Minimize Liability, Manage Risk, Ensure Patient Safety: Effective Strategies in Opioid Prescribing

Facilitator: Todd Mandell, MD
Faculty: Ilene Robeck, MD
Alan Wartenberg, MD

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Managing Risk, Patient Safety, and Best Practices – Part I

An OTP Perspective
Red Flags in Routine Admission

- Program Admission Criteria
- Patient assessment
  - History
  - Physical Exam and labs
- Methadone dosing start up and titration
- Responding to change in patient status
- Early take homes
Mary T.
Segment I Presenting Information

Patient Summary:
Mary T. is a 28 year old Hispanic female who presented to an opioid treatment program on July 13, 2007.

Chief Complaint:
“I need to get clean; I’m tired and run down and I don’t want to be a drug addict for the rest of my life because I know it’s going to kill me.”

History of Present Illness:
Mary admitted using opiates intravenously for the past five years. Her substance of choice is OxyContin, but when she can’t access OxyContin, she uses heroin. She began drug use as a teenager and has used other drugs including alcohol, marijuana, cocaine, benzodiazepines, ecstasy and LSD. She admitted smoking cigarettes, 1PPD times 15 years.

Upon intake she denied using any opiates for the past week. She admitted withdrawal symptoms of sweats, chills, restlessness, sleep disturbance, daytime fatigue, and loose stools. However these symptoms had resolved and she denied withdrawal symptoms for the past three days.
Mary T.
Segment I Presenting Information

Past Treatment History:
Mary admitted to several admissions for inpatient and outpatient detoxification. Despite participation in 12 Step Meetings, she was unable to sustain abstinence for longer than two or three months. Mary admitted a six month period of sobriety several years ago after she relocated to another state to live with her aunt and uncle.

Psych History:
She admitted a history of treatment for “depression” and was evaluated by two psychiatrists within the past three years; she admitted previous prescription for Prozac, Celexa and Wellbutrin but they were ineffective and she had discontinued the medications. She admitted to “self medicating” her symptoms by increasing her drug use.
Mary T.
Segment I Presenting Information

**Review of Systems (ROS):**
Except for her previously noted resolved withdrawal symptoms, her ROS was only remarkable otherwise for weight loss of ~ 5lbs within the past 6 months regarding physical complaints.

**Mental Status Examination:**
Remarkable for feelings of sadness and depression, described as moments of “darkness” when she “didn’t believe there was a point to her suffering” and while she had considered overdosing, she had not found the “strength” to act upon it. Mary stated she found some comfort in her religion, and the Catholic church.
Mary T. 
Segment I Presenting Information

Physical Examination:
Mary was examined by the nurse practitioner. Her physical examination revealed vital signs within the normal limits. Her skin was smooth, warm and moist. Her arms and hands revealed scattered scarring consistent with injection marks, but no fresh puncture wounds or abscess formation was visible. Her sclera were mildly injected; pupils slightly dilated; nasal mucosa appeared mildly erythematous; the remainder of her focused physical examination was unremarkable.

Laboratory Results:
Urine toxicology screen at intake was negative for amphetamines, barbiturates, benzodiazepines, cocaine, opioids, methadone and methadone metabolites.
What Are the Issues?

Intake recap and red flag discussion
Clinical Opiate Withdrawal Scale

**Resting Pulse Rate:** _______ beats/minute
*Measured after patient is sitting or lying for one minute*
- 0 pulse rate 80 or below
- 1 pulse rate 81-100
- 2 pulse rate 101-120
- 4 pulse rate greater than 120

**GI Upset:** over last ½ hour
- 0 no GI symptoms
- 1 stomach cramps
- 2 nausea or loose stool
- 3 vomiting or diarrhea
- 5 Multiple episodes of diarrhea or vomiting

**Sweating:** over past ½ hour not accounted for by room temperature or patient activity.
- 0 no report of chills or flushing
- 1 subjective report of chills or flushing
- 2 flushed or observable moistness on face
- 3 beads of sweat on brow or face
- 4 sweat streaming off face

**Tremor:** observation of outstretched hands
- 0 No tremor
- 1 tremor can be felt, but not observed
- 2 slight tremor observable
- 4 gross tremor or muscle twitching

**Restlessness** Observation during assessment
- 0 able to sit still
- 1 reports difficulty sitting still, but is able to do so
- 3 frequent shifting or extraneous movements of legs/arms
- 5 Unable to sit still for more than a few seconds

**Yawning** Observation during assessment
- 0 no yawning
- 1 yawning once or twice during assessment
- 2 yawning three or more times during assessment
- 4 yawning several times/minute

**Pupil size**
- 0 pupils pinned or normal size for room light
- 1 pupils possibly larger than normal for room light
- 2 pupils moderately dilated
- 5 pupils so dilated that only the rim of the iris is visible

**Anxiety or Irritability**
- 0 none
- 1 patient reports increasing irritability or anxiousness
- 2 patient obviously irritable anxious
- 4 patient so irritable or anxious that participation in the assessment is difficult

**Bone or Joint aches** If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored
- 0 not present
- 1 mild diffuse discomfort
- 2 patient reports severe diffuse aching of joints/ muscles
- 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort

**Gooseflesh skin**
- 0 skin is smooth
- 3 piloerrection of skin can be felt or hairs standing up on arms
- 5 prominent piloerrection

**Runny nose or tearing** Not accounted for by cold symptoms or allergies
- 0 not present
- 1 nasal stuffiness or unusually moist eyes
- 2 nose running or tearing
- 4 nose constantly running or tears streaming down cheeks

**Total Score** _______
*The total score is the sum of all 11 items*

Initials of person completing Assessment: ______________

**Score:**
- 5-12 = mild
- 13-24 = moderate
- more than 36 = severely withdrawn

Mary T.
Segment I Presenting Information

Preliminary Treatment Plan:

The physician’s statement for documentation of current physiological dependence upon opioids was completed and signed. The patient was recommended for admission to opioid maintenance treatment because her lack of minimal family and community support which places her at high risk for relapse.
Mary T.
Segment II: Dose Titration Schedule

Mary’s dosing schedule per standing orders:

Day 1  Thur  Methadone dose 30mg
Day 2  Fri  Methadone dose 40mg
Day 3  Sat  Methadone dose 50mg
Day 4  Sun (TH)  Methadone dose 60mg
Day 5  Mon  Methadone dose 65mg
Day 6  Tue  No Show
CSAT Guidance
“Standing Orders”

- Dear Colleague Letter – September 9, 2007
- Risks associated with initial methadone dosing and the first two-weeks during induction process
- OTP Inspections
- Published literature review (Maxwell, 2005)
- OTP physician responsibility
- Knowledge of methadone pharmacokinetic and pharmacodynamic properties
- Individualized initial methadone dosing

resource: Physician Clinical Support System  www.PCSSmentor.org
Mary T.
Segment III: Induction

Day 1

Mary was started on a dose of 30 mg. methadone with a standing order to increase 5 to 10 mgs daily up to a maximum dose of 80 mg.

There were no symptom indications to guide the dose increases.

Methadone Dosing Schedule

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<thead>
<tr>
<th>Day</th>
<th>Thur</th>
<th>Dose</th>
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<td>Day 1</td>
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<tr>
<td>Day 6</td>
<td>Tue</td>
<td>No Show</td>
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Mary T.
Segment III: Induction

Day 2
Mary received a dose of 40mg of methadone

Methadone Dosing Schedule
Day 1  Thur  Dose 30mg
Day 2  Fri  **Dose 40mg**
Day 3  Sat  Dose 50mg
Day 4  Sun  (TH)Dose 60mg
Day 5  Mon  Dose 65mg
Day 6  Tue  No Show
What Are the Issues with the Dosing Schedule?
Methadone Pharmacology

• Pharmacokinetics
  – Long plasma elimination half-life, drug-drug interactions, individual variation, special populations

• Pharmacodynamics
  – Tolerance, peak respiratory effect, cardiac conduction effects, CNS depressant and other drug interaction effects, individual variation

• “Start Low and Go Slow”

• Practitioner education

• Patient education
A Road-Map to “Steady State”

Days/Half-Lives – Methadone half-life= 24-36 hours
Dose constant at 30 mg daily.

Interdose interval = 24 hrs (trough to trough)
Peak levels increase daily for 5-6 days with NO increase in dose!

Mary T.

Segment IV: Complication - Withdrawal Symptoms

Day 3

Mary reported to the dispensing nurse that she was experiencing withdrawal symptoms and asked to see the nurse practitioner.

The dispensing nurse advised Mary that her dose was to be increased and administered methadone 50 mg. according to the standing order protocol.

She also gave Mary her Sunday take-home methadone 60 mg. dose for Day 4. The clinic was closed on Sundays and as per regulations, the clinic customarily gave all patients Sunday take-home medication.

Methadone Dosing Schedule

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<th>Day</th>
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CSAT Guidance
“Take-home doses”

• “Dear Colleague Letter” – January 28, 2008
  – Rescinded 10/21/09
  – SAMHSA is “in the process of reviewing the guidance provided in the January 24, 2008 letter. Our goal for the review is to provide additional clarity on SAMHSA’s policy and to ensure safe and effective treatment services are available for people in need”.

• Medical Director responsibility for all decisions

• Eight-point criteria in § 291.505(d)(6)(iv)(B) and 42 CFR,8.12(i)(2)

• Accreditation Guidelines 2007

• Clinic closure for business, Sunday, state and federal holidays

• Alternative arrangement for patients determined by the medical director not to be appropriate candidates
Mary T.

Segment V: Titration Resumed

Day 5

Mary reported that she was no longer experiencing withdrawal symptoms and that she did not want an increase because she did not want to be like those “other patients on high doses”. Mary was noted to be slightly unsteady on her feet at the dispensing window.

The dispensing nurse recommended to Mary to adhere to the standing order protocol for a further increase in her dose and Mary was given methadone 65 mg.

Methadone Dosing Schedule

Day 1  Thur  Dose 30mg
Day 2  Fri  Dose 40mg
Day 3  Sat  Dose 50mg
Day 4  Sun  (TH)Dose 60mg
Day 5  Mon  **Dose 65mg**
Day 6  Tue  No Show
Mary T.
Segment VI: No Show

Day 6
Mary’s counselor made an outreach telephone call to her apartment building due to her no-show status for dosing.

The counselor was advised during that call that Mary had passed away the day before. When she was found by her landlord that morning, she appeared to have fallen asleep on the couch. She was not breathing and her lips were blue.

An ambulance was called and she was pronounced dead at the hospital emergency room.

Methadone Dosing Schedule
Day 1 Thur Dose 30mg
Day 2 Fri Dose 40mg
Day 3 Sat Dose 50mg
Day 4 Sun (TH)Dose 60mg
Day 5 Mon Dose 65mg
**Day 6 Tue No Show**
Mary T.
Segment VI: No Show

Day 6

A subsequent autopsy was performed within 48 hrs of Mary’s death. As the Circumstantial Cause of Death, the autopsy report stated cardiopulmonary arrest due to pulmonary edema secondary to methadone intoxication, history of opioid prescription drug and heroin abuse.

The forensic toxicology report indicated high levels of methadone and methadone metabolites. No other drugs were reported.

Methadone Dosing Schedule

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<tbody>
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<td>3</td>
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<tr>
<td>4</td>
<td>Sun</td>
<td>(TH) 60mg</td>
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<tr>
<td>5</td>
<td>Mon</td>
<td>65mg</td>
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<tr>
<td>6</td>
<td>Tue</td>
<td>No Show</td>
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### Methadone Dose

**“Equivalent Effect”**

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<th>Equivalent Effect</th>
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<tr>
<td>Sat</td>
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<td>Sun (TH)</td>
<td>60mg</td>
<td>98.75mg</td>
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<tr>
<td>Mon</td>
<td>65mg</td>
<td>114.375mg</td>
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<tr>
<td>Tue</td>
<td>No Show</td>
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</table>

Methadone “dose equivalent effect” due to accumulative effect of tissue buildup.
Take Home Points

• Everyone is responsible for best practice and risk management

• Go Low - GO SLOW

• Avoid Standing Orders

• Respond to patient changes in status

• Saying “I’m sorry”? 
Case II

Third Party’s at Risk!

OTPs having responsibility to the Community
Patient Profile

- On admission. GE began participating in methadone maintenance treatment at the Treatment Center on April 4, 2000.
- Drug use history. According to the “Substance Abuse History” form GE completed at the time she was admitted, she was using Lorcet, Dilaudid, Valium and marijuana daily.
Treatment contract:

GE signed a “Contract for Methadone Treatment Using Methadone and Supportive Counseling” GE on admission. In her Treatment Contract, she said she understood:

- Her treatment would consist of supportive counseling and methadone medication.
- Her continuing participation in treatment was conditioned on her following the program’s rules and regulations, and she faced discharge for violating them.

(continued)
Treatment contract, cont:

GE also said she understood that –

• The Treatment Center allowed methadone maintenance treatment for 24 months continuously.

• If she did not make progress toward the objective of achieving drug free status (off all drugs including methadone) within that time period she could face a medically safe withdrawal and would have to remain off methadone for 30 days before being considered for readmission.

• If she made progress toward that objective, methadone maintenance could be extended.
First five months of treatment (according to court decision’s description):

- **Dose.** As of September 8th, the day of the accident, GE’s daily methadone dosage was 85 milligrams.

- **Take-home schedule.** No take-homes.

- **Drug testing.** Between April 4 and September 8, when the accident happened, the Treatment Center had GE undergo 12 (presumably random) urinalyses.
First five months of treatment (cont.):

• **Urinalysis results.** GE tested positive for drugs other than methadone on 11 of those 12 occasions:
  
  – 10 of the 11 dirty urines were positive for benzodiazepines (which her program knew were not prescribed – that she was using illicitly).
  
  – 7 of the 11 dirty urines were positive for THC (marijuana).
  
  – Her September 6th test (2 days before the accident) was positive for benzodiazepines and marijuana.
First 5 months of treatment (cont.):

- **Counseling.** The court decision does not say how frequently GE was expected to attend counseling sessions.
- But the court does say that the Center’s clinical notes (on 6/21/00 and 7/25/00) reflected that
  - GE “was not attending group counseling sessions, and
  GE “reported having no desire to stop using.”
On September 8, 2000, five months after she entered methadone maintenance treatment at the Gasden Treatment Center in Alabama, a 90-minute trip from her home, GE made her daily drive to her treatment program. After receiving her 85 milligram dose of methadone at around 6:00 a.m., she began driving home.

At 7:23 a.m., her car crossed into the lane of oncoming traffic and collided with a car driven by Lola Ann Taylor, who suffered injuries in the accident.
The Court’s Ruling:

• The plaintiffs injured in the car accident caused by the OTP’s patient were allowed to sue the methadone program and its Medical Director for negligence.

• Methadone programs have a legal duty to take reasonable care to protect third parties (the driving public) from injuries resulting from a patient’s conduct, in circumstances like those presented in this case.
Legal and Liability Issues: Impaired Driving Concerns

Key Current Concerns

- Driving Under the Influence (DUI)
- Negligence Lawsuits Against OTPs Stemming from Patient Driving
- Negligence Law and OPT Standards of Care
Impaired Driving Concerns: OTP Patients

Driving by patients raises related legal & liability concerns:

1. Criminal liability concerns – patients:
   - DUI/drugged driving laws and opioid treatment medications (methadone, buprenorphine)
   - Criminal liability for other driving offenses

2. Civil liability concerns – patients and OTPs:
   - Negligence lawsuits against patients seeking to hold them liable for injuries caused by patients’ driving
   - Negligence lawsuits against OTPs seeking to hold the OTP liable for injuries caused its patients’ driving
Dosing and Monitoring Issues  
... Impaired driving concerns: DUI

Criminal Law: Drugged Driving (DUI)

- State drugged driving (DUI) laws: 3 general categories:
  1. Laws that require the drug to render driver “incapable” of driving safely
  2. Laws that require the drug to impair the driver’s ability to operate safely, or require driver to be under influence of or affected by “intoxicating” drug
  3. Per se laws that make it criminal offense to have drug(s) in one’s body while driving.
Dosing and Monitoring Issues

. . . Impaired driving concerns (DUI)

• Are OTP patients vulnerable to arrest and prosecution on DUI charges just for “driving while on methadone”?
  – Yes – This has happened, and can, based on driver’s status as a patient in methadone treatment:
    • Driver is identified as methadone patient – e.g., police see driver leaving OTP; find medication in driver’s in car; or driver identifies self as methadone patient; or
    • Driver is found to have “methadone on board” – e.g., driver reports use, or drug test shows medication present in driver’s bodily fluids.

• Can someone be convicted of DUI just for “driving while on methadone”?
  – Sometimes – but not automatically, and not always, and OTPs can help prevent patients’ arrest and conviction.
Dosing and Monitoring Issues: . . . Impaired driving concerns (DUI)

• What is required to prove a DUI charge against an OTP patient driver?
  – In states with category (1) or (2) laws, prosecution must show that drug was present AND that patient’s ability to drive was actually impaired. Fact that methadone is present in body is not enough to convict.
  – In states with category (3) “per se” laws, proof that drug (methadone) was present in body, by itself, may be legally sufficient to convict.
Dosing and Monitoring Issues:  
. . . Impaired driving concerns (DUI)

- Strategies for **defending** DUI charges against OTP patients in States with category (1) or (2) DUI laws:
  - Prosecution: understand proof prosecution needs to convict:
    1. Presence of drug in driver’s body, PLUS
    2. Causal connection: evidence that this drug impaired this driver’s functioning/driving, and
    3. Evidence of impaired driving.
  - Defense: understand proof needed for defense to disprove prosecution’s case:
    1. Driver’s use of methadone was **legal** & medically appropriate
    2. No causal connection: driver’s use of methadone did not impair functioning/driving
    3. No evidence of other drug(s)/alcohol whose interaction with methadone could/might impair driving ability.
Dosing and Monitoring Issues:  
. . . Impaired driving concerns (DUI)

• How to show the 3 elements needed to defend a DUI charge in States with category (1) or (2) DUI laws:

1. Show that this driver's use of methadone was legal
   - Verify driver is OTP patient in good standing:
     1. Treatment is legal: is taking methadone as part of medically accepted and legally authorized course of treatment
     2. Source of methadone is legal: is administered methadone by OTP as part of prescribed course of medication-assisted therapy
Dosing and Monitoring Issues:
... Impaired driving concerns (DUI)

How to defend DUI charge in category (1) or (2) State, cont.

2. Show that this driver’s use of methadone did not affect or impair driving-related functioning – that there is no scientific or medical basis for assuming it did.

- Confirm driver was stabilized on clinically appropriate dose – so was not experiencing any side effects from medication that did/would impair normal functioning, including driving ability (no cognitive, psychomotor skills impairment from methadone); and

- Point to studies of methadone-maintained patients’ functioning, including driving abilities: no cognitive, psychomotor skills impairment from methadone.
Dosing and Monitoring Issues: . . . Impaired driving concerns (DUI)

How to defend DUI charge in category (1) or (2) State, cont.

3. Show this driver is/was not known or shown at time of arrest to be using/abusing other drugs or alcohol:

   ➢ No evidence of drug interactions that might impair functioning or driving ability

   ➢ If driver is taking other medications, address questions raised by that issue and, if possible, allay concerns about potential impairing effects of medication/medication interactions.
Dosing and Monitoring Issues: Impaired driving concerns (DUI)

- Strategies for defending DUI charges against OTP patients in States with category (3) “per se” DUI laws:
  - In states with “per se” laws, may not be able to successfully defend/disprove DUI charge, since:
    1. Presence of drug (methadone) in driver’s body is itself legally sufficient to prove DUI charge, and
    2. Legality of treatment, and lack of effect on functioning/lack of impairment of driving ability, are legally irrelevant.
  - Community relations and public education efforts may help change law enforcement attitudes – and how they apply DUI law to patients in methadone treatment.
Dosing and Monitoring Issues: Impaired driving concerns (DUI)

- What can an OTP do to help prevent & defend DUI cases against its patients?

- Develop a **DUI Response & Defense Protocol** and **DUI Toolkit**

1. Be ready – at request of and with consent of the patient – to communicate to law enforcement relevant information about driver’s status as an OTP patient, showing:
   a. his/her medication is legally prescribed and possessed,
   b. he/she is stabilized on clinically appropriate dose, and what that means in terms of medication’s lack of impairing effect on normal functioning, and
   c. (where possible) this is a patient in good standing, making good progress in tx: no OTP evidence/documentation of concurrent drug or alcohol abuse at time of arrest
Dosing and Monitoring Issues: Impaired driving concerns (DUI)

2. Be prepared to follow your **DUI Response & Defense Protocol** in response to DUI charges against patients if & when they happen.
   - Put in place procedures for obtaining patient’s written consent to above communications by OTP to law enforcement in DUI cases, before verifying patient status or disclosing any patient-identifying information
   - Develop a **DUI Toolkit**
     - Prepare boilerplate consent form for use in DUI cases, authorizing disclosure of relevant info (listed above) needed to defend charge
     - Offer patients option of signing such a consent in advance, authorizing these communications in the event a DUI arrest happens
Dosing and Monitoring Issues:

. . . Impaired driving concerns (DUI)

3. Educate **patients and staff** about your **DUI Response and Defense Protocol**:
   - Tell patients as part of initial & ongoing patient information/education process
   - Train staff as part of initial and periodic staff training
   - Assign OTP staff to be designated DUI “point person” to ensure appropriate response in all DUI cases
   - Where do “Do Not Drive” orders fit in?
Negligence Law: Impaired driving concerns

Impaired Driving Concerns:
Civil Liability for Negligence

1. What are civil liability concerns under negligence law relating to OTP patients’ driving?
   • Patient liability for negligence in cases involving driving
   • Program liability for negligence in cases stemming from patient driving

2. What is the state of the law today?
   • Case law developments in negligence lawsuits brought against OTPs by third party non-patients injured in car accidents caused by OTP patients: Alabama, Florida, Oklahoma, New York

3. What strategies can OTPs use in preventing and defending negligence claims stemming from patient driving?
Negligence law

. . . Impaired driving concerns

1. OTP patients’ responsibilities and potential liability for negligent driving
   • Do OTP patients owe a legal duty of care to others?
   • Yes.
     – Every person owes other members of society a legal duty to take reasonable care to avoid causing reasonably foreseeable harm to others.
     – If an individual breaches that duty, and his/her failure to take reasonable care to avoid injuring others does, in fact, result in injuries to other persons, he or she may be sued for negligence and held liable to pay damages to compensate the injured persons for the injuries his/her negligence caused.
TAKE HOME POINTS

- Strategies for addressing impaired driving concerns with patients
  - Make clinically appropriate dosing and treatment decisions
  - Patient education: about treatment, medication effects, drug interactions, patient responsibilities in driving
  - Monitor and respond to identified patient driving risks as part of individualized treatment plan
  - Document OTP’s actions in taking reasonable steps to prevent impaired/unsafe patient driving
  - Do community (and law enforcement) education
  - Is it time to consider “Do Not Drive” orders in some cases?
Managing Risk, Patient Safety, and Best Practices – Part II
A Pain Management Perspective
The Opiate Agreement

- The Opiate Agreement is a crucial part of safer pain management when opiates are used.
- It serves as a tool for educating the patient of the risks inherent in opiate therapy.
- It clearly defines the responsibilities of the provider as well as that patient when opiates are used for chronic pain.
The Opiate Agreement

- It informs the patient about the risks of cognitive impairment with opiates and the risk of an additive effect when other drugs or medications are used that can also impair cognition.
- It informs the patient of the need for communication with other providers and family members for successful therapy.
The Opiate Agreement

• It informs the patient of the known risks associated with opiate therapy so that an informed decision can be made prior to and revisited during chronic opiate therapy.
• It informs the patient that there are state and federal laws that govern opiate use that must be complied with.
Opiate Agreement

• The Opiate agreement also makes it clear at the onset that Opiate Therapy is a trial and can be discontinued for a number of reasons that may be related to risk or lack of functional benefit.

• The discussion of risk with the patient allows the patient to understand the need for life style changes to decrease the incidence of an adverse event but cannot eliminate it.
Case Study III – Chronic Pain and Marijuana

• 60 year old Vietnam veteran with chronic back pain presents to the ambulatory care pain clinic for evaluation and treatment, as his previous primary care provider has left the VA and his new primary care provider is unwilling to prescribe opiates in the face of his ongoing marijuana use.

• The patient smokes marijuana regularly as he states that it helps his pain and symptoms of anxiety and ptsd.

• He is unwilling to get help at the Alcohol and Drug Treatment Program for counseling about his marijuana use.
Key Points

- Marijuana use represents a significant health risk and all users should be offered an opportunity for education concerning this and treatment when appropriate.
- Marijuana use represents a significant drug interaction with opiates and chronic opiate therapy increases the risk of an opiate adverse event in a person using marijuana.
- Chronic marijuana use can transiently improve some unpleasant symptoms but ultimately interferes with successful long term treatment outcomes.
- Cognitive impairment with marijuana is a significant risk and is increased when mixed with drugs or medications that are also at risk for cognitive changes.
Case Study

- He does see a psychiatrist in mental health because of worsening depression and behavioral problems treated with quetiapine.
- His back pain interferes with his ability to work as he had worked in construction in the past.
- Full workup revealed evidence of degenerative disk disease without significant spinal stenosis.
Key Points

• Using opiates in a patient with inadequately treated psychiatric symptoms increases the risk of the opiate being used to mask these symptoms rather than pain control.

• Chronic marijuana use has been associated with increased risk for psychiatric problems including schizophrenia.

• Decisions about medications for patients for co morbid psychiatric problems need to take into account the role that a drug is playing in this symptom complex.
Case Study

• The patient has had Oxycodone prescribed by his provider for his chronic back pain.
• The patient does admit that he is now sometimes having difficulty remembering whether or not he has taken his medication recently.
• The patient also admits that he now gets much less relief from his Oxycodone than he has previously.
Key Points

• Both opiates and marijuana can be associated with cognitive impairment, making proper dosing a problem, especially with short acting opiates needing to be dosed multiple times during the day.

• Tolerance to the positive effect of opiates is a common occurrence and requires a comprehensive approach to pain management to overcome.
Case Study

- The patient has never had physical therapy or non-opiate therapy for his pain.
- Although he is able to function around the house he is interested in a motorized scooter to minimize his activity because he is afraid that it will become too difficult for him to move in the future.
- The patient was tapered off of his opiate therapy and non-opiate therapy was initiated with an NSAID, muscle relaxer and an anticonvulsant. Nightmares were treated with Prazosin.
Key Points

• Fear of pain is a significant deterrent to exercise for patients with chronic pain. Frequently patients will not increase their activity level more out of fear of pain than actual experienced pain.

• Sleep is important for adequate pain control. Address issues of sleep and include education about sleep hygiene and appropriate medication (if indicated). Also ask the patient about what they are using to help sleep.
Case Study

• After conversation with his psychiatrist a dual acting anti depressant was added to his regimen.

• A pill box was obtained from pharmacy to help with his medication.

• His wife came to his second meeting and a full discussion was held with the patient and his wife about the rationale for treatment without opiates.
Key points

• Communication between providers is key for safe and effective treatment. Shared information on mutual patients will decrease the risk of an adverse event related to inadequate information or uncoordinated medication changes.

• Sometimes the most important intervention does not involve adding another pill.

• Family members are a very important part of the history and solution, especially in patients at high risk who are not doing well.
Case Study

- During the course of treatment the patient reluctantly participated in physical therapy and was instructed on the use of a TENS unit.
- His wife was extremely grateful that someone was addressing the issue of his marijuana use as his level of functioning around the house was worsening and was less than reported by the patient.
- His pain, to his surprise, improved and after 6 months of being seen by the ambulatory care pain clinic the patient agreed to go into treatment for his marijuana use.
Key points

• Getting into treatment for a Substance Use Disorder is a process and the option for treatment should be offered at every visit when appropriate.

• Non pharmacologic treatment options are part of all chronic pain management and enable the patient to function on less medication over time. All medications can have side effects and improving function is the key to success with pain management.
Case Study IV – Opiate Dependence

• The patient is a 50 year old male who is seeking treatment at the VA because he has lost his medical benefits because the company he has been working for has gone out of business.
• He has chronic back pain and at one point in his life had a physically demanding job which required him to be on his feet all day.
• He was able to remain employed because he took extra classes to learn an IT job that was more sedentary.
Key Points

• Unemployment may make chronic pain worse as there can be increased stress, decreased level of activity, decrease in positive distractions and an increase in symptoms of depression.

• The ability to learn new skills is important in pain management as life style changes are as important as medication changes.
Case Study

- The patient had been seeing a private physician who has been prescribing Oxycodone in higher and higher doses without other therapy.
- His initial response to Oxycodone was good but gets progressively worse each year. He has now been on Oxycodone for 5 years and is taking 20 mg every 3 hours and states that after the second hour he is watching the clock until his next dose can be given.
- He admits to occasionally running out of Oxycodone because he takes an extra dose because of pain. When this happens and he misses medication prior to his next appointment he develops symptoms of irritability, worsening pain, sweating and diarrhea.
Key Points

• Understand the difference between Addiction, Dependence and Tolerance when using opiates for any reason.

• Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur.

• This is a normal physiological response.

• The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one’s mood. It should be noted that physical dependence does not equal addiction.
Key Points

- Addiction is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation.
- It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings.
- This means the drug decreases one’s quality of life.
- Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug’s effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient’s pain.
Key Points

• Chronic opiate therapy can lead to hyperalgesia, in which there is an increase in pain level related to opiate therapy that is most apparent in between doses.

• Tolerance to opiate effects and withdrawal can occur in patients without addiction.

• Opiate therapy in high doses has been associated with an increase risk of opiate adverse events even when taken as prescribed.
Case Study

- The patient was referred to the ambulatory care pain clinic because of his opiate dependence despite the fact that there is no behavior to suggest addiction.
- A full workup of his pain included an MRI which showed degenerative disk disease with bulging disks without herniation.
- A comprehensive approach to his pain was outlined by the clinic provider including adjuvant pharmacologic therapy with a NSAID, Anticonvulsant, and Muscle Relaxer.
Key Points

• Non opiate adjunctive therapy is important to begin initially prior to considering chronic opiate therapy.

• Adding non opiate adjunctive therapy once opiates have been initiated can help lower total opiate doses by improving pain control without reliance on the mu receptor that is the hallmark of opiate therapy.

• Utilizing medications that have different functions and work with different receptors can frequently improve pain with less side effects that relying on one medication alone.
Case Study

- The patient was converted to Morphine SA with low dose Oxycodone for break through pain which he now rarely uses.
- The patient participated in a pool therapy program followed by a physical therapy program and was also given a TENS unit and instructions on a low impact exercise program.
- The patient has now found another job and states that his pain is better now than it ever was prior to his conversion to a more complete regimen for his pain. His opiate dose has been tapered significantly and continues to be lowered at each visit.
Key Points

• The use of long acting opiates can be helpful to decrease opiate withdrawal hyperalgesia and end of dose break through pain. It also provides a regimen in which the patient’s life is not ruled by frequent medication dosing and improves compliance.

• Non pharmacologic management and improved function are critical for long term successful pain management.
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