Monitoring of, and provision of information about risk factors in prescribing combined oral contraceptive (11HDC00440, 14 November 2013)

General practitioners ~ Medical centre ~ Combined oral contraceptive ~ Good prescribing practice ~ Information provision ~ Discussion of risk factors ~ Medical review ~ Monitoring ~ Documentation ~ Rights 4(1), 4(2), 6(1)(b)

A woman was repeatedly prescribed the combined oral contraceptive pill (COC) Estelle, even though she presented with a number of risk factors that should have been carefully discussed with her.

The woman was overweight, a smoker, over 35 years of age, and had a family history of thromboembolism. She was therefore at risk of developing a deep vein thrombosis (DVT) and, given that risk, Estelle was not a recommended method of contraception. However, she also had polycystic ovary syndrome (PCOS). Estelle is indicated for treatment of symptoms associated with PCOS. The woman had taken Estelle in the past, but her general practitioner (GP) at the time deemed Estelle to be unsuitable because of the woman's risk factors for DVT, and had prescribed the minipill instead (which does not carry the same risks as Estelle).

The woman transferred her primary care to a Medical Centre where she saw a GP, who prescribed Estelle for the woman, but did not document the provision of that prescription. The GP also did not document any discussion of the risks associated with Estelle or the alternative options for contraception or treatment of PCOS.

Over the next three and a half years, the first GP and two other GPs at the Medical Centre provided repeat prescriptions of Estelle for the woman. Over that time, the woman's risk factors increased. No medical review was undertaken to determine whether Estelle was suitable, and there is little documented evidence of a discussion with the woman about her risk factors. The woman's blood pressure was not recorded for two years. Each of the GPs who prescribed Estelle for the woman assumed that the previous provider had discussed risks of, and alternatives to, Estelle with her.

The woman underwent a cholecystectomy at the local hospital. She developed a pulmonary embolism after surgery and, sadly, died.

It was held that the first GP breached Right 4(1) by reinstituting Estelle for the woman without a proper reassessment of her suitability, or recording her blood pressure. The first GP also breached Right 6(1)(b) by failing to inform the woman of her risk factors or suitable alternatives to Estelle. The first GP breached Right 4(2) by failing to comply with professional standards in respect of her documentation.

The medical centre breached Right 4(1) by failing to ensure that the woman's ongoing use of Estelle was adequately monitored through regular, specific medical reviews and counselling on her risk factors.

The other two GPs' care fell below an appropriate standard, but they did not breach the Code.