Repeat scripts for patients

One of the quandaries of general practice is the patient who seeks a repeat prescription of a medication prescribed by another practitioner, or even one prescribed previously by you. There is often considerable pressure to accede to a patient's wish for a repeat to "tide them over" until they can come in for a proper consultation. Naturally, practitioners want to be helpful and it may simply be expedient to authorise a repeat, given the doctor's own time constraints. On the other hand, doctors will be cognisant of their duty of care to patients, and the need to reassess whether potent (even if commonly prescribed) medications are still appropriate.

I have addressed the topic of "Traps in repeat prescriptions" in a previous column relating to a repeat prescription for the third generation oral contraceptive pill to a woman in her early 30s, who died of a pulmonary embolism after her 9th repeat prescription.[1] I noted: "If a review of medication is overdue, it is entirely reasonable and appropriate for a doctor to require it before renewing the prescription. Doctors are not beholden to their patients' demands for services, including repeat prescriptions. The Code does not give patients, even if fully informed, the right to demand services. If a patient decides not to have a medication review, it is clinically inappropriate to renew the prescription."

A recent case highlights the same point in the context of a mental health patient asking a doctor at her medical centre to renew a psychiatrist's prescription of sleeping pills.

A mental health patient

Mrs A had a history of depression since 2006. She had been managed principally by various doctors in the Medical Centre where she was a casual patient (without a regular doctor) and community mental health services. Mrs A was prescribed 30 Imovane 7.5mg tablets by Dr B in early 2007.

Three weeks later, Mrs A saw Dr C at the Medical Centre, complaining of feelings of depression and anxiety. Dr C prescribed an antidepressant, paroxetine, and referred her to the community mental health service.

Mrs A presented to the local hospital's Emergency Department the following day, complaining of worsening feelings of depression and anxiety. She was subsequently admitted to the inpatient mental health unit as a voluntary patient. Because Mrs A was thought to have experienced side-effects from the paroxetine prescribed the previous day, she was started on a different antidepressant, citalopram 20mg daily. Mrs A was discharged three days later with planned community follow-up with CMHS. She was reported to have no suicidal ideation and her mood was "more bright and reactive" at the time of discharge. An appointment was scheduled with psychiatrist Dr D for one week later.

Following his consultation with Mrs A, the psychiatrist noted that she generally remained well but continued to have trouble sleeping. Dr D continued her on citalopram and recommended ongoing counselling. He also prescribed her Imovane

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[1] See http://www.hdc.org.nz Traps in repeat prescribing

7.5mg with directions to take one to two tablets at night before going to bed. Dr D sent a letter to the Medical Centre which stated: "I also suggested to [Mrs A] that she should not continue using [Imovane] for more than 14 to 21 days, although I gave her 30 tablets which will enable her to have a supply lasting perhaps up to 3 to 4 weeks."

An obliging doctor
Two weeks later, Mrs A presented to the Medical Centre and was seen by Dr E (who had seen her on one previous occasion). According to Dr E, the consultation was very brief. Mrs A simply told him that she was going away for two months and wanted some more Imovane. She had found taking two tablets at night beneficial.

Before Dr E complied with her request he familiarised himself with her history of depression and checked for any previous suicidal ideation. Dr E read Mrs A's records, noting that she had a history of poor sleep, she had no outward signs of distress and her mood seemed reasonable. He read Mrs A's recent discharge summary from the inpatient unit, noting she had been a voluntary patient and had no thoughts of suicide for three months, and the psychiatrist's letter of 2 April, noting that Dr D had prescribed enough tablets for 15 days, if she was taking two tablets a night.

On observation, Dr E did not consider Mrs A was showing any outward signs of distress and her mood seemed reasonable. He concluded that there were no real concerns about her safety. Dr E calculated that, based on how much Mrs A had reported to be taking, she would have completed the Imovane prescribed by her psychiatrist. Therefore, because she was going away for two months, Dr E considered it appropriate to prescribe a further 60 Imovane tablets (one month's supply based on two tablets a day).

Mrs A committed suicide a few days after her consultation with Dr E. Her family complained to HDC.

Expert advice
General practitioner Dr Caroline Corkill advised HDC that although the care provided by Dr E was generally appropriate, his prescribing was not sufficiently cautious. Dr Corkill acknowledged that "it is difficult to evaluate services after something very sad has happened", and that as a reviewer she "had the advantage of more time and information to consider possibilities than Dr E did when he was face to face with Mrs A". Nonetheless, Dr Corkill concluded that about half of Dr E's peers would consider that his standard of care was "lower than it should have been", and that she shared this view. Her specific criticisms were:

- Imovane is potentially harmful because it belongs to a group of drugs that can become addictive and that interact with alcohol and can be fatal. Prescriptions are generally limited to one month's supply at a time. While recommended dosage is 3.75–7.5mg, 15mg (the dose prescribed by Dr E, two 7.5mg tablets per night) is not unusual.
- Dr E's prescribing complied with legal requirements but was "at the high end of the permissible amount".
- Dr E's record of the consultation was "brief, barely adequate, but it is like many other consultation records of other competent doctors".

- Although the consultation was "essentially for a repeat prescription", at a face-to-face consultation Dr E should have given a little more consideration about Mrs A's use of the medication and why she was taking it.

Dr E's response
Dr E accepted that it would have been appropriate to discuss with Mrs A her use of Imovane as a short-term measure for her sleeping problems. However, he disagreed with Dr Corkill's criticisms about his lack of follow-up, noting that Mrs A was going away for two months. Dr E also submitted that my advisor's comment that his "prescribing turned out not to be sufficiently cautious" showed the influence of hindsight bias.

HDC decision
As Commissioner, I was required to form an independent opinion on the reasonableness of Dr E's care for Mrs A, setting aside my knowledge of her suicide. The tragic outcome was legally irrelevant to my investigation, and in any event suicide is an unpredictable and sometimes inevitable outcome in mental health cases.

There was no doubt that Dr E's motivation was the best interests of his patient. Mrs A had requested more Imovane because of ongoing sleep problems. It had worked for her, and been prescribed before in the same dose. She was going away for two months and didn't want to run into further sleep problems.

It is apparently common practice for Imovane to be prescribed for prolonged periods for sleep disorder sufferers (particularly the elderly), a month at a time for month after month. However, to do so in a patient with a recent history of suicidal ideation, who was not known well by the doctor (and therefore in the absence of a trusting relationship) and in the amount given, was open to criticism.

I noted, "Imovane is not an innocuous medication to be dished out on demand to casual patients with a history of depression and a recent mental health inpatient admission." Mrs A had taken 30 Imovane tablets in the previous 15 days. Dr E prescribed 60 Imovane tablets (another month's supply), even though Mrs A was already nearing the maximum period that her psychiatrist recommended her to use Imovane. He had recommended that she should not continue to take Imovane for longer than 14 to 21 days.

In my view, Dr E should have taken more time to discuss Mrs A's recent admission to the inpatient mental health unit and visit to the psychiatrist. Although Mrs A said she was going away for two months, Dr E should have discussed a follow-up appointment with him or CMHS to review her sleeping patterns. He should also have documented the discussion.

I stated: "I do not consider it my role to endorse mediocre practice, even if 50% of busy medical practitioners in general practice might act as Dr E did. Patients are entitled to better care. In my view, the care Dr E provided to Mrs A was below the standard expected of a responsible GP." I concluded that Dr E had breached Mrs A's rights, by not exercising reasonable care (right 4(1)) and failing to provide services in a manner that minimised potential harm to her (right 4(4)).

I noted that Dr E had “taken this matter very seriously and put in place steps in [his] practice to ensure that requests for potentially harmful medications are more closely perused and more adequately documented” and that the case had been a “salutary lesson”. However, Dr E was not vocationally registered as a GP, and I had received no evidence about the collegial oversight of his practice, nor of the practice arrangements at the Medical Centre. As required by law, I notified the Medical Council of my findings, and I recommended that the Council consider whether a review of Dr E’s competence, or any other supportive intervention, was warranted.

Proceed with care

Some doctors may see this as a tough ruling on a busy doctor who was not careless and was simply trying to help a patient in need. My decision is intended to send a clear signal that, however good their intentions may be, doctors are expected to be more than patient-pleasing pill-pushers. The request for a repeat prescription can be a trap for the unwary practitioner. Depending on the nature of the medication, the doctor may be expected to decline a repeat prescription in the absence of a review. If a review raises doubt about the appropriateness of a repeat, the cautious doctor should refrain from authorising it – or risk sanction from later reviewers.

Ron Paterson
Health and Disability Commissioner
NZ Doctor, 22 April 2009