Risk Management Review

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Patient Commits Suicide Following Long-Term Alcohol and Medication Use

Theodore Passineau, JD, HRM, RPLU, CPHRM, FASHRM

Introduction

One of the challenges in any outpatient practice is keeping track of how the patient is "really doing." This task becomes more complex if the patient is taking one or more prescription medications, or if more than one provider in a multiprovider practice is caring for the patient.

This case from the Northern Plains illustrates how poor documentation, poor communication, and possibly questionable medication prescribing can combine to produce a very unfortunate outcome.

Facts

The patient was a 39-year-old male who had been a patient of a five-doctor family medicine practice for more than 10 years prior to the timeline of events described in this case.

In July of year 1, the patient was seen by Dr. A for complaints of insomnia, stress, and headaches of 3 months duration. His medical history was unremarkable; however, he did have a history of multiple drunk driving arrests.

Dr. A offered to arrange counseling for the patient (which he declined) and prescribed a trial of Ambien® 10 mg. On this occasion, Dr. A went through an informed consent process for the use of this medication, including indications, proper dosage, contraindications, potential interactions, and potential side effects.

The patient was continued on the Ambien at the same dosage (10 mg), with Dr. A and three other doctors in the practice ordering refills. All refills appeared to be at appropriate intervals, and there was no indication that the patient was abusing the medication. In year 4, the patient was prescribed hypertension medication and, at his request, Viagra®.

In September of year 5, the patient indicated to Dr. A that he was depressed; however, he denied any suicidal ideation.

Dr. A began the patient on Wellbutrin® and asked him to follow up with the practice about how he was doing; the patient also continued on the 10 mg of Ambien. A few days later, Dr. A received a phone call from the patient's wife indicating that the Wellbutrin was not working. Dr. A advised her that the Wellbutrin would take a few weeks to become effective; Dr. A also recommended that the patient see a mental health professional.

In December of year 5, Dr. A saw the patient for a follow-up. The patient indicated to her that he was seeing a counselor, but he was still depressed. (It appears that this was court-ordered counseling following a drunk driving conviction, but it does not appear that Dr. A knew this.) Dr. A discontinued the Wellbutrin and started the patient on Effexor®, at 150 mg daily.

In May of year 6, the patient saw Dr. A again. He indicated that he was no longer seeing the counselor, that he was feeling much better, and that he would like the dosage of Effexor reduced. Dr. A reduced the dosage to 75 mg daily. However, by August of that year, the patient's depression had worsened, and he was feeling chronic fatigue. Dr. A returned the dosage of Effexor to 150 mg, and the patient was feeling better by September.

In May of year 7, the patient was seen by Dr. B (another doctor in the practice) for insomnia. On this occasion, he indicated that he was having difficulty sleeping even with the Ambien. Dr. B switched him to a controlled release Ambien, at 12.5 mg daily. Two weeks later, the patient saw Dr. A again for depression; he told her that he couldn't tolerate the side effects of the Effexor and had stopped taking it.

Two weeks later, Dr. C (also a member of the practice) saw the patient for follow-up on the depression. The patient indicated that the depression was worse; he stated that he could not get out of bed and that he felt like "his life was over." Dr. C recommended that the patient restart the Effexor and see a psychiatrist. He also gave the patient five tablets of Xanax® (dosage unknown).

The practice followed up with the phone number of the recommended psychiatrist, but they left it to the patient to arrange an appointment. The patient's record shows no indication that the practice followed up to determine whether the patient saw the psychiatrist.

In July of year 7, the patient called to indicate that the controlled release Ambien was not working as well as the previous compound, and Dr. D (also in the same practice) switched him back to the original 10 mg compound. Later that month, the patient presented for a work physical, which Dr. B performed. During that visit, Dr. B did not address the insomnia or depression, and did not ask whether the patient had followed through with seeing the psychiatrist.

From July of year 7 to March of year 8, the patient was not seen in person, but he received regular phone renewals of the 10 mg Ambien and Viagra.

In March of year 8, the patient was again arrested for drunk driving. Upon his release, he went home and briefly spoke to his daughter by phone. He then committed suicide by hanging. Postmortem toxicology on the patient showed metabolites of alcohol, cocaine, and Ambien — but not Effexor.

A malpractice suit was brought against all five physicians and the practice. With the doctors' consent, the case was settled prior to trial in the midrange, with expenses also in the midrange.

Discussion

In this case, the crux of the plaintiff's allegations was that the patient was continued on Ambien much longer than he should have been. The plaintiff and defense experts (family medicine, psychiatry, and pharmacology) sharply disagreed on this point.

It is beyond the scope of this article to conclude whether the practice's medication management was appropriate. However, in cases where it is appropriate to exceed the manufacturer's dosing recommendations, the provider should acknowledge the decision with a note in the patient's record (to show that it was not an oversight).

For example, in the patient's record, the provider might note:

> *"This dosage exceeds the manufacturer's recommendations; however, I have concluded that this dosage is safe for Mr. _____ and appropriate for the treatment of his condition."*

Several risk management issues may have contributed to this unfortunate outcome as well, which the plaintiffs did not identify.

The first of these issues is continuity of care. In this busy five-doctor practice, patients were assigned to a particular physician (in this case, Dr. A). However, it was common for patients to see other physicians in the practice, and it was also very common for a physician other than the primary doctor to prescribe or renew existing medications.

It is not difficult to see how this approach could lead to discontinuity of care. In effect, each physician may only be familiar with some "slice" of the patient, but it is likely that no one is thoroughly familiar with the whole. In some instances, this approach might be okay, but only if the communication among the physicians (or physicians and advanced practice providers) is ongoing and very thorough.

That leads us to the second issue: communication. Within the medical context, the parameters of communication include

provider to provider, provider to staff, provider to patient, and/or staff to patient. In this case, it appears that two of these parameters (provider to patient and provider to provider) may not have been adequate.

Because so many doctors saw this patient over the 8-year period, none of them (not even Dr. A, his primary physician) may have really known him. This man had a very troubled life on multiple levels (e.g., legal problems, marriage problems, and work problems). The short snippets of time that the providers spent with the patient may not have offered them the opportunity to fully understand his situation. Although today's tight "production schedules" do not allow time for extended conversation with patients, they do not diminish the importance of knowing as much of the patient's "social history" as possible. Further, no evidence in the record shows that the various physicians treating this patient ever discussed his case with each other.

Not all communication between providers needs to be synchronous. Good communication in the patient record can help keep everyone on the same page when face-to-face communication is not practical. Unfortunately, the detail of the narrative notes in this case was very limited. Only when all of the physicians were deposed was a comprehensive "picture" of the patient's medical status assembled. If this case had been tried, the lack of documentation may have greatly impaired a jury's understanding of the overall situation with which the physicians were dealing.

The final issue is the referral to a psychiatrist. Obviously, Dr. C felt that the patient's mental status was concerning enough that a specialty referral was in order. The argument can be made that he should have had someone in the practice follow up with the patient to see whether the appointment had been made and kept (especially because the practice had called the patient to give him the name and number of a particular psychiatrist). Also, if the documentation had been better, and if Dr. B had reviewed it, he could have easily inquired about the psychiatric visit during the patient's subsequent work physical.

Summary Suggestions

The following suggestions may assist physicians who are managing patients with long-term medication therapy:

- The physician should be aware of and comply with the drug manufacturer's recommendations for dosing. When it is appropriate to prescribe outside of those guidelines, the physician should include a brief explanation of the rationale for the deviation in the patient's chart.

- When multiple providers are prescribing medications for a patient, they must establish ongoing and thorough communication.
- Documentation of the patient's current status and the current therapeutic approach is critical, especially if multiple providers might be involved in the patient's care.
- Prompt follow up should occur when a specialty referral is made, particularly if the referral is time sensitive due to the patient's condition.

Conclusion

In any busy medical practice, there is the fear that a patient will slip through the cracks and not receive the care she or he needs and deserves. Although to err is human, giving special attention to the aspects of patient care that have been identified as presenting exceptional risk for error can help a medical practice improve patient safety and minimize professional liability exposure.