 drops per day between 15/11/16 and 10/1/17 under instruction from [Dr B] at a visit on 15/11/17 which would be considered a high dose. In addition, at the visit on 10/1/17 there is a prescription for T3 30mcg SR generated by [Dr B] for [Ms A]. This equates to around 120–150mcg thyroxine which would be considered a high starting dose. Based on the accepted guidelines above a further thyroid function blood test should have been performed approximately six to eight weeks after [Ms A] reached the top dose of 6 drops per day and also after [Ms A] was started on T3. There was a lab form generated on 10/1/17 but there is no record of what the lab request was for. If this was for thyroid function tests and [Ms A] failed to have the test then failing to ensure [Ms A] had the test would be considered by my peers to be a mild departure from accepted practice. If a lab form for thyroid function testing was not generated at the visit on 10/1/17 (when T3 was started) then this would be considered by my peers to be a moderate departure from accepted practice. [My mentor] concurs with this.

4. In regard to the appropriateness of [Dr B's] management of [Ms A's] symptoms.

   a. Although there is no information in this record of whether or not [Dr B] had seen or planned management regarding the email from [Ms A] to [Ms C] dated 8/2/17, [Dr B] did record in her record of 20/2/17 (which includes record of a telephone call from [Dr B] to [Ms A]) 'cortisol information we haven't checked so far' and a lab form was generated. This would lead me to assume that [Dr B] had seen the email from [Ms A] to [Ms C] dated 8/2/17. This lack of clarity due to poor record keeping would be deemed a mild departure from accepted practice.

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b. In regard to thyroid management. Based on the above guidelines it would be deemed a moderate departure from accepted practice to treat TSH of [Ms A's] levels. This is based on the above guidelines with acknowledgement that there is evidence that lower (than accepted by conventional medicine) TSH reduces CAD risk as referred to above. However, whilst it is reasonable to give T3 to balance out thyroxine and to also give iodine this needs to be done carefully and testing of thyroid function needs to occur 6–8 weeks after a change in thyroid management (Thyroid April 2004 14 (4) 271–275). The use of iodine at the doses referred to in the clinical records would be deemed a high dose and would be deemed by my peers as a severe departure from accepted practice. [My mentor] concurs with this decision.

c. In regard to the use of homeopathic remedies. The homeopathic remedies given to [Ms A] have multiple uses. As there is no record in the clinical notes regarding the indication for use … I am unable to comment regarding the appropriateness of their use. If no discussion took place regarding the risks and benefits of homeopathic remedies versus conventional treatment then this would be deemed a mild to moderate departure from accepted practice among my peers. However, based on the patient handout given by [Dr B] to [Ms A] on 15/11/16 it would be reasonable to assume this discussion did take place. Again, a report from the naturopath [Ms E] regarding her impression of her visits with [Ms A] to [Dr B] may help to confirm this.

d. It would be reasonable to assume a discussion around informed consent was made prior to each of the clinical management changes. However, if there was no discussion on reducing insulin or commencing supplements then this would be deemed a moderate departure as per the HDC and MCNZ guidelines above.

d. How would it be viewed by your peers?
See g above.

e. Do you have any recommendations for how this aspect of care could be improved?

1. Asking patients for a copy of their BSL readings would ensure accuracy of the information that the treating clinician is basing their information on.
2. A daily notes audit would be ideal to ensure all notes had been entered, for example thyroid examination findings. With the complexity of [Ms A's] case it would be easy to omit information.
3. The clinic needs a follow up system for ensuring clinicians receive replies from patients to important clinical questions posed by the GP. An example of this is that there is no record of a reply to [Dr B's] question asking '… what sort of blood glucose readings have you been getting?' sent via email to [Ms A] dated 13/3/17. With the quick reduction of insulin this would be an important question to have answered. However, the self-responsibility of the

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patient needs to be factored in here and it is [Ms A's] duty to reply to requests for information from her healthcare practitioner to ensure she receives best medical care.

Regarding the lab form generated on 10/1/17, the Medtech PMS has a facility to generate an automatic task for the clinician generating the lab form to alert them to check that results have been received for that test. This facility would have helped [Dr B] to ensure that pertinent lab results were received.

f. Any further comments

Of note, there is record in the notes dated 24/1/17 that '[Dr B has a bereavement] so next apt with [Dr B] needed to be rescheduled'. It does not state when this appointment was rescheduled to but the PMS would record this. This unfortunate event in [Dr B's] life would be expected to have a significant impact on her personal but also her professional life and may be a factor in subsequent events.

Patient record taking of each individual record was of an exceptionally high standard. However the recording of handover of clinical responsibility between the clinic's practitioners is of a poor standard and could potentially lead to errors in management. I understand that the clinic is wishing to reduce the cost of medical care to the patient by reducing the number of visits but this must take second place to the safe clinical management of the patient. As the GP in the practice [Dr B] takes ultimate clinical responsibility for her practice nurses. In addition, it seems also that [Ms C] did not hand over to [Dr B] [Ms A's] 'increased blood sugar levels' that [Ms A] mentioned in her email to [Ms C] dated 8/2/17. If this were the case I would be critical of this.

[Dr B's] use of collegial advice, e.g. [Dr B] contacted the Medical Registrar for advice following the 31/10/16 appointment shows a high level of care in seeking outside advice.

From the clinical records [Dr B] appears to have [Ms A's] best interests at heart as evidenced by multiple text and phone communication from [Dr B] to [Ms A] is above and beyond expected standards of care. In addition and also above and beyond usual clinical care, [Dr B] took time to email relevant medical articles to [Ms A] and to also read her [noted reflections] (with the apparent intention to 'gain extra insights') in her own time in order to understand and more ably manage [Ms A's] multiple medical problems.

Due to the thoroughness of [Dr B's] consultation notes, I would be surprised that if [Ms A] was in tears that this would not have been recorded. Again, corroboration from [Ms E] would clarify if this was the case.

As according to [Dr B] [Ms A's] naturopath [Ms E] 'attended every consultation that I had with [Ms A]' I feel it would be essential to this case to have written comments from the naturopath regarding her version of the complaint by [Ms A]."

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Dr Chandler provided the following further expert advice on 19 July 2018:

"The instructions I have been given are to provide comment on the following:

1. Whether your comment about [Ms A's] email dated 8/2/17 has changed in light of the additional explanations provided by [Dr B].
2. Whether the 'policy and procedure' described by [Dr B] when following up queries from clinical staff changes your opinion.
3. [Dr B] states that [Ms A] was consulted about the risks and benefits of lowering her insulin however this does not appear to be documented. Is this a departure from accepted standards, if so, to what degree?
4. Please review [Dr B's] explanations around thyroid examination. Does this change your opinion? Please also elaborate on what a thyroid examination would involve.
5. Please review [Dr B's] explanations around homeopathic versus conventional treatment. Does this change your opinion?

Due to the complexity of the case and the integrative nature of the complaints and question I have elected to answer each question in a flowing format in this one document but have numbered the answer to each of the questions above in the body of each answer below. Please note that the answers to Q1 and Q2 are amalgamated as they cover the same topic.

Key:

PMS = Patient Management System
HDC = Health and Disability Commissioner
MCNZ = Medical Council of New Zealand
RNZCGP = Royal New Zealand College of General [Practitioners]

I have been provided with the following information to base my review on:

I have reviewed the available information:

1. Expert advice report on [Dr B];
2. Response to expert from [Dr B] dated 20 December 2017;
3. [Dr B's] comments in a further letter dated 18/7/18

Background of complaint
This is covered in my original report.

…

1. Whether your comment about [Ms A's] email dated 8/2/17 has changed in light of the additional explanations provided by [Dr B].

2. Whether the 'policy and procedure' described by [Dr B] when following up queries from clinical staff changes your opinion.

3. [Dr B] states that [Ms A] was consulted about the risks and benefits of lowering her insulin however this does not appear to be documented. Is this a departure from accepted standards, if so, to what degree?

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4. Please review [Dr B's] explanations around thyroid examination. Does this change your opinion? Please also elaborate on what a thyroid examination would involve.
5. Please review [Dr B's] explanations around homeopathic versus conventional treatment. Does this change your opinion?

a. What is the standard of care/accepted practice?
This is covered in my previous report.

Answer to the HDC questions:
1. and 2. To not address [Ms A's] comment about her blood sugar levels would not be considered a departure from expected standards or care if, as [Dr B] states in her reply to my report that, 'As previously discussed, there was a clear plan that if there were any problems with elevated blood sugars [Ms A's] desire was to initially address that with further nutritional supplements'. I am unable to confirm from the notes provided if there was indeed 'a clear plan that if there were any problems with elevated blood sugars supplements'. In downgrading my previous view that this represented a mild to moderate departure from expected standards or care I have considered the additional information provided by [Dr B] (for example the information above). In addition, I have also considered [Dr B's] comment that 'Once I was perceiving that the tone of her interactions appeared to have switched from enthusiasm for help she hoped I could offer her, to what may have suggested an increased element of wariness, I knew I needed to give even further care and attention to fostering the therapeutic relationship. In these situations, one has to carefully strike the best balance between pushing in the interests of the patients health and being respectful of the patients choice to not engage as we may wish.' Lastly, I have considered [Dr B's] policy and procedure regarding queries and feel that there is a reasonable system in place. However, please note my comments in the recommendations part below regarding email communication.

3. [Dr B] states that 'the risks and benefits of meeting [Ms A's] request to lower insulin were discussed with her at her first visit, and subsequently.' To proceed with reducing insulin and implementing complimentary management without documenting informed consent would be deemed by my peers to be a mild departure from accepted practice. In downgrading my previous view that this represented a moderate departure from expected standards of care I have considered the additional information provided by [Dr B] (above and below). In particular I have also considered [Dr B's] comments that 'I knew I needed to give even further care and attention to fostering the therapeutic relationship. In these situations, one has to carefully strike the best balance between pushing in the interests of the patients health and being respectful of the patients choice to not engage as we may wish' and 'Routine consultations with [Ms A] were of at least an hour in duration (initial consultation two hours) and discussion of lifestyle factors such as food, activity, sleep and stress management was always a significant component'. I have also factored in the immense complexity of [Ms A's] case and also the challenges posed by [Ms A] such as explained in [Dr B's] comments that 'it was difficult for [Ms A] to get to us for consultations' and 'I was very much wanting to get specific details from [Ms A] but I

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suspected that pushing harder was not going to be a successful method.' Lengthy and challenging consultations make it nearly impossible to record all the information discussed with the patient.

4. To not document performing a thyroid examination in the context of this case would not be deemed by my peers to be a departure from accepted practice. In downgrading my previous view that this represented a mild to moderate departure from expected standards or care I have considered the following additional information provided by [Dr B]: 'I have not recorded performing a thyroid examination and because some patients find them uncomfortable I may wait until I have established a rapport with them. [Ms A] had no obvious goitre or symptoms suggesting thyroid cancer or a thyrotoxic nodule.' and 'I knew I needed to give even further care and attention to fostering the therapeutic relationship. In these situations, one has to carefully strike the best balance between pushing in the interests of the patients health and being respectful of the patients choice to not engage as we may wish'.

The following resource has been replicated to answer the question 'Please also elaborate on what a thyroid examination would involve.':

https://www.ncbi.nlm.nih.gov/books/NBK244/. Technique:

> 'The patient should hold a glass of water and be seated. There should be room for the examiner on all sides of the seated patient. Place the patient's head in slight hyperextension with good crosslight falling on the anterior neck and then ask the patient to swallow. The outline of the thyroid gland in thin individuals can be observed frequently as a protuberance on both sides of the trachea moving cephalad in tandem with but 2 cm below the crest of the thyroid cartilage. Look for abnormal enlargement, contour, asymmetry, and masses while the patient swallows repeatedly. The neck should also be inspected for abnormal masses and prominent pulsations.
>
> Frequently it is advantageous to examine the gland while you stand behind as well as on each side of the patient. Identify the thyroid cartilage, the thyrocricoid membrane, and the cricoid cartilage, a horizontal structure 5 mm wide that marks the superior border of the isthmus. Palpate the isthmus (frequently impalpable unless enlarged), and if standing to the side of the patient, slide the tips of your fingers so that their palmar surfaces rest on the trachea with the dorsal surface medial to the sternocleidomastoid muscle. The ipsilateral lobe can be palpated simultaneously with your thumb or with the other hand from the opposite direction. When you stand behind the patient, identify the landmarks and isthmus with one hand, and when in position to feel the thyroid lobe on that side, place the fingers of your other hand symmetrically on the other side of the trachea. Again, identify each lobe while the patient swallows. Feel the gland's surface, note any asymmetry, texture, and estimate the size of each lobe (normally 7 to 10 g). When goiter is present, measure any discrete masses as well as the neck's greatest circumference. A pencilled tracing of the goiter's outline provides a reliable record for future comparison. One should also palpate the neck for

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lymphadenopathy and search for masses (especially in the midline for abnormalities of the thyroglossal duct) and surgical scars.'

5. To clarify, I am aware that as [Dr B] states '[Ms A] was not using homeopathic remedies instead of conventional treatments. I continued conventional prescriptions for the medications that [Ms A] was willing to take.' I am not critical of [Dr B's] use of homeopathic medications. In downgrading my previous view that [not documenting the use for homeopathic medications] represented a mild to moderate departure from expected standards or care I have considered the additional information provided by [Dr B]. In particular, I have considered [Dr B's] comments that 'I have a separate computer on my desk which contains my homeopathic software programme (Radar). It does not have the ability to print nor to copy and paste etc in the same way that can be done in Medtech but it does record indications for use' and [Ms A] 'was informed of desired benefits and potential risks of treatment strategies she chose. With regards to homeopathy this was both verbal and written.' I have also considered [Dr B's] explanation of the complexities of recording the indications of homeopathic medications.

b. Do you have any recommendations for how this aspect of care could be improved?

1. In regard to Q1 — no.

2. In regard to Q2 — the 'policy and procedure[s]', I remain impressed by the quality of the introduction letter to patients. However, I do believe the practice email should ideally only be used for making appointments. I feel that [Dr B] is putting unnecessary extra pressure on herself and her team responding to email queries, especially as by accepting clinical information over email they are accepting clinical responsibility and unfortunately patients do not have the ability to determine the urgency of their clinical issue and may not realise they should make a follow up phone-call. I realise that [Dr B] has implemented this system in the best interests of the patient and is wishing to be as accessible as possible and encourage less phone-calls to the practice and I commend [Dr B], who clearly has very positive intentions towards her clients, for this. However, I have concerns that this policy is overloading her practice with unnecessary work, which can lead to a higher potential for clinical information being missed and also practitioner burnout.

[Dr B] states in her response to my report that she felt it was more tactful to not respond to that email (given that she had not addressed it to me specifically). The reasons for not responding ideally to patients' emails should be documented in the notes. In addition, whilst the email was not addressed to her, [Dr B] ultimately assumes clinical responsibility for her team.

A possible solution to [Dr B's] well-intentioned desire to make herself and her team more accessible to patients may be to implement a certain time in her nurses' schedule where patients are able to ring (rather than email) in to discuss concerns and for the nursing team to triage the calls.

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3. In regard to documenting the risks and benefits of for example, lowering [Ms A's] insulin I propose that [Dr B] inform her patients that, for optimal patient care and accurate record keeping, she will record key notes into the PMS as she goes during the consultation. These can then be expanded on, if required, after the consultation.

c. Any further comments

I note [Dr B's] comments in a further letter dated 18/7/18 that 'when I join a nurse consultation I generally change the MedTech login to my own to facilitate me writing my own notes at the time in such situations.'

And

'we have reviewed our emails policy and updated it to remind everyone that our policy is to adjust the date in MedTech so that emails are pasted into the Daily Record under the date on which they were sent.'

and

'One of the difficulties in caring for [Ms A] was that a small practice such as ours doesn't have all the equipment that can be useful for larger people. My usual practice in examining a person with thyroid issues is to check their reflexes. I wasn't able to do this for [Ms A]. I am pleased to report that we have now made an upgrade to our practice in that we have purchased a new examination couch.'

I commend [Dr B] for the changes she has made to her practice and the clear intention she has to do the best she can for the patient especially in this case which was clearly a very challenging one. I would like to add that the series of consultations that [Dr B] had with [Ms A] would rank among the most difficult any GP would ever have to experience. It is also clear that [Dr B] offers a high standard of care to her patients in all other respects."

Dr Chandler provided the following further expert advice on 22 May 2019:

"Answers to questions posed by the HDC April 2019

1. On page 10–11 of your initial advice (point 1b), it appears that you identified a moderate departure as it would have been 'accepted practice to perform an HbA1c at 3 months after the first HbA1c performed by [Dr B] (on 1/11/16) and so this should have been performed around early February'.

I wanted to seek clarification whether you feel this departure still stands, in light of [Dr B's] statement on page 2 of your response (dated 20 December 2017) to your report. In this she stated that on 10 January 2017 she requested a mid-stream analysis to check [Ms A's] urine microalbumin ratio, and that 'There was no need to check an HbA1c at that time as it [the urinalysis] gives an indication of how blood sugars have been over a three month period. [Dr B] performed a further HbA1c on 5 April 2017.

I could not find any further comment in relation to this matter in your follow-up advice, and thus why I am seeking confirmation at this time regarding whether you feel [Dr B's] explanation is adequate.

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.

Dr T Chandler: I have not been able to find any evidence to back up [Dr B's] explanation as all three guidelines that I have referred to advise using HbA1c as the best way to monitor glycaemic control over the previous 3 month period. However [Dr B's] explanation suggests she was aware of the need to monitor and so I have down-graded my response from a moderate departure to a mild departure from accepted practice.

2. On page 12–13 of your initial advice (point 3c), you identified a moderate departure if [Dr B] did not order a thyroid function test on 10 January 2017.

I wanted to seek clarification whether you feel this departure still stands, in light of [Dr B's] statement on page 4 of her response (dated 20 December 2017) to your report. In this she explained her reason for not performing a thyroid function test. I could not find any further comment in relation to this matter in your follow-up advice, thus why I am checking for confirmation whether you feel [Dr B's] explanation is adequate or if the identified departure remains, and why.

Dr T Chandler: [Dr B's] explanation is adequate.

3. Practice systems

Dr T Chandler: [Dr B's] explanation of the Practice systems indicates they are adequate."

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Appendix B: In-house advice to the Commissioner

The following expert advice was obtained from GP Dr David Maplesden:

> "I have reviewed the information provided including complaint from [Ms A], provider responses to the complaint and to the expert advice, and expert advice from Dr Chandler. I think it is important to note the complexity of [Ms A's] clinical and self-perceived health issues and the complex interaction between these.
>
> 1. Management of [Ms A's] diabetes by [Dr B]
>
> I agree with Dr Chandler that there were several aspects of [Dr B's] management of [Ms A's] diabetes that departed from expected standards of care. Most significantly, I agree that if a decision was made to decrease [Ms A's] insulin, it was particularly important that there was a robust and reliable method in place to closely monitor [Ms A's] blood sugar levels, with appropriate instructions to her regarding titration of insulin in relation to these levels. I believe my peers would regard this aspect of [Ms A's] care as departing from expected standards to at least a moderate degree, and [Ms A's] health was placed at risk because of this deficiency. I agree with Dr Chandler's assessment of degree of departure from expected standards in relation to other aspects of [Ms A's] diabetes management, noting she has expertise in integrative medicine which I do not. I believe the threshold for referral to Investigations has been reached in regard to [Ms A's] diabetes management.
>
> 2. Management of [Ms A's] thyroid issues by [Dr B]
>
> I agree with Dr Chandler that the overall management and monitoring of [Ms A's] thyroid function departed from expected standards of care to a moderate degree, mainly in relation to administration of T3 when there was no clinical indication, and inadequacy of monitoring following this treatment. It may be difficult to prove the dose of iodine prescribed to [Ms A] was a severe departure from expected standards as this is not a conventional approach to management of thyroid dysfunction and as illustrated by [Dr B's] response to Dr Chandler's advice, it may be difficult to establish any consistent local or international recommendation in this regard. I believe the threshold for referral to Investigations might be considered in relation to [Ms A's] thyroid management.
>
> 3. Timeliness of [Dr B's] referral of [Ms A] for endocrinology review
>
> I think this has been accurately determined by Dr Chandler to be a mild departure from expected standards of care. [Ms A] did not meet DHB criteria for such a referral. It is not always clinically appropriate to make a specialist referral, at least in the public system, just because a patient requests such a referral. I do not believe this issue alone warrants referral to Investigations."

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