An Avoidable Deadly Drug Reaction

written by Nancy Brent | May 26, 2016

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In Brown v. Starmed Staffing[1], a patient came into the ED with a swollen tongue and difficulty swallowing. The patient's regular physician was called and the on-call physician from the office came to the ED and determined that the patient had probably had an allergic reaction to his blood pressure medication, Zestril.

The patient was admitted to the ICU and the doctor asked the patient's wife to go home and call the ICU with the names and doses of all of his blood pressure medications. The doctor also ordered the patient be "NPO".[2]

The patient' wife brought all of her husband's medications back to the hospital and gave the blood pressure medication to one of the ED nurses at the nurse's station. The wife then returned to the waiting room in the ED. An ICU bed was not available.

A few hours later, an ED nurse gave the patient the blood pressure medication thought to have caused his reaction. The ED nurse later testified that the on-call physician treating the patient told her to give the patient his "regular doses of blood pressure medicine."[3]

Later that day, the patient's regular physician examined the patient and informed his wife that the reaction he experienced was probably due to Zestril. The wife told the physician that the ED nurse had given her husband his Zestril earlier that morning and asked if her husband would be OK. The physician told her he would probably be fine, discharged him, and made an appointment to see the patient the next morning.

However, the patient experienced another allergic reaction early the next morning and was gagging for breath. The wife called 9-11 but the patient died choking on his "grossly swollen tongue".[4]

The patient's wife filed a medical malpractice action against the physicians, the medical center, the ED nurse and the nursing staff agency that placed the ED nurse at the facility. She alleged it was reckless to administer Zestril to her husband when both the nurse and the on-call physician knew his allergic reaction may have been caused by Zestril, and administering it was the proximate cause of her husband's death.

The wife also alleged that the regular physician was negligent in not treating her husband for an allergic reaction immediately after she told him that Zestril had been given earlier in the day. The hospital itself and the staffing agency were alleged to be responsible for the ED nurse's negligence based on the *respondeat superior* doctrine.

The trial court ordered several motions, each of which was appealed by those affected. Cross-appeals were also filed.

The court of appeals affirmed all the judgments of the trail court:

1. The staff nursing agency was dismissed from the case because the ED nurse was the "borrowed servant" of the hospital at the time she administered the Zestril;
2. The hospital's motion to be dismissed from the case was not granted because there were questions still unresolved as to why the ED nurse gave the medication and the importance of what "NPO" meant to the nurse (e.g., no food and drink and medication or no food and drink but medication was OK);
3. The hospital's contention that it did not proximately cause the death of the patient but that the primary physician's inactions were the proximate cause of the patient's death was denied, as both parties could be responsible for the patient's death;
4. The on-call physician and ED nurse's position that punitive damages were not available in this case was denied because of the "grave factual dispute as to whether the nurse, the on-call physician or both were responsible for the patient's death."[5]

This case is important in underscoring the need for you as a nurse to constantly use your critical thinking skills when providing care to patients. You cannot blindly follow a physician's order. The ED nurse should have determined what an "NPO" order meant at that facility, either by asking another ED nurse or the ED nurse manager or checking the facility policy on abbreviations and their meanings.

Likewise, had the nurse questioned the order to administer the Zestril, the patient might still be alive today. Had the doctor confirmed the order, the ED nurse should have notified her nurse manager about her concerns of administering the medication suspected of causing the initial allergic reaction.

This case also illustrates the complex legal battle that can follow the death of a patient when parties in a suit try and shift the burden of who is responsible for a patient's death to another person or entity. Although legally understandable and standard practice when one is named in a lawsuit, it can result in a delay in the ultimate decision in a case. In this instance, the appeals court decision was rendered in 1997. The patient's death occurred in 1992.

FOOTNOTES

1. 490 S.E.2d 503, 227 Ga. App. 749 (Ga. App. 1997).

2. Id. , at 505.

3. Id.

4. Id ., at 506.

5. Id ., at 506-509.