Failure to prescribe correct medication dosage

By Greg Harmon, Assistant Vice President, TMLT and Shannon Quinn

PRESENTATION

On June 1, a 37-year-old male with complaints of a two-week history of progressively worsening dizziness and unsteady gait came to the ED of a large hospital. A head CT scan revealed a “25 x 41 mm left paramidline cerebellar mass. A cystic neoplastic lesion is suspected.”

The patient exhibited signs of hydrocephalus and was admitted to ICU for observation. Dexamethasone was started. Further testing revealed a “33 x 33 x 43 mm left cerebellar multiloculated cystic mass suspicious for a neoplasm with a 15 mm extension to the right cerebellum and possible involvement of the left posterior margin of the pons.”

A neurology consultant noted a left upper extremity finger-to-nose pointing abnormality and referred the patient to a neurosurgeon for the cerebellar mass and a consult with an oncologist.

On June 5, the neurosurgeon performed a left suboccipital craniotomy for the gross total resection of the posterior fossa tumor. Frozen section diagnosis and final consultant neuropathology report revealed a high-grade permeative neuroectodermal tumor with diffuse medulloblastoma type areas. Bone marrow biopsy and cerebrospinal fluid were negative for metastatic disease, and a diagnosis of medulloblastoma was made. Upon discharge, the patient was to follow up with oncology for radiation therapy and physical therapy.

PHYSICIAN ACTION

The patient came to the oncologist’s office on June 21 for an initial consult. The treatment plan included chemotherapy and radiation. A discussion of the side effects was documented with handouts given. Prognosis included, “Survival is markedly improved with regimen and there is a very high 5-year survival.”

On July 2, the physician ordered vincristine 2 mg IV to be given in her clinic. The intravenous vincristine was administered weekly for six weeks. On August 8, the radiation therapy was completed and the oncologist’s plan was to proceed with lomustine and cisplatin therapy in three weeks.

On September 4, the patient returned to the oncologist’s office. Physical examination found no abnormalities with the exception of alopecia secondary to treatment. The seventh dose of intravenous

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. The study has been modified to protect the privacy of the patient.
vincristine was administered and the cisplatin and lomustine were started. Documentation included “cisplatin to be given 50 mg/square meter every 21 days and the lomustine to be given per regimen.” The physician wrote a prescription of lomustine 150 mg daily for 1-month supply and 3 refills. The nursing notes stated that 150 mg of cisplatin was infused intravenously over four hours. The physician’s notes and the nursing notes were silent regarding a discussion of the administration of lomustine.

The prescription was erroneously written; the dosage was correct, but the frequency should have been one dose every six weeks instead of daily. The pharmacist failed to detect the error. On September 7, a bottle of 100 mg capsules, 1 bottle of 40 mg capsules, and another bottle of 10 mg capsules were dispensed to the patient. The label for each bottle read, “Take one capsule by mouth once a day as directed.”

The patient returned to the oncology clinic on September 12 and 19 for his remaining vincristine infusions. His only complaint was mild numbness and tingling in the toes.

On October 3, the patient came to the ER complaining of fatigue, weakness, cough, chest pain, and shortness of breath with fever, nausea, vomiting, and pancytopenia. A physical exam found diffuse petechiae and ecchymosis. The oncologist considered the symptoms to be secondary to chemotherapy.

The patient’s clinical course deteriorated. He was eventually sent to ICU with confusion, respiratory distress, Klebsiella pneumonia, sepsis, and end-organ dysfunction. The lomustine overdose was diagnosed, and the patient was treated aggressively with antibiotics, colony-stimulating factors, and transfusions of packed RBCs and platelets. The patient died on October 21 due to cardiopulmonary failure secondary to multi-organ system failure.

**ALLEGATIONS**

A lawsuit was filed against the oncologist, pharmacist, and pharmacy. It was alleged the oncologist prescribed excessive lomustine and failed to detect the dosage error during follow-up visits on September 12 and 19.

**LEGAL IMPLICATIONS**

The defense oncology reviewers were not supportive of the care rendered by the oncologist. It was opined that the patient clearly received an overdose of lomustine that ultimately caused the patient’s death. The reviewers felt the patient initially had a good prognosis related to his diagnosis of medulloblastoma.

**DISPOSITION**

The case was settled on behalf of the oncologist, pharmacist, and pharmacy.

**RISK MANAGEMENT CONSIDERATIONS**

The prescription given to the patient was handwritten, and no copy was made for the patient’s chart, nor were the dosage or instructions documented. Texas Medical Board guidelines state that for a medical record to be adequate, the written plan should be documented to include “medications specifying amount, frequency, number of refills, and dosage.” The patient made follow-up visits to the physician after the initial prescription, and the error may have been found had the dosage been easily visible in the chart. A patient’s current medication list should be reconciled with the patient’s chart at each visit.

When prescribing multiple dosages of the same prescription, it is helpful to provide the patient with written instructions regarding dosage and to maintain a copy of these instructions in the patient’s record. If the written instructions are different from what is printed on the prescription bottle, it may prompt the patient to contact the office for clarification.

Finally, although one would assume that the pharmacy has safety procedures in place to avoid medication errors, there is always a chance of an error going undetected. This error was not discovered by the pharmacy technician, pharmacist, or the pharmacy computer. Physicians should be very familiar with the proper dosage of dangerous medications prior to prescribing and double-check to ensure the prescription meets the manufacturer’s recommended dosage.

**Source**

1. TMB Rule 165.1(a) (6) (A)
   http://www.tmb.state.tx.us/idl/D9A7601F-3756-4776-E46E-EFB1085B03C7

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Online reputation management for physicians

by Laura Hale Brockway, ELS

As more patients go online to find information about physicians, your reputation is being built and managed on the Internet. And like it or not, your online reputation plays a role in acquiring new patients and maintaining trust with existing patients and colleagues. It is imperative for physicians to have a plan and focus on online reputation management.

Online reputation management is the process of preventing and repairing threats to your online reputation. It is done by tracking what is written about you and using techniques to address or moderate the information on search engine results pages or in social media. The goal is to promote positive or neutral content while suppressing negative content.

For physicians, online reputation management involves addressing information in three areas:

1. information found on search engine results pages (Google);
2. information found in social media (LinkedIn, Facebook, blogs); and
3. information on rating websites, such as Vitals, HealthGrades, Rate MDs, Yelp, and Angie's List.

Recently, a physician received an email from a company offering online reputation management services to help him mitigate negative online reviews on sites such as Yelp, Google, and health care review sites such as Vitals.

There are hundreds of companies out there offering these services. However, physicians are urged to use extreme caution when choosing a reputation management company. Some companies engage in questionable techniques that could lead to disciplinary action by the Texas Medical Board (TMB).

Specifically, the company that emailed this physician said they “will post reviews for our clients to over 40 social media websites … We post up to 25 reviews per month.”

This claim is alarming in the context of medical practice. How are they managing to post reviews from the patients of a particular physician? Are they making up reviews and then posting them?

It is unethical and dishonest to post reviews on these sites that are not from actual patients. Physicians are held to a different standard than other businesses, and posting fake patient reviews is inappropriate. Doing so would also violate TMB advertising rules, as this type of advertising (and the TMB does consider this to be advertising) would be considered “misleading.”

Here are a few techniques for managing your own online reputation.

KNOW WHAT IS BEING SAID.
Conduct web searches on yourself and your practice regularly. Review the first 30 hits of the search. (Any hit past 30 is generally considered extraneous and not likely to be read.) Among the top 30 hits, what are these sites saying about you? Continue to monitor these online discussions.

KNOW WHAT YOU CAN AND CANNOT DO ABOUT NEGATIVE REVIEWS.
Because of health care privacy laws, physicians cannot respond to online reviews. The fact that a patient’s identity is protected information directly hinders the physician’s ability to refute a complaint. Simply acknowledging publicly that the complaining party is a patient breaches confidentiality and violates HIPAA.

CONSIDER GIVING PATIENTS MORE CONSTRUCTIVE WAYS TO OFFER THEIR FEEDBACK.
Conducting a patient survey, for example, would be a good way for patients to express their dissatisfaction and feel empowered.

Another option is to talk to the patient directly if you can identify who made the comment. This should be done in person or over the phone. Begin by asking the patient why he or she is dissatisfied.

It is also a good idea to investigate the patient’s complaints. Is the complaint legitimate? Was the problem with a procedure, a staff member, or the patient’s wait time? Can the problem be fixed?

OPTIMIZE YOUR WEBSITE FOR SEARCH ENGINES.
Optimizing your website for search engines will ensure that anyone typing in your name or your practice name will see your website at the top of the search list. Optimizing your site involves creating comprehensive and targeted meta tags and website page titles that help search engines index your site.

More sophisticated techniques include editing your site’s content, HTML, and associated coding; removing barriers to the indexing activities of search engines; increasing inbound links; or purchasing related web addresses.

CREATE YOUR OWN BLOG.
You cannot control what other people say about you online, but you can create your own. (Continued on page 4)
The next time you receive a thank you note or email from a patient or family member, ask that person to post their comments on your blog, on your LinkedIn profile, or on physician rating sites.

Keep in mind that with the prevalence of smartphones and tablet PCs, patients can post a review of you — a positive or negative review — at any time and from anywhere. Even from your waiting room. Don’t ignore what’s being said.

For more information on online reputation management, please see the following TMLT resources: