Pharmacist dispensed wrong medicine and did not provide information or privacy (00HDC03977, 7 June 2002)

Pharmacist ~ Pharmacy ~ Dispensing error ~ Information about side effects ~ Privacy ~ Follow-up when error discovered ~ Rights 1(2), 4(1), 4(2), 4(5), 6(1)(a), 6(1)(b)

A woman complained that a pharmacist dispensed her Diflucan tablets, an antifungal agent, instead of danazol. A five-week course of danazol, an endometrial thinning agent, had been prescribed prior to surgery. The pharmacist breached Rights 4(1) and 4(2), as he did not dispense the prescription with reasonable care and skill and in compliance with professional standards. Pharmacists need to be vigilant when dispensing medication.

The woman also complained that she was not given any information about the prescribed medication. Independent advice noted that the prescribing doctor usually provides patients with information on side effects, and that a pharmacist would not normally give any information other than the instructions on the packet or bottle. However, Right 6(1), which affirms a patient's right to receive information, is a patient-centred standard, based on a patient's reasonable expectations, rather than the accepted practice among providers. While accepting that the prescribing doctor is best placed to discuss in detail the risks, side effects and benefits of proposed medication, this does not absolve the pharmacist of responsibility for informing patients of common side effects and giving instructions about how to take their medication. The information sheet provided by the manufacturer is not sufficient to discharge the pharmacist's obligations. By failing to provide the woman with any information about the side effects of her prescribed medication, danazol, the pharmacist breached Right 6(1)(b).

The woman also complained that another pharmacist informed her in a public area of the pharmacy and in a loud manner that she had been provided with the incorrect medication. No assistance was provided when her accompanying son became distressed. The pharmacy breached Right 1(2) by failing to have in place an appropriate written policy for communicating sensitive information. Pharmacy staff need specific instructions about how to handle disclosure of sensitive information.

The Commissioner noted that when a dispensing error is discovered, resulting in a consumer taking the wrong medication, it is imperative that the medical practitioner who prescribed the medication be contacted to ensure appropriate follow-up care. Right 4(5) of the Code requires health care providers to co-operate to ensure quality and continuity of care for consumers. The pharmacy was considered to have acted reasonably in attempting to contact woman's surgeon.

The matter was referred to the Director of Proceedings, who decided not to issue proceedings.