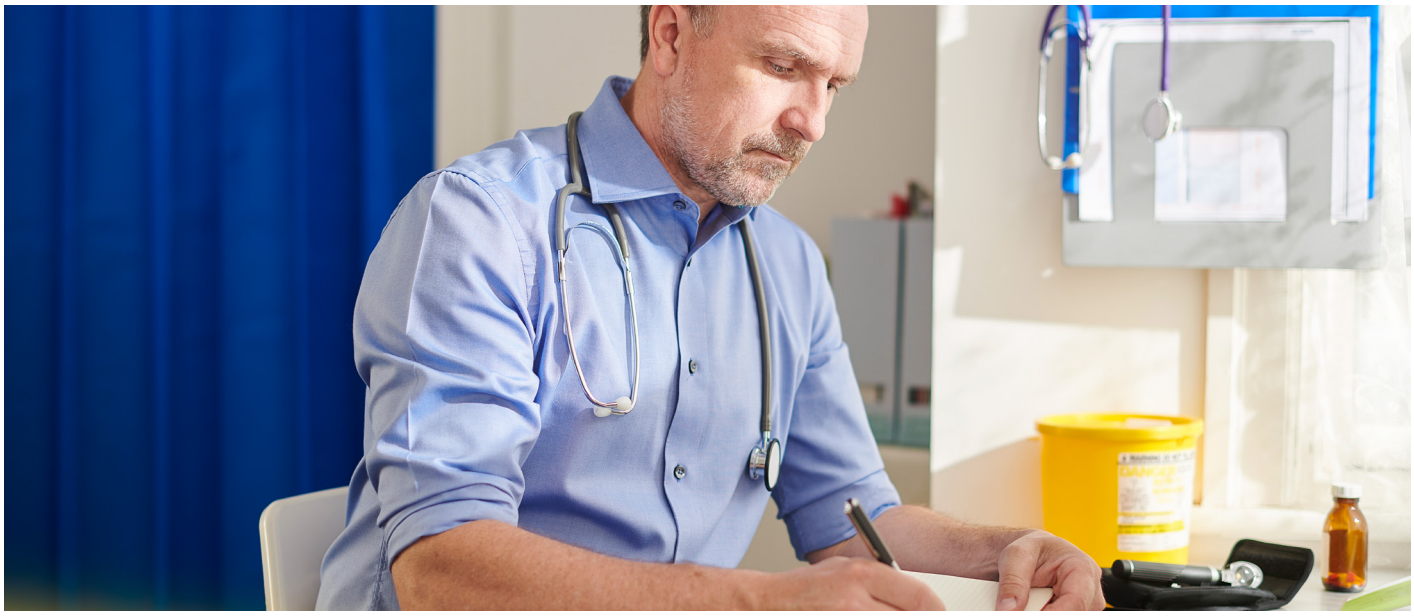
Rural GP's registration suspended over repeated prescribing errors



Key messages from the case

Doctors are responsible for making sure any medication they prescribe is safe, appropriate and clinically indicated.

Failing to follow fundamental prescribing practices such as taking an adequate history and ensuring appropriate follow-up can put patient safety at risk.

Good prescribing practice also includes taking steps to avoid inadvertent prescribing errors and ensuring adequate knowledge about medications and their interactions to provide safe clinical care. If an error does occur, doctors are expected to take active steps to correct the error and protect patient safety, as a case involving a regional GP illustrates.

Details of the decision

Dr H was in a solo general practice in a regional town when concerns were raised over 11 instances of inappropriate prescribing.

Medication errors – failure to take adequate care when prescribing

Issues included prescribing an inappropriate medication or dosage for the patient and their condition. Some errors put the patient at considerable risk – for example instead of prescribing doxycycline for a 16-year-old patient's acne, Dr H prescribed doxepin (a treatment for major depression that should only be used with caution in children or adolescents because of the increased risk of suicidality).

Dr H admitted the errors, claiming most were inadvertent errors caused by selecting the wrong medication or dosage in his prescribing software. In most cases he only became aware of the error when he was contacted by the pharmacist.

The tribunal was highly critical of Dr H's 'reckless prescribing' particularly given that:

- he admitted he had not checked the prescriptions before printing them, re-read them before signing them, or read them when he handed them to the patients
- he did not discuss the medication, dosage or administration, potential side effects or drug interactions with the patient before prescribing
- when he was made aware of the errors, he generally did not contact the patients – even where errors were potentially serious
- he did not record the prescribing errors. In some cases he did not cancel the incorrect prescription in the patient's records – then repeated the error next time he prescribed for the patient
- he made no changes to his processes to ensure dangerous errors did not reoccur.

Responsibilities when prescribing – examinations, assessments

Dr H was also heavily criticised for prescribing without any evidence that he had taken an adequate history, conducted appropriate examinations or ordered any investigations.

One complaint involved a patient who presented for a Q Fever vaccination. Dr H prescribed the vaccine without conducting the required pre-vaccination serology tests.

Dr H admitted he had never prescribed Q-vax, but he did not check the Therapeutic Guidelines or medicines information in his prescribing software. He only became aware of the need for skin and antibody tests when the pharmacist phoned to check these had been performed. Dr H did not follow up with the patient and assumed she had gone to the hospital for the vaccine. When he eventually ordered the tests some weeks later, the patient tested positive for antibodies and was at risk of serious hypersensitivity reaction. There was no record the patient was ever informed of these results.

Responsibilities when prescribing – documentation and records

The tribunal was extremely critical of Dr H's records, which showed no evidence he had conducted appropriate examinations or assessments before prescribing to these patients. He had often used templated notes that listed examinations that were clearly irrelevant and had not been performed.

His records did not record any discussions with patients about side-effects, drug interactions, dosage directions or follow up.

Prescribing for children / off-label prescribing

One complaint related to prescribing an anti-depressant (escitalopram) off-label to a 12-year-old child. There was no documentation to indicate Dr H had conducted an appropriate assessment or considered alternatives such as psychotherapy.

Dr H claimed the patient's mother and a community health professional were present at the consultation, however this was not reflected in the records.

There was no record of discussion with the child about involving her parents in the treatment or about steps to ensure her safety given the increased risk of suicidal ideation and behaviour associated with the medication. There was a record for review in a week, but no specific safety netting instructions.

Dr H provided referrals to a psychiatrist and psychologist, however there was no evidence Dr H had advised either of those professionals of his prescription.

The tribunal accepted Dr H had checked his prescribing with a US-based source, however the US guidelines were inconsistent with Australian therapeutic guidelines.

Given known risks associated with SSRIs for children, Dr H needed to have taken steps to safeguard the patient and ensured appropriate consent discussions including whether the child's parents needed to be involved and advised of risks.

Outcome

The tribunal found Dr H's prescribing constituted unsatisfactory professional conduct and professional misconduct.

Dr H admitted the errors. He accepted the seriousness of the errors and explained in mitigation that he had been out of his depth and isolated in a solo rural practice and that he had been dealing with some personal stressors including family illness.

He had since made changes to his practice, including undertaking further education and moving to a shared practice.

The tribunal accepted the difficulties the practitioner was experiencing but noted that he had a responsibility to try to ensure he practised safely – such as seeking help or reducing the number of patients he saw each day.

The tribunal reprimanded Dr H and suspended his registration for 4 months.

It imposed conditions for two years, including to practise under supervision in a group practice, see no more than 30 patients in any one day, and submit to a practice audit.

Key lessons

Take an adequate history, conduct any examinations and order any investigations necessary to ensure you have enough information to assess the suitability of the prescription for the patient and their symptoms.

If you are unfamiliar with the medication, consider objectively whether a reasonable standard of care requires you to either consult with a colleague who is familiar with the medication and its indications, conduct further education on the specific medication, or refer the patients on to an appropriate specialist.

It is important to communicate any treatment or advice given to patients to their other treating practitioners.

Your obligation to ensure patients consent to treatment means you need to discuss the proposed treatment with the patient, including any risks, side-effects or contra-indications.

To reduce the risk of inadvertent errors:

- check the prescription before you sign it
- read through the prescription with the patient and check they understand the dosage and instructions.

If you do make a medication error, follow an adverse event procedure with the patient, ensure the error is documented in the patient record and consider any changes to your practices or procedures to avoid repeating the error.

References and further reading

Avant - Elearning, Prescribing principles: Part one- general prescribing issues

Avant - Feature Page Prescribing safely

Prescribing Competencies Framework - NPS MedicineWise

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