Physician Liability for Suicide after Negligent Tapering of Opioids

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Abstract: The precipitous and medically contraindicated reduction or "tapering" of opioids for patients with chronic pain due to serious medical conditions has caused needless suffering and, increasingly, suicide. Physicians could be liable for wrongful death based on negligent tapering of opioids.

Drug overdose deaths in the United States caused a total of 500,000 deaths from 1999-2019,[1] and the tragedy is getting worse. Between April 2020 and April 2021, there were approximately 100,000 deaths from accidental and intentional drug overdoses.[2] Numerous causes of the opioid crisis have been noted,[3] including aggressive and misleading marketing by pharmaceutical companies,[4] overprescribing by physicians,[5] lack of diligence in filling prescriptions and bulk orders by retail pharmacies and drug distributors,[6] unsuccessful interdiction of illicit opioids,[7] inadequate levels of drug treatment,[8] and socio-economic struggles in many parts of the country.[9]

The magnitude of the opioid crisis has led to drastic policy changes that directly and indirectly affect prescribing practices. These measures include state prescription drug monitoring laws, opioid contracts between providers and patients, and clinical guidelines and institutional policies limiting opioid prescribing. Some of these measures, however, have had grievous, unintended consequences for chronic pain patients, including unremitting pain, anxiety, depression, decreased quality of life, accidental overdoses, and even suicide. This article focuses on the possibility of legal liability for physicians whose negligence in reducing or "tapering" the opioids of a patient results in suicide.[10]

The Pendulum Swings Back Too Far

Pain control became an important part of American healthcare policy in the mid-1990s, as pain as the "fifth vital sign" and hospitals including pain control questions on patient satisfaction surveys drove the prescribing of opioid analgesics.[11] OxyContin, an extended-release opioid originally developed to relieve chronic cancer pain,[12] received unrestricted approval from the Food and Drug Administration in 1995. The package insert for OxyContin contained the following baseless statement: "Delayed absorption, as provided by OxyContin tablets, is believed to reduce the abuse liability of the drug."[13] With such flagrant misstatements of the drug's capacity to cause addiction and aggressive marketing to physicians,[14] sales of OxyContin skyrocketed from $45 million in 1996 to $1.1 billion in 2001.[15]

Opioid prescriptions and opioid use disorder (OUD) continued to increase in the next decade and peaked in 2012, when American physicians wrote 255 million prescriptions for opioid pain relievers, enough for every adult in the United States to have a bottle of opioid pills.[16] By 2016, "only" 215 million opioid prescriptions were dispensed

About This Column

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by retail pharmacies.[17] The National Institute on Drug Abuse estimated that in 2015, 91.5 million Americans were taking opioids, such as OxyContin and Vicodin.[18] In 2015, at least 2 million Americans had OUD involving prescription opioids.[19]

In response to the widespread harms caused by overprescribing of opioids, in 2016, the Centers for Disease Control and Prevention (CDC) issued its Guideline for Prescribing Opioids for Chronic Pain.[20] Because most of the opioid prescriptions were written by primary care providers (including physicians' assistants and nurse practitioners), the Guideline "provides recommendations for the prescribing of opioid pain medication by primary care clinicians for chronic pain (i.e., pain conditions that typically last >3 months or past the time of normal tissue healing) in outpatient settings outside of active cancer treatment, palliative care, and end-of-life care."[21] Despite the best of intentions by the CDC, the Guideline has been an unmitigated disaster for individuals with chronic pain by making access to essential pain relief difficult or impossible to obtain.[22] According to the American Medical Association: "It is clear that the CDC guideline has harmed many patients."[23]

There are at least five major problems with the Guideline:

First, the Guideline recommends that "[n]onpharmacologic therapy and nonopioid therapy are preferred for chronic pain."[24] This unequivocal statement, though supported by some pain management experts,[25] has been contested by other experts, including a recent comprehensive review of the literature. "Because of the absence of comparative effectiveness studies, there are no scientific grounds for considering alternative non-pharmacologic treatments as an adequate substitute for opioid therapy but these therapies might serve to augment opioid therapy, thereby reducing dosage."[26]

Second, the Guideline recommends a 90 morphine milligram equivalents (MME) daily dosage cap. It further states that use of opioids for "more than seven days will rarely be needed,"[27] positions that do not account for the needs of individuals with long-term, extreme pain who have tolerated higher MME levels. "Many patients currently receiving long-term opioids were started when opioids were still considered a viable treatment option and if satisfied with their pain control and using their medications appropriately should not be unilaterally compelled to wean off opioids."[28]

Third, although expressly limiting its applicability to outpatient settings and primary care clinicians, the Guideline has been applied in numerous inpatient settings and by pain management physicians. "[T]he guideline has achieved its greatest impact by convincing health care provider organizations that violations of the guideline by their member physicians may increase organizational liability exposure."[29] The Guideline also served to encourage the enactment of prescribing restrictions by legislatures in 30 states.[30]

Fourth, the Guideline explicitly states that it is not applicable to cancer care or end-of-life care. Nevertheless, its use for both situations has resulted in inexcusable misery for the most vulnerable patients. A recent study of older patients dying of cancer found a substantial reduction in the number and strength of opioid prescriptions, especially those for long-acting opioids.[31]

Fifth, the Guideline recommends the tapering of opioid patients. Aggressive, especially nonconsensual, tapering is unethical[32] and dangerous. The Guideline specifically calls for gradual reductions with the consent of patients,[33] but it has been applied without the consent of patients, abruptly, and with tragic results. A recent study of more than 100,000 patients receiving opioids long-term for pain found a 68 percent increase in overdoses and a doubling of mental health crises in tapered versus untapered individuals.[34] Another study found that up to 30 percent of all overdose deaths are suicides.[35]

Concerns about possible legal or professional jeopardy have been a significant factor in drastically reducing opioid prescribing by physicians. Liability for failing to prescribe opioids when medically indicated, especially if it results in a patient's suicide, may now be emerging as a countervailing force against the heedless tapering of patients with chronic pain.

Slone v. Commonwealth Pain and Spine

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In 2011, Brent Slone was severely injured in a car accident, sustaining a broken pelvis, compressed spinal cord, and paralysis from the waist down. In 2014, he became a patient at Commonwealth Pain and Spine (Commonwealth), which has several clinics in Kentucky and Indiana. Mr. Slone was prescribed an opioid dose of 240 MME for his pain, although the subsequent 2016 CDC guideline recommended a limit of 90 MME.[37]

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In 2016, Mr. Slone started traveling to California for advanced wound care after pressure sores from his wheelchair caused bone infections. In the summer of 2017, Mr. Slone went to California for surgeries, including skin grafts, and he had his recovery at a nursing facility in La Jolla. His pain level increased, and his daily opioid dosage rose to 400 MME, on occasion reaching 540 MME.

On August 11, 2017, Mr. Slone was discharged from the nursing facility to travel to Kentucky. His medical team in California contacted Commonwealth and said he had enough medication to last through August 16. Dr. Stephen Young, who along with Dr. James Jackson, was his pain management physician at Commonwealth, wrote him a bridge prescription at 540 MME to last until his August 22 appointment. At that appointment, Mr. Slone's dose was summarily dropped to 240 MME. This dosage was inadequate for Mr. Slone, and he began taking 300 to 400 MME per day. By September 11, he was running out of medicine, though his next appointment was scheduled for September 18. On September 12, Dr. Young denied a refill or bridge prescription to last until his appointment, saying that Mr. Slone had violated his narcotic contract by taking more than the prescribed dosage. On the afternoon of September 12, Mr. Slone texted his wife: "they denied script im done love you." Shortly thereafter, he took his own life. He was 40 years old.

His widow brought a wrongful death action against Commonwealth and Drs. Young and Jackson, alleging negligence in summarily reducing his dosage from 540 MME to 240 MME and in failing to provide him a bridge prescription when the 240 MME dose proved to be inadequate to relieve his pain. A jury in Jefferson County, Kentucky Circuit Court awarded the plaintiff $6.925 million, with $3 million designated for Mr. Slone's daughter.[38] According to the lead lawyer for the plaintiff, based on post-trial interviews the jurors had a negative impression of the pain clinic, but they did not have a negative view of Mr. Slone, a long-time user of opioids for chronic pain.[39]

Elements of a Legal Action for Negligent Tapering

A legal action to recover for the death of a patient allegedly caused by a physician's improper tapering of the patient from opioids would be based on negligence. The well-known elements of an action for negligence are duty, breach, causation, and damages.[40] In a wrongful death action[41] the defendant is alleged to have breached a duty to the decedent by failing to exercise reasonable care under all the circumstances, [42] which led to the death of the decedent. The issues of duty and causation are especially important in cases based on negligent tapering of opioids.

Duty

A duty is "an obligation, recognized by the law, requiring the person to conform to a certain standard of conduct, for the protection of others against unreasonable risks."[43] Professionals, including physicians, have a higher standard, "to have and use the knowledge, skill, and care ordinarily possessed by members of the profession in good standing."[44] Physicians also have ethical obligations to their patients, as noted by the American Medical Association.

> Relationships between patients and physicians are inherently unequal: the fact of illness renders patients vulnerable, in greater or lesser degree, and dependent on physicians' expertise and fidelity. Yet patients bring to interactions with physicians their values, goals, and preferences as well as their needs. Patients must therefore be able to trust not only that their physicians have the knowledge and skills to provide competent care, but equally that their physicians will do so with respect for the patient as a moral agent and compassion for the patient as a human being.[45]

Patients treated for chronic pain with opioids are highly vulnerable. They have medical conditions with severe pain that cannot be controlled by other treatment modalities or less potent analgesics. Their underlying medical condition, their pain level, and the opioids they take all may interfere with their cognitive or reasoning abilities. They are dependent on their physician's renewal of their prescriptions; there are no safe and effective alternatives. Significantly, they bear the stigma of requiring drugs often associated with personal immorality or criminal activity.[46] As a price for access to a substance that allows them to lead the semblance of a normal life, patients with chronic pain are often required to sign contracts pledging compliance with terms imposed on them,[47] to submit to periodic or random urine testing,[48] and to bear humiliation by a society that is frequently fearful, suspicious, and intolerant. Few other patients are subject to such indignities.[49]

The substantial vulnerability of patients treated for chronic pain means that the duties of their treating physicians are heightened, especially when a patient is taking higher doses of opioids, is being treated for depression, or demonstrates possible self-damaging behavior.[50] The duty includes monitoring the patient, especially when the individual's opioid dosing is being changed via tapering or otherwise, conducting in-person assessment of the patient's condition, and referring the patient for consultation with a specialist (e.g., psychiatrist, pain management specialist) when medically indicated. Vulnerable patients should not be abandoned or have their treatment unreasonably delayed when they are at risk of accidental or intentional overdosing.

Breach

A plaintiff must prove that the defendant-physician failed to meet the appropriate standard of care, which almost always requires expert testimony. An important issue is whether the standard may be established by the introduction of nonbinding professional guidelines or recommendations. In *In re Jankowski*,[51] a state

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licensing agency brought disciplinary proceedings against a physician for, among other things, prescribing excessive levels of opioids without medical justification. The appellate court, in affirming sanctions against the physician, held that the 2016 CDC Guideline was the standard of care for a pain management physician, notwithstanding the statement in the Guideline that it applied only to primary care clinicians.[52]

Causation

In a negligence case, "a plaintiff must prove that it is more likely than not that, if the defendant had not acted tortiously, the plaintiff's harm would not have occurred."[53] This causation-in-fact is relatively easy to prove, especially in a case such as *Slone* because of the final text message he sent to his wife. It is much more difficult for a plaintiff to prove that the action of the defendant was the proximate or legal cause of suicide.[54] This latter issue involves complex and contested matters of public policy.

In wrongful death cases, the traditional rule is that suicide is considered a superseding cause that precludes liability of the alleged wrongdoer.[55] The decedent's act is considered unforeseeable as a matter of law. Three limited exceptions to the general rule have been recognized: (1) if the decedent's action was caused by delirium, insanity, or irresistible impulse;[56] (2) if the defendant had a duty to protect the decedent, especially in a custodial setting such as a jail, hospital, or mental institution;[57] and (3) if there was a special relationship between the defendant and the decedent, such as a psychoanalyst-patient relationship in which the decedent displayed suicidal ideation.[58]

There is a trend in recent cases to reject the old, inflexible rule and hold that the question of whether a suicide was foreseeable should be decided by juries applying a modern "scope of liability" analysis. Several of the cases holding that the jury could conclude that suicide was foreseeable involved the suicide of young people, thereby underscoring the role of public policy. For example, courts upheld verdicts for plaintiffs where a middle school student's suicide was foreseeable to the school board because of two recent on-campus suicide attempts,[59] where a college knew that a student had previously threatened suicide,[60] and where a 13-year-old student who stuttered was the subject of intense bullying.[61]

In a series of medical malpractice cases the courts also have upheld jury verdicts finding that suicide was foreseeable.[62] These include a case where negligent surgery left the decedent partially paralyzed and in intense, continuous pain[63] and where the decedent took his life after unknowingly ingesting a prescription that his wife, on the physician's advice, gave to him secretly.[64] Of most relevance to this article, *Edwards v. Tardif*[65] involved a patient who had been treated for depression for several years. When she had a recurrence of depression she called her regular physician's office. An internist who had never treated the decedent and who was covering for her regular physician, without reviewing the decedent's chart or examining her, prescribed 100 anti-depressant pills with two refills of a drug that was contraindicated for a patient who also had a history of alcoholism. Eight days later she took her own life. According to the Supreme Court of Connecticut, "a physician may be liable for a patient's suicide when the physician knew or reasonably should have known of the risk of suicide and the physician's failure to render adequate care and treatment proximately causes the patient's suicide."[66]

These cases strongly suggest that at a time when the opioid crisis is causing at least 30,000 suicides a year by drug overdose, it is foreseeable that the negligent tapering of a chronic pain patient taking opioids could result in suicide.

Damages

Successful plaintiffs in wrongful death actions are able to recover a range of compensatory damages, including pain and suffering, lost income, and loss of consortium. Punitive damages also are recoverable if the defendant's conduct was willful, wanton, or evidenced a reckless disregard for the health of their deceased patient.

Defenses

Few traditional defenses to medical malpractice are applicable in a typical wrongful death case for negligent tapering resulting in suicide. Comparative negligence, however, might be relevant in some jurisdictions. For example, in the *Slone* case discussed above, the jury determined that Mr. Slone was two percent at fault.[67] In a jurisdiction that only permits a plaintiff to recover if the decedent's suicide was caused by delirium, insanity, or irresistible impulse, if the decedent was in such a compromised mental state, then the defense of comparative negligence would appear to be precluded because the decedent lacked the capacity to act negligently. However, in jurisdictions that apply general foreseeability principles, the decedent need not be so profoundly impaired, and comparative negligence could be applicable.

Conclusion

America's opioid crisis is well into its third decade. There are many causes of this problem and resolving them will take a variety of measures over an extended time. Unfortunately, some past efforts to reduce the morbidity and mortality associated with improper use of prescription opioids have been ineffective and led to disastrous unintended consequences. One such attempt to limit the supply of prescription opioids involved the issuance of prescribing guidelines. Between 2012 and 2020, the number of opioid prescriptions declined dramatically from 255 million to 142 million,[68] but the number of overdose deaths soared from 41,000 to 100,000.[69] One of the most tragic consequences of curtailing the use of opioids for managing severe, chronic pain has been an increase in suicides, which now account for an estimated 30 percent of drug overdose fatalities.[70] It is not known how many suicides result from a physician's negligent, aggressive tapering of opioids.

Many physicians are concerned that prescribing opioids could lead to criminal prosecution, license revocation, loss of employment or hospital privileges, or malpractice litigation.[71] On the other hand, legal jeopardy for

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failing to continue prescribing opioids to existing patients, even when the standard of care requires it, does not seem to be a widespread concern. Wrongful death actions for negligent tapering of opioids resulting in a patient's suicide is a legal theory that more courts are likely to accept and thus could become a counterbalancing concern for physicians. Although sound health policy should not be based on dueling litigation risks, if fear of liability for discontinuing medically necessary opioids leads to appropriate treatment of vulnerable patients with chronic pain, then it will serve an important purpose.

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54. The Restatement (Third) of the Law of Torts uses neither the term "legal cause" nor "proximate cause," instead using "scope of liability" to address the issue of how far liability should extend as a matter of policy. *See id.* at ch. 6.
55. *Rollins v. Wackenhut Servs.*, 703 F.3d 122 (D.C. Cir. 2012); *Riesbeck Drug Co. v. Wray*, 39 N.E.2d 776 (Ind. Ct. App. 1942); *Sindler v. Litman*, 887 A.2d 97 (Md. Ct. App. 2005); *Wickersham v. Ford Motor Co.*, 853 S.E.2d 329 (S.C. 2020); *Cotton v. Wilson*, 576 S.W.3d 626 (Tenn. 2019). *See generally* A.B. Long, "Abolishing the Suicide Rule," *Northwestern University Law Review* 113, no. 4 (2019): 767-824.
56. *Parton v. Jeans*, 2019 WL 6608750 (Ariz. Ct. App. 2019); *Porter v. Murphy*, 792 A.2d 1009 (Del. Super. Ct. 2009); *Crumpton v. Walgreen Co.*, 871 N.E.2d 905 (Ill. 2007); *Bertrand v. Air Logistics, Inc.*, 820 So. 2d 1228 (La. Ct. App. 2002); *Truddle v. Baptist Mem'l Hosp.-Desoto, Inc.*, 150 So. 3d 692 (Miss. 2014); *Lenoci v. Leonard*, 21 A.3d 694 (Vt. 2011); *Arsnow v. Red Top Cab Co.*, 292 P. 436 (Wash. 1930); *McMahon v. St. Croix Falls School Dist.*, 596 N.W.2d 875 (Wis. Ct. App. 1999); *R.D. v. W.H.*, 875 P.2d 26 (Wyo. 1994). *See generally* Restatement (Second) of the Law of Torts § 445 (1958). This exception has been criticized as being medically and legally defective and stigmatizing mental illness with rhetoric from the Middle Ages. *See* Long, *supra* note 55, at 811-812.
57. *Gilmore v. Shell Oil Co.*, 613 So.2d 1272 (Ala. 1993); *Joseph v. State*, 26 P.3d 459 (Alaska 2001); *Meils v. Northwestern Bell Tel. Co.*, 355 N.W.2d 710 (Minn. 1984); *McPeake v. Cannon*, 553 A.2d 439 (Pa. Super. Ct. 1989. (*Worsham v. Nix*, 83 P.3d 879 (Okla. Civ. App. 2003); *Moats v. Preston County Comm'n*, 521 S.E.2d 180 (W. Va. 1999).
58. *Kockelman v. Segal*, 61 Cal. App.4th 491 (Cal. App. 1998); *Lee v. Corregedore*, 925 P.2d 324 (Haw. 1996); *Costigan v. Plets*, 2011 WL 6376016 (Mich. Ct. App. 2011).
59. *Wyke v. Polk County School Board*, 129 F.3d 560 (11th Cir. 1997).
60. *Schiezler v. Ferrum College*, 236 F. Supp. 2d 602 (W.D. Va. 2002).
61. *Patton v. Bickford*, 529 S.W.3d 717 (Ky. 2016).
62. *See, e.g., Meir v. Ross General Hospital*, 445 P.2d 519 (Cal. 1968); *Wozniak v. Lipoff*, 750 P.2d 971 (Kan. 1988); *Champagne v. United States*, 513 N.W.2d 75 (N.D. 1994).
63. *Kivland v. Columbia Orthopaedic Group* LLP, 331 S.W.3d 299 (Mo. 2011).
64. *White v. Lawrence*, 975 S.W.2d 525 (Tenn. 1998).
65. 692 A.2d 1266 (Conn. 1997).
66. *Id.*, at 1270.
67. *Slone v. Commonwealth Pain & Spine*, *supra* note 38 (Instruction No. 6).
68. *See* Centers for Disease Control and Prevention, *supra* note 17.
69. National Center for Health Statistics, Centers for Disease Control and Prevention, Drug Overdose Deaths in US Top 100,000 Annually (Nov. 17, 2021), *available at* <https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/2021117.htm> (last visited Dec. 12, 2021).
70. *See* Oquendo and Volkow, *supra* note 35.
71. *See, e.g., Koon v. Walden*, 539 S.W.3d 752 (Mo. Ct. App. 2017) (affirming multi-million-dollar damage award for overprescribing opioids, which resulted in the plaintiff's addiction). *See also* S. Slat et al., "Opioid Policy and Chronic Pain Treatment Access Experiences: A Multi-Stakeholder Qualitative Analysis and Conceptual Model," *Journal of Pain Research* 14 (2021): 1161-1169, ("fear of litigation as justification for decreasing opioid prescribing").

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