Litigating through the opioid epidemic

Duck, cover, and sue drug dealers: A look at how narcotic-based pain management can impact PI cases

By Nathaniel Leeds

With the deaths of Michael Jackson, Prince, and most recently Tom Petty all attributed to the chronic misuse of prescription painkillers and the national attention being drawn to the "opioid crisis," it is time to reflect on how the opioid epidemic and changing perceptions of pain management will impact our practices.

Increasingly, our clients find themselves in a difficult spot: if they received narcotic-based pain management, they will be accused of drug-seeking behavior; if they did not, it will be assumed that they were not injured.

This article does not offer a solution to a cultural shift which will almost certainly complicate our cases, but it does offer some tools to help navigate a challenging landscape in which we need to understand patterns of abuse, because jurors certainly will.

Understanding the culture of the opioid epidemic

I was having dinner with a hospital administrator a couple months back who told me that at her hospital the standing policy was to give patients one-half of the narcotics that they reported receiving outside of the hospital, and slowly increasing the dose. The reason: So many people who have long-term narcotic prescriptions are selling part of their prescription that they had a number of in-hospital overdoses when they tried to match in-hospital doses directly to the doses reflected in the patients' medical records.

The story is a window into the caustic mix of bad policy and bad medicine that have created the opioid epidemic.
I blame Bill Clinton and Purdue Pharma.

Welfare reform

One of the hallmarks of Clinton's welfare reform, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 was an attempt to force people to join the labor market in order to get public assistance. Recipients of welfare were required to begin working after two years of receiving benefits, and

were limited to five years of lifetime benefits.

For people who cannot find meaningful employment or who are needed at home to care for their families, the current system requires some very difficult choices. For many the answer is Social Security Disability (SSDI) benefits, a program which is now larger than welfare and food stamps combined.

More than 35 percent of people on SSDI benefits attribute their disability to chronic pain conditions. For these roughly 3 million working-age people if their pain goes away, so do their social security benefits. And, if they need to keep getting pills to keep their benefits, they might as well sell some to supplement their SSDI income.

I do not want to say that everyone, or even the majority of people, on SSDI for chronic pain is "gaming" the system, only that there are enough people caught in this situation as to create an ecosystem which floods our communities with unneeded pain pills. It is no coincidence that opioid deaths are highest in parts of our country like Pennsylvania, Ohio, Michigan, and Kentucky which have seen recent job decline, while it is lower in places with job growth.

Extended-release formulations

The second component of the epidemic was the largely debunked representation by manufacturers that opioids were not addictive if used for chronic pain. If people were going to be using these medications for chronic pain control, the pharmaceutical marketers reasoned, they would want large-dose "extended-release" formulas. The chicken-and-egg between the medicine and marketing is hotly contested.

Whatever their motivations, drug manufacturers started developing and heavily marketing various "extended-release" formulas. The longer the release time, the more drug the manufacturer could put in each pill/patch. Thus were born such drugs as OxyContin, an "extended-release" oxycodone tablet. Drug abusers quickly figured out that most "extended-release" formulas could be crushed, or ground up so that 48-72 hours of medication could be delivered in an instant. Street prices of these drugs are typically $1 per mg, which offers insight into how attractive the OxyContin 160 mg must be.

In 2013 Purdue's original formula or OxyContin (NDA 20-553) was discontinued and a new abuse-deterrent formula which was harder to crush into a powder (NDA 22-272) was introduced.

Just because OxyContin has been reformulated does not mean that the problem has gone away. The next wave is Johnson & Johnson's Duragesic fentanyl patches. Like OxyContin, these patches can deliver days of pain relief, some of them offering the equivalent of 1680 mg of morphine in a single patch. Also, like OxyContin, the drug can be extracted with a solution mixed from a vitamin C powder.

Drug abuse: A sharing economy

In one of the cases I am working on, I interviewed a number of current and former drug dealers who sold prescription pharmaceuticals (regrettably, none of them would agree to be on an expert disclosure). What impressed me about what they told me was how efficient the social networks of abuse are in connecting users with prescribers.

Dealers know which users are coming to them for a bridge between legally obtained prescriptions and which doctors are writing those prescriptions. Doctors who are more liberal with their prescription pads are efficiently identified and can find themselves unwittingly being turned into providers for a small underground network. Dirty doctors who are consciously assisting do not need to market themselves – the market comes to them.

When you talk to people in developed drug markets, the pattern of acquisition, sale, use and abuse is clear. But what makes abuse so dangerous is that in most cases it is less obvious to anyone involved. Patients who have become dependent will often switch doctors when issues of abuse are brought up, attributing the problem to the doctor, not their own use of medications. One doctor I deposed said that 50 percent of her patients who she referred to pain management because of concerns about medication misuse would quit her practice.

Eventually, these patients will either find negligently liberal doctors, or confront their addictions – I fear that many more do the former than the latter. This seems to have been what happened to Michael Jackson and Prince, both of whom had very unhealthy relationships with the doctors who gave them lethal doses of medication.

Spotting drug-dependent clients

When I started off as a criminal prosecutor, spotting drug-dependency seemed easy enough: chronic meth smokers had bad teeth; junkies felt itchy and scratched themselves when they were high; and crack cocaine users floated around with a fragile vacancy. I never would have suspected Ms. B, an upper-middle-class woman with a successful business was an addict – nor would she. Ms. B had slipped and fallen on a clearly defective sidewalk and broken her hip. Three years post-fall she had a constellation of vague pain complaints which she attributed to her injury. Then there was the statement "I just don't feel right until I have had my pills in the morning," which led to my question, "What is it like when you do not take them?" and her response: "I don't know, I am more frightened of the pain than anything else." About two years into litigation Ms. B confided in me that she thought she might have a problem.

Here are some tools for spotting chronic narcotic dependency:

Methadone, Suboxone and Subutex:

If you see any of these drugs in your client's medical history it means someone

suspected abuse. Like methadone, Suboxone and Subutex help people with opioid addictions combat the symptoms of withdrawal so they can ween off the medications. Suboxone and Subutex can produce mild euphoria, but the effect is thought to plateau, limiting how attractive these drugs are for abuse. Suboxone can actually induce withdrawal symptoms if misused. Because methadone, Suboxone and Subutex can also be prescribed as painkillers, it is not uncommon to see doctors who use them as a first-line pain management for people who they know have a history of abuse.

CURES reports: California maintains a database called the Controlled Substance Utilization Review and Evaluation System (CURES) which tracks the prescription of controlled substances. The database helps doctors know if their patients are doctor-shopping, and helps law enforcement track down unscrupulous prescribers. Doctors and law enforcement can access CURES reports; patients and litigants cannot. Because very few doctors request CURES reports for all of their patients, any time you see one in a medical file you should be concerned that the doctor was suspicious that their patient was addicted – or at the very least that their complaints were not explained by their injury and care. I read every CURES report carefully, and view them as a red flag that my client's doctor may be ready to criticize my client.

Gastrointestinal complaints: Many long-term users of opioids develop bowel problems including nausea, bloating, and pain. I have had several cases in the last couple of years with clients who have suffered abdominal injuries, overused pain medications, and believed that their subsequent and lingering bowel problems were caused by their initial injury. Asking clients at the initial intake about their GI complaints can be a quick shorthand to understanding how long they have been on pain medications. The answer can be particularly instructive if the GI complaints predated the injury they are calling you about.

Doctor shopping/drug mixing/cash payments: One of the hallmarks of significant chronic drug problems is a rocky relationship with prescribers, which includes shopping for doctors who are more willing to offer medications. More serious warning signs are when patients are paying for their pain killers in cash while they are awaiting insurance authorization (I have seen this more than once) and asking for large prescriptions which include a mixture of pain medications. Both cash payment and mixed prescriptions suggest that part of the prescription is going to a dealer.

Suing the drug dealers: The Drug Dealer Liability Act

Anyone who comes into contact with prescription drug abuse should assume that there is a bad doctor overprescribing medication in their community. Any plaintiffs' attorney should ask themselves how they can put that doctor out of business.

Often the answer can be found in the little-used Drug Dealer Liability Act (Health and Safety Code section 11700 et seq.). The statutory scheme set forth in the DDLA is robust and powerful. Here are some key provisions:

- Broad standing so lawsuits can be brought by users, parents and employers. (H&S 11705)
- Attorney fees and exemplary damages. (H&S 11705)
- In some circumstances, a "market participant" liability scheme where plaintiff does not need to show that defendant sold drugs to them. (H&S 11708)

Because providing drugs to addicts is typically not covered under the medical malpractice statute, MICRA, in order for the MICRA statutes to apply, the claim needs to be one of "Professional negligence." "Professional negligence" is conduct "undertaken by a health care provider for the purpose of delivering medical care to a patient; . . . tortious actions undertaken for a different purpose . . . are not." (*So v. Shin* (2013) 212 Cal.App.4th 652, 667; see also *Central Pathology Service Medical Clinic, Inc. v. Superior Court* (1992) 3 Cal.4th 181, 191-93). In a wrongful death case our office is currently litigating against a doctor who was herself an addict that provided drugs to other addicts. We are arguing that whatever her motives (i.e., financial or social), because she knew the drugs were not being used for a medical purpose, that she cannot avail herself of the protection of the MICRA statutes.

Conclusion

We cannot be blind to the fact that our society is awash in prescription medications. Many of our clients are at risk of becoming ensnarled in the vicious cycle of pain, treatment, dependency, and addiction. We owe it to them to not shy away from these issues, but to spot them and do our best to understand what our client is going through so we can explain it in the most charitable light. We also owe it to society to look for opportunities to use the considerable tools available to us in the civil justice system to disrupt the practice of physicians who have been corrupted by their proximity to the powerful medications they prescribe.


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