

Patient Dies While Receiving Long-Term Pain Management Treatment

Theodore Passineau, JD, HRM, RPLU, FASHRM

Introduction

It is well recognized that the physician–patient relationship is — in the truest sense — a partnership. When the parties do not work together in pursuit of a clearly defined goal, the likelihood of a suboptimal outcome increases significantly. That reality is well illustrated by this interesting case.

Facts

The patient was a 55-year-old male with an extensive medical history, consisting of chronic lower back pain (from a previous lifting injury), morbid obesity (5'7", 320 lbs.), congestive heart failure, atrial fibrillation, coronary artery disease, elevated cholesterol, hypertension, gastroesophageal reflux disorder, severe sleep apnea (he was prescribed continuous positive airway pressure [CPAP], but did not use it), and erectile dysfunction. He also had a major depressive disorder (for which he saw a

psychiatrist). Lastly, he had bilateral decubitus ulcers in the sacral region and cellulitis in the right lower leg.

Dr. J — a MedPro-insured, board-certified internal medicine specialist — started to care for the patient in November of Year 1. The patient's chief issue was severe, chronic back pain. He had previously seen a neurosurgeon, who recommended surgery (which he refused), and he had briefly received treatment at a pain clinic (but stopped because of the cost).

Dr. J's treatment of the patient was essentially confined to his back pain in 77 visits over 4 years. Other providers treated the patient's occasional "flare-ups" from cardiac issues. The salient portions of Dr. J's treatment will be discussed further.

At his first visit with Dr. J, the patient said his pain was in the lower back and sometimes it radiated to his right leg. A different provider

had prescribed oxycodone/acetaminophen in the past, which had been helpful. Dr. J's examination showed significant limitations to the patient's range of motion, and his condition was diagnosed as lumbosacral degenerative joint disease with some radicular symptoms on the right side. Dr. J started the patient on oxycodone/acetaminophen 10 mg/325 mg, one tablet per day.

The following month, the patient indicated that he was still in pain, and that gabapentin also had been helpful in the past. He started taking gabapentin, and the oxycodone/acetaminophen was increased to four tablets per day. Thereafter, he had return visits every 3 to 4 weeks, having his oxycodone/acetaminophen refilled at 120 tablets, with no refills. These return visits generally lasted 5 to 10 minutes and consisted of a few questions and renewal of the prescriptions. No further physical examination was performed. In February of Year 2, the patient called the office to say his prescription went down the toilet and he needed a replacement. His request was denied.

When the patient began to take six oxycodone/acetaminophen tablets per day (running out of his allotment early), Dr. J switched him to oxycodone/hydrochloride (extended release [ER]) 20 mg, two tablets per day. The patient

indicated that the oxycodone/hydrochloride ER did not help him, but that he had taken two oxycodone/hydrochloride (immediate release [IR]) tablets (which his brother gave him), which did help. He requested the IR medication, but Dr. J returned him to oxycodone/acetaminophen, six tablets per day. The prescription was refilled in July of Year 2, but there is a discrepancy in the patient record regarding how many were prescribed (84 vs. 120).

In September of Year 2, Dr. J's office ran a computerized medication history on the patient through the state prescription drug monitoring program (PDMP) and found that he had received medications from eight different physicians and six different pharmacies in the previous year. Dr. J had only written about 20 of his 30 prescriptions.

In December of Year 2, the patient had laser disc surgery at L4–L5, which he contended didn't relieve his pain. Dr. J indicated that he would start the patient on oxycodone/hydrochloride IR, but that he must only get it from Dr. J. The patient agreed to comply. The pattern of office visits and refills of the oxycodone/hydrochloride IR continued into Year 3.

In October of Year 3, another review of the PDMP showed 50 prescriptions (40 from Dr. J)

filled in the past year, written by six different physicians and filled by three different pharmacies. The patient was required to sign a narcotic agreement for the first time in November of Year 3.

In June of Year 4, the practice received an anonymous telephone call stating that the patient was “high as a kite, out of his mind, and yelling and screaming at no one in particular.” The practice followed up this phone call at the next visit by talking to the patient and his wife, both of whom denied any such behavior. At this visit, Dr. J ordered a urine drug screen for the first time; however, the drug screen results cannot be located.

An office visit in August of Year 4 resulted in a confusing notation in the patient’s health record. The history portion of the record (unknown author) indicated that the patient wanted to see a pain management specialist, but the plan portion of the record (written by Dr. J) states the opposite.

On the day after that visit, the practice received a call — this time from a home healthcare nurse caring for the patient’s wife — explaining how the patient was confused, kept falling asleep, and had a pulse oximetry reading of 86 percent. He was taken to a local emergency department and released a few hours later.

Dr. J speculated that the patient’s untreated obstructive sleep apnea caused this event; he did not attempt to see the patient.

Interestingly, a police report from that event states that some of the medication prescribed by Dr. J was missing from its usual location; the patient contended that it had been stolen (even though other medications and valuables in the same vicinity remained). When the patient subsequently requested replacement medications, Dr. J refused.

In October of Year 4, the patient requested a refill of his 4-week oxycodone/hydrochloride IR prescription after 2 weeks; this request was also denied. A few days later, the patient was visited by two “associates” who accompanied him to his garage for about 30 minutes. Shortly after their departure, the patient collapsed in his kitchen and could not be resuscitated. An autopsy was performed, which identified the cause of death as ingestion of oxycodone/hydrochloride IR and carfentanil (a potent opioid).

A medical malpractice lawsuit was commenced against Dr. J and one of the patient’s pharmacies. At the doctor’s request, the case against him was settled with a payment in the mid-range; defense costs were in the high range.

Discussion

One interesting factor in this case is that the patient did not die from ingesting medication that Dr. J prescribed. Although the toxicology from the autopsy showed a high level of oxycodone/hydrochloride IR, it was not enough to cause death.

The cause of death was clearly the presence of carfentanil, a medication intended to anesthetize very large animals (elephants, rhinoceroses, etc.). It is 100 times more potent than conventional fentanyl and has no indications for human use. Presumably, the patient acquired the carfentanil from his “associates” (who were subsequently and successfully prosecuted for manslaughter).

The essence of the malpractice lawsuit against Dr. J was the allegation that he mismanaged the patient’s pain, causing the patient to develop an addiction to painkillers. As a result, the patient was seeking the pills not only from healthcare providers but also “off the street.”

This was a very complicated case; over the 4 years discussed, the patient also saw providers for cardiac and psychiatric issues, as well as care for his decubitus ulcers (discussion of this care was not included for brevity). The true extent of his drug seeking from illegitimate

sources is unknown. Nevertheless, the defense experts did not support Dr. J in several important respects. Dr. J should have recognized the following events as drug-seeking behavior:

- The patient using the excuse of losing his medication down the toilet
- The patient admitting taking medication amounts higher than prescribed
- The patient admitting taking narcotics from his brother
- The practice receiving the (second) phone call indicating confusion and lethargy and a low pulse oximetry (which resulted in no follow-up care)
- The patient giving an implausible explanation that his medication had been stolen after that phone call

Other aspects of Dr. J’s care also were not helpful to the case’s defense, including:

- The confusion on one visit regarding how many tablets had been prescribed
- The inconsistent documentation on another occasion regarding whether the patient desired a referral to a pain management specialist

- The failure to conduct periodic physical examinations to determine the continuing state of the patient's disability
- Lack of a narcotic agreement until late in Year 2
- Failure to require a urine drug screen until the middle of Year 3 (then losing the results from documentation)

Although the PDMP indicated that the patient was receiving prescriptions from other providers, it does not definitively establish that he was “doctor shopping”; other legitimate providers may have prescribed these medications. However, no documentation indicates Dr. J attempted to coordinate care with the patient's psychiatric, cardiac, or wound care providers.

Again, the patient's death clearly was caused by his decision to purchase and consume illicit substances from an unreliable source. However, it is not hard to see how these shortcomings in Dr. J's management could easily portray him as an uncaring physician (which was not the case).

The doctor, his defense counsel, and the MedPro defense team agreed that settlement was the best way to protect him from excessive liability exposure.

Summary Suggestions

The following suggestions may be helpful when providing care for patients with subacute and chronic pain:

- Ensure compliance with state laws regulating how physicians prescribe opioids. Noncompliance or negligence in prescribing may lead to investigations by state medical boards, the Drug Enforcement Administration, or other federal agencies.
- Prioritize self-management strategies and nonpharmacological therapies for subacute or chronic pain. If pharmacological therapy is necessary, determine whether nonopioid medications might be effective.
- When considering opioids for subacute or chronic pain treatment, evaluate patients for risks related to misuse or harm (e.g., a history of substance abuse, mental health conditions, sleep-disordered breathing, etc.).
- Request toxicology screening to assess for prescribed and nonprescribed medications and controlled substances that increase the risk of overdose when combined with opioids.

- Prior to prescribing opioids, assess the patient's baseline pain and function, determine the current extent of the patient's medication usage, and consult with any other providers who have treated, or are also treating, the same condition.
- Conduct a thorough [informed consent](#) conversation with the patient, and review the risks and benefits of opioid therapy as well as alternative therapies. Establish treatment goals, including realistic goals for pain and function as well as criteria for stopping or continuing opioids.
- Consider initiating a [pain management agreement](#) with the patient when first prescribing opioids. Have the patient review and sign it annually.
- Conduct regular physical examinations to assess treatment efficacy and determine whether the treatment plan needs adjustment.
- Be alert to any signs of drug seeking (e.g., requests for early refills), and regularly monitor patient compliance through regular (possibly unannounced) urine screening and PDMP consultation.

- Refer the patient to a pain management specialist when their prescribed treatment is ineffective or they demonstrate intentional nonadherence to their treatment plan.
- As with all care, ensure that documentation is complete, accurate, and up to date. When multiple providers are documenting in one health record, be watchful for inconsistent entries.

Conclusion

Chronic pain management may be one of the most challenging aspects of patient care that some practitioners face. Underprescribing can cause unnecessary patient suffering and impaired function, while overprescribing can lead to misuse, diversion, dependence, and death.

Thus, taking a cautious, judicious, and consistent approach to pain management is imperative to maintain safety and reduce liability exposure.

For more information and strategies related to pain management, see MedPro's [Risk Management Strategies for Opioid Prescribing](#) and [Risk Resources: Opioids Prescribing and Pain Management](#).

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