Wrong prescription of pain medication results in death

On August 19, 2010, Jane Doe underwent a scheduled outpatient orthopedic arthroscopic surgery where she was to be discharged the same day. She was in her mid-fifties, healthy, and enjoyed a full and active life. The surgery itself went well and Mrs. Doe was transferred to the hospital's Post Anesthesia Care Unit (PACU). While in the PACU, Mrs. Doe experienced the moderate post-operative pain that can be expected following the surgery she underwent. In an apparent effort to treat her moderate post-operative pain, the anesthesiologist ordered Mrs. Doe a 50 mcg/hr fentanyl pain patch. The order was approved by the hospital's pharmacist and the patch was applied to Mrs. Doe by a hospital nurse. Mrs. Doe was discharged from the hospital without any written discharge instructions regarding the fentanyl patch that was applied to her in the hospital's recovery room. On the second evening following her surgery, Mrs. Doe went to bed next to her doting and caring husband of twenty eight years in no apparent distress. In the early morning hours the next day, her husband awoke to what he thought were gurgling sounds. When he looked over at his wife, he discovered that she was not breathing and he immediately started CPR. The paramedics that responded were not able to resuscitate Mrs. Doe and she was ultimately pronounced dead. The Medical Examiner later concluded that the fentanyl found in Mrs. Doe's blood contributed to her untimely death. After reviewing the Medical Examiner's report, the family of Mrs. Doe contacted Searcy Denney attorneys **Chris Searcy** and **Jack Hill** seeking both answers and justice for Mrs. Doe's death.

Fentanyl is a powerful synthetic opioid used for pain management. In the mid-1990s fentanyl was modified into a gel that is placed into a patch worn on the skin. Fentanyl patches work by slowly releasing the fentanyl through the skin and into the bloodstream. Each patch lasts roughly 72 hours and provides a constant absorption rate. Because fentanyl is approximately 100 times more potent than morphine, the indications for the use of a patch are very restricted. Fentanyl patches should only be given to chronic pain patients who are already opioid tolerant. In fact, the Food and Drug Administration mandates that fentanyl patches come with the highest level of warnings that can be required of prescription drugs. The FDA-required "black box warnings" that accompany all fentanyl patches prohibit their use in patients who are not opioid tolerant, to treat acute pain, or for the treatment of any post-operative pain or following outpatient surgery. The chief hazard of fentanyl patches is hypoventilation or respiratory depression.

Upon reviewing Mrs. Doe's medical records, the circumstances surrounding her being administered a 50mcg/hr fentanyl patch, and the literature regarding fentanyl patches, it was readily apparent to Mr. Searcy and Mr. Hill that Mrs. Doe never should have been administered one, let alone a 50 mcg/hr patch. The anesthesiologist who ordered the patch for Mrs. Doe admitted at his deposition that he had an incomplete understanding of the contraindications for fentanyl patches and acknowledged that he had never before ordered a patch under circumstances similar to those for which he prescribed one for Mrs. Doe. The hospital pharmacist that approved the fentanyl patch prescription testified that she did not thoroughly evaluate the prescription because it was for an outpatient and that she relied on the anesthesiologist's assessment about the appropriateness of the drug given all of its warnings and contraindications. The nurse who administered the powerful drug to Mrs. Doe admitted that she did not know that fentanyl patches came with FDA-required "black box warnings" but that she should have. Notwithstanding the powerful evidence to the contrary, the responsible parties argued that their care of Mrs. Doe was appropriate. Furthermore, the defendants argued that fentanyl played no role in Mrs. Doe's death and that she suddenly died of unrelated heart issues. Ultimately, the case was resolved for a confidential amount in the weeks leading up to the date for trial after a third mediation. Mrs. Doe's family, including her husband and now 28-year-old son, are still mourning her passing but can now hopefully find closure regarding her death. ◆