Medication Management Mistakes

By Stephanie Deupree, JD, BSN

Linda Powell[1], a 52-year-old woman, presented to the office of gynecologist Dr. Brenda Farmer for an annual exam in June. During the office visit, Ms. Powell complained of bloating and fluid retention associated with her menstrual cycle. For these complaints, Dr. Farmer prescribed Dyazide™, writing the prescription for one pill by mouth once a day with 30 pills; the prescription included six refills.

According to Dr. Farmer, she counseled the patient to use the Dyazide only as needed during her menstrual cycle. However, Dr. Farmer failed to record her instructions to the patient in the visit note or elsewhere in the medical record, and the label on the prescription did not reflect this instruction.

Approximately two weeks after receiving and filling the original prescription, Ms. Powell called Dr. Farmer's office, informing the nurse that the Dyazide had worked well for two weeks but requesting an increase in the dosage. Without consulting Dr. Farmer, the nurse "increased the Dyazide to 2 every other day."

One month after receiving the new dosing instruction from Dr. Farmer's nurse, Ms. Powell

called the office and stated that her Dyazide prescription had been doubled and that she had run out of refills. Ms. Powell requested more Dyazide. Without any investigation regarding Ms. Powell's statement that she had run out of refills, Dr. Farmer authorized another prescription for Dyazide with instructions of one pill by mouth once a day with 30 pills and six refills.

Ms. Powell had the medication refilled three times before returning in October for an office visit. During the visit, Ms. Powell indicated that the Dyazide was not working well for her. Dr. Farmer told the patient to stop taking the Dyazide and prescribed spironolactone instead. Despite these verbal instructions, there is nothing in the medical record documenting that Dr. Farmer instructed Ms. Powell to stop the Dyazide. The record only reflects that spironolactone had been prescribed.

Pharmacy records indicate that Ms. Powell filled the spironolactone once following the October visit but never again. She began taking the Dyazide again in November without consulting Dr. Farmer. Over the next eight months, Ms. Powell refilled the Dyazide six times.[2]

In July, over one year after the initial prescription, Ms. Powell called Dr. Farmer's office for another refill of Dyazide. A new nurse, without realizing Dr. Farmer had discontinued it, and without questioning the patient or consulting Dr. Farmer, called in a one-month supply.

Two weeks later Ms. Powell collapsed at home, and a family member called 911. Shortly before the EMTs arrived, Ms. Powell went into cardiac arrest. Upon arrival, the EMTs initiated resuscitation measures and transported Ms. Powell to the emergency room. After arriving at the hospital, the medical team succeeded with resuscitation.

Tragically, Ms. Powell suffered an anoxic brain injury. Initial lab work at the hospital revealed a potassium level of 2.1. After several days in the ICU, Ms. Powell was transferred to hospice care where she remained until her death a few days later. Ms. Powell's death certificate listed her cause of death as anoxic brain injury resulting from ventricular arrhythmia.

Less than one year after her death, Ms. Powell's family filed a wrongful death suit against Dr. Farmer and her practice. The complaint alleged that Dr. Farmer failed to meet the standard of care for managing and monitoring chronic diuretic therapy. More specifically, it alleged that failure to monitor Ms. Powell's potassium levels resulted in hypokalemia which led to cardiac arrhythmia and, ultimately, death.

The chasm between the medical records and the testimony of Dr. Farmer made a successful defense of this case very difficult. In her deposition, Dr. Farmer testified that she does not prescribe or oversee chronic diuretic therapy but only prescribes diuretics on an as-needed basis which does not require potassium monitoring. If a patient needs daily diuretics, then the patient is referred to their primary care physician for management. This was Dr. Farmer's testimony even though within the first two months of seeing Ms. Powell, she authorized prescriptions for fourteen months of daily Dyazide.

Similarly, Dr. Farmer testified in her deposition that she instructed Ms. Powell at the initial June visit to take the Dyazide only as needed; however, the medical records did not support her testimony. In fact, her testimony conflicted with the actual instructions written for the prescription which read to take one pill daily. The discrepancy between her testimony and the medical records presented not only a standard of care challenge, but also a credibility issue.

In some cases, it is possible to prevail even when the standard of care is not met if the alleged negligence did not cause an injury to the patient. This was not one of those cases. Although the likelihood of hypokalemia from Dyazide is low, it is possible, and it provided a straightforward explanation for Ms. Powell's arrhythmia and subsequent death. Dr. Farmer admitted in her deposition that chronic diuretic therapy requires electrolyte monitoring, which was not done in this case. Furthermore, the defense experts conceded that Dyazide could have caused hypokalemia, arrhythmia, and death.

The defense experts could not provide an alternative explanation for the cause of Ms. Powell's cardiac arrest. Given the issues with the overall defensibility of the case, the parties settled several months prior to the scheduled trial date.

Unfortunately, Dr. Farmer and her staff missed numerous opportunities to recognize a problem with the patient's medication management. Some recommendations that can be drawn from this case:

1. develop and maintain a policy for prescribing and dispensing all medications that includes a clear direction that staff should not renew prescriptions without specific provider approval;
2. document important conversations with the patient regarding medication management;
3. make sure that verbal and written instructions are consistent;
4. review patients' prescription history carefully before authorizing refills;
5. question unusual refill requests; and
6. order appropriate tests for monitoring if needed.

For more information, please click here.

[1] Names have been changed.

[2] During the discovery process, the defense team learned that Ms. Powell had gone to her PCP in November for the same complaint of edema. Her PCP provided her with yet another prescription for Dyazide. The lawsuit did not name the PCP as a defendant.
