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A REPORT TO CLIENTS & ATTORNEYS
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Failure to Monitor Mother and Baby During Labor Results in Severe Damage

Settlement just under eight figures provides care for child's lifetime.

In the summer of 1999, a young couple was looking forward to the birth of their second child, a little girl. Their first-born daughter was especially excited about having a baby sister. The pregnant mother established prenatal care with a local obstetrician. The 31-year-old woman was in excellent health, experiencing a normal, healthy pregnancy. Prenatal screening tests, including several tests designed to determine whether the baby had any genetic disorder, all reported normal. Neither the mother nor father had any family history of genetic problems. There was no indication that the obstetrician should be concerned about any genetic abnormality.

By August 1999, the obstetrician noted that the baby was measuring larger in size than expected for a baby at her gestational age, and she decided to induce labor. The mother was admitted to a local hospital and placed under the care of the hospital's labor and delivery nurses. The assigned nurse was expected to closely monitor and report the progress of the mother's labor to ensure that the baby responded appropriately.

Unfortunately, communications between the nurse and the obstetrician failed tragically during the most critical time in the labor process. Despite the fact that the woman was already experiencing labor contractions, the nurse began administering Cytotec (misoprostol), a prostaglandin used to induce labor. This powerful drug can cause hyper-stimulation and severe uterine contractions that may result in injury to the baby; it should not have been given to a patient already in labor. The nurse never advised the doctor about the contractions before administering the drug shortly before 10:00 p.m. *(Continued on page ten.)*

Misfilled Methadone Prescription Causes Woman's Death

Patient received ten times intended dose of medication.

As Florida's population continues to increase in average age, we note a related increase in prescription misfill cases. Since elderly people typically take more medications than younger people, the risk for the older population is greater. SDSBS attorneys **Karen Terry** and **Jack Scarola** recently represented two adult children regarding the wrongful death of their 87-year-old mother, Mrs. A, who died of methadone toxicity due to a misfilled prescription. Mrs. A had been given ten times the intended dose of the medication.

The horrific chain of events leading to Mrs. A's death began on March 14, 2007. She was residing in an assisted-living facility and under the care of a physician. Mrs. A had never before taken methadone, a potent narcotic. An order was written by her physician for 2.5 mg of methadone to be given to her three times each day. The pharmacy misfilled the order, delivering the drug in doses of 25 mg. The pharmacy later explained that the misfill occurred because they had failed to see the decimal point between the "2" and the "5" and blamed the physician for not writing the order more clearly. Mrs. A's caregivers administered a total of 75 mg of methadone on the first day. That excessive dosage continued *(Continued on page seven.)*

Misfilled Methadone Prescription Causes Woman's Death

(Continued from page one.)

until a toxic reaction caused her to be rushed to the hospital. It was, however, too late to save her.

A prescription for a controlled substance such as methadone, in this quantity, should have set off a red flag for any pharmacy or assisted-living facility. It is particularly true in this case which involved an elderly woman with no prior history of receiving this medication. The standard of care for pharmacies requires them to develop, establish, and maintain protocols for receiving prescriptions in a form that is both clear and legible, and therefore readily confirmable. Tolerance of anything less invites catastrophic error. It is well established that a vigilant pharmacist is the last line of defense in patient protection. The pharmacist must carefully review each prescription and the prescription history of the patient, with particular diligence and care toward the dangers posed by prescriptions for such powerful controlled substances. No pharmacist should allow a prescription to be dispensed if there is any indication of an error, or if the prescription is illegible.

Compounding the pharmacy's negligence in this case, the assisted-living facility's staff transcribed the order into their records as "25 mg," but never questioned the order for such a high dosage of the medication for this patient. They simply administered the incorrect dosage of the medication, charging the patient extra fees for each time the medication was given. Mrs. A's family later learned that someone had gone back into the files and darkened the decimal point between the two numbers in an effort to make it clear that the order was meant to read "2.5 mg" and not "25 mg." Mrs. A's physician denied that he was the person who had altered the order.

Losing their mother suddenly and unexpectedly because of negligent and improper medical care was devastating for Mrs. A's children. They had placed their mother in the hands of carefully selected medical professionals, at great expense, only to have that trust betrayed. As if that was not horrible enough, the defense tried to describe Mrs. A as an elderly and feeble woman with limited life expectancy, admitted to a Hospice program in the last months of her life. Both children testified to their mother's general physical fitness and, despite her advanced age and some physical limitations, her well-intact mental capacity.

After litigating the case for many years, including the successful defense of a pre-trial appeal, the case against the physician, the pharmacy, and the assisted-living facility was very favorably resolved for confidential sums totaling in excess of seven figures. ◆

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