SPSO decision report

Case: **201202297, A Medical Practice in the Tayside NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, no recommendations

Summary

Ms C complained that doctors at the practice failed to manage her medication regime appropriately. Ms C was suffering from bi-polar disorder (a condition that affects a person's mood). She was prescribed medication, including lithium (a medicine used to treat mood disorders) and quetiapine (a drug used to treat bi-polar disorder). Her lithium levels were monitored every three months at a special clinic as lithium may interact with other drugs and can cause toxicity (a poisonous effect on the body). She was also monitored by a community psychiatric nurse (CPN) and a consultant psychiatrist every four to six weeks.

On one occasion Ms C went to the practice as she felt she was suffering from toxicity. She saw a locum GP (a doctor in a temporary position at the practice), who did not think that she was but asked her to speak to her CPN to organise a blood test. The CPN told her to go back to the practice, and another doctor did the blood test. The results showed that she was not suffering from toxicity.

After investigating, we did not uphold Ms C's complaint. We took advice from as independent medical adviser, who said that the evidence in the clinical notes showed that it was unlikely Ms C was suffering from toxicity when she saw the locum GP. Although the adviser was concerned that the locum GP asked Ms C to arrange her own blood tests, she considered this to be a misunderstanding about the resources available. In light of this, although we did not uphold Ms C's complaints, we drew to the practice's attention that the adviser had suggested they might wish to consider placing an alert on the notes of patients prescribed lithium, with information on how to obtain urgent blood tests where there is a suspicion of possible lithium toxicity.

Ms C also complained that the practice would not prescribe her extra quetiapine. She was under the impression that her psychiatrist had increased the dose. Having looked at Ms C's clinical notes and the communication between the psychiatrist and practice, the adviser confirmed that the psychiatrist had not further increased the dosage. Ms C also had helicobacter pylori (h-pylori - a bacterium found in the stomach) and complained that the practice had not adequately treated it. The adviser confirmed that the dose and duration of treatment for h-pylori was appropriate.