MIEC

Write On!

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Medication mismanagement: a costly prescription

INSIDE

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A publication of the Loss Prevention Department, Medical Insurance Exchange of California, 6250 Claremont Avenue, Oakland, CA 94618.

As reported by the Physician Insurers Association of America, claims arising from medication errors/medication mismanagement are among the top five most prevalent medical misadventures.[i] According to the Institute of Medicine (IOM), at least 1.5 million Americans experience adverse drug events (ADE) annually.[ii] These numbers exclude outpatient settings and have been tallied primarily in hospitals, long-term care facilities, and for Medicare patients 65 years of age and older. Studies estimate that an ADE increases the cost of each hospital stay by $8750, equaling approximately $3.5 billion per year for 400,000 inpatient visits. The cost of ADEs for Medicare recipients 65 or older equals $887 million per year. Efforts to help reduce ADEs and their associated expenses include: e-prescribing, repackaging medications, FDA-ordered bar coding (less than 20% of all US hospitals have the costly bar code reading systems), pharmacy oversight/feedback and electronic medical records with drug-interaction alerts.

MIEC has defended approximately 1600 medication-related claims or suits since 1975. Most of the cases fall into two main categories: failure to manage medications and negligent prescription of medication resulting in a severe side effect or complication (Figure 1). Other claims have arisen from injuries caused by overlooked allergies, dosing errors, pharmacy or staff errors, mismanagement of pain medications, and failure to obtain informed consent when prescribing medications that could cause significant injury. Seventy-one percent (71%) of MIEC's medication-related claims arise from events in physician offices, while 28% occur in a hospital setting, and one percent in surgery centers and skilled nursing facilities.

The cases presented in this issue of *Write On!* highlight a sampling of MIEC's most costly medication-related suits, all settled or lost at trial in the six-figure-or-higher range. **Of note:** Most of the cases cited were compromised by documentation problems or systems failures that either directly contributed to the injury or impaired the physician's defense. Some details of the cases have been changed to protect the identities of both plaintiffs and defendant physicians.

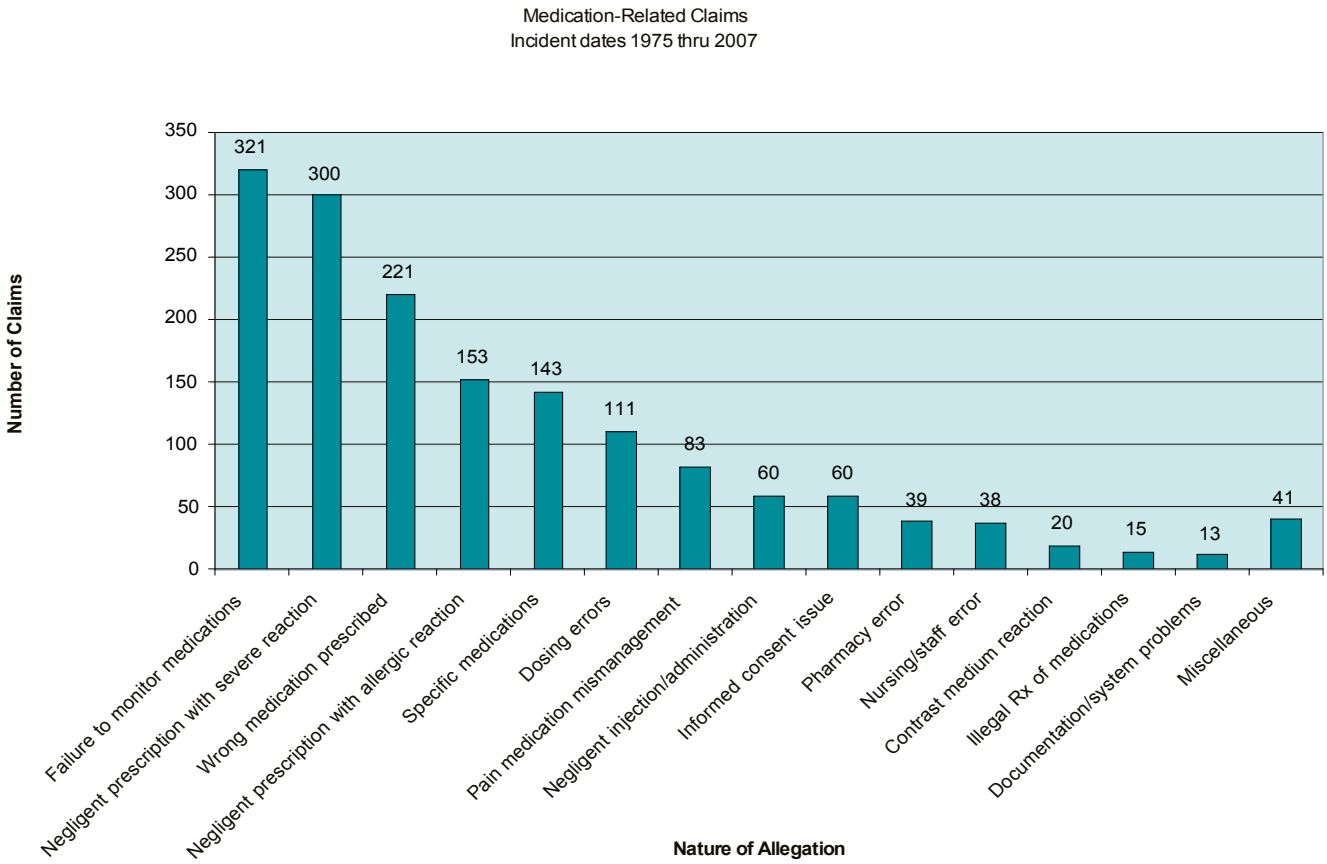

Figure 1

Closed Medication-Related Claims by State

State	Average indemnity	% Claims closed without payment to plaintiff
Alaska	$258,475.00	95%
California	$72,893.00	87%
Hawaii	$206,626.00	84%
Idaho	$176,822.00	82%
Nevada	$111,190.00	81%

Figure 2

Figure 2 illustrates the average indemnity paid (by state) on behalf of policyholders and the percentage of claims or suits that were closed without payment to the plaintiff. Overall, the **average indemnity paid per claim was $107,030.40**; 86% of all closed claims were resolved without payment to the plaintiff. In addition to indemnity monies, MIEC paid approximately **$19,038,377** to defend the medication-related claims.

Case 1 (Dosing error): Patient with history of asthma and diarrhea. A small bowel X-ray suggested Crohn's Disease. Physician diagnosed "regional enteritis" and recommended Prednisone, intending to prescribe 5 mg Prednisone tabs to be taken four times a day (QID) for two weeks and reduced to 2.5 mg QID for two weeks. The physician inadvertently prescribed 20 mg tabs to be taken QID for two weeks, reduced to 3 ½ tabs per day for one week and 3 tabs per day for one week. Patient developed asceptic necrosis of the hips and required left hip replacement.

Case 2 (Overlooked allergy): Patient had upper respiratory infection and a known allergy to penicillin, but allergy information was buried in the chart. Physician prescribed Amoxicillin; patient hospitalized for four days due to anaphylactic reaction.

Case 3 (Failure to monitor medications): 76-year-old patient hospitalized for major depression with suicidality. Treating psychiatrist prescribed Risperdal and Remeron. Five days into admission, prescribed Eskalith (lithium carbonate) 450 mg in the morning and 675 mg in the evening to augment effects of the other medications prescribed. Psychiatrist did not know patient was taking lisinopril, a medication that increases lithium serum levels. Psychiatrist planned to observe patient for toxicity and obtain serum lithium levels within 72 hours. One day later, psychiatrist increased lithium dosage to 675 mg twice a day and added Navane, but did not document reason for the increase. Day 7 of admission, psychiatrist saw patient but results of the lithium serum tests were not available during that visit; the lab did not report elevated lithium levels directly to psychiatrist. Over the weekend, patient deteriorated and psychiatrist was not notified. Day 10, patient was transferred with altered mental status. Lithium serum level 3.2 (effective serum levels range from 1 – 1.5 mEq/L for acute treatment and 0.6 – 1.2 mEq/L for long term treatment). Results were not filed in the chart. One month later the patient suffered a stroke and died within six months. A professional reviewing committee was of the opinion that the lithium treatment was too aggressive for the elderly patient and questioned whether lithium should have been prescribed at all. **Of note:** The physician's decision to settle this matter was impacted by a secondary allegation of elder abuse.

Case 4 (Pain medication mismanagement): 42-year-old female referred to neurosurgeon for chronic back and neck pain. Examined by neurosurgeon who recommended an MRI and who added Neurontin to the patient's medication regimen. Patient never obtained MRI and told physician that she recently had an X-ray which was read as normal. The neurosurgeon failed to obtain a copy of the X-ray or to definitively determine the cause of patient's back and neck pain. Over the next year, the neurosurgeon adjusted the patient's Neurontin dosage to no effect on her pain. At the time of last visit, patient was on numerous medications and the neurosurgeon prescribed methadone. Unfamiliar with methadone, he used an Oxycontin conversion chart to calculate the medication amount, and prescribed two 40 mg tablets daily for two weeks, to be decreased to one 40 mg tablet per day. Two days later patient died of methadone toxicity.

Case 5 (Failure to monitor medications): 49-year-old patient with cerebrovascular accident with ischemic changes in the right occipital brain. MRI and MRA revealed possible cerebellar tumor and hemangioblastoma. Primary care physician (PCP) admitted the patient and dictated an H&P without reviewing the patient's prior admission chart. The PCP prescribed *aspirin* and *Plavix* a year earlier, but did not realize that the patient continued to take both medications. Preoperatively, the neurosurgeon met with patient. He did not have the patient's prior chart; did not

look at the admitting orders; and did not ask about medications or discuss patient's current medications with the PCP. He performed a left posterior fossa/suboccipital craniotomy and excision of the cerebellar lesion. Immediately post-op the patient developed increased apnea, hypoventilation, and marked hypertension. CT scan revealed massive cerebellar hemorrhage. Patient deteriorated and expired.

MIEC Board of Governors' Loss Prevention Committee members offer policyholders helpful advice to reduce medication-related claims:

Committee Chair Gene Cleaver, MD, Mt. Shasta, CA, recommends that physicians develop a Treatment Record to help them monitor medications, "An internal medicine practice deals with so many medicines and so many trials of some of them that space for all of this information in one central place in the chart is most helpful. This type of form helps physicians to manage higher risk medications and to eliminate the misinterpretation of side effects." *[For a copy of Dr. Cleaver's form and two other sample medication control records, contact the Loss Prevention Department.]*

Douglas G. Smith, MD, Anchorage, AK, emphasizes the importance of computerized prescribing in the hospital setting: "It should be mandatory. Implementing an electronic prescribing system in the outpatient setting could help reduce errors as well."

Russell T. Stodd, MD, Kahului, HI, advises physicians to embrace the electronic age, "Physicians must be ready to embrace technology designed to maximize their practice of medicine. Electronic tools increase physicians' ability to collect data, access records, prescribe safely, document legibly, educate patients, and make sound medical decisions, often in less time. It may even strengthen a physician's defense if the medical record is required in court."

Cheryl A. Tanasovich, MD, Greenbrae, CA, reminds policyholders, "We know that medication-related claims originate in outpatient care, even though the data is derived primarily from hospitals, rest homes and other inpatient facilities. It's time for physicians in office practice to take seriously the need to reduce the risks related to medication prescribing and follow standard quality assurance protocols similar to what might be done in the hospital setting."

Case 6 (Informed consent): 63-year-old female patient with history of hypertension and diabetes. Treating ophthalmologist prescribed Neptazane (methazolamide) for glaucoma; patient developed Stevens-Johnson reaction and suffered bilateral blindness. Physician alleged that he discussed the "significant" or "material" risks with the patient but the informed consent discussion was not documented in chart. An expert reviewer found documentation of patient's care to be inadequate.

Case 7 (Negligent prescription with severe reaction/complication): Patient with history of Hodgkin's lymphoma and radiation therapy was admitted to rural hospital for congestive heart failure (CHF) and severe anemia. She was treated with an ACE inhibitor and transferred to her local hospital to be followed by her PCP. A cardiac consultant diagnosed cardiomyopathy and congestive heart failure; recommended ACE inhibitor. Patient was discharged from hospital, and on the way home, stopped at the PCP's office to pick up medication samples and prescriptions that included two sample boxes of Prinivil 20 mg, and a prescription for Zestril 20 mg. No exam was done and patient was told to return in two weeks. According to plaintiff, her PCP told her to take one Prinivil a day, but failed to advise that she *should not* use or fill the Zestril prescription until after she finished the Prinivil. The PCP claimed the opposite, but failed to document the discussion. The patient believed that Prinivil and Zestril are two different medications (the pills looked different) and took one of each daily for 12 days. Patient returned to the PCP two weeks later with a blood pressure of 74/60. She was immediately sent to a cardiovascular consultant. When being treated, she suffered a stroke expert reviewers said was caused by low blood pressure induced by an excess of lisinopril.

Loss Prevention Recommendations:

Physicians have at their disposal multiple resources to assist them in their efforts to avoid adverse drug events and medication errors.[iii] Most medical academies and colleges provide guidelines for their members. MIEC offers the following advice to help policyholders avoid a costly claim:

(1) Take a complete medication history. Document current medications prescribed by co-treaters. Don't rely solely upon patients to report what medicines they are taking. Ask them to bring a complete list (e.g., prescriber, drug name, dose, amount, instructions) or advise them to bring their medications to the scheduled office visit. Consider offering patients a pill card to help them manage their medications. For instructions to create a pill card, visit the Agency of Healthcare Research and Quality's website at www.ahrq.gov/qual/pillcard.htm.

(2) Follow-up on ordered laboratory tests to measure therapeutic levels. Develop a tracking system to ensure that results are returned. Remind office and hospital nursing staff to promptly advise you of results and to avoid filling reports in patients' charts that lack evidence of your review (e.g., initials, circled values, instructions for follow-up). When the information is not returned in a timely manner, contact the laboratory or patient and document your efforts to obtain test results.

(3) Have a clear understanding of interim medical treatment (e.g., emergency care, hospitalizations, consultations, out-patient surgeries) and medications prescribed. Ask for copies of medical records before prescribing new medications.

(4) Document allergies or "no-known-drug allergies" (NKDA) in a consistent and prominent chart location and update the information periodically.

(5) Document medication orders legibly. Encourage staff to question any medication orders that appear to be out of the ordinary (e.g., doses are too high; calculations appear to be incorrect; words or numbers are illegible; refill intervals indicate improper use, etc.).

(6) Prior to prescribing a new medication or a medication with which you are unfamiliar, take the time to: research proper dosing; use the proper conversion table; and avoid prescribing simply because the patient asks for the drug by name.

(7) When managing chronic pain medications, be *vigilant* in documenting indications for the drugs, efficacy, changes in dose and frequency of use, level of pain, therapeutic levels, and efforts to wean or decrease dosages. Ask the patient to sign a pain management agreement. When appropriate, transfer the patient's care to a pain specialist.

(8) Consider investing in an e-prescribing system. The advantages are great (e.g., legible prescriptions; standardized dosing; third-party payer accepted formulary; drug-interaction alerts; and more).

(9) Discuss even "remote" medication complications if the risks or side effects are "significant" or "material" and could result in permanent injury or even death. Obtain patient's informed consent and document the discussion.

For additional information, contact MIEC's Loss Prevention Department for a copy: "Medication-related claims: the causes and their prevention," *Special Report MIEC Claims Alert*, No. 30; "Challenge for psychiatrists: collaborative treatment with nonphysician co-treaters," *Special Report MIEC Claims Alert*, No. 37A. Ask for a copy of the Pain Management Agreement. Review MIEC's website at www.miec.com for more helpful advisories

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[i] Physician Insurers Association Data Sharing Project
[ii] Institute of Medicine, *Report Brief: Preventing Medication Errors*, July 2006
[iii] Institute for Safe Medication Practices (www.ismp.org)
The Joint Commission (www.jointcommision.org)
United States Pharmacopeia (www.usp.org)
American Medical Association (www.ama-assn.org)