

THE IMPACT OF PRESCRIPTION DRUG USE ON THE EVALUATION OF LIABILITY AND DAMAGES



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Nearly all of us who handle claims involving medical treatment, whether they are tort or workers' compensation, have seen a dramatic rise in the cost of treatment related to prescription medications. A significant cost driver of those claims has been the use and abuse of opioids, particularly in the setting of alleged chronic pain. A related issue is a plaintiff's comparative fault for those who are already using prescription pain medication prior to the accident at issue. Also, the legitimacy of pain complaints in the face of dependence must be evaluated.

Opioids are categorized as narcotic analgesics and central nervous system (CNS) depressants. "Natural" opioids, such as morphine and codeine, are derived from the poppy plant, recognized scientifically as *Papaver somniferum*. These drugs are also referred to as "opiates". "Semi-synthetic" opioids, such as oxycodone and hydromorphone, are made from those naturally occurring opium products. "Synthetic" opioids, such as fentanyl and methadone, are produced entirely in a lab using various chemical compounds and are designed to bind to opioid receptors.¹²

Opioids can easily lead to dependency. Furthermore, some individuals may develop tolerance to these drugs, which can result in an escalation of use and type. It is noteworthy that overall, opioids represent three-fourths of all prescription drugs being abused.³ Amazingly, the United States consumes 99 percent of the world's hydrocodone and 83 percent of its oxycodone according to a 2008 study by the International Narcotics Control Board. Here in New England, barely a week goes by where one does not see stories about drug related crimes, including pharmacy robberies for opioids throughout Maine.

Statistics reflect Maine is not alone in dealing with a narcotics epidemic. According to the 2008-2009 National Survey on Drug Use and Health, New Hampshire's young adults are abusing pain medication at a significantly higher rate than young adults nationwide (NH =16.78% vs. US=11.94%) and New Hampshire's rate of nonmedical use of pain relievers by 18 to 25 year olds is the

second highest among the states and territories.⁴

Drowsiness is a common side effect in people taking opioids. As a result, individuals in certain professions, like bus drivers or pilots, are subject to special regulations and laws for prescription drug use.⁵ Opioids can also cause dizziness and are known to influence sensory and motor skills. In addition, there is evidence that cognitive function can be influenced by use of opioids.⁶

Another consideration in evaluating damages is opioid-induced hyperalgesia. Hyperalgesia means an increased sensitivity to pain. Individuals using opioids to relieve pain may paradoxically experience more pain as a result of their medication.⁷ There is a growing consensus among medical professionals that continued use of opioids can actually increase pain.⁸ Additionally, both acute and chronic use of opioids can compromise immune system functioning. Opioids may also inhibit healing in fractures.⁹

Liability:

With so many individuals in our communities using prescription pain medication on a regular basis to treat chronic pain, it is important to consider the effects of these drugs on the liability analysis.

Opioids impact fine motor skills and cognitive functioning. As such, their use can result in an increase in accidents, both involving falls and motor vehicle accidents.¹⁰ Consider employing

4 Substance Abuse and Mental Health Services Administration, *Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings.*, available at <http://oas.samhsa.gov/NSDUH/2k9NSDUH/2k9ResultsP.pdf>.

5 Orriols L, Delorme B, Gadegbeku B, et al., *Prescription medicines and the risk of road traffic crashes: a French registry-based study*, PLoS Med. 7(11) (2010).

6 See, Scott A. Strassels, *Cognitive effects of opioids*, CURRENT PAIN AND HEADACHE REPORTS, February 2008, Volume 12, Issue 1, pp 32-36. Available at <http://link.springer.com/article/10.1007%2Fs11916-008-0007-4#>;

7 Marion Lee, MD, Sanford Silverman, MD, et al., *A Comprehensive Review of Opioid-Induced Hyperalgesia*, PAINPHYSICIANJOURNAL.COM (2011), available at http://www.integration.samhsa.gov/pbhc-learning-community/Opioid-Induced-Hyperalgesia_Article.pdf.

8 See, Jane C. Ballantyne, M.D. & Dr. Jianren Mao, M.D., *Opioid Therapy for Chronic Pain*, NEW ENGLAND JOURNAL OF MEDICINE, November 13, 2003; see also, Dr. Wilder-Smith & Dr. Arendt-Nielsen, *Postoperative Hyperalgesia: Its Clinical Importance and Relevance*, 104 ANESTHESIOLOGY: 601-607 (March 2006).

9 Matthew Miller, MD, MPH, ScD, Til Stürmer, MD, MPH, et al., *Opioid analgesics and the risk of fractures in older adults with arthritis*, 59(3) J AM GERIATR. Soc. 430-38, (June 11, 2012).

10 See, Geneva Pittman, *Opioid painkillers tied to driving injuries*, NEW YORK (Jan. 15, 2013), available at <http://www.reuters.com/article/2013/01/15/us-opioid-painkillers-idUSBRE90E14420130115>; see also, JOHN BRIC & CARLTON K. ERICKSON, *DRUGS, THE BRAIN, AND BEHAVIOR: THE PHARMACOLOGY OF ABUSE AND DEPENDENCE* (1998).

1 U.S. Department of Justice, Drug Enforcement Administration, *Drugs of Abuse*, available at http://www.justice.gov/dea/docs/drugs_of_abuse_2011.pdf (last visited August 2013).

2 Michael G. Bissell, MD, PhD, MPH & Michael A. Peat, PhD, *Opioids 1: Opiates*. COLLEGE OF AMERICAN PATHOLOGISTS, available at http://www.cap.org/apps/docs/cap_press/clinical_toxicology_testing_chapter17.pdf (last visited August 23, 2013).

3 Office of National Drug Control Policy, *Epidemic: Responding to America's Prescription Drug Abuse Crisis*, available at http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/rx_abuse_plan.pdf.

similar strategies as you would in dealing with cases of alcohol impairment in arguing comparative fault even when opioids are being used as prescribed by a physician. Opioid use can serve as a strong comparative negligence argument.

For fall cases, a plaintiff's opioid use can make the inherent comparative fault defense even better. In a recent New Hampshire case, the plaintiff tripped on a step while exiting a major fast food restaurant. She claimed to have sustained a new ankle injury as well as aggravating prior back problems. At the time of her accident, she was using 30 mg. of Valium, a 25 mcg. Fentanyl Patch every three days, and 15 mg. of Oxycodone three times a day for a pre-existing back injury. All of the drugs were prescribed by her doctor and were purportedly being taken as directed. Each drug had the potential of causing drowsiness, dizziness, decreased motor skills and sensory deficits. Evidence of her use of pain medication assisted in showing that her failure to navigate the step was likely not due to the step's size and height. Moreover, the number of prescription drugs that she was taking was evidence of the severity of the pre-existing back problems.

Opioids can play a role in other types of personal injury cases, as well. Consider the case in which a patron at a New Hampshire resort was taking his wife's prescription Oxycontin to relieve aches and pains after a long day of skiing. He also had several alcoholic beverages throughout the day, some of which had been served in the hotel bar. He finished up the day with a soak in the resort's hot tub where he died from heart failure. The plaintiff's complete health picture and blood evidence changed the landscape of the case from Dram Shop liability to one predominated by comparative fault. The plaintiff's pre-existing heart condition, narcotic use and alcohol use was deadly when combined with being in the hot tub.

Damages:

When assessing damages in cases involving significant opioid use, defense counsel should consider not only their impact on special damages, but also whether the plaintiff exhibits dependence or drug seeking behavior and how such behavior might impact a plaintiff's credibility. As noted above, where a plaintiff's existing conditions are being treated with opioids, consider challenging that a plaintiff's pain complaints are in fact related to a "new injury".

Given their costs, defense counsel's goal will usually be to mitigate ongoing claims for narcotics. Defense counsel should assess whether a particular prescription is both reasonable and necessary for the medical condition at issue. With the help of a pharmacist, defense counsel should also discern whether the claimant has in fact filled all of his/her prescriptions on a timely basis and assess whether the medications prescribed were actually taken by the claimant or potentially diverted.

Diversion is a particular concern, where family member or others with access to the claimant's medications desire it. In addition, the street values of narcotics (reflected below) pose a considerable incentive for claimants to obtain more narcotics than they need.¹¹

11 See Parija Kavalanz, *Prescription drugs worth millions to dealers*, CNNMONEY (June 1, 2011), available at http://money.cnn.com/2011/06/01/news/economy/prescription_drug_abuse/index.html; see also, *Latest street prices for prescription drugs*, available at <http://streetRx.com>.

- Vicodin® (Hydrocodone/ APAP) \$5-\$20 per tablet
- Methadone \$10 per tablet
- Oxycodone \$12-\$40 per tablet
- Percocet® (oxycodone/ APAP) \$10-\$15 per tablet
- Fentanyl 100mcg patch \$50 per patch
- Oxycontin® \$50-\$80 per tablet

In cases involving significant opiate usage, it is critical for the defense counsel to obtain all records regarding a claimant's acquisition of medications. Many claimants use multiple pharmacies. As such, it is necessary not only to obtain records from each pharmacy but also doctors, clinics and emergency rooms which may have provided medications directly to the claimant. A pharmacist can assist in reviewing the records, calculating the amount of opiates prescribed at a given time and the amount which the records document was provided to the claimant. By reviewing records from the claimant's physicians, such as urine drug screen testing or even pill counts, one can assess the level of a claimant's compliance in taking his/her medications.

A slip/fall on ice case from northern New Hampshire exemplifies the need to scrutinize drug use. The plaintiff claimed to have sustained a knee injury. She had arthroscopic surgery and was prescribed Hydrocodone. Discovery included medical records with noted concerns of drug-seeking behavior but toxicology screens showed only the prescribed amount or sometimes none at all. About eight months into the case, there was a notation in the newspaper police log that the plaintiff had been arrested for selling prescription pain medication. Plaintiff's counsel withdrew from the case soon thereafter.

Where medications are being prescribed in significant doses, a pharmacist can also assist in discussing the relevant pharmaceutical/medical literature and guidelines with regard to the use of narcotics and the amounts at which narcotic medications should initially be prescribed or increased.¹² Such testimony in conjunction with that of a physician can provide powerful evidence regarding the appropriateness of the medical care being provided to the claimant or the excessive nature of the claim for opiates.

At this September's TDLA conference, Curt Cyr, Ph.D., R.Ph, a Senior Lecturer in the department of Pharmaceutical Sciences at the University of New England's College of Pharmacy, will discuss a case study directly on point, wherein his testimony was used to challenge a plaintiff's life care plan which included a request for over a million dollars for narcotic medications.

12 Peter D. Anderson, *The Broad Field of Forensic Pharmacy*, JOURNAL OF PHARMACY PRACTICE (2012), available at <http://jpp.sagepub.com/content/25/1/7>.