

## Inadequate Supervision of Patient With Chronic Pain Ends With Patient Death

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### Introduction

Significant conversation is ongoing regarding what, how much, and under what circumstances controlled substances should be used to control chronic pain. Although consensus has not been achieved, it is clear that patients with chronic pain should be closely monitored; when they do not comply consistently with medical advice, remedial action should be taken sooner rather than later. This case from the Northeast illustrates what can result when necessary monitoring and accountability do not occur.

### Facts

The patient was a 43-year-old female with many physical and emotional issues, including bipolar disorder, posttraumatic stress disorder (PTSD), agoraphobia, anxiety/panic disorder, major depression, venous insufficiency,

Raynaud's disease, acid reflux, peripheral neuropathy, chronic hypertension, asthma, chronic obstructive pulmonary disease (COPD), and hypokalemia.

In March, when she presented to the practice of Dr. W, a board-certified physical medicine and rehabilitation physician, the patient listed more than 15 prescription medications – including alprazolam, sertraline, zolpidem, esomeprazole, pregabalin, and gabapentin – that she was taking. Her primary care physician referred her to Dr. W for her chief complaints of neck pain (postcervical fusion of C4-C5 and C5-C6), lower back pain, and pain in her hands and feet.

Dr. W performed a thorough assessment of the patient and diagnosed her with lumbar facet arthropathy, sacroiliitis, and chronic pain syndrome. His records also reflected her previous

diagnoses of bipolar disorder, PTSD, depression, anxiety/panic disorder, COPD, and Raynaud's disease. His initial medication regimen consisted of acetaminophen/oxycodone 7.5 mg/325 mg and a series of injections.

At the patient's first follow-up appointment in April, a nurse saw her instead of Dr. W. The patient received a renewal for her acetaminophen/oxycodone prescription and a fentanyl patch prescription. The patient had not yet had any injections, so the practice scheduled an appointment for her to get them. Later in April, she received the scheduled injections, which were completed without difficulty and provided some pain relief.

In May, a nurse saw the patient at the practice, and the patient reported continued relief from the injections. She received a renewal for her prescriptions, including a higher dose of the fentanyl patch. A urine drug screen also was ordered. In July, the patient presented to the practice again and saw another nurse. The patient complained that her back pain had returned and the acetaminophen/oxycodone no longer provided relief. Significantly, her urine drug screen indicated a .125 blood alcohol level. The patient indicated she had indulged in heavy

drinking the night before. The drug screen results were documented in the health record, including the patient's explanation for the high blood alcohol level; however, they were not directly communicated to Dr. W. The patient also requested to switch to rizatriptan because her pharmacist recommended it to her. Instead, her acetaminophen/oxycodone was renewed and oxymorphone 20 mg was prescribed to replace the fentanyl patch.

At the end of July, Dr. K, a different doctor at the practice, saw the patient. The doctor renewed her medications and increased her oxymorphone dosage to 30 mg. Dr. K also discussed with the patient the danger of mixing these medications with alcohol; however, this conversation was never communicated to Dr. W (her primary physician in the practice).

After a nurse renewed the patient's medications in August, the patient was seen in September. At that visit, she was scheduled for injections in response to continuing complaints of pain. However, she failed to make that subsequent appointment.

In mid-October, the patient returned to the practice, complaining of continuing pain (the injections had not been given). Her condition was assessed as essentially unchanged. She

scheduled a follow-up appointment for the middle of November, and her oxymorphone dosage frequency was increased from every 8 hours to every 6 hours.

In early November, the patient presented to the practice 2 weeks early, smelling of alcohol and admitting to being intoxicated for the past 3 days because “her pain meds weren’t working.” The nurse who saw her on this occasion renewed her medications and again educated her regarding the danger of mixing them with alcohol. During this conversation, the patient admitted that she was an alcoholic. Although the conversation was carefully documented in the patient’s health record, it was not specifically brought to Dr. W’s attention. Because of this conversation, the patient was scheduled to personally see Dr. W the following Monday.

On the following Monday, the patient kept her appointment with Dr. W. She was noted to be very upset and complained that her medications were not controlling her pain. Dr. W’s impression was unchanged, and he instructed the patient to schedule back injections for pain relief. He warned her that if she failed to do so, he would begin weaning her off her oral medications. Four days later, however, the

patient called the practice and a nurse renewed her oxymorphone at a 40 mg dosage. Apparently, the patient misrepresented her prescription status to the nurse who renewed the medication.

The following day, the patient was found dead. The examining pathologist attributed her death to the interaction of elevated levels of oxymorphone and alcohol.

A malpractice suit was filed against Dr. W and one of the practice nurses. The suit against the nurse was dismissed without payment, while – at Dr. W’s request – the suit against him was settled by a payment in the mid-range. Defense costs were in the low range.

## Discussion

From a risk management standpoint, chronic pain may be one of the most difficult conditions that physicians regularly treat. In this case, the situation was complicated because it was a very busy practice, with many practitioners at different levels seeing patients in a somewhat random order.

The larger the practice, the more opportunities for miscommunication and misunderstandings. As a result, as a practice gets larger, it must become more bureaucratic in

that it must have more standardized protocols for patient management as well as regular review and communication among providers.

The patient's many comorbid conditions and "laundry list" of medications made this a challenging case from the beginning. Nevertheless, Dr. W performed an initial assessment and developed an appropriate treatment plan for her. However, after the initial appointment, he seemed to lose contact with her, even though he was her primary physician in the practice.

In the succeeding months, a variety of providers saw the patient, and the approach seemed to be a maintenance schedule of medications, with minimal effort expended to identify and fix the underlying sources of her pain. Expert reviewers criticized this approach, especially when they identified a slow but steady increase in the medication strength prescribed to her.

The expert reviewers identified failure to deal with the patient's alcoholism as the biggest deficiency in this case. No later than July, Dr. K, who counseled the patient about her concurrent use of alcohol and her medications, recognized her alcohol problem. However, nothing indicates that Dr. K assisted her

in seeking treatment for her addiction, nor did he discuss the need to deal with this problem with Dr. W. During her earlier visit in November, the patient admitted to being an alcoholic. As the others had, this nurse documented her alcohol problem and educated her regarding the simultaneous use of alcohol and her medications; however, no movement was made toward getting her into a drinking cessation program.

One expert reviewer opined that all narcotic medications should have been discontinued immediately when the patient admitted to being an alcoholic. However, this did not happen initially or during the patient's appointment with Dr. W the following Monday. Apparently, the nurse who saw the patient the previous week did not inform Dr. W of her concerns, and Dr. W did not review the patient's health record (where the admission of alcoholism was documented) before the appointment.

All of the nurses' actions were permissible under the state's nursing practice and prescribing acts. However, the minimal direct communication about the patient within the practice combined with Dr. W's failure to review the health record/monitor the patient's

course of treatment were major contributors to the patient's decline and eventual death.

Finally, it appears that the patient secured her oxymorphone renewal sooner than scheduled and at a dosage stronger than should have been prescribed, showing a weakness in the practice's medication renewal protocol.

## Summary Suggestions

The following suggestions may be useful to practitioners treating patients for chronic, pain-related conditions:

- It is preferable for patients to be seen routinely by the same practitioner or team of practitioners rather than by random assignment, so that they can become more familiar with the patient through the repeated contacts.
- As a practice becomes larger, its processes should become more structured and standardized. Practitioners should not be allowed to do things "their own individual way."
- In any treatment setting, communication is critical. Miscommunication, including missing communication, leads to mistakes, greatly increasing the risk of treatment-related injury to patients.

- Even when documentation of care is good, if that documentation is not reviewed by subsequent providers, then it does little to contribute to quality patient care.
- When patients are on a "high risk" medication therapy (including the risk of addiction), it is important to identify trends in prescribing. Dosing has the potential to "creep up" unless it is carefully monitored.
- Renewal protocols for Schedule II and Schedule III medications should be carefully structured and rigidly adhered to because those medications can be potentially abused.

## Conclusion

Continuity of care is a critical component of quality healthcare. Such continuity needs to span across different practices when simultaneously treating patients as well as within large, busy practices. Good continuity is most likely to occur when practices have well-designed, easy-to-understand policies and procedures, effective communication, regular review of patient care, and a commitment to strong patient relationships. The end result is safe, efficacious patient care.

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