Inappropriate prescription of Codeine Linctus to baby (99HDC01986, 31 October 2000)

General practitioner ~ Pharmacist ~ Appropriate medication for infant ~ Appropriate dose for baby ~ Referral to hospital ~ Standard of care ~ Rights 4(1), 4(2)

A seven-week-old baby was suffering from a cough, vomiting and diarrhoea. Her GP diagnosed acute bronchitis, but did not consider the condition serious enough to warrant medication. However, because the baby's coughing was keeping the household awake, the doctor prescribed Codeine Linctus "5ml if necessary up to every four hours" and an antibiotic. He did not specify the strength of the linctus on the prescription.

The prescription was filled that day.

Codeine Linctus comes in two strengths: adult and paediatric. The doctor said he had only ever prescribed it for children aged two years or older, and that he had intended to prescribe Pholcodine Linctus.

The GMS coding scale on the prescription was circled as "Y1", which covers the age group from birth to six years of age. Although the date of birth was correctly stated on the form, the pharmacist said he was under the impression that the child was three years old, not three months, and so he thought the dose suitable for the age of the child and filled the prescription.

Over the next 24 hours, the baby was given four doses of the Codeine Linctus. She became limp and was "not looking good"; at one point, she stopped breathing for a few seconds. The baby was taken back to the doctor, who thought she appeared "drugged", but when he was assured that the only medication given to the child was what he had prescribed, he asked the baby's grandmother to fetch the medicine bottle.

Upon seeing the bottle and telephoning the pharmacist, the doctor diagnosed a codeine overdose and told the family that the medicine should "wear off" later that day. He instructed the family to take the baby straight to hospital if she stopped breathing again.

Later that evening, the baby looked worse and an after-hours doctor contacted by telephone told the family to take the baby to hospital. The baby was diagnosed with a mild/moderate codeine overdose and viral gastroenteritis.

The Commissioner's general practitioner advisor stated that Codeine Linctus should not be prescribed to such a young child, and the GP should have written the desired concentration of the medication on the prescription. He should have been "cautiously conservative" and admitted the child to hospital for assessment. In addition to the fact that the baby had stopped breathing, it was doubtful whether the family could deal with an emergency situation — they lived on an island, and had limited telephone access, transport and caregivers able to regularly observe and analyse the baby's condition and do CPR if necessary.

An independent pharmacist advisor said that the pharmacist should have contacted the doctor to ascertain the strength of the medication required; if he could not reach the doctor, he should have "dispensed the paediatric formulation … and then only with caution".

The GP was found to have breached Right 4(1) in prescribing an inappropriate medicine, failing to indicate the strength of the medication required to be dispensed, and failing to admit the baby to hospital at the follow-up consultation. By not indicating the desired concentration on the prescription, he also failed to comply with a legal standard and thereby breached Right 4(2). By not consulting with the doctor to clarify the prescription, the pharmacist had failed to comply with the Pharmaceutical Code of Ethics, and so breached Right 4(2).

The case was referred to the Director of Proceedings. A charge against the GP alleging professional misconduct was upheld by the Medical Practitioners Disciplinary Tribunal, and it imposed a penalty of censure and ordered payment of $4,000 towards costs. A charge of professional misconduct against the pharmacist was not upheld by the Disciplinary Committee of the Pharmaceutical Society of New Zealand, although it found that the pharmacist had breached his duty of care. He should have taken notice of the child's birth date recorded on the prescription and questioned the appropriateness of the medication prescribed.