

Patient's Chronic Pain Is Improperly Managed, Resulting in Overdose Death

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Introduction

Patients who suffer from chronic pain can be particularly challenging to successfully treat. Although a range of treatment modalities (including many medications) are available, finding the right combination of therapies can be daunting.

In this interesting case from the Southwest, a patient who had well-documented, severe pain progressed from compliance with his treatment regimen, to noncompliance, to addiction and drug-seeking — ultimately resulting in his death at a young age.

Facts

The patient was a 36-year-old male who suffered a significant lumbar spine injury while serving in the military. Nevertheless, when he left the military, he secured a position as a

police officer. During his service with the police force, he experienced several emotionally traumatic events for which he had difficulty coping. Eventually, he left police work because of the depression he suffered as a result of his chronic pain and the posttraumatic stress from his law enforcement experiences. The patient had no other significant medical conditions.

The patient began treatment at a pain clinic in September of Year 1, when he underwent a right nerve block at L5-S1, performed by Dr. L. After several outpatient visits, the patient was lost to follow-up until returning in May of Year 4. He still had complaints of chronic lumbar pain, and he was again seen by Dr. L. In the intervening 3 years, the patient had undergone three epidural steroid injections, which had provided temporary relief.

He also had a L5-S1 lumbar fusion, which had significantly improved his symptoms.

At the time of the patient's evaluation in May of Year 4, he was complaining of achy lumbar pain above the waist only. He was taking Ambien®, Cymbalta®, and Abilify®. Dr. L prescribed tramadol and ibuprofen, and he requested lumbar X-rays. Additionally, in June of Year 4, Dr. L performed a L3-L4 right nerve root block.

Later in June of Year 4, the patient visited the pain clinic and was seen for the first time by Dr. S, a MedPro-insured anesthesiologist who subspecialized in pain management. Dr. S performed a radiofrequency ablation (RFA) of the nerve branches at L3-L4 and L4-L5. The patient's health record shows that, at that time, he was also receiving Ambien and Klonopin® from a psychiatrist, and he had received occasional Percocet® prescriptions from a family practitioner in the year prior to commencing treatment with Dr. S.

After the RFA in June of Year 4, Dr. S next saw the patient in November of the same year. The patient indicated that the procedure had helped, but that his pain was returning. His health record reflects that MAPS (a prescription medication tracking system) was

checked that day. Dr. S wrote the patient a prescription for tramadol 50 mg.

An important factor to note is that the pain clinic had a policy that all patients must bring in their medications for review at every visit. At the beginning of each appointment, a medical assistant would see the patient to conduct a pill count. The treating provider would then review the medical assistant's note regarding the pill count.

If the pill count documentation was inconsistent with the medication being prescribed, the provider would discuss the situation with the patient to find out why. If MAPS revealed that the patient was receiving controlled substances from another physician, it was customary for the clinic to contact that physician.

The patient was next seen at the pain clinic by Dr. L in January of Year 5. At that visit, the patient rated his lumbar pain at 6 on a scale of 10 (6/10), and he was returning for medication refills.

Dr. L refilled the tramadol and also provided a prescription for ibuprofen. His note for that visit indicated that the patient should return to Dr. S for a repeat lumbar RFA in February.

Dr. S performed that procedure at the L4-L5 nerve branches in February of Year 5.

Dr. S next saw the patient in April of Year 5, at which point he rated his pain at 6/10. He did not bring his pills that day so the medical assistant did not perform a pill count. The patient's health record contains no documentation regarding a physical exam at the April visit. Dr. S renewed the patient's tramadol prescription and increased his ibuprofen dosage to 800 mg every 3 hours as needed because she did not feel the patient was receiving adequate pain relief. Dr. S also prescribed a Butrans® patch (10 mcg/hour).

At the patient's April Year 5 visit, the MAPS report was reviewed and considered acceptable. An in-house urine drug screen (UDS) also was done and the results were negative for benzodiazepines, even though the MAPS report showed that the patient's psychiatrist was prescribing them. The patient's record contains no reference to any discussion (either with the patient or the psychiatrist) regarding the benzodiazepines.

At a visit to the pain clinic in December of Year 5, the patient rated his pain level at 8/10 but said that his pain was better. He stated that he had recently been physically

overexerting himself, and documentation in his health record reflects that he had been taking as many as 10 ibuprofen pills (800 mg each) per day. Dr. S discontinued the Butrans patch and started the patient on a fentanyl patch (25 mcg/hour), with a 30-day supply. A MAPS report indicated that the patient was still receiving Klonopin on a monthly basis.

In January of Year 6, the patient and his wife visited the psychiatrist. According to the psychiatrist's records, the wife was concerned about the patient's detachment from family responsibilities around the house and his medication use. She felt that the Klonopin was causing lack of motivation and lethargy. She also suggested that he was overusing his prescribed medications. The patient admitted that he was drinking excessively. The psychiatrist reduced the patient's previously prescribed Paxil® and Klonopin doses in response to these concerns.

Dr. S saw the patient in March of Year 6, at which time he rated his pain at 7/10. The patient's health record contains no documentation of a physical exam during this visit, other than an indication that he was unchanged. After the visit, Dr. S documented the observation that the patient might be developing

medication dependence. This documentation also indicated that the patient was receiving inadequate pain control and would like an increased dose of his medications. Dr. S felt that the patient's statements regarding inadequate pain relief were credible, and his fentanyl dose was increased to 50 mcg/hour.

Also in March of Year 6, the patient presented to a local hospital emergency department (ED) after consuming a large amount of liquor over the previous 4 days. In the ED, he reported routine on-and-off drinking for the last 3 years. He was admitted from the ED to a behavioral health facility for alcohol detoxification.

The patient's health record from the facility indicates that the patient was drinking 1.75 liters of whiskey every 2 days for the last 2 years, and that he was using a fentanyl patch "which he was abusing." The record also indicates that the patient had been abusing Klonopin.

The attending psychiatrist at the facility had the patient's wife bring in his fentanyl so it could be destroyed. The patient was discharged home on Paxil and Suboxone® (8 mg/day).

Dr. S saw the patient again in April of Year 6. Dr. S testified that she had no knowledge of the prior behavioral health admission, the follow-up treatment, or the use of Suboxone.

The behavioral health psychiatrist ordered a toxicology screen later in April, and the results indicated that the patient had no Suboxone in his system, but fentanyl was present. Nevertheless, the psychiatrist did not take any action and continued the patient's Paxil and Suboxone.

The psychiatrist testified that the patient told him that he wanted to go back on pain management and simply wanted the psychiatrist to address his mental health issues.

At the end of April, Dr. S performed a repeat RFA procedure at L4-L5. A follow-up phone call the next day indicated that the patient was having significant pain relief.

In June of Year 6, the behavioral health psychiatrist saw the patient again. The patient reported that he was taking Percocet but not attending Alcoholics Anonymous. Nevertheless, the psychiatrist provided a prescription for Suboxone.

Later in June, Dr. S saw the patient, who indicated that he needed something to help on the days when he was in severe pain because he was standing all day at his job. Dr. S increased his Percocet dose from Percocet-5 to Percocet-10 and provided a 25-day supply.

Dr. S next saw the patient in July of Year 6. Once again, he came to the clinic without his medicines, and his pill count was noted to be unacceptable. The patient indicated that he had no Percocet remaining and three fentanyl patches at home. A UDS was not obtained.

Dr. S continued the patient's Percocet-10 prescription and increased the dose from three pills per day to four pills per day due to inadequate pain relief. No physical exam was documented during the July visit.

A certified nurse practitioner (NP) was the next provider to see the patient at the pain clinic in September of Year 6. A MAPS report was obtained and a UDS was performed; however, the NP did not see either report until after the patient's visit had ended.

The NP testified that because she had not seen either report until after the patient left, and because Dr. S had indicated that she saw no evidence of misuse or signs of diversion

(which is inconsistent with a previous entry in the patient's health record), she (the NP) did not make any changes in the patient's medications for this visit.

Five days later, the patient was found dead in bed. An autopsy was performed, which revealed three fentanyl patches within the patient's stomach. The cause of death was identified as fentanyl toxicity.

A malpractice lawsuit was commenced against Dr. S, Dr. L, both psychiatrists, the NP (also a MedPro insured), and the pain clinic. The case against Dr. S was settled with a payment in the midrange and defense costs in the high range. A payment was not made on behalf of the NP. The other defendants also made payments to resolve this case, but those amounts are not known.

Discussion

For many years in the field of healthcare risk management, experts have recognized that when multiple healthcare providers are simultaneously treating a patient, there is the potential for a "perfect storm," leading to errors, miscommunication, contradictory assumptions, and/or manipulation by the patient. This potential is even greater when

the providers are in the same specialty and/or when multiple providers are prescribing for the patient, which was the circumstance in this case. This discussion will focus on Dr. S for two reasons: (1) she was a MedPro insured, and we have the most information about her involvement, and (2) she had the most contact with the patient.

Several medical specialists reviewed this case, including pain management experts, who were critical of Dr. S in multiple respects. First, her documentation was poor throughout the case, making it difficult for her follow the patient's clinical progression and creating a challenge for anyone who consulted the patient's record to understand the case. Further, from a legal standpoint, the inadequate documentation made the malpractice suit difficult to defend.

Second, the experts felt that the scope and volume of narcotics prescribed were excessive, especially when Dr. S rarely performed physical exams (or, at least, rarely documented them). Some experts felt the patient should have undergone a psychiatric evaluation at the pain clinic before narcotics were prescribed.

Third, on numerous occasions, the patient's pill counts were unacceptable, either because he didn't bring his pills or he did not have the correct amount of medication remaining. These unacceptable pill counts were clear violations of his pain management contract and should have been more firmly addressed than they apparently were.

Fourth, the communication between the providers was abysmal throughout this case. No documentation indicates that the providers within the pain clinic ever actually discussed this patient, let alone engaged in communication with either of the outside psychiatrists.

At some point, Dr. S became aware that the patient was on (or, at least, had been prescribed) Suboxone. The experts were very concerned about the fact that she continued the patient on narcotic medications when it was likely he was taking Suboxone.

Finally, the experts felt that a time came when it was clear that the patient was addicted and engaging in drug-seeking behavior. The experts felt that an addiction specialist should have been brought in to help manage the patient's care.

Given the number of concerns in this case, everyone involved agreed that a settlement was the best option.

Summary Suggestions

The following suggestions might be helpful to healthcare providers treating patients who have chronic pain:

- Recognize that any case involving simultaneous treatment by multiple providers presents an increased risk of miscommunication and subsequent errors, particularly when multiple providers are prescribing for the patient.
- Be aware that most communication between providers is nonsynchronous and frequently occurs through documentation in health records. Provide clear and adequate documentation of patient care to minimize the risk of error.
- Carefully monitor patients who have chronic pain for addictive or drug-seeking behaviors. Patients who have chronic pain might have a higher-than-average potential to become addicted to medication, particularly narcotics.

- Closely adhere to prescribing guidelines (especially for narcotics), including contraindications such as the concurrent use of narcotics and Suboxone. If deviation from these guidelines is appropriate, carefully document justification for the deviation in the patient's health record.
- When possible, designate a single provider to manage the patient's care. This strategy prevents a situation in which multiple providers are handling different aspects of the patient's care, but no one is monitoring the totality of the patient's condition and treatment.

Conclusion

Medicine is becoming more complex, with more “moving parts” and the potential for more and varied types of providers involved in patient care. With this complexity, comes greater risk of communication failures and errors. Careful attention to the aforementioned principles, combined with carefully designed healthcare surveillance and delivery systems, can minimize the risk of patients inadvertently or intentionally “slipping through the cracks.”

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