Pharmacist

Report on Opinion - Case 98HDC11321

Complaint

The Commissioner received a complaint from a midwife. The complaint is that:

- *In mid-July 1997, the provider, a pharmacist, annotated a prescription for Minulet to include "28" and a symbol indicating "one", without notifying the prescriber.*
- *The provider did not provide the consumer with advice that Minulet is contraindicated for lactating women.*
- *Three months later a repeat prescription for Minulet was dispensed for another three months without authorisation.*

Investigation

The complaint was received on 26 February 1998 from the complainant, a midwife. An investigation was commenced and information was obtained from:

The Consumer
The Complainant (a Midwife)
The Provider / Pharmacist

The Commissioner also received advice from a pharmacist.

Outcome of Investigation

During an investigation into the prescribing of an oral contraceptive, it was discovered that the provider, a pharmacist/pharmacy owner, may have annotated a prescription for Minulet to read "Minulet 28". The prescriber, a midwife, (the complainant) stated she intended to write "Microlut", but wrote "Minulet" by mistake as this was what the consumer had just told her she had previously been prescribed. The midwife explained that normally when writing "Minulet", she would write "Minulet 28" and when writing "Microlut", she would write just the name with "oral contraceptive" written underneath it. The midwife reported that if the pharmacist had not altered the prescription, but contacted the midwife to ask that it be filled in correctly, then the dispensing error would have been picked up at that point.

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Outcome of Investigation, ***continued***

In reply, the pharmacist stated she is not sure whether the "28" was added by herself, another pharmacist or by the midwife. The number "28" indicates the number of tablets in the package. However, the provider stated that correct pharmacy protocols were followed in dispensing the contraceptive. "Minulet" was clearly written on the prescription and therefore no ambiguity was evident that would have made contacting the pharmacist necessary before dispensing the medication.

The provider further stated that the prescription was annotated according to usual practice to clarify the amount supplied to the consumer and to enable accurate payment from Health Benefits Ltd. In addition, both prescriptions were checked and initialled by two pharmacists, according to correct pharmacy dispensing protocols. Signatures of the two pharmacists are visible on the photocopied prescription sent to the Commissioner.

A pharmacist who advised the Commissioner said it is normal practice for a pharmacist to fill in details about the packaging of a particular drug as often the prescribers are not aware of how tablets are packaged and leave this information out. The pharmacist then completes the information so that the correct number is given and the correct payment can be obtained from Health Benefits Ltd.

The midwife also complained that the pharmacist did not provide the consumer with advice that Minulet is contraindicated for lactating women. In reply the provider stated that her Pharmacy does not have a policy of asking women who are dispensed oral contraceptives whether or not they are breastfeeding. The provider's view is that to request this information would raise issues of privacy and confidentiality.

The pharmacist advising the Commissioner stated it would be unreasonable to expect the pharmacist to have informed the consumer that taking Minulet would be contraindicated when lactating, as this would be the prescriber's role.

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Outcome of Investigation, *continued*

In mid-October 1997, a repeat prescription for Minulet was dispensed by the provider without authorisation for another three months. Midwives have limited prescribing powers and have authority to dispense oral contraceptives post-natally for a three-month period only. After this time, consumers must obtain a prescription from their GP if they wish to continue with the medication.

The provider states that her Pharmacy was incorrect in dispensing the repeat prescription of the Minulet three months later. The provider advised the Commissioner that she had discussed this with the consumer and her husband and apologised to them for this error.

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

RIGHT 6
Right to be Fully Informed

1) *Every consumer has the right to the information that a reasonable, consumer, in the consumer's circumstances, would expect to receive, including*
   a) *An explanation of his or her condition; and*
   b) *An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option;…*

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Opinion: No Breach

Right 4(1)

In my opinion there has not been a breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights. The pharmacist had no reason to assume the prescription was for anything other than Minulet, and therefore the pharmacist was correct in dispensing this product. While there is some doubt on whether the pharmacist annotated the prescription with "28" after the word "Minulet", it would not have been unreasonable or incorrect for the pharmacist to have added this number.

Right 6(1)

In my opinion the pharmacist has not breached Right 6(1) of the Code of Health and Disability Services Consumers' Rights. In the circumstances, it would not have been appropriate for the pharmacist to ask if the consumer was breast-feeding and to inform her that Minulet is not suitable for those who are lactating. This is the role of the prescriber.

Opinion: Breach

Right 4(2)

In my opinion the provider breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights. The pharmacist should not have dispensed another three months' supply of Minulet to the consumer in October 1998. The Code of Ethics of the Pharmaceutical Society of New Zealand, in Rule 1.1 and Rule 1.2 states that:

> *A pharmacist must, at all times, comply with the laws, rules, codes and Council statements applicable to pharmacy practice. (1.1)*
>
> *A pharmacist must maintain a working knowledge of the laws, rules, codes and Council statements applicable to his/her sphere of pharmacy practice and always comply with the requirements of these. (1.2)*

The Pharmaceutical Society views the ability to know and comply with a regulatory framework for pharmacy practice as a basic professional standard. In dispensing the repeat prescription, the provider did not demonstrate awareness of the limitations on midwife prescribing and did not comply with relevant professional standards.

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Actions

The pharmacist is to provide written evidence to the Commissioner that the Pharmacy she owns has a copy of the regulations relating to midwife prescription writing.

The pharmacist is to provide a written apology for her breach of the Code of Rights to the consumer. The apology should be sent to this Office and the Commissioner will then forward it to the consumer. A copy will remain on the investigation file.

A copy of this report will be sent to the Pharmaceutical Society of New Zealand.