Pharmacist/General Practitioner

Report on Opinion - Case 99HDC00621

Complaint

On 3 June 1998 the Pharmaceutical Society of New Zealand received a complaint from the consumer about services provided by the pharmacist. The Pharmaceutical Society referred this complaint to the Health and Disability Commissioner. The consumer's complaint was that:

- *In late May 1998 the consumer went to a chemist in a city suburb, to pick up a repeat prescription of his blood pressure medication. The computer generated label on his previous box of tablets stated "1 repeat by 25 May 1998." The pharmacist advised the consumer that the pharmacy computer was showing that the repeat prescription had to be collected by 23 May 1998, not 25 May 1998. The pharmacist would not dispense the medication.*

Investigation

Information was obtained from:

The Consumer	
The Pharmacist / Provider	
The GP	General Practitioner / Provider
The consumer's GP	General Practitioner

Copies of the consumer's medical records were obtained and copies of the computer generated prescription labels were viewed.

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Background

On 25 August 1998 the consumer's complaint was referred to advocacy to help him try and resolve the matter directly with the pharmacist. Through the advocate the consumer requested a written apology from the pharmacist. The pharmacist provided this. The consumer advised that he did not feel that the letter of apology was sincere or that the pharmacist had admitted liability for the error. The consumer later advised the advocate that he did not wish to pursue his complaint any further.

On 30 October 1998, I wrote to the consumer and the pharmacist informing them that I would take no further action on this matter. In my letter to the pharmacist I also noted that the advocate had advised me that she understood that the pharmacist could have called the consumer's doctor and arranged for another prescription to be sent. I advised the pharmacist that this should have occurred and the consumer should have been informed.

On 9 November 1998 the pharmacist contacted the Commissioner advising that the letter to him contained factually incorrect information. The pharmacist advised that he did phone the consumer's doctor and he arranged a replacement prescription. He telephoned the consumer's home and left a message for the consumer explaining what he had done.

Further information was obtained from the consumer and he advised that he obtained a further prescription for his medication from his GP and had this prescription filled at another chemist. At a later date he received an account from a different general practitioner. The consumer did not know what this account was for. He rang the GP's surgery. He was informed that the account was for a replacement prescription that was provided by the GP. The consumer advised the surgery that he did not request a replacement from them and he did not receive one.

On 14 December 1998 I commenced an investigation on my own initiative into the consumer's complaint.

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Information Gathered During Investigation

At approximately 6pm on a day in late May 1998 the consumer went to the chemist requesting a repeat dispensing of his blood pressure medication. The consumer had previously had a prescription for *adalat* tablets filled at the pharmacy. The computer generated label on the medication box stated "*one repeat by* […] *May 1998.*"

The pharmacist was the pharmacist on duty. He acknowledged that the label on the box stated "*25 May 1998*" but he advised that his computer showed that the repeat had expired on 23 May 1998. He would not dispense the medication. The consumer left the pharmacy without his *adalat* tablets.

The pharmacist advised the Commissioner that the following day he telephoned the GP, who he thought was the consumer's doctor. He spoke to the GP's nurse and explained the situation. He requested another prescription to cover the consumer for his blood pressure medication. The pharmacist advised that the nurse referred to the doctor and then came back and told him that the GP wanted the consumer "*on atenolol*." A prescription for *atenolol* tablets was faxed through to the pharmacist. The pharmacist advised that he thought it was a bit unusual that the medication was being changed without a doctor's consultation and he made a note to discuss this with the consumer. The pharmacist made up the prescription and telephoned the consumer's home to inform him of what had been done. The consumer was not home so he left a message with a person who the pharmacist presumed was the consumer's wife.

The pharmacist advised that a few days later he was thinking about the case, and when he looked further into the consumer's file he realised that the consumer also saw a another GP at a another medical clinic. The pharmacist made a note to determine with the consumer who his regular doctor was going to be.

The *adalat* medication that the consumer attempted to collect in late May 1998 was prescribed by the consumer's GP. The pharmacist advised that the reason he rang the GP instead of the consumer's GP was that he still had an old computer system in place. The pharmacist obtained the consumer's record from that system not knowing that the consumer had changed his GP.

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Information Gathered During Investigation *continued*

The pharmacist provided a letter from a computer software company that he had approached about the problem with the inconsistent dates on the label of the consumer's medication. The company advised that it could not provide a conclusive explanation about what occurred. The software account manager stated:

> *"It appears that after the first dispensing the expiry date for the repeat has changed. However, after the second dispensing the expiry date has reverted back to the original expiry date – Accordingly the system would not recognise the date printed on* [the consumer's] *repeat label when he presented the prescription for the final issue. We have interrogated the database and can find no conclusive evidence to explain why the date has changed or how it changed."*

The GP advised the Commissioner that in late May 1998 the pharmacist contacted the medical centre. The GP was unable to speak to the pharmacist directly as he was operating in the procedures theatre and was wearing sterile gown and gloves. A nurse practitioner spoke to the pharmacist. The GP advised that the nurse practitioner informed him that the consumer was at the pharmacy and was seeking to pick up a repeat of his blood pressure medication as he had run out. The nurse relayed to the GP that the pharmacist indicated that there was a problem because the date for the repeat of his medication had expired. The GP informed the Commissioner that this is not an uncommon occurrence and it can happen for various reasons. The GP asked the nurse to check the medication and dose on the clinic's computerised records and "*to confirm that this was correct with* [the consumer] *through the pharmacist."* The nurse confirmed that the consumer was taking *atenolol* 50mg tablets once daily. The GP informed the Commissioner that he wished to resolve the situation in the safest, most convenient and expeditious manner for the patient. He advised that anti-hypertensive medications, especially beta-blocker such as *atenolol* should not be stopped suddenly. The GP instructed the nurse to advise the pharmacist to dispense a one month supply of *atenolol* 50mg tablets to the consumer, a written script to follow, and to advise the consumer to make an appointment to see him within the next month to check on his hypertension and health. The GP advised that this is his usual practice in this situation.

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Information Gathered During Investigation *continued*

The GP informed the Commissioner that he was advised by the pharmacist two days after he had written the prescription that there had been a mix up over the consumer's medication. The consumer had been to see another GP who had changed his blood pressure medication to *adalat*. The pharmacist informed the GP that the *atenolol* tablets had not been dispensed when it was realised that it was in fact *adalat* that the consumer had been seeking.

The GP later contacted the consumer who confirmed that the *atenolol* was not dispensed to him and that he was currently taking *adalat*. He advised that he would see the other GP for his hypertension but wished to continue to use the medical centre for other problems if the need arose.

In his response to the Commissioner the GP stated:

> "*I agree with you entirely that switching medication without seeing the patient would not be generally appropriate and I was not attempting to do that. I believed that I was assisting a known patient on existing medications to renew them, as stopping anti-hypertensive medications could be clinically unsafe."*

The consumer's medical records were obtained from the medical centre and show that the consumer first consulted the GP in January 1991 and he saw him intermittently during the following years. In April 1996 the GP prescribed *atenolol* medication for the consumer to treat hypertension. A prescription for 90 days medication was provided. In mid-December 1996 the GP issued a further prescription for 90 *atenolol* tablets, one tablet to be taken per day. Although the consumer attended the GP on a number of occasions during 1997 and 1998, no further *atenolol* prescriptions were provided.

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Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

...

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

...

Other Relevant Standards

Medicines Regulations 1984

Regulation 44 states:

Prescriptions not required in certain cases - *Nothing in this Part of these regulations shall apply to the sale or dispensing of a prescription medicine if the medicine is sold to or dispensed for –*

...

(m) A person who has previously been supplied with the medicine on the prescription of a medical practitioner or a registered midwife for a particular condition, and is so sold or dispensed –

(i) By a pharmacist who is satisfied that the person requires an emergency supply of the medication for that condition; and

(ii) In an amount not exceeding the quantity reasonably required by that person for a period of 72 hours, or a minimum pack of a special container from which it is not practicable to dispense a lesser amount.

...

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Opinion Breach: The Pharmacist

Right 4(2)

The pharmacist contacted the wrong doctor to arrange a repeat of the consumer's medication. I accept that this situation came about due to computer and record problems within the pharmacy and that the incident occurred while he was trying to rectify the original problem with the prescription date. However, the consumer's GP's name is clearly visible on the computer generated medication label. In my opinion the pharmacist breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

I also note that under regulation 44 of the Medicines Regulations 1984 a pharmacist is able to dispense, up to 72 hours, treatment in an emergency situation. As the error with the dispensing date appears to be caused by the pharmacy's own computer system and not through any fault of the consumer, in my opinion it was appropriate for the pharmacist to dispense 72 hours worth of *adalat* to the consumer which would have allowed either the consumer or the pharmacist further time to arrange a new prescription through the consumer's general practitioner. This would have prevented any interruption to the consumer's treatment.

Opinion No Breach: The GP

Right 4(2)

When the pharmacist contacted medical centre requesting a repeat of the blood pressure medication it was approximately 17 months after the last date on which the GP had prescribed anti-hypertensive medication for the consumer. While the GP failed to ascertain the correct situation before authorising a prescription for *atenolol*, in my opinion, his actions were reasonable in the circumstances as he was currently in the operating room. However, I recommend that the GP ensures that in future a consumer's current medication is verified before telephone prescription instructions are issued. The GP's practice nurse should be informed of this requirement.

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Actions

I recommend that the pharmacist takes the following actions:

- In future, when requesting prescriptions from a consumer's doctor all relevant information should be confirmed by a customer before contact is made with the doctor or medication is requested.

Other Actions

A copy of this opinion will be sent to the Pharmaceutical Society of New Zealand.