

# A Cocktail of Medications Leads to Death

Following sledding and auto accidents, a man sought treatment from Dr G. for back and shoulder strain. During this time, he was prescribed several different pain medications, including oxycodone, carisoprodol, and alprazolam.

The motor vehicle accident occurred in April 2008 and resulted in a compression fracture. In January 2009, a neurosurgeon performed a surgical alternative, and the patient was discharged the next day with a prescription for 30-mg oxycodone. This dosage was twice the amount that Dr G. had already prescribed, but Dr

disease and that the combination of medications in his system could not have led to death in such a drug-tolerant individual.

## OUTCOME

According to a published account, a defense verdict was returned.

## COMMENT

There are two important points here. First, medication errors are more likely when several clinicians treat a single patient. This is particularly true when the care is of short duration (ie, related to surgery). Problems arise when the consulting team does not

“what is usually given.” Take a moment to review the patient’s active medication list—don’t put yourself on autopilot, as tempting as it may be.

Second, we live in a time when many patients do not simply take “a pill” from “their doctor.” It is far more common for patients to take a recipe of pills from an extensive medical team. Each member of the team focuses on the system of his/her specialty and directs pharmaceutical intervention at that system. But we all want the same net result: the patient’s overall condition optimized without adverse effects or drug interactions.

One way to help patients handle a medical regimen is to recommend the use of a single pharmacist. That pharmacist serves as a gatekeeper to safeguard the patient from adverse results when a consulting clinician prescribes an interacting medication. The consulting clinician may have bad information; we have all seen a patient haul a weathered medication list from the depths of her pocket, only to learn that it is not current or is incomplete. A gatekeeper pharmacist will have an up-to-date list and can help to prevent errors.

Patients are also the last line of defense against a self-administered error. Inform the patient of the general class of medication you are prescribing, as well as the impact it may have: “This is a strong pain pill. It shouldn’t be taken with any medications or anything else that can make you sleepy—including alcohol.”

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*“We live in a time when many patients do not simply take ‘a pill’ from ‘their doctor.’”*

G. advised the patient to continue with his original prescriptions. Three days after the procedure, the man was found dead with oxycodone, carisoprodol, and alprazolam in his system.

The plaintiff alleged negligence in the prescription of this drug combination, which caused respiratory depression and arrest. The defendant claimed that the patient died from aggravation of severe chronic cardiovascular

have full knowledge of a patient’s medication list—making the obtaining of a complete and current list critical. And yes, in some cases, this may mean reviewing a dozen different medications for potential interactions with the agent you contemplate giving the patient.

Does this mean the consulting surgeon is duty-bound to optimize the patient’s regimen for diabetes and hypertension? No, but the surgeon is duty-bound to wade through all those medications to be sure there will be no interactions.

Surgeons often use a standard postoperative regime. But as clinicians, we can’t simply order

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Commentary by **David M. Lang, JD, PA-C**, an experienced PA and a former medical malpractice defense attorney who practices law in Granite Bay, California. Cases reprinted with permission from *Medical Malpractice Verdicts, Settlements and Experts*, Lewis Laska, Editor, (800) 298-6288.

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Additionally, it helps to have a clear delineation of which clinician is responsible for what problem. After surgery, it helps to clearly identify for the patient who will treat pain and for how long. The primary care provider (PCP) is probably not the best source of postoperative pain control, since the surgical team has a better understanding of expected pain and the typical medications and dosages to control it and is on alert for problems heralded by prolonged or atypical pain. Of course, the PCP should be aware of the selected agent, but a clear delineation of the surgical team's responsibility for pain control should minimize frantic calls to the PCP's office from the patient claiming to be in pain and out of medication.

In this case, chronic pain was managed by the PCP and postoperative pain by the surgical team. It is unclear if the surgical team was aware of the carisoprodol and alprazolam and the additional

prescription for oxycodone. It is also possible that the patient was milking both sources for the oxycodone and overdid it—another reason it is advisable for one clinician to manage the patient's pain. Make sure all parties are clear as to who that clinician is.

Finally, exercise caution when the potential effects of a medication are additive, even more so if they are synergistic. As we all know, there is a synergistic effect between central nervous system (CNS) depressants. Use caution when prescribing these agents together. Patients will often add more—diphenhydramine for allergies, one of their sister's zolpidem for insomnia, cough suppressants for a cold—and of course, ethyl alcohol for any reason (or no reason at all). A sedated patient is a distracted patient, more prone to grogginess and forgetfulness, which may lead to self-medication errors.

If for some reason the patient genuinely requires multiple

strong CNS depressant agents, he should ideally be followed by a pain management specialist. The risks should be fully explained and the patient informed that any additional agents causing drowsiness will have a substantially heightened effect. Tolerance can require larger doses and multiple agents with overlapping characteristics (eg CNS depressants); however, although the patient in this case was not opiate naïve, he still died of a fatal overdose. Be wary about adding agents or increasing the dosages of medications with synergistic effects.

One last thought: Different regions of the country have different juror demographics and beliefs. While this case was tried to a defense verdict in Macomb County, Michigan, the verdict may have been different in New York City or San Francisco, where jurors might be less likely to be swayed by what were certainly suggestions that the patient was improperly self-medicating. —DML **CR**

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