Delayed referral to hospital of young woman with diabetes (15HDC01116, 27 June 2016)

General practitioner ~ Medical centre ~ Diabetes Type 1 ~ Referral ~ Rights 4(1), 4(2), 6(1)

An 18-year-old woman and her mother consulted a general practitioner (GP) at a medical centre. The woman was complaining of constipation, being thirsty and tired, and having had an unintentional weight loss of 30 kilograms (kg) over a couple of months. The GP tested the woman's blood glucose level, which was found to be 34mmol/L (normal being 4.0 to 5.9mmol/L). The GP made a diagnosis of diabetes and, during the consultation, attempted to contact the local diabetic nurse, but was unsuccessful.

The appointment was on a Friday. The GP provided a prescription for laxatives and advised the woman to avoid sugary food and drinks over the weekend, and to have a fasting blood test the following Monday morning. Over the weekend the GP spoke to the woman's mother. The GP asked how the woman was and advised that she had still been unsuccessful in contacting the diabetic nurse.

On Monday, the woman returned to the surgery and her blood glucose level was still high at 16mmol/L. The GP assessed the woman and contacted the hospital registrar, who advised hospital admission. The woman went to the Emergency Department at a public hospital, where a diagnosis of diabetic ketoacidosis was made. This is a common, and potentially life threatening, presentation of newly diagnosed Type 1 diabetics, which can develop rapidly, over a 24-hour period.

It was held that the GP failed to take immediate action for the management of the woman's serious presentation on the Friday. In the circumstances, the GP should have made an immediate referral for hospital management. Overall, the GP failed to provide services with reasonable care and skill and breached Right 4(1).

The woman was not provided with an explanation of her condition and, in particular, was not told about the potential risks of diabetic ketoacidosis. The GP did not provide the information that a reasonable consumer, in that consumer's circumstances, would expect to receive and, accordingly, the GP breached Right 6(1).

The GP's documentation for the first visit was very brief. There was no documentation regarding her discussion with the woman about diabetes, including her diagnosis, management plan and "safety-netting" advice. The GP made no documentation of her telephone discussion with the woman's mother over the weekend and, for the second visit, the GP made no notes of her examination of the woman other than the information in her referral letter. Accordingly, the GP failed to comply with professional standards and breached Right 4(2).

The medical centre was found not to have breached the Code.

It was recommended that the GP undertake further education and training on diabetes management. The GP advised that since these events, she has been attending a diabetic clinic and has learnt "a great deal on specialist care and management of complex patients with diabetes".

It was recommended that the GP undertake an audit of the last six months of her clinical documentation in order to identify any patients where a diagnosis had been made but not documented and report back to HDC regarding the above audit within six months. The GP was also required to provide a written apology to the woman.

The Medical Council of New Zealand advised that the GP will undergo a performance assessment under section 36 of the Health Practitioners Competence Assurance Act 2003. An update to HDC was requested at the conclusion of the assessment.