Management of anticoagulation therapy (09HDC01765, 15 June 2011)

General practitioner ~ District health board ~ Rural medical practice ~ INR monitoring ~ Warfarin ~ Patient compliance ~ Patient reviews ~ Documentation ~ Right 4(2)

A 22-year-old man underwent an urgent aortic valve replacement. Following the heart surgery, he was placed on medication which included an ongoing anticoagulant regime. His warfarin dosage and INR level were to be monitored through regular blood testing and review by his rural general practitioner and the practice staff of his local rural medical centre.

Over the next three years the young man's INR level fluctuated between periods of stability within a desired therapeutic range, and periods of instability involving variable levels of compliance which clinic staff advised him posed a serious risk to his health. Sadly, he collapsed and died while playing social sport, aged 25. His mother and partner complained that he had not been adequately monitored and managed by the GP.

It was held that the GP and his staff took appropriate, persistent, and sometimes innovative steps to inform and communicate the importance of compliance with prescribed warfarin doses, regular INR testing, and the risks involved if this did not occur. When the man had a potentially harmful INR result in mid-2008, the GP adopted a reasonable clinical course of action, to stop the medication and then re-warfarinise.

However, it was also held that the GP failed to consistently attend to a fundamental of good medical practice and ensure that the clinical record was complete and adequately reviewed. Prolonged deficiencies in documentation affected the patient's ongoing monitoring. The GP was found to have breached Right 4(2) of the Code.