Conditions imposed after NZ GP prescribes antibiotics for the wrong patient

Key messages from the case

Doctors should only prescribe medicines or treatment when they have adequately assessed the patient's condition and are satisfied the treatment is in their best interests. Correctly identifying the patient and obtaining an accurate history are fundamental to this assessment, as a case involving a GP in New Zealand illustrates.

Details of the decision

Patient misidentification and medication error

Ms A, aged 24, presented to a medical centre with sharp abdominal pains. She was 14 weeks pregnant. The registered nurse on duty recorded Ms A's history and vital signs and placed her name in the electronic patient queue.

Another patient's name, Ms D, was also in the queue for urgent recall for treatment for gonorrhoea and chlamydia. The notes indicated Ms D had failed to respond to previous recalls.

Dr B, the GP on duty, did not know either Ms A or Ms D. She reviewed Ms D's notes and claimed she called Ms D in for treatment. Ms A came into the treatment room.

Dr B did not check Ms A's identity and failed to obtain a history or ask about the presenting complaint. She told Ms A she needed urgent treatment for STIs. She did not make further inquiries when Ms A denied having abnormal test results or receiving a recall notice, but insisted that Ms A needed the treatment.

Dr B ordered an antibiotic and Ms A was so shocked to hear she had STIs that she agreed. The error was discovered after the RN administered the antibiotic and queried why it had not been recorded in Ms A's notes.

Ms A was recalled, re-assessed and provided with a prescription for her abdominal symptoms.

The NZ complaints commissioner criticised Dr B's failure to check the identity of a patient she did not know before consulting with her. Even if Ms A had mistakenly responded when Ms D's name was called, it was Dr B's responsibility to satisfy herself of the identity of the patient she was treating.

The NZ complaints commissioner noted that asking a patient about the presenting complaint and obtaining an accurate history was a basic element of a medical consultation. Dr B's failure to do so was unacceptable.

The errors meant that Dr B had failed to ensure she had an adequate knowledge of Ms A's condition. She could not be satisfied the medication was in Ms A's best interests.

Medical records

Dr B recorded Ms A's attendance for abdominal pain, her examination findings and the prescription written for Maxolon and paracetamol. She made no note of the mistaken identity or medication error.

The NZ complaints commissioner found not documenting the medication error was also breach of Dr B's professional obligations.

Communication

Ms A complained that Dr B had not listened to her when she claimed she was not aware of any abnormal test results or recall notice. Dr B accepted that this should have alerted her to a possible error and to check again whether she was treating the right patient.

The NZ complaints commissioner was highly critical that Dr B had not heeded Ms A's comments or recognised that she needed to question Ms A further. The NZ complaints commissioner was concerned that Ms A had been unable to fully participate in the consultation. In failing to listen carefully, Dr B missed another opportunity to avoid the medication error.

Ms A also complained Dr B had not apologised or accepted responsibility for the error at the time. She said Dr B had blamed her for the error and kept asking why she had responded when Ms D's name was called. She felt she was rushed out afterward because the clinic was closing. She also claimed Dr B did not apologise the following day when she returned to ask for details of the antibiotic prescribed.

The NZ complaints commissioner was unable to make a finding on whether or not Dr B had apologised at the time, but reminded Dr B of the importance of good communication and taking responsibility for errors.

Outcome

Dr B had failed to provide the appropriate standard of care.

The NZ complaints commissioner noted that the practice had apologised to Ms A, and that Dr B had also written a letter of apology.

The commissioner imposed a condition that Dr B attend further training on communication.

Key lessons

Before prescribing medication or treatment, make sure you have adequately assessed the patient's condition and satisfied yourself the treatment is in their best interests.

Effective communication is central to the doctor-patient relationship. This means you need to listen to patients and avoid making assumptions, even if you are concerned the patient may not be telling you the entire truth.

To minimise the risk of medication error:

- Ensure you establish the identity of any patient you have not treated before by asking them to repeat their full name and date of birth.
- Obtain the patient's medical history and discuss any concerns about current or past prescriptions.
- Check that the patient has understood the information you are giving them.
- Avoid making assumptions and listen carefully to any patient concerns. These may raise important 'red flags.'

If an error does occur, record both the identity error and the incorrect administration of any medication in the patient's medical records.

References and further reading

Avant factsheet – Medical records: the essentials

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