Pharmacist

Report on Opinion - Case 98HDC12776

Complaint

A complainant complained to the Pharmaceutical Society of New Zealand about a pharmacist who dispensed the wrong medication to his mother. The complaint was that:

- *In mid-February 1998 the pharmacist incorrectly dispensed Diamicron tablets rather than Diamox tablets which had been prescribed for the consumer.*

Investigation

The complaint was received by the Commissioner on 17 March 1998 and an investigation was undertaken. Information was obtained from:

The Consumer
The Complainant
The Pharmacist / Provider
Solicitors for the Pharmacist
Pharmaceutical Society of NZ

Outcome of Investigation

In mid-February 1998 the consumer had an operation to remove a cataract from her eye. Two days later she returned to an eye clinic so that her eye specialist could monitor her progress. The specialist prescribed some eye drops and Diamox tablets. The prescription was dispensed on the same day at a Pharmacy by the provider, a registered pharmacist. The consumer took the tablets as directed.

Another pharmacist visited the consumer on the evening of the following day, and discovered that the medication received was not Diamox tablets but Diamicron tablets. The label on the medication stated, "14 Diamox Tablets 250 mg. Take ONE tablet twice daily". The pharmacist was suspicious because he had only ever seen Diamox dispensed in a bottle, not a carton and opened the carton to discover Diamicron tablets. He was able to arrange 3 Diamox tablets from another Pharmacy that night.

The following morning, the eye specialist was informed of the situation by the consumer's son. The consumer was checked by the specialist who confirmed that no harm had been done.

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Outcome of Investigation, *continued*

The pharmacist was contacted about the error by the consumer's daughter. The complainant advised the Commissioner that the pharmacist had initially attempted to lay blame for the accident on the consumer's daughter. The pharmacist denies this. The pharmacist then claimed the eye specialist's handwriting had been difficult to read, though the doctor apparently has a reputation for clear handwriting. The pharmacist had correctly entered the prescription into the computer as the label on the box containing the tablets was correct.

Through his solicitor, the pharmacist advised that he used the procedure for dispensing medication set out in the 1998 Pharmacy Practice Handbook issued by the Pharmaceutical Society of New Zealand. His solicitor also confirmed that the pharmacist has apologised to the consumer, and has taken further steps so that he applies a practice even tighter than that recommended by the Pharmaceutical Society.

The complainant was advised by the pharmacist that proper checking procedures had been put in place which meant it was now unlikely that a similar error would occur again. The complainant advised the Commissioner that he did not wish the matter to go any further as it had been resolved to his satisfaction. However, the Commissioner decided to continue with the investigation.

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.

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Relevant Standards

Pharmaceutical Society of New Zealand Code of Ethics 1996

Rule 2 Pharmaceutical Services

2.1 A pharmacist must safeguard the interest of the public in the supply of health and medicinal products.

2.12 A pharmacist must dispense the specific medicine prescribed.

Rule 3 Professional Conduct

3.2 A pharmacist must maintain high professional standards at all times.

Opinion: Breach

In my the opinion the pharmacist breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights by dispensing Diamicron rather than Diamox tablets. By dispensing the wrong medication the pharmacist did not safeguard the interest of the public and did not dispense the specific medication prescribed.

In my opinion the pharmacist did not comply with his professional obligations as specified by the Pharmaceutical Society's Code of Ethics.

Actions

I recommend that the pharmacist take the following actions:

- Apologise in writing to the consumer for his breach of the Code. This should be sent to my office and I will then forward it to the consumer.
- Reimburse the consumer the cost of the medication. This should be sent with the apology to my office.
- Advise what procedures and policies are in place at the Pharmacy to ensure such a dispensing error does not occur again. I note here that this advice must be substantially more than *"…The system that was used… was set out in the code and in particular the Pharmacy Handbook dated January 1998 issued by the Pharmaceutical Society of New Zealand"* as advised by the pharmacist's solicitors.

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