Investigations prior to discontinuing warfarin (13HDC01237, 11 February 2015)

General practitioner ~ Medical clinic ~ Nurse ~ Transfer of medical records ~ Investigations ~ Warfarin ~ Rights 4(1), 6(1), 7(1)

A man was a patient of a general practitioner (GP) at a medical clinic for a number of years, before transferring to a GP at another clinic. Five years later the man transferred his care back to the original GP.

The second clinic transferred an electronic and a paper copy of the man's medical records to the first clinic. The GP said that the electronic notes he received from the second clinic lacked clear identification of the long-term conditions and medications. The practice nurse at the first clinic received the paper copy, reviewed the transfer summary, and noted incorrectly that there had been no changes to the man's medication since 2003.

After his care was transferred, the man attended a consultation with the GP. A trainee intern was briefed by the GP to assess the man as a new patient, to conduct a comprehensive medical history, and thorough clinical examination. However, the intern did not elicit from the man that he had had cardiac surgery, and the man did not advise him that he was taking warfarin. During the physical examination, the intern did not detect a metallic "click", which is associated with a mechanical mitral valve, or record that man had a sternotomy scar.

The next day the man attended a further consultation. At this appointment, the GP was made aware by the man that he was taking warfarin. When he asked the man why he was taking it, he said that the man gave a vague reply about it being for his heart. The GP assumed the man was taking warfarin for a rhythm disturbance. He did not investigate further, and advised the man to stop taking warfarin.

Four weeks later the man consulted the GP with complaints of palpitations. The man advised that he had taken four warfarin tablets, which had made him feel better. The GP was concerned that the man was self-medicating with warfarin, and again advised him to stop taking it. Shortly afterwards, the man died in hospital after suffering several strokes.

It was held that the GP breached Right 4(1) for failing to review the man's medical records adequately, and for failing to investigate the reason why the man had been prescribed warfarin before advising him to stop taking it.

The GP also breached Right 6(1) for failing to provide the man with information about the risks and benefits of discontinuing warfarin therapy, and Right 7(1) as the man did not receive sufficient information about the risks and benefits of stopping warfarin, and so was not in a position to make an informed choice and give informed consent to the discontinuation of that treatment.

Both medical clinics and the nurse at the first clinic were also criticised.