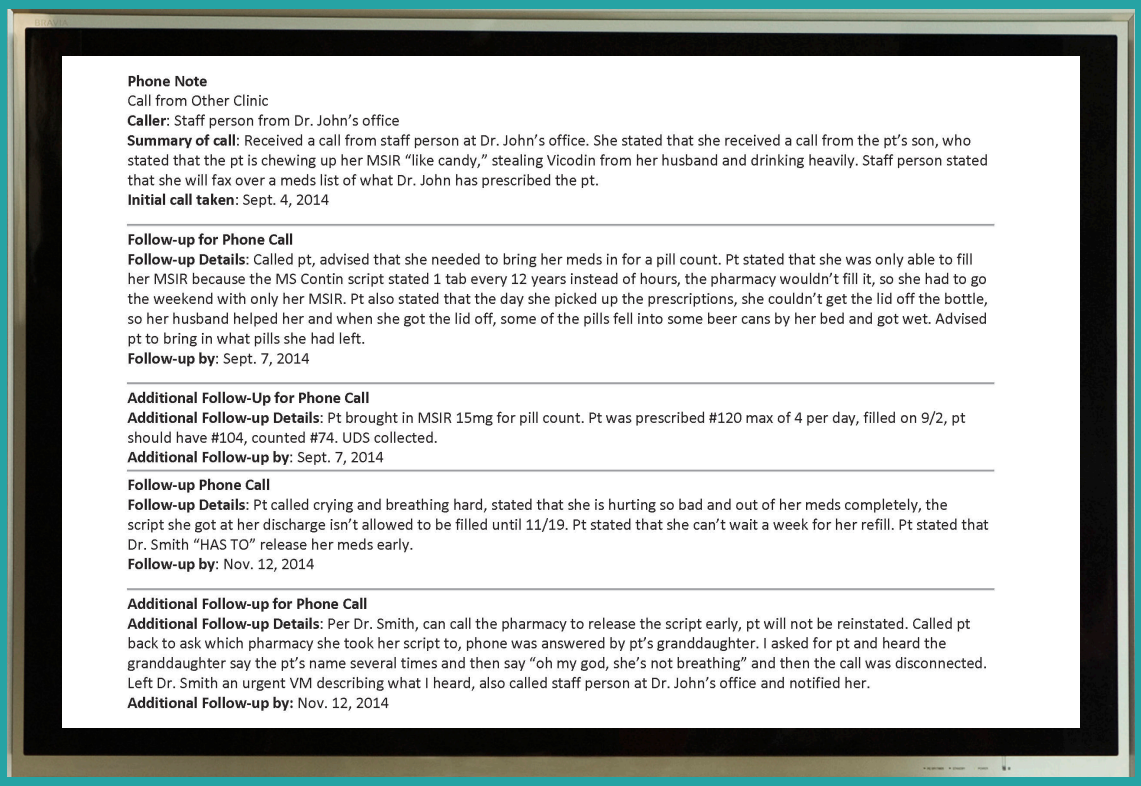
WHAT'S WRONG WITH THIS PICTURE?

A 52-year-old female, chronic pain patient is new to Dr. Smith's practice. She is seen initially for a 20-minute routine office visit. Her opioids are refilled at the same dosages, and old records are requested. She returns, as scheduled, one month later (early September). Her old records are still not available, and pending those, her opioids are refilled. She is instructed that the next return visit will be scheduled for one hour with a comprehensive review of her old records, a complete physical exam, and an assessment of her medication regimen. Prior to that visit, a call is received from Dr. John's office (the patient's previous physician). The screenshot to the right includes the actual notes regarding the patient's subsequent care*.



Phone Note
Call from Other Clinic
Caller: Staff person from Dr. John's office
Summary of call: Received a call from staff person at Dr. John's office. She stated that she received a call from the pt's son, who stated that the pt is chewing up her MSIR "like candy," stealing Vicodin from her husband and drinking heavily. Staff person stated that she will fax over a meds list of what Dr. John has prescribed the pt.
Initial call taken: Sept. 4, 2014

Follow-up for Phone Call
Follow-up Details: Called pt, advised that she needed to bring her meds in for a pill count. Pt stated that she was only able to fill her MSIR because the MS Contin script stated 1 tab every 12 years instead of hours, the pharmacy wouldn't fill it, so she had to go the weekend with only her MSIR. Pt also stated that the day she picked up the prescriptions, she couldn't get the lid off the bottle, so her husband helped her and when she got the lid off, some of the pills fell into some beer cans by her bed and got wet. Advised pt to bring in what pills she had left.
Follow-up by: Sept. 7, 2014

Additional Follow-Up for Phone Call
Additional Follow-up Details: Pt brought in MSIR 15mg for pill count. Pt was prescribed #120 max of 4 per day, filled on 9/2, pt should have #104, counted #74. UDS collected.
Additional Follow-up by: Sept. 7, 2014

Follow-up Phone Call
Follow-up Details: Pt called crying and breathing hard, stated that she is hurting so bad and out of her meds completely, the script she got at her discharge isn't allowed to be filled until 11/19. Pt stated that she can't wait a week for her refill. Pt stated that Dr. Smith "HAS TO" release her meds early.
Follow-up by: Nov. 12, 2014

Additional Follow-up for Phone Call
Additional Follow-up Details: Per Dr. Smith, can call the pharmacy to release the script early, pt will not be reinstated. Called pt back to ask which pharmacy she took her script to, phone was answered by pt's granddaughter. I asked for pt and heard the granddaughter say the pt's name several times and then say "oh my god, she's not breathing" and then the call was disconnected. Left Dr. Smith an urgent VM describing what I heard, also called staff person at Dr. John's office and notified her.
Additional Follow-up by: Nov. 12, 2014

DISCUSSION

COPIC uses real, closed, and public record cases to illustrate important findings, while avoiding Monday morning quarterback criticism.

Dr. Smith tried to follow best practices by having a plan to review the old records, perform a thorough exam, do risk mitigation strategies, and manage her chronic opioid therapy. But, prior to being able to enact this plan, the physician continued to refill the medications and failed to accelerate her response when all the obvious red flags went up.

As time continued and Dr. Smith's refill log of opioids lengthened, her responsibility for the management of the patient increased. The lawsuit for wrongful death took years to complete, long hours of trial preparation, and a significant disruption to her practice. The physician faced serious challenges when the state medical board reviewed the case and applied the guidelines that are part of the opioid prescribing policy best practices.

The physician received a stipulation seriously curtailing her practice, including public discipline, suspension of her opioid prescribing privileges, and mandatory education.

There are several federal and state resources about prescribing and managing opioids that are now available. COPIC has created an "opioid resources" section on our website to list some of these. We will continue to update this as new information is published.

Visit **www.callcopic.com/resource-center/guidelines-tools/opioid-resources** to access this information.

**Names, dates, and identifying features of this case have been changed, but the phone notes reflect what was entered into the public record at trial.*