Monitoring of lithium treatment
(13HDC00048, 14 April 2014)

General practitioner ~ Medical centre ~ Monitoring treatment ~ Lithium ~ Test results ~ Informed consent ~ Rights 4(1), 6(1)(f), 7(1)

A young man was diagnosed with depression and bipolar affective disorder. The man's psychiatrist prescribed him lithium carbonate (lithium) as a mood stabiliser.

Six years later the man transferred to the care of a general practitioner (GP). The GP continued to prescribe lithium for the man without informing him of the risks of the treatment at any stage.

Over the next five years, the man experienced a range of symptoms including severe constipation, faecal impaction, vomiting, anorexia, weight loss, dehydration and episodes of polyuria. During that time the GP monitored the man's lithium levels and renal function inconsistently.

Initially the man's blood tests for renal function were normal. However, two and a half years after the man transferred his care to the GP, the man's blood test results began to show abnormalities, including elevated creatinine levels indicating evidence of mild renal impairment. Ten months later, the man's lithium dose was reduced.

A year later the GP referred the man to a psychiatrist. The psychiatrist advised the GP to discontinue the man's lithium treatment due to renal impairment evident on blood tests. Following the psychiatrist's advice, the GP ceased the man's lithium treatment.

The GP tested the man's renal function only once a year over the following three years. The results of the second and third tests were abnormal. The GP failed to advise the man of his test results at any time. Fourteen years after commencing lithium treatment, the man was diagnosed with chronic kidney disease.

It was held that it was appropriate for the GP to continue lithium treatment until he was advised by an appropriate specialist to discontinue. However, the GP had a responsibility to monitor the man's renal function and the levels of lithium in his blood, and to act appropriately with regard to any abnormal results. The failure by the GP to monitor the man's treatment adequately was a breach of Right 4(1).

In addition, it was held that the GP failed to inform the man of his abnormal test results and, consequently, the man was unable to make informed choices about his treatment. In doing so, the GP breached Rights 6(1)(f) and 7(1).

It was also held that the GP was aware of the need to monitor the man and should have made the man aware of the ongoing importance of monitoring. By doing so, the GP would have further empowered the man in participating in his care.