

Post-Operative Narcotic Drug Overdoses Causing Respiratory Arrest, Brain Death and Death.

According to the records, the patient was described as morbidly obese. She was 4 feet 11 inches in height and weighed 152 pounds. Much of this was fat, and her muscle mass and organ size, which would be responsible for the metabolic destruction and elimination of medications, including the narcotic medication, morphine, was certainly that of a small, elderly woman at age 72. Elderly patients are much more sensitive to the effects of narcotic medication, including the well-known respiratory depression effects of that type of drug.

The patient had known lung disease. She was a heavy smoker, smoking five packs a day for many years, and then cut back to a half a pack a day. They believe, and I agree, that the heavy cigarette smoking was a substantial proximate causation of her kidney cancer.

Her lungs were not normal. Prior to surgery on room air, she had a measurement of her oxygen capacity and pO₂, the partial pressure of oxygen within the blood, that was only 65. Although the oxygen saturation was 96%, the hemoglobin will suck up and hold on to oxygen quite readily. But when the pO₂ is at 65%, only a small drop of another 10 pressure points will totally drop the saturation curve down dramatically and put a patient in grave danger.

Furthermore, the anemia that the patient had decreased postoperatively down to a hemoglobin of 8.2 (with a normal range of 12.4-15.2) and a hematocrit (the packed red blood cell volume) of 25.8 (with the normal range of 36.7-45.1). This meant that postoperatively the ability of her blood to carry oxygen throughout her body was at approximately only two-thirds of normal. Thus, there was a lowering of the oxygen content within the blood, and with the anemia level showing that her blood could not carry a normal amount of oxygen into her body, these would both contribute to a potential fatal outcome.

The patient developed painless, bloody urine and her physician correctly obtained an intravenous pyelogram (kidney x-ray dye study) which showed a probable cancer of the kidney. This was confirmed by the CAT scan and then by the cystoscopy examination and evaluation. Thus, the radical operation that was scheduled and performed on this patient by Dr. #1 on January 2 the radical left nephroureterectomy (removal of the kidney and the adjacent flesh, including the adrenal gland and the ureter) was clearly indicated.

My review of the detailed operative report shows that the patient was placed under general anesthesia, and after the correct operation to remove the kidney with the cancer and the adjacent flesh, a separate incision was made in the lower abdomen to excise that specimen along with the ureter as an intact specimen. All this meets the standard of care.

The Pathologist confirmed that the patient had a grade I-II papillary transitional cell carcinoma, and that the cancer was confined to the kidney. This is a low-grade cancer that had not had any evidence of metastatic spread, and thus this patient had a high chance of a cure, particularly considering her age at 72.

According to the anesthesia record, the patient had a pulse oximeter measuring her blood oxygen level, and the safeguard measurement of expired carbon dioxide confirmed that there was no dislodgment of the endotracheal tube or the connection between the ventilator and the endotracheal tube during the anesthesia. The patient was generally reasonably stable and I find no fault with the actual operation itself, or with the anesthesia performance.

Postoperatively, the patient was admitted to the postanesthesia recovery room in basically an extremely stuporous condition, and shortly thereafter as the minutes began to pass, she began to awaken. During that time, to control pain, the patient did receive injections of the narcotic medication, morphine.

Generally speaking, an elderly patient at age 72 who was actually a small person in a fat body, in my opinion, should not receive more than 1-2 mg of morphine every two to four hours. The morphine given to the patient must be to control pain, and only when the patient has pain.

In the recovery room, the patient received her first dose of morphine, 1 mg intravenously, at 17:42, and through 18:20, received a total of 8 mg of morphine as well as 30 mg of the non-narcotic pain medication, Toradol. This is a lot of morphine and the patient, who was awakening initially, was noted to have very shallow respirations at 19:30, at the time she was discharged from the recovery room. This was an ominous sign.

When she was admitted to her regular hospital floor and bed from the PACU, she was noted to be lethargic. She opened her eyes and was trying to get out of bed and thus was obviously quite confused. This confusion is not pain. I have not seen the doctor's orders to determine who, in fact, actually ordered the PCA (Patient Controlled Analgesia), which is a button the patient pushes that allows a special calibrated pump to inject narcotic medication, in this case, morphine, into the intravenous line. The calibration adjustments are determined by the Physician's order and set by the Nurse. Thus, when the patient has pain, the patient pushes the button and get a dose of narcotic medication.

Usually, the Anesthesiology Department is in charge of the PCA orders and machine, but this can vary from hospital to hospital. I cannot tell who ordered the medication or which Physician was responsible for monitoring the dosage given to the patient at the Hospital #1.

According to the records, the patient had very poor eyesight. At 21:30, she opened her eyes. The respiratory rate was 16. The PCA was being used for pain control as noted in the nurse's notes. She was receiving 3 liters of nasal oxygen, and the pulse oximeter on 3 liters of oxygen showed that her percentage of saturation of oxygen in the blood was 97%.

After midnight on January 3rd at 00:05, the patient was noted to be very lethargic and not responding to verbal stimuli or pain. If she was not responding to verbal stimuli or pain, why was she still receiving dosages of the narcotic pain medication? Obviously, a lethargic or stuporous patient would not be pushing the button. Who was pushing the button all this time because throughout her entire stay until the respiratory arrest that caused the cardiac arrest, she was noted to be lethargic or stuporous and still was getting pain medication.

At 01:30, she remained lethargic, only opening her eyes, but they had a glazed appearance. At 02:20, the patient said yes, but not in response to any question, and she was lethargic. At the time that the number appears to be blocked but looks like it ends in a 45, so it was either 04:45 or 05:45, it was noted that the patient had a leg in the bed rail and was repositioned. Then it says, "PCA pushed for patient," by a Nurse or Nursing assistant who appears to be #1. In my opinion, that is a negligent act. Why would a Nurse or Nurse's aid push a button of a patient on narcotic medication other than to basically have them more easily controlled? That is not the purpose of the PCA machine in giving the patient pain relief, and stuporous patients are not in pain. This act defies any rational basis in my mind.

The patient remained lethargic, including at 8:40 in the morning and throughout that day. At 17:00, she was noted to be lethargic at times. She was resting. At 19:00, she was noted to be resting comfortably. This was from the Nurse's aid. Thirty minutes later at 19:30, (7:30 p.m.), the family yelled for "help," and that "she is not breathing." They found the patient without respirations, cyanotic (blue from lack of oxygen) and pulseless.

How much delay was there? What occurred before she stopped breathing? How shallow was her breathing? Cardiopulmonary resuscitation was immediately started and I have no concerns with regard to the adequacy of that process. However, the patient was without oxygen for such a long period of time that she ended up with severe brain damage (hypoxic encephalopathy). A number of EEG studies (brain wave studies) performed after the event and over the ensuing months were all consistent with that finding. In addition, the patient had a CAT scan on January 5 that showed no evidence of any hemorrhage or other abnormalities. An MRI was performed on January 9th. Again, there was no evidence of any mass, mass effect or hemorrhage. There were no other mechanical problems in the brain. Another CAT scan on January 23rd showed that the brain was within normal limits. That is, there was no evidence of any hemorrhage or abnormality within the brain to cause the patient's brain to be damaged.

All of the above is consistent with a gross overdose of narcotic medication (morphine) given repetitively to a stuporous and lethargic patient by negligent orders by the physicians not terminating the PCA machine and by the nurses actually pushing the button at least one time. The doctors in their progress notes questioned who was pushing the button. The family denied pushing the button giving the stuporous patient more pain medication.

In any event, the order should have been changed to stop the PCA machine, or at least to drop it back to 1 mg of morphine, not every hour, but every two or three hours as needed, or to stop the PCA machine and give the patient injections of pain medication as had been done for many years upon demand when, in fact, the patient needed pain medication and was not in a stuporous state.

The Hospital Patient Controlled Analgesic (PCA) flow sheet is most informative. She was receiving morphine sulfate (MSO4) initially at 2 mg per dose, and then sometime on January 3rd, with the time not stated, was decreased to 1 mg with 10 minutes of lock out. This would allow the patient to receive 6 mg of morphine on an hourly basis. This is a gross overdose for a 72-year-old woman who is of very small muscular and skeletal stature.

I want to point out that I was shocked to note that on this sheet, as of 6:30 in the morning on January 3rd, she had received 11 mg of morphine and until 19:00, which is 7 p.m., she received 25 mg. Thus, in the twelve and one-half hours between 6:30 in the morning and 7 p.m., she received 1.12 mg of morphine per hour. This, in my opinion, is a significant overdose for such a small patient of age 72. But more importantly, she did not need this pain medication. The patient was narcotized; that is, she was receiving a continuous gross overdosage of narcotic medication when she was continually stuporous. The first thing to consider in a patient who is postanesthesia who is still not waking up to the extent that one would want is to stop the pain medications.

I also wanted to point out that by 15:20, she had received 23 mg of morphine through the PCA machine. But, from 15:20 until 19:00, she received another 2 mg. Why was she receiving all this narcotic medication when the record shows the patient was not in any pain? She was resting very quietly, but that quiet resting was actually substantial oversedation from the narcotic medications. All of this is negligent care.

The patient was also receiving an antipsychotic medication which, to some degree, can also cause some sedation, but, in my opinion, the clear negligence is in giving a stuporous patient, a patient who is not in pain, narcotic pain medication. She could not push the button. Who was pushing the button? How did she get all these high dosages throughout the night? Was there someone sitting by her bedside pushing the button throughout the night, and why do the Nurses' notes show that, in fact, a Nurse or Nurse's aid actually pushed the button for the patient when the patient was stuporous or lethargic. This is not a patient who needed pain medication.

This was a patient who needed a doctor to stop the pain medication to allow the metabolic effect, that is, the stuporous effect of the narcotic and the excessive sedation of this patient, to terminate for many reasons. Patients who are so stuporous cannot effectively cough and clear their airways. They can choke on food and on liquid. Such patients will be breathing shallowly. There are times she had shallow respirations. Such a patient will eventually end up with an accumulation of the narcotic within her body and the effect of respiratory depression to such an extent, and particularly as her anemic state progressed and became worse, in a patient who had chronic lung disease to start with wherein it would all combine to basically kill the patient. To kill patient by stopping her breathing.

I cannot tell from these records whether or not the oxygen, that is the supplemental nasal oxygen of 3 liters per minute, was on in a continual, ongoing basis. This will have to be clarified through discovery. However, giving a patient nasal oxygen where they are so overdosed with a narcotic that the respiratory center is so depressed will not keep them alive. You cannot give enough nasal oxygen to a patient. They need to be placed on a positive ventilator to actually force air and oxygen into their lung, but in this case it would have been so simple to just stop the narcotic for a period of time and give the patient an adequate dosage to relieve the pain, but not to overly sedate her and not to place her into the great zone of danger through which all of the negligence of the Nurses and of the Physicians combined to cause her to have a respiratory arrest that stopped oxygen through her entire body and caused her heart to temporarily stop. They were able to restart the heart, but the brain is much more sensitive to oxygen deprivation, and after three to five minutes of lack of oxygen, one would have a patient who, in this case, had severe and irreversible hypoxic encephalopathy; that is, brain damage from lack of oxygen. The subsequent CAT scans and MRI studies, as well as the EEG studies, were all consistent with this finding. There is no other cause of this condition.

In addition, the patient did not sustain a pulmonary embolism. As for the traveling blood clot from the leg or pelvic veins to the heart-lung circuit as a cause, the findings here are not consistent with that, and in fact, she had a lung scan study a number of weeks later that showed no evidence of any pulmonary embolism. Pulmonary embolism in an acute postoperative period would be quite unusual in any event. All of the above, in my opinion, was related to the negligence of a gross overdose on an ongoing basis in this patient to the point where it overwhelmed her, stopped her breathing and caused her to have irreversible brain damage, which was the proximate cause of her eventual death.

I would suggest that you authorize us to have Experts review these records, who would be Experts in the field of Nursing and in Anesthesiology. You also need to determine who, in fact, was responsible for the PCA narcotic orders, and because the patient was also treated by a Urologist, a Urologist as a Surgeon would be responsible also for seeing the patient and determining what would be necessary to benefit the patient, which, in this case, would be to read the medical orders and stop the narcotic pain medication until she awakened, and call any consultations as necessary.