Indefensible Medicine

By Stephanie Deupree, JD, BSN

Nathan Brown,[1] a 55 year-old man, fell from a 6 foot ladder outside his home while working on a home improvement project. Mr. Brown was able to get up and ambulate after the fall. The fall caused pain from his left shoulder blade down to his rib cage and coccyx. He took over-the-counter medication for pain.

The next day, his pain unresolved, Mr. Brown presented to Dr. Joan Everly's office, where he was seen by Elaine Smithson, PA. Mr. Brown rated the pain as moderate in intensity with aggravating factors of coughing, general movement, and walking. On examination, PA Smithson noted pain in the neck, left shoulder, and back with movement and tenderness in the left rib cage and scapula.

PA Smithson ordered an x-ray series of the ribs. The study showed a displaced closed rib fracture and two other possible fractures. PA Smithson planned to repeat the x-ray in two weeks. She prescribed Lortab and Flexeril and instructed Mr. Brown on heat therapy, ice therapy, and rest. The office scheduled a follow-up appointment for Mr. Brown in two weeks.

On the following day, Mr. Brown called the practice to report an increase in pain. NP Smithson prescribed Percocet, because the Lortab and Flexeril were not providing adequate pain relief. The Percocet failed to relieve Mr. Brown's pain. In fact, Mr. Brown reported his pain as worsening when he went to the clinic again the next day.

At this second visit, he saw Lorelai Broadnax, NP. After examination, NP Broadnax decided to order a CT without contrast to further evaluate Mr. Brown's chest. Unsure of how to treat Mr. Brown's pain, NP Broadnax consulted with Dr. Everly, who recommended a Fentanyl transdermal patch but did not provide any guidance on dosing. Neither Dr. Everly nor NP Broadnax had previously prescribed a Fentanyl transdermal patch.

According to the visit note, NP Broadnax prescribed Fentanyl transdermal patch

40 mcg/1 dose apply 1 to clean, dry, intact skin q 72 hours #5 systems for severe rib pain. However, Mr. Brown left the office with a prescription for Fentanyl transdermal patch 75 mcg/1 dose apply 1 to clean, dry, intact skin q 72 hours #5 systems for severe rib pain. Mr. Brown went to the hospital for the CT scan before having his Fentanyl transdermal patch prescription filled and going home.

Late that afternoon, NP Broadnax checked to see if Mr. Brown's CT results were ready. The report had not been dictated so NP Broadnax called Mr. Brown's home and advised his wife that the results were not back yet. Mrs. Brown reported that Mr. Brown had applied a Fentanyl transdermal patch and was feeling better. NP Broadnax told Mrs. Brown she would call the next day when the CT results became available.

The next morning, Mrs. Brown called the office around 7:30 a.m. to report that Mr. Brown had been sleeping since 8:00 p.m. the night before and was not waking up. NP Broadnax spoke with Mrs. Brown and told her to check Mr. Brown's breathing. Mrs. Brown assessed her husband and said he was snoring and his breathing was okay. NP Broadnax informed Mrs. Brown that the pain medication would make Mr. Brown sleepy and that she should continue to check on him periodically.

Around 10:30 a.m., NP Broadnax called the Brown home to inform Mr. Brown of his CT results. Mrs. Brown answered the call. While discussing the CT results, Mrs. Brown went to check on Mr. Brown. He was unresponsive, and Mrs. Brown told NP Broadnax that she did not think he was breathing. When NP Broadnax asked if his chest was moving, Mrs. Brown responded, "no." NP Broadnax told Mrs. Brown to call 911 immediately.

The clinic staff later learned EMS could not resuscitate Mr. Brown. The medical examiner performed an autopsy. The autopsy report listed acute Fentanyl toxicity as a contributing cause in Mr. Brown's death. Mrs. Brown filed suit against Dr. Everly and NP Broadnax.

Evaluation of the case demonstrated that mounting a successful defense would be difficult. As previously noted, Dr. Everly and NP Broadnax had no experience prescribing Fentanyl transdermal patches. NP Broadnax recorded the dosage for

the Fentanyl transdermal patch as 40 mcg, a non-existent dosage, in her office note, but then proceeded to write a prescription for Fentanyl transdermal patch 75 mcg for this opioid naïve patient.

If Dr. Everly and NP Broadnax had reviewed the PDR or other drug reference material, which they did not, before issuing the prescription, then they would have seen that the Fentanyl transdermal patch had a black box warning. According to the black box warning, the Fentanyl transdermal patch is contraindicated for treatment of acute pain in an opioid naïve patient. It also warns of the potential problems of hypoventilation.

Although there may be reasonable off-label uses for a medication even in light of a black box warning, this case illustrates the need for diligence when prescribing a new or unfamiliar medication and good communication with an advanced practice provider under your supervision. The outcome in this matter may have been different if either Dr. Everly or NP Broadnax had consulted drug reference material or a colleague and discussed indications, contraindications, and dosing.

The lawsuit settled through the mediation process.

[1]The names of the patient, physician, and advanced practice providers have been changed.
