Management of medication for patient with complex health issues (15HDC00196, 23 June 2016)

General practitioner ~ Medication toxicity ~ Lithium serum ~ monitoring ~ Right 4(1)

A 49-year-old man complained about the care provided by his general practitioner (GP). The man had complex and longstanding psychiatric issues and a number of physical co-morbidities, including diabetes, obesity, obstructive sleep apnoea, fatty liver and previous pulmonary embolus. When the man became a patient of the GP he was on a drug regimen that included high doses of diazepam, paroxetine, lithium and codeine. This drug regimen had been established by psychiatrists in both New Zealand and overseas.

Over a period of six years, the man was prescribed lithium without regular reviews of his serum lithium levels. Serum lithium levels are taken to ensure that patients on lithium are not developing lithium toxicity.

In February 2011 blood tests indicated deterioration in the man's renal function (his test results were outside the normal range). In November 2011 the man reported a hand tremor, a common side effect of lithium toxicity.

In November 2011 the man was reviewed by a consultant psychiatrist who recommended changes to the man's paroxetine prescription. These changes were not implemented at the practice until September 2012.

Additionally, in January 2012, the GP's practice received notice from a DHB endocrinology service that the lithium levels should be reduced. Recommended changes to the man's lithium prescriptions were not implemented until September 2012.

The GP failed to assess the serum lithium levels adequately, did not document any consideration that the man might be suffering side effects from lithium toxicity, took no action to assess whether the lithium might be causing the tremor or the deterioration in renal function, and failed to ensure that specialist ordered changes to the man's medication regimen were made in a timely manner. While it was acknowledged that the patient's conditions and management were complex and a mitigating factor when considering those failures, it was found that the GP did not provide services to the man with reasonable care and skill, and breached Right 4(1).

The GP's practice failed to have systems in place to facilitate co-operation between providers to ensure that quality and continuity of services were provided to the man and, accordingly, breached Right 4(5).

The Commissioner recommended that the GP provide a written apology to the man and undertake training on the prescribing of psychotropic medication.

It was recommended that the Medical Council of New Zealand consider whether a review of the GP's competence was warranted.

It was recommended, with specific reference to Royal New Zealand College of General Practitioners Foundations Standards, that the GP's practice develop and

finalise a repeat prescribing policy that includes information on patient review timeframes; and a policy for the robust filing of reviews and reports, including specialist advice, received by the practice that require action.