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Anticoagulants and Medical Malpractice

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Millions of Americans take anticoagulants every day to prevent blot clots. Many take anticoagulants because they have atrial fibrillation, which significantly increases the chances of clotting. Others are born with blood clotting disorders (such as Factor V Leiden, a relatively common clotting disorder among people of European descent) or acquire clotting disorders (such as antiphospholipid syndrome, an autoimmune condition that raises the risk of clotting).

Anticoagulants prevent countless deaths of patients at a high risk of developing blood clots. However, they are also considered high risk medications, not only because they cause excessive bleeding, but also because errors in the dispensing of anticoagulants are extremely dangerous and, unfortunately, are not infrequent

In this article, we discuss common types of medical malpractice claims involving anticoagulants.

"Classic" medication error cases

As we noted in a previous article, medication errors remain an intractable problem in health care. Such mistakes can, and often do, have catastrophic consequences when it comes to the dispensing of anticoagulants, particularly when such mistakes occur with vulnerable patients, such as infants or the elderly. A famous incident concerning the dispensing of the wrong dosage of an anticoagulant occurred in 2007, when actor Dennis Quaid's newborn twins nearly died at Cedar Sinai after receiving 1,000 times the indicated dose of heparin. Interestingly, after settling with Cedar Sinai, Quaid sued the manufacturer of the medication, Baxter Healthcare Corp., alleging that the company was negligent and strictly liable in failing to make the labels on high- and low-dose heparin vials sufficiently dissimilar.

Warfarin: Scylla on one side, Charybdis on the other

Warfarin (sometimes referred to by its brand name, Coumadin) is the most commonly prescribed anticoagulant in the United States. Warfarin is a Vitamin K antagonist (VKA). Vitamin K is essential to the production of proteins involved in the clotting process; thus, by inhibiting the production of vitamin K, warfarin prevents clotting.

The therapeutic level of warfarin is measured via international normalized ratio (INR). INR is a measurement of the blood's clotting ability and is used to measure whether there is an appropriate amount of warfarin in the blood. Generally, an INR of 2.0 to 3.0 means the warfarin is at a therapeutic level – if the INR is below 2.0, the patient isn't sufficiently anticoagulated; if it is above 3.0, the patient is too highly coagulated.

Because a patient's INRs can vacillate, they must be monitored and dosages must be adjusted when they are too low or too high. Where a responsible physician fails to take appropriate action to ensure a patient's warfarin is in therapeutic range, the physician may be held liable for adverse outcomes.

Bridging

One problem with warfarin is that it takes, on average, approximately five days for the medication to reach therapeutic levels in the blood. Likewise, stopping warfarin does not immediately reverse the effects of the medication.

This is a challenge when it comes to performing surgery on a patient on warfarin. On the one hand, for obvious reasons, there are significant dangers associated with patients undergo surgery and are prone to bleeding. On the other hand, however, for patients highly prone to clotting, the absence of any blood thinner for five days before surgery and five days after may be unacceptable.

Thus, the advent of "bridging," whereby -- in the days leading up to and following a surgery -- patients are taken off warfarin and giving injections of short-acting anticoagulants, such as low molecular weight heparin (Lovenox) or unfractionated heparin, which are only effective for about 12 hours. This allows patients to remain anticoagulated for the days leading up to and following surgery.

Of course, whenever a patient is moved between two different, dangerous medications, opportunity for error abounds. Consider one case that Taylor litigated several years ago – there, an 80-year-old woman was "bridged" with Lovenox during a spinal procedure. A day after the procedure, she was discharged from the hospital and told to continue injecting Lovenox until her warfarin was back at therapeutic levels. Several days later, she was instructed to have her INR checked. It was only 1.2, meaning that she was far below therapeutic levels. Nonetheless, she was told she could stop taking her Lovenox. Two days later, she suffered a massive stroke.

Another potential problem with bridging is that levels of Lovenox, like those of warfarin, can become supratherapeutic. Levels of Lovenox are monitored using Anti-factor Xa laboratory assays. In addition, where Lovenox or another type of heparin is administered, physicians should be on the lookout for dangerous types of bleeds.

A colleague of ours from Connecticut, Paul Slager, recently brought a case on behalf of a gentleman who was bridged with Lovenox before and after a kidney biopsy. However, in the days following the biopsy, the patient's physicians failed to timely measure his level of Lovenox in his blood and he became over-coagulated. He developed a significant bleed in the area of the biopsy and a markedly low blood pressure that became life-threatening. The hospital was able to save his life using vasopressors (medicines that raise blood pressure), but the patient suffered horrific adverse side effects from the treatment.

Emergencies in patients on anticoagulants

Medical malpractice claims can arise not only from the failure to manage a patient's anticoagulant, but from a failure to consider a patient's anticoagulant altogether.

Several years ago, we had a case concerning an elderly man who tripped and fell on the sidewalk. He felt fine and planned to walk home but was persuaded by ambulance personnel to go to the Emergency Department. He presented to the ED with a bruise on his face, but he otherwise seemed fine. He was discharged a few hours later, without any imaging of his head.

Several days later, he complained to his wife that he was feeling dizzy, and she noticed that he seemed confused. He was rushed back to the hospital, where a CT scan was performed. It revealed a significant brain bleed. He was admitted to the hospital, but unfortunately, died several days later.

The ED doctor failed to realize the importance of a fact noted in the history taken from the triage nurse: that this patient was on an anticoagulant due to atrial fibrillation. When an anticoagulated patient hits his head, imaging to rule out a brain bleed is a must.

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Savage's practice with the firm involves medical malpractice, trucking accidents, and other complex personal injury cases. He is a 2017 graduate of Maine Law and worked for a Portland-based litigation firm for several years before joining Gideon Asen in January 2023.

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