Prescribing when a patient refuses medical review

A **competent** patient may refuse assessment or treatment. However, that refusal does **not** create an entitlement to a prescription or remove the prescriber's independent obligation to prescribe safely. Under the HDC Code, services must meet **legal**, **professional** and **ethical** standards, while patients retain the right to refuse services.

Do not prescribe merely because the patient requests it, and do not withhold merely because the patient refuses the preferred review format. *Make and document an individualised decision based on clinical information, medicine-specific risk, accessibility of alternative assessment and the consequences of interruption*.

Issue	Reasons favouring limited continued prescribing	Reasons favouring withholding or restricting prescribing	NZ legal/professional position and prudent response
Patient autonomy	Respects the competent patient's right to decline an appointment, examination, tests or a particular mode of consultation. May accommodate disability, cost, transport, trauma, cultural concerns or work obligations.	Autonomy permits refusal of review but does not require the doctor to provide treatment that the doctor considers unsafe or clinically inappropriate. "Informed refusal" requires the patient to understand the likely consequences.	Right 7(7) protects refusal of services. Explain why review is recommended, available alternatives, and the risks of both non-review and interrupted treatment. Document the discussion.
Adequate clinical knowledge	A repeat may sometimes be defensible where the condition is stable, recent reliable information is available, monitoring is current, and the medicine has a wide safety margin.	Without updated history, examination, medication reconciliation or monitoring, the prescriber may lack sufficient knowledge to determine indication, benefit, contraindications, interactions, adherence or adverse effects.	MCNZ states that medicines should be prescribed only after adequate assessment and/or where the doctor has adequate knowledge of the patient's condition and is satisfied treatment is in the patient's best interests.
Repeat prescriptions	A short, explicitly time-limited "bridging" supply may reduce foreseeable harm while permitting time to arrange review. This is more defensible where abrupt cessation is hazardous.	Repeatedly issuing medication despite overdue assessment may convert a temporary accommodation into unsafe indefinite prescribing. The signing doctor remains responsible for each prescription.	MCNZ requires review of relevant information before issuing repeats. Patients should be assessed in person regularly; where further examination or assessment is needed, a repeat should not be issued without the patient being seen. The decision remains the doctor's discretion and must be explained and documented.
Beneficence and continuity	Continued supply may prevent withdrawal, relapse, decompensation, seizure, uncontrolled pain, psychiatric deterioration or loss of disease control. It may preserve therapeutic engagement.	Continuing without assessment can delay diagnosis, allow deterioration to go unnoticed, and expose the patient to cumulative toxicity or ineffective treatment. Continuity is not equivalent to automatic continuation of every medicine.	Balance the foreseeable harm of stopping against the foreseeable harm of continuing. Consider the smallest clinically reasonable quantity, clear safety-netting and an achievable review pathway rather than an all-or-nothing response.
Non-maleficence and monitoring	Where objective monitoring is recent and reliable, the incremental risk of a brief extension may be low. Information may sometimes be obtained from another clinician, shared records, pharmacy data or community testing, with appropriate authority.	Risk rises where the medicine requires blood pressure, weight, ECG, blood tests, pregnancy assessment, mental-state assessment, misuse review, or examination for efficacy or toxicity.	MCNZ expects periodic review of benefits and harms during extended treatment and accurate, timely records. Right 4 requires reasonable care and skill and minimisation of potential harm.
Telehealth or alternative review	Telephone or video consultation, home visit, outreach clinic, nurse observations, community laboratory testing or review by another appropriate practitioner may overcome barriers without insisting on conventional attendance.	Telehealth is inadequate where physical findings are material, identity cannot be reliably established, safeguarding concerns exist, or necessary observations/tests cannot be obtained.	MCNZ indicates that when in-person assessment is not possible, telehealth or discussion with another NZ-registered practitioner able to verify history and identity may sometimes be appropriate. The clinician must still decide whether physical examination is necessary.

Issue	Reasons favouring limited continued prescribing	Reasons favouring withholding or restricting prescribing	NZ legal/professional position and prudent response
High-risk medicines	Exceptionally, a very short supply may prevent serious withdrawal or destabilisation while urgent review is arranged.	Controlled drugs, sedatives, opioids, stimulants, anticoagulants, lithium, methotrexate, insulin and other narrow-therapeutic-index or monitoring-dependent medicines carry greater risks from unreviewed continuation. Risks include toxicity, diversion, dependence, interactions and prescribing to an outdated diagnosis.	Apply a substantially higher threshold. Confirm indication, dose, dispensing history, other prescribers, monitoring and misuse risk. Controlled-drug requirements under the Misuse of Drugs legislation also apply independently of the ethical analysis.
Legal authority versus legal standard of care	The Medicines Act and Regulations may permit an authorised prescriber to issue a prescription and set formal requirements such as scope, prescription content and maximum supply.	Technical authority to prescribe does not establish that prescribing is clinically defensible. A prescription can satisfy formal requirements yet breach professional standards or the HDC Code.	The Medicines Act provides the statutory framework, while HDC Right 4(2) requires compliance with legal, professional and ethical standards. MCNZ prescribing guidance may be used by MCNZ, HDC or the Health Practitioners Disciplinary Tribunal when assessing conduct.
Fairness and access barriers	Refusal may reflect unaffordable fees, rurality, disability, caregiving duties, fear, previous trauma, language barriers or distrust. Rigid withholding may disproportionately harm already disadvantaged patients and undermine equity and cultural safety.	Equity does not justify exposing a patient to avoidable medication harm. Making exceptions without defined criteria may create inconsistent or discriminatory practice.	Explore and record the reason for refusal. Offer proportionate alternatives such as funded/community services, interpreter or support person, flexible appointment formats, transport assistance, limited-scope review or transfer to an accessible provider. Rights 1, 3, 5 and 8 are relevant.
Coercion and therapeutic relationship	Avoiding abrupt, punitive discontinuation can preserve trust and allow shared decision-making.	Using medication withdrawal primarily to force attendance may be experienced as coercive, especially when cessation is dangerous. Conversely, acceding to pressure or threats from a patient compromises professional independence.	Frame the decision around clinical safety rather than punishment: “I cannot safely authorise a routine supply without X information.” MCNZ states that medicines must not be prescribed merely because a patient demands them.
Capacity and safeguarding	A capacitous patient may make an apparently unwise decision. Respecting that choice can be ethically appropriate after adequate information and support.	Persistent refusal may reflect cognitive impairment, severe mental illness, coercion, neglect, substance dependence, health-literacy problems or communication barriers.	Capacity is presumed, but assess it where there are reasonable grounds for concern. Support communication and involve whānau or another support person with consent. Obtain senior or legal advice where capacity, best interests or serious risk is uncertain.
Documentation and accountability	Clear records demonstrate a reasoned, proportionate response and support continuity between clinicians.	A templated note such as “patient refused review” is insufficient if it omits risk assessment, information provided, alternatives offered and the rationale for prescribing or declining.	Record the current history available, missing information, capacity considerations, risks discussed, patient’s stated reasons, alternatives offered, clinical rationale, quantity and conditions of any bridge prescription, safety-netting and follow-up plan. MCNZ requires records of clinical information, options, decisions and reasons, information given, management plan and treatment prescribed.
Ending or limiting the relationship	Transfer to another provider may be appropriate where the patient’s preferred model of care cannot be safely provided.	Immediate deregistration or abandonment may expose the patient to preventable harm, particularly where treatment cannot safely stop abruptly.	Where the therapeutic relationship must end, provide reasons, reasonable notice, urgent care during transition, appropriate interim arrangements and prompt transfer of records. MCNZ emphasises justification and continuity when ending a doctor–patient relationship.

Practical prescribing threshold

Clinical situation	Generally defensible approach
Stable condition, recent review and monitoring, low-risk medicine	Consider a routine or shortened repeat after reviewing the record, confirming no material change and documenting the basis. Arrange the next appropriate review.
Review overdue but stopping poses meaningful risk	Consider a **limited bridge supply**, only after obtaining the best available history and safety information. State that further prescribing depends on specified assessment or monitoring.
Essential examination or monitoring missing	Do not issue a routine repeat. Offer an accessible alternative pathway and consider only the minimum emergency supply justified by the relative risks.
Serious adverse effects, deterioration, diversion, dependence or diagnostic uncertainty	Withhold or tightly restrict prescribing pending urgent assessment; arrange appropriate urgent or emergency review.
Repeated refusal despite multiple reasonable alternatives	Reassess capacity and barriers, communicate a clear prescribing boundary, document comprehensively, seek peer/medicolegal advice for high-risk cases, and arrange safe transfer of care where necessary.

Bottom line

The ethically and legally stronger position is usually **not** “prescribe indefinitely” versus “stop everything.” It is a proportionate response based on:

current clinical knowledge + medicine-specific risk + harm from interruption + reasonable alternatives + informed discussion + contemporaneous documentation.

A patient may lawfully refuse review; the prescriber may lawfully and professionally decline a prescription when the information required for safe prescribing is unavailable. Conversely, abrupt withholding without assessing withdrawal or destabilisation risks may itself be difficult to justify.

Key decision points

Step	Key question	Practical NZ prescribing principle
1	What exactly is being requested?	Every repeat is a fresh prescribing decision.
2	Would stopping cause harm?	Consider withdrawal, relapse, destabilisation.
3	Do I have enough information?	Do not prescribe unless you have adequate knowledge to do so safely.
4	Is the situation low-risk and stable?	Stable, low-risk medicines are more defensible for limited repeats.
5	Is review clinically necessary?	If examination, tests, or monitoring are needed, routine repeat is harder to justify.
6	Why is the patient refusing review?	Explore barriers before concluding “non-compliance.”
7	Can review occur another way?	Telehealth or alternative review may satisfy obligations in some cases.
8	Is refusal informed and capacitous?	Patients may refuse review, but refusal does not compel prescribing.
9	Is prescribing still safe and defensible?	The prescriber retains independent responsibility for the prescription.

Useful “end points” in practice

Outcome	When appropriate
Routine repeat	Stable condition, low-risk medicine, sufficient recent information, no major safety concerns
Short bridging supply	Some risk if medication stops, but review is overdue or information incomplete
No prescription until review	Insufficient information, high-risk medicine, monitoring overdue, or prescribing would be unsafe
Urgent escalation	Capacity concern, marked deterioration, withdrawal risk, suicidality, toxicity, misuse/diversion, or safeguarding concerns

High-risk situations requiring a higher threshold

Use extra caution if the repeat request involves:

- **controlled drugs**
- **opioids / benzodiazepines / sedatives**
- **stimulants**
- **anticoagulants**
- **lithium**
- **methotrexate**
- **insulin**
- **antiepileptics**
- medicines needing **regular blood tests / BP / ECG / pregnancy assessment**
- concerns about **dependence, diversion, or non-adherence**

Suggested documentation prompts

Document:

- medicine requested, dose, indication
- date of last review
- risks of stopping vs continuing
- what information was available / missing
- why review was recommended
- patient's reason for refusing
- alternatives offered
- capacity / informed refusal assessment
- rationale for prescribing, bridging, or declining
- quantity supplied
- monitoring / follow-up requirements
- safety-net advice given

Short version for clinic wall / prescribing policy

Repeat request → assess risk of stopping → check whether you have enough information → decide if review is required → offer accessible review options → assess informed refusal/capacity → prescribe only if safe and defensible → if needed, provide limited bridge only → document everything

Top prescribing mistake	Why it is risky	Practical mitigation
1. Issuing repeat prescriptions without sufficient current clinical information	The prescriber may miss deterioration, adverse effects, interactions, non-adherence, changed contraindications or overdue monitoring. Each repeat remains a new prescribing decision; previous prescribing does not automatically justify continuation. MCNZ expects the prescriber to have appropriate information available and to review whether the repeat remains suitable.	Review the record, indication, dose, dispensing history, recent symptoms, other medicines and required monitoring. Confirm whether examination, observations or tests are necessary. Where information is incomplete but interruption is hazardous, consider only the **smallest clinically reasonable bridging supply** while arranging review.
2. Treating refusal of review as either an automatic entitlement to medication or grounds for punitive abrupt cessation	A patient has the right to refuse a proposed review, but that does not oblige the clinician to prescribe unsafely. Conversely, suddenly withholding medicine solely to force attendance may cause avoidable withdrawal, relapse or destabilisation. The response must comply with professional standards and remain proportionate to the clinical risks.	Explain why review is required and distinguish a **clinical safety boundary** from punishment. Compare the harms of continuing versus stopping. Offer realistic alternatives such as telehealth, nurse observations, community laboratory testing, a shorter appointment or assessment by another clinician. Provide urgent safety-netting where interruption may be dangerous.
3. Failing to document the refusal, risk assessment and prescribing rationale	A note stating only “patient declined review” does not demonstrate informed refusal or a defensible prescribing decision. Poor records also impair continuity and make it difficult to show that risks, alternatives and follow-up requirements were addressed. MCNZ identifies clinical records as an essential component of good medical practice.	Record the medicine and indication, date of last review, information available and missing, risks of continuing and stopping, the patient’s reasons, capacity concerns, alternatives offered, advice given, final rationale, quantity supplied or declined, monitoring required, review deadline and safety-net plan. Seek peer or indemnity advice when the risk or ongoing impasse is significant.

Useful rule of thumb

Do not prescribe merely because the patient requests it, and do not withhold merely because the patient refuses the preferred review format. Make and document an individualised decision based on clinical information, medicine-specific risk, accessibility of alternative assessment and the consequences of interruption.

Example of a clinical Note

Clinical note – repeat prescription request where patient declines review

Date/time: [DD/MM/YYYY, HH:MM]
Contact type: Telephone / video / portal message
Clinician: [Name and designation]

Reason for contact
Patient requested a repeat prescription for **[medicine, dose, frequency]**, prescribed for **[indication]**.

Relevant clinical background
Last documented clinical review was **[date]**. Last relevant monitoring was **[date/results]**. Current medication list and allergies were reviewed. Dispensing history was checked where available.

During today's contact, the patient reported:

- Current symptoms: [stable / describe changes]
- Perceived benefit from treatment: [details]
- Adverse effects: [none reported / details]
- Adherence: [details]
- New diagnoses, medicines, pregnancy possibility, alcohol or substance use, or other relevant changes: [details]
- Red-flag symptoms: [specify negatives and positives]

No current evidence was identified from the available history of **[toxicity, acute deterioration, misuse, diversion, significant interaction, or other relevant risk]**. However, the following information remains outstanding: **[physical examination, blood pressure, weight, blood tests, ECG, mental-state review, medication reconciliation, or other monitoring]**.

Review recommendation and refusal
I advised the patient that a clinical review is recommended because **[specific reason]** and that continued prescribing without this information may carry risks including **[specific risks]**.

The patient declined **[in-person review / all review]**. Their stated reason was **[cost, transport, work, anxiety, previous experience, preference, or other reason]**.

Alternative options were discussed, including **[telephone/video review, shorter appointment, nurse observations, community laboratory testing, support person, interpreter, home or outreach review, or review by another clinician]**. The patient declined / accepted **[details]**.

Informed refusal and capacity
The patient was able to:

- explain why review had been recommended;
- describe the material risks of continuing treatment without review;
- describe the risks of stopping treatment;
- understand the available alternatives; and
- communicate a clear and consistent decision.

There was no apparent evidence during this contact of impaired decision-making capacity. The patient understands that declining review does not guarantee ongoing repeat prescribing.

Risk–benefit assessment
The risks of abrupt cessation include **[withdrawal, relapse, seizure, psychiatric destabilisation, loss of disease control, or other risk]**.

The risks of continuing without full review include **[toxicity, unrecognised deterioration, interaction, inadequate monitoring, dependence, diversion, or other risk]**.

On balance, based on the currently available information, I consider that:

[Choose one]

A. Limited prescribing is justified:
A short bridging supply is the least harmful and most proportionate option while review is arranged.

B. Routine repeat prescribing is justified:
The condition appears stable, the medicine is relatively low risk, monitoring is sufficiently current, and adequate clinical information is available.

C. Further prescribing is not clinically safe:
Essential assessment or monitoring is unavailable, and the risk of continuing outweighs the risk of withholding.

Decision
[Medicine, strength, dose] prescribed for **[quantity/duration]** only.

No automatic repeats authorised.

Further prescribing will require **[specific review, examination, test or monitoring]** by **[date/timeframe]**.

OR

Prescription declined because **[specific clinical reason]**. The decision was explained as a safety-based clinical decision rather than a punitive response to refusal of review.

Safety-netting
The patient was advised to seek urgent medical care if they develop **[specific red flags]**. They were advised whom to contact during business hours and after hours. The patient was able to repeat back the key advice / confirmed understanding.

Follow-up plan

- Review arranged/offered for: [date]
- Monitoring requested: [details]
- Responsible clinician/service: [details]
- Transfer or alternative care options discussed: [details]
- Senior/peer/medicolegal advice sought: [if applicable]

Clinician:
[Name, designation, signature]

Here are four of the most **common pitfalls**, framed from a **NZ MCNZ/HDC medicolegal perspective**:

Common mistakes	Why it is problematic	How to avoid it
1. Prescribing without adequate current clinical information	Every repeat prescription is a new prescribing decision. Continuing medication without sufficient knowledge of the patient's current condition, monitoring or risk factors may breach the duty to prescribe safely.	Review the patient's history, indication, recent consultations, investigations, monitoring requirements and dispensing history before prescribing. If information is insufficient, consider a limited bridging prescription only if clinically justified.
2. Assuming refusal of review means you must either prescribe or stop medication completely	Patients have the right to refuse review, but they do not have the right to demand a prescription. Equally, abruptly stopping medication purely to force attendance may expose patients to avoidable harm.	Balance the risks of continuing versus stopping treatment. Consider alternative methods of review (telehealth, nurse assessment, investigations) and, where appropriate, provide a time-limited bridging prescription while arranging reassessment.
3. Poor documentation of the clinical decision-making	In complaints or medicolegal reviews, the clinical record is often the strongest evidence of appropriate practice. A note stating only "patient refused review" does not demonstrate informed refusal or clinical reasoning.	Document the discussion, patient's reasons for refusing, alternatives offered, capacity assessment (where relevant), risks discussed, rationale for prescribing or declining, quantity supplied, follow-up plan and safety-net advice.
4. Failing to individualise the decision according to the medicine and clinical risk	Applying the same approach to every repeat prescription ignores that some medicines require much closer monitoring than others. High-risk medicines (e.g. opioids, benzodiazepines, lithium, anticoagulants, methotrexate) require a higher threshold for prescribing without review.	Perform an **individual** risk assessment for each medicine. Consider the need for examination, laboratory monitoring, potential toxicity, withdrawal risk, misuse/diversion and the consequences of delaying review before deciding whether prescribing remains clinically defensible.

A simple principle to remember

When faced with a patient refusing review, ask yourself four questions before prescribing:

1. **Do I have enough current clinical information to prescribe safely?**
2. **What is the risk of continuing versus stopping this medication?**
3. **Have I explored reasonable alternatives to an in-person review?**
4. **If my decision were reviewed by the HDC or MCNZ in two years' time, would my documentation clearly explain why it was safe and reasonable?**

These four questions provide a practical framework that aligns well with MCNZ Good Prescribing Practice and the HDC Code of Rights.

In New Zealand, retrospective scrutiny (whether by the **Health and Disability Commissioner (HDC)**, the **Medical Council of New Zealand (MCNZ)**, the **Health Practitioners Disciplinary Tribunal (HPDT)**, or the courts) generally asks a single overarching question:

"Was the clinician's decision reasonable and consistent with accepted professional standards, based on the information available at the time?"

Importantly, decisions are judged **prospectively**, not with the benefit of hindsight. An adverse outcome alone does not mean the care was substandard.

The following features are those most likely to help a clinician defend their decision.

Feature	Why it is important in retrospective review	Example documentation
1. Clear clinical reasoning	Decision-making is judged on the reasoning process, not simply the outcome. A well-reasoned decision is easier to defend even if the outcome was poor.	"Benefit of continuing medication to avoid seizure relapse considered greater than short-term prescribing risk pending review."
2. Demonstration of risk–benefit analysis	Shows that competing risks were actively weighed rather than ignored.	"Risk of abrupt cessation discussed alongside risks of continuing without updated monitoring."
3. Evidence of informed refusal	Demonstrates respect for patient autonomy while showing the patient understood the consequences of declining review.	"Patient able to explain reasons for declining review and demonstrated understanding of potential risks."
4. Exploration of alternatives	Shows the clinician attempted to reduce risk rather than presenting an "all-or-nothing" choice.	"Telehealth, nurse review and laboratory monitoring offered; patient declined all options."
5. Appropriate documentation	The record is often the strongest evidence of what occurred. If it is not documented, it can be difficult to demonstrate the reasoning later.	Record discussion, alternatives, rationale, safety-netting and follow-up plan.
6. Compliance with recognised professional standards	Alignment with MCNZ Good Prescribing Practice and Good Medical Practice demonstrates that accepted standards informed the decision.	Evidence that adequate information was sought before prescribing and review was recommended.
7. Individualised assessment	Avoids criticism that prescribing was automatic or based on practice habit rather than the patient's circumstances.	Consideration of medicine-specific risks, monitoring requirements and patient-specific factors.
8. Proportionate prescribing	Demonstrates that the least risky option was selected.	"Issued a 7-day bridging prescription pending review rather than a routine 3-month supply."
9. Safety-netting	Shows reasonable steps were taken to minimise harm if the patient's condition changed.	Advice regarding red flags, emergency services, and when to seek urgent review documented.
10. Follow-up plan	Indicates that prescribing was part of an ongoing management strategy rather than indefinite continuation.	Review date, monitoring requirements and circumstances for further prescribing clearly recorded.

Common themes seen in HDC opinions

Many HDC cases identify similar recurring deficiencies:

- **Insufficient assessment before prescribing**
- **Poor or absent documentation**
- **Failure to recognise known risks**
- **Inadequate monitoring**
- **Failure to arrange appropriate follow-up**
- **Ignoring relevant clinical guidelines**
- **Inadequate communication with the patient**

Conversely, clinicians tend to receive less criticism when they can demonstrate:

- a logical and documented decision-making process;
- that recognised standards informed their actions;
- that the patient was involved in decision-making;
- that foreseeable risks were considered and mitigated where possible;
- that reasonable alternatives were offered; and
- that the documentation accurately reflects what occurred.

A defensibility checklist

A useful mental checklist is whether your note answers these questions:

1. **What did I know at the time?**
2. **What important information was missing?**
3. **What were the reasonably foreseeable risks?**
4. **What options did I consider?**
5. **Why did I choose this option?**
6. **What alternatives did I offer the patient?**
7. **How did I confirm informed refusal (if applicable)?**
8. **How did I reduce the remaining risk?**
9. **What follow-up and safety-netting did I arrange?**
10. **Would another reasonable NZ clinician be able to understand and follow my reasoning from the record alone?**

One practical principle

The strongest defence in a retrospective review is **not a perfect outcome but a transparent, contemporaneous record demonstrating thoughtful clinical reasoning, adherence to accepted professional standards, respect for patient autonomy, and proportionate risk management**. This reflects how HDC and MCNZ generally assess whether care met the required standard, rather than judging the decision solely by the eventual outcome.

Illustrative Example

Below is a **hypothetical example** illustrating how the principles may be applied. It is not intended to represent the “correct” decision in every case, but rather to demonstrate **defensible clinical reasoning**.

Hypothetical Case

Clinical Scenario

A 56-year-old man requests a repeat prescription for **lisinopril 20 mg daily** via the patient portal.

He has not attended for review for **22 months**, despite several reminders.

The practice notes indicate:

- Hypertension
- Type 2 diabetes
- CKD Stage 3a
- Last blood tests 20 months ago
- Last BP recorded 18 months ago
- Pharmacy dispensing suggests regular adherence.

He writes:

“I’m too busy to come in. Just send my usual prescription.”

Poorly Defensible Approach

The GP authorises another 6 months of medication without contacting the patient.

Clinical note:

“Repeat issued.”

Problems

❌ No assessment

❌ No consideration of overdue renal monitoring

❌ No discussion of risks

❌ No attempt to arrange review

❌ No explanation of clinical reasoning

If the patient develops severe AKI two months later, there is little evidence that the prescribing decision was made safely.

Better Defensible Approach

The GP telephones the patient.

Discussion includes:

> “I’d like to continue your medication if it’s safe to do so. Your kidney function and blood pressure haven’t been checked for almost two years, and this medication can affect kidney function and potassium. I can’t safely continue routine prescribing indefinitely without updated information.”

The patient states:

> “I’m not coming in. I don’t have time.”

Exploration of barriers

GP asks:

- Is cost the issue?
- Difficulty getting appointments?
- Transport?
- Work commitments?

Patient replies:

> “I’m working away during clinic hours.”

Alternatives offered

GP offers:

✓ Early morning appointment

✓ Video consultation

✓ Nurse blood pressure check

✓ Community laboratory testing

Patient agrees to:

- blood tests
- nurse BP check

but refuses GP review.

Clinical reasoning

The GP considers:

Benefits of continuing

- Prevent uncontrolled hypertension
- Reduce cardiovascular risk

Risks of continuing

- Unknown renal function
- Possible hyperkalaemia
- No recent BP
- CKD increases risk

Risk of abrupt cessation

Stopping immediately may increase cardiovascular risk.

Decision

The GP prescribes:

30-day supply only

Conditions:

- Blood tests within one week
- Nurse BP within one week
- GP review after results

No further repeats until review.

Documentation

Repeat request received.

Last clinical review 22 months ago.

Last renal function 20 months ago.

Explained medication requires ongoing monitoring because of CKD and ACE inhibitor therapy.

Discussed risks of continued prescribing without current renal function or BP.

Patient declined GP review due to work commitments.

Explored barriers.

Offered telehealth, early appointment, nurse BP and laboratory testing.

Patient accepted nurse BP and laboratory testing but declined doctor consultation.

Patient demonstrated understanding that declining review may limit ongoing prescribing.

Considered risks of stopping medication versus short continuation.

Risk of abrupt discontinuation considered greater than short bridging prescription pending updated monitoring.

Prescribed 30 days only.

Blood tests and BP requested.

No further prescriptions until results reviewed.

Safety-net advice provided regarding dizziness, collapse, reduced urine output, chest pain and severe headache.

Two Months Later…

Unexpectedly, the patient develops severe AKI following gastroenteritis and is admitted to hospital.

A complaint is made.

What Would an HDC/MCNZ Reviewer Likely See?

Question	Evidence available
Did the GP simply issue repeats?	**No**
Was there evidence of clinical reasoning?	**Yes**
Were the risks recognised?	**Yes**
Was the patient informed?	**Yes**
Was refusal respected?	**Yes**
Were alternatives offered?	**Yes**
Was prescribing proportionate?	**Yes—30-day bridge only**
Was follow-up arranged?	**Yes**
Was documentation comprehensive?	**Yes**

Contrast with a Less Defensible Example

Suppose instead the GP wrote:

> "Patient refuses review. Prescription declined."

No discussion.

No exploration.

No risk assessment.

No consideration of withdrawal.

No alternatives.

If the patient suffered a stroke after stopping antihypertensive medication, reviewers might ask:

- Why was no attempt made to understand the refusal?
- Why were no alternatives offered?
- Why wasn't a short bridging prescription considered?
- Where is the evidence that competing risks were balanced?

The criticism would not necessarily be that the prescription was declined, but that **the clinical reasoning process was not apparent or may not have occurred**.

The Central Medicolegal Principle

The most defensible clinicians are rarely those who can show they **predicted the outcome**. Rather, they are those who can demonstrate that they:

1. **Recognised the clinical risks**.
2. **Obtained as much relevant information as reasonably possible**.
3. **Considered reasonable alternatives**.
4. **Respected the patient's autonomy while maintaining professional independence**.
5. **Made a proportionate prescribing decision**.
6. **Documented the reasoning clearly and contemporaneously**.

In a retrospective review, this kind of documentation allows an independent reviewer to conclude:

"Although the outcome was unfortunate, the clinician's decision-making was thoughtful, consistent with accepted professional standards, and reasonable based on the information available at the time."

At least I "TRIED"

How to manage repeat prescriptions in a patient who refused to engage in review

Dr. Paul Tervit

T	**Talk** to the patient / Establish communication and therapeutic rapport / is there **capacity?** / **Engage**
R	**Reasons** for disengagement / explore **barriers** - consider **equity** / access – rurality / disabilities / **knowledge**
I	**Inform** patient / foreseeable **risks** – of stopping **or** continuing / safety issues / **why** the review recommended - what **information** is required for safe prescribing / beware miscommunicating punitive action – don't **create** barriers.
E	**Explore** options and **alternatives** to barriers for **safe** prescribing / bridging prescriptions for **low risk** Rx / telehealth / nurses / outreach / involve colleagues re **high-risk** medications (collaboration)
D	**Document** everything clearly / **outcomes** – why declining-restricting / **safety netting** and FU / document **safe** clinical reasoning to **mitigate** risk and minimizing harm. Maintain engagement