Management of patient with diabetes and thyroid concerns
17HDC01144, 11 September 2019

General practitioner ~ Natural health ~ Diabetes ~
Referral ~ Testing ~ Rights 4(1), 4(2)

A woman in her fifties was referred to a general practitioner (GP) who specialises in natural health solutions. The woman had a total of five consultations with the GP over a period of approximately six months concerning management of diabetes and thyroid issues.

The woman had been prescribed 20 units of insulin twice daily. Having obtained an HbA1c result of 50mmol/mol, the GP agreed to a trial of reducing the woman's insulin owing to concerns that she might be allergic to it. The GP did not document her discussions with the woman regarding the risks and benefits of reducing insulin, or lifestyle management of her diabetes in those circumstances.

At the second consultation, the GP prescribed a 25ml bottle of Lugol's iodine to address the woman's hypothyroid concerns, and noted that the woman should start with one drop daily and increase as directed to a maximum of six drops daily on the skin. The GP acknowledged that this was a high dose, but said that she felt that it was appropriate in the woman's case.

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

At the third consultation, the GP recorded a plan to reduce the insulin to 6 units twice daily. At the fourth consultation, the GP prescribed T3. A thyroid function test (TFT) from the previous day showed the woman's thyroid stimulating hormone (TSH) level at 4.8.

At a subsequent consultation with a nurse at the GP's clinic, the woman requested an endocrinology referral. The GP stated that she explained to the woman that she did not meet the guidelines for a referral to an endocrinologist regarding her thyroid or pituitary. The GP did not document this discussion, and did not inform the woman of the option of seeking endocrinology care privately.

On the fifth and final GP consultation, the woman consulted the GP owing to elevated BSLs, and a further HbA1c test was carried out. The woman later emailed the GP's clinic to cancel all future appointments.

Findings

The GP was found to have breached Right 4(1) for the following reasons:

a) She prescribed reduced insulin when the woman'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 BSL levels in the context of relatively rapid insulin reduction.
c) She prescribed T3 when the woman's TSH was not at a level that clinically indicated that treatment.
d) She prescribed a high dose of iodine despite the extent of the woman's potential iodine deficiency being unclear.
e) She did not inform the woman of the option of seeking endocrinology care privately.

The GP was also found to have breached Right 4(2) as she did not document (a) her discussions with the woman regarding the risks and benefits of reducing insulin, and lifestyle management of diabetes during insulin reduction; or (b) that she explained to the woman that she did not meet the guidelines for an endocrinology referral.

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

Recommendations

It was recommended that the GP provide a written apology to the woman, and undertake the following actions:

- Provide an update on the plan to employ another doctor at the clinic.
- Conduct an audit of daily notes for a period of two months, and report to HDC on the outcome of the audit.
- Consider adopting the Medical Council of New Zealand's recommendation in relation to a written consultation protocol, and report her decision to HDC.