
General Practitioner

Report on Opinion - Case 98HDC11015

Complaint

A complainant complained to the Commissioner about the services provided to her mother, (the consumer), by the provider, a general practitioner. The complaint is that:

- *In early December 1997 the provider prescribed Augmentin to the consumer despite her wearing a medical alert bracelet and a note in her paper file. The consumer wears the medical alert bracelet because she is allergic to penicillin.*
 - *The consumer suffered a reaction to the penicillin. The provider did not contact the consumer after the incident.*
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Investigation

The complaint was received by the Commissioner on 13 January 1998 and an investigation was undertaken. Information was obtained from:

The Complainant
The Provider

The consumer's medical records were obtained and viewed.

Outcome of Investigation

In early December 1997 the consumer attended a medical centre for treatment for a leg infection. The consumer wears a Medic Alert bracelet because she is sensitive to penicillin.

The consumer's regular general practitioner was not available and the provider, the duty doctor, was asked to see her infected leg. The provider had not seen the consumer before. The provider advised that he did not consult the consumer's paper file but called up her details on the computer screen.

The provider also advised that he asked the consumer if she suffered from any antibiotic allergies and the consumer replied "no".

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**Outcome of
Investigation
*continued***

The provider prescribed Augmentin and explained the drug and side effects to the consumer. The consumer's responses indicated that she understood his explanation. The provider was not aware that the consumer wore a Medic Alert bracelet because she wore a long sleeve blouse that day. The provider did not consult the consumer's complete medical notes which record her penicillin sensitivity.

Four days later the complainant telephoned her mother, who was very distressed. The complainant rang the consumer's usual general practitioner who visited her immediately.

The consumer suffered a reaction to the penicillin, with swelling and redness of the face and hands and a rash on her legs and body. The consumer's blood pressure and pulse remained normal and there was no respiratory reaction. She was treated with antihistamine drugs.

In early January 1998 the provider learned of the consumer's allergic reaction for the first time. He met with the consumer and the complainant and apologised for the distress and medical error he had caused.

In response to the Commissioner's enquiry the provider advised the Commissioner:

My immediate preamble to this decision-making process [which antibiotic to prescribe] is to ask ALL patients... "no allergies to drugs or medicines" ...I fully accept that had I consulted [the consumer's] paper medical file I would have observed the clear statement that [the consumer] was allergic to Penicillin.

Our practice in the past 15 months changed our record system from a paper-based system to full computerised records. Because records are incomplete particularly where drug allergies are concerned it is even more important to enquire of the patient the nature of any allergies...as the partner responsible for the transition to computerised medical records I am aware, perhaps more than my partners, of omissions in the computer records."

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**Outcome of
Investigation
continued**

The provider added:

"...this incident has caused our practice to review our systems so as to prevent similar experiences happening. We now provide the attending doctor with a paper file, where the doctor is not the patient's usual practitioner. We have re-doubled our efforts to have all allergy reactions documented on the computer wherein alerts arise "automatically" against the prescribed drug reported as causing an allergy reaction.

The provider again apologised to both the consumer and the complainant for the distress and medical injury suffered by the consumer.

**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.

**Opinion:
No Breach**

In my opinion the provider did not breach the Code of Health and Disability Services Consumers' Rights in regards to his failure to contact the consumer after prescribing the Augmentin. The provider was not the consumer's usual doctor and there was no reason for him to follow up the consultation. Once the provider became aware of the situation he made himself available to meet with the consumer and the complainant.

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**Opinion:
Breach** In my opinion the provider breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights in relation to prescribing penicillin to the consumer.

The provider did not know the consumer and had not treated her before. The provider knew the computerised medical records were incomplete as far as drug allergies were concerned. The consumer allergy was documented in her paper medical records and on her medic alert bracelet. The provider did not check the medical records and did not know about the bracelet.

The provider's failure to consult the consumer's full medical record before prescribing any drugs was a breach of her right to receive care of a professional standard.

Actions

I recommend that the provider:

- Submit a cheque to the consumer for \$59.00 being the costs of the appointment and apologise in writing to the consumer for his breach of the Code. This apology should be sent to the Commissioner's office where it will be forwarded to the consumer.
- Confirm to the Commissioner the changes made to the computerised medical record system to prevent this mistake happening again.

A copy of this opinion will be sent to the Practice Manager of the medical centre where the provider works, for educational purposes and wider discussion. I suggest that all doctors at the centre who see a patient with whom they are not familiar also have immediate access to the paper medical file as well as the computerised file. I note that the computerised file also did not record that the consumer was suffering dementia and such information would have been useful knowledge for the provider in terms of his communication with her.

A copy of this opinion will also be sent to the Medical Council of New Zealand for their information.
