Prescription of anti-emetic to six-month-old baby (05HDC07953, 27 February 2007)

Locum in general practice ~ Pharmacist ~ Prescribing ~ Supervision ~ Dispensing ~ Standard of care ~ Professional standards ~ Information ~ Non-referral to Director of Proceedings ~ Rights 4(1), 4(2), 5(1), 6(1)(b)

A six-month-old baby was taken to a medical centre by her parents, with diarhorrea, vomiting, eczema, irritability and an itchy rash. The locum in general practice (who was relatively inexperienced and working under supervision) diagnosed a urinary tract infection, impetigo, oral thrush and gastroenteritis. She prescribed three different antibiotics and a 3mg dosage of Maxolon (metoclopramide) solution three times daily for gastroenteritis. (The prescribing of Maxolon is not recommended in these circumstances and, if prescribed, should be limited to 1mg under Medsafe guidelines.)

The pharmacist dispensed the medication in tablet form but provided a 5mg dosage instead of 3mg, then retyped the label but did not include the frequency of dosage on the label. The baby vomited after her parents gave her the first dose of Maxolon and was given another dose approximately two hours later. The baby experienced an overdose reaction and, as a result, required hospital treatment.

The local pharmacy had been compiling a list of concerns about the doctor's prescribing, and contacted the medical centre shortly after the incident. The doctor argued that the pharmacy and medical centre should have discussed concerns about her prescribing at an earlier date.

It was held that, while there was some indication that the doctor's supervision was less than ideal, she should have been aware that the prescribing of Maxolon was not appropriate, notwithstanding her relative inexperience as a locum in general practice. The pharmacy did everything possible in relation to developing concerns about the doctor's prescribing. Overall, it was held that the doctor breached Right 4(1) in relation to the prescribing of Maxolon and in her unnecessary multiple diagnoses and over-prescribing of antibiotics. In addition, the doctor provided insufficient information about the risks of Maxolon to the baby's parents, and breached Rights 5(1) and 6(1)(b). However, the public interest did not require the referral of the doctor to the Director of Proceedings.

The pharmacist was held to have breached Right 4(2) because of the errors with her dispensing. The pharmacist also failed to comply with her professional responsibility to assess the suitability of the prescribed medication (Maxolon) for a baby.