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**CASE REPORT**

# Narcotic-Seeking Behavior and Self-Injury: A Report of Three Cases

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Patients addicted to prescription opiates have found innovative ways to reliably obtain their desired prescription opiates at a time when such prescriptions are restricted due to the opioid crisis. Instead of turning to the black market, some patients deceive their health care providers and malinger to create or enhance severe chronic pain conditions that require medically necessary treatment with prescription opiates. Such sophisticated narcotic-seeking patients set up situations by which they become severely and chronically injured through natural or iatrogenic means. This article reports 3 cases of narcotic seeking manifested through deceptive self-injury behavior that were underwritten for life expectancies in legal matters. Underwriting mortality risk requires different authority, resources, and anti-fraud skills than what is typically available to health care providers. Using such authority, resources, and anti-fraud skills, life underwriters can identify deception, malingering, and sophisticated narcotic-seeking behavior that health care providers typically do not or cannot explicitly acknowledge.

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One of the commonly anticipated outcomes of the opioid crisis restrictions on prescription opiates is the increased use of black market opiates, such as heroin and fentanyl.[1-5] Evidence for increased mortality due to black market opiates is routinely monitored by examination of overdose death statistics.

However, increased mortality from black market opiate overdose is not the only outcome that can be reasonably anticipated from restrictions on prescription opiates. Despite a 2015 *JIM* case report of an 88-year-old female patient who was sufficiently fearful of possible prescription opiate addiction to engage in safer alternatives to resolve pain from her hip replacement,[6] there are other patients who already have become addicted to prescription opiates.

Instead of turning to the black market as a ready source of their opiates, some of these sophisticated narcotic-seeking patients intentionally cause injury to themselves to such a degree that a chronic supply of prescription opiates becomes a medically necessary treatment. Medical necessity supersedes the opioid crisis restrictions commonly placed on prescription opiates, and the evidence shows that the more medically necessary the condition, the more prescription opiates are typically prescribed.

This report of 3 cases featuring severe chronic self-injuries intended to deceive health care providers into prescribing a reliable supply of

opiates arose from the underwriting of life expectancies in legal matters. Authority was given to the life underwriter to properly evaluate the patient's mortality risk from all available resources, not to provide health care to the patient. In all 3 cases, the malingering of these severe chronic self-injuries was not explicitly noted or acknowledged in the records by any of the sophisticated narcotic-seeking patient's health care providers.

Health care providers usually do not have access to a patient's complete medical history and records, facilitating deception since the sophisticated narcotic-seeking patient is typically relied on by the health care providers as the primary historian. When health care providers do perceive narcotic-seeking behavior and malingering by the patient, only the objective detailed facts and quotes that indicate the deception are noted in the records, so that the reader of those records must interpret those records correctly to explicitly identify the narcotic-seeking behavior and malingering. During the underwriting of a life expectancy, any evidence of narcotic-seeking behavior and malingering in the records must be clearly identified and acknowledged by the life underwriter.

The advantage of underwriting a life expectancy to identify any narcotic-seeking behavior and malingering comes from the authorized ability of the life underwriter to obtain and review the patient's complete medical history and records that may span many different health care providers over many years. Access to similar resources by any health care provider at the point of service is extremely unlikely, so sophisticated narcotic-seekers can keep health care providers unaware of their malingering.

When health care providers do become aware of narcotic-seeking behavior and malingering, it often appears that they do not want to explicitly acknowledge this in their patient's records, as it may be perceived as stigmatizing to the patient and potentially a subject of litigation. A life underwriter's authority, broad perspective of the records and anti-fraud training that provides the correct interpretation of the records enables the sophisticated patient's narcotic-seeking behavior and malingering to be properly addressed without any disruption to the health care provider's clinical practice.

## CASE #1: CHRONIC BONE FRACTURES

A 73-year-old female with a long history of narcotic-seeking behavior was underwritten for a life expectancy in a legal matter. The patient was being transported home in a wheelchair in the back of an ambulance after she had just finished weeks in inpatient rehabilitation for a broken ankle. When the ambulance came to a sudden emergency stop, the patient released the harness restraints on her wheelchair. The patient flew out of the wheelchair feet first toward the front of the ambulance and fractured the ankle that had just finished healing. The patient blamed the ambulance attendants for not securing her properly in her wheelchair as the cause of her injury.

It appeared that the end of the patient's rehabilitation of an injury, which included administration of prescription opiates was not desired by the patient, and the patient set up a new injury to continue her access to prescription opiates. A life expectancy was calculated to determine the economic loss to the patient from the alleged poor safety practices by the ambulance attendants and the rehabilitation provider that had hired the ambulance. The patient's malingering behavior thus not only included narcotic seeking but also fraud to obtain monetary rewards by blaming her health care providers for causing her self-inflicted injuries.

The records show that the patient was recognized by her health care providers as having opioid dependency and addiction, but there was no explicit notation that her decades-long history of chronic pain syndrome, falls, injuries, and severe withdrawal symptoms were associated with narcotic-seeking behavior or malingering. The patient had a history that includes failed back surgery, post-surgical infections, a fall off a commode that fractured an ankle, a fall out of bed that fractured her

arm, a fall outside of her home that fractured a clavicle, a fall from slipping next to a swimming pool while taking her seeing-eye dog for training that fractured her wrist, a fall when she tripped and fell over her walker while getting on a bus that caused severe back pain, and severe and chronic neck and leg pain from a motor vehicle accident.

Each time the patient fell or injured herself, she would go to the emergency room (ER) and would demand and receive large amounts of prescription opiates. She never established care with a personal care provider but had a back specialist and pain management specialist assigned to her. The patient would ask for refills of her prescription opiates from each of these specialists without the specialists becoming aware of what the other was prescribing.

The patient often claimed that her chronic pain from injuries was so severe that the dosage of prescription opiates was insufficient, and she needed higher dosage levels to function. Sometimes she would cry uncontrollably in the ER and complain of insomnia and depression due to the severity of her pain.

There were many occasions when the patient was brought to the ER for confusion, lethargy and altered mental status from intoxication by the large doses of prescription opiates she was taking. Whenever health care practitioners attempted to discuss her overuse of prescription opiates, the patient became evasive and would not engage in the discussion.

Sometimes the patient would try the following techniques to avoid discussing her opiate use:

- Slur her words and appear that she could not comprehend the discussion
- Start coughing uncontrollably or have dry heaves to stop the discussion
- Start acting anxious and express strong fears about her ability to safely ambulate to stop the discussion
- Simply stated that she was too exhausted and fatigued to have a discussion

The patient's family noted that the patient always seemed to want more prescription opiates and told her health care providers that she was "out of control" at home regarding prescription opiates. However, when the patient's family tried to have her admitted to inpatient detox, she withdrew from all of her medications and became nauseous, anxious, confused, and complained of severe generalized body pain. The plan for her to go through inpatient detox was then canceled, and she was instead given IV morphine followed by methadone to stabilize her acute withdrawal condition.

The patient routinely went into withdrawal whenever she ran out of prescription opiates, and she would go to the ER demanding prescription opiates to stop her pain and withdrawal symptoms. The withdrawal symptoms were typically severe; the patient often collapsed suddenly and had questionable seizures.

The patient is morbidly obese and by age 73 she was wheelchair bound and needed complete assistance with her activities of daily living and instrumental activities of daily living. Her musculoskeletal impairments include: muscular disuse/atrophy, general muscle weakness, osteoporosis, osteopenia, bilateral ankle equinus contractures, spinal canal stenosis, spondylolisthesis, spinal surgery, bilateral knee replacements, bilateral ankle surgeries, carpal tunnel release, rotator cuff injury, fibromyalgia, arthralgia, degenerative osteoarthritis, Charcot's joint in foot, cellulitis, disability, and debility.

The patient also has a long history of poorly controlled Type 2 diabetes with diabetic retinopathy and polyneuropathy and was considered legally blind. The patient had experienced a stroke with hypertensive encephalopathy and hemiparesis, and had a history of metabolic syndrome, myocardial infarction, congestive heart failure, cardiac tamponade, pericarditis, cardiomyopathy, cardiomegaly, hypertension, peripheral vascular disease, angioplasty with stents, anemia, gastroesophageal reflux disorder, chronic obstructive pulmonary disease, and obstructive sleep apnea. She was diagnosed with mild cognitive impairment,

depressive disorder, dysthymic disorder, generalized anxiety disorder, tremor, Bell's palsy, Parkinson's disease, and restless legs syndrome.

An underwriting impression was formed that the patient is a narcotic-seeker, malingerer, and engaged in deceptive self-injury behavior not only to obtain prescription opiates but also to gain monetary rewards by blaming her health care providers for causing her self-inflicted injuries.

## CASE #2: CHRONIC AMPUTATIONS

A 67-year-old male with a long history of narcotic-seeking behavior was underwritten for a life expectancy in a legal matter. The patient underwent a total knee replacement of his right knee due to osteoarthritis at age 62. Over the subsequent 5 years, the patient complained of the knee "clunking" whenever he walked, making him fall repeatedly and becoming so uncontrollably infected that the right leg was amputated above the knee at the patient's request.

The patient blamed the orthopedist who performed the knee replacement and the hospital for medical malpractice as the cause of his amputation and associated severe decline in health. A life expectancy was calculated to determine the economic damages to the patient from the alleged medical malpractice.

The patient is a retired gastroenterologist and pharmacist, and all of his treatment was done at the hospital where he was formerly employed as a staff physician. The hospital gave the patient priority in his treatment, in that any time the patient wanted to be seen by health care providers at that hospital, all other appointments were suspended to give the patient immediate service, no matter how solidly booked the appointment schedule was. The patient was able to demand specific medications and their doses, including prescription opiates, and the hospital filled those prescriptions with no questions asked.

The patient was thus able to directly oversee and specify his own plans of treatment, which meant that the patient could exhibit narcotic-seeking and malingering behavior with impunity. For example, the patient insisted that an orthopedist who specialized in hand surgery instead of knee surgery perform his right total knee replacement. It turned out that the hardware for the knee replacement was not a perfect fit for the patient, which the orthopedist admitted in deposition was from his inexperience with replacing knees.

The amputation of the patient's right leg for massive infection of his knee implant came after years of high daily doses of prescription opiates for the associated chronic pain. The patient's left leg also experienced a series of amputations due to massive bone infections, starting with the toes and then ending up with the entire left foot being amputated for uncontrollable osteomyelitis. It appears that the patient fostered chronic open wounds on his toes and did not take proper care of those wounds to the point that severe and progressive osteomyelitis became established in his left foot.

The patient also experienced extensive issues with back pain, intervertebral disc syndrome, spondylosis, osteoarthritis, osteoporosis, cervical and lumbar radiculopathy. As these orthopedic conditions are extremely painful, the patient was given all the prescription opiates that he demanded for the associated chronic pain syndrome. No questions were asked of the patient despite contact with the hospital's pain management specialists.

Besides the narcotic-seeking behavior that indicates the presence of opiate use disorder, the patient also has symptoms and conditions consistent with alcohol use disorder, including a history of alcoholism in his father. Such symptoms and conditions include paroxysmal atrial fibrillation, chronic gastric ulcer, gastroesophageal reflux disorder, elevation of liver blood tests, anemia, depression, peripheral neuropathy, and denial of alcohol use.

The patient also experienced drug rash with eosinophilia and systemic symptoms syndrome (DRESS syndrome), central sleep apnea associated with chronic opioid use, and chronic respiratory failure with hypoxia. Cardiovascular conditions include congestive heart failure, chronic systolic and diastolic dysfunction, acute and chronic cor pulmonale, mild biatrial enlargement, dysrhythmia treated with ablation, severe hypertension, and dyspnea.

The patient had been diagnosed with diffuse large B-cell lymphoma (DLBCL) at age 58, and his course of chemotherapy was completed at age 59. However, at age 67, recent tumor marker tests were positive, indicating that some residual impairment from the DLBCL was still present.

As a result of all these issues, the patient became frail and by age 67 was wheelchair bound and has difficulty with his activities of daily living. The patient is engaged in other litigation besides the medical malpractice complaint against the orthopedist and hospital and has filed several lawsuits unrelated to his health status. The seeking of financial gain through litigation is an underwriting red flag for malingering by this patient.

An underwriting impression was formed that the patient is a narcotic seeker, malingerer, and engaged in deceptive self-injury behavior not only to obtain prescription opiates but also to gain monetary rewards by blaming his health care providers for causing his self-inflicted injuries.

## CASE #3: CHRONIC NON-HEALING WOUNDS

A 74-year-old woman with a long history of narcotic-seeking behavior associated with non-healing wounds was underwritten for a life expectancy in a legal matter. The patient was crushed to death under a pile of large stones that were in a high steep retaining wall that slid off a hillside during a rainstorm onto the patient. The retaining wall was located next to the smoking area routinely used by the patient behind her apartment complex. The patient's family blamed the apartment complex for allowing the retaining wall to pose an imminent risk to the apartment complex's residents and sued for the wrongful death of the patient.

Examination of the evidence showed that the patient was trying to incur an injury from the retaining wall, and had loosened the bottom stones of the retaining wall so they would fall onto her foot during a rainstorm. The patient positioned herself in her walker with an outstretched foot toward the retaining wall and was in the perfect place next to the retaining wall for the expected injury to happen. As there was no one else using the smoking area during the rainstorm, there were no witnesses to this event.

However, the patient's loosening of the bottom stones of the retaining wall was so effective that instead of a few stones falling onto her outstretched foot as planned, the entire retaining wall slid down and piled on top of the patient, causing her death. The patient's narcotic-seeking and self-injury behavior ended up causing extremely severe injury beyond the control of the patient.

The patient had a long history of non-healing wounds from surgery and non-surgical conditions that established the medical necessity of long-term prescription opiates. Such wounds included those resulting from surgery for hernia repair and leg ulcers from peripheral vascular disease and cellulitis. Despite oversight by pain management specialists, the patient was able to demand and receive repeated renewals of her prescription opiates because of this established medical necessity.

How the patient managed to keep her wounds from healing is unknown, but the patient did allow different wounds to heal quickly at times when the patient thought it would keep her health care practitioners from escalating their therapy and interfering with her narcotic-seeking behavior. The patient's daughter is a nurse who appeared to be an accomplice to her mother's narcotic-seeking behavior and malingering.

The records do not show any explicit notation that the patient's non-healing wounds were associated with narcotic-seeking or malingering. What the records did show was an accounting of the number of days each wound was active that appeared to be too long to be considered routine healing. For example, a non-pressure ulcer in the right distal leg was active for 2317 days; a midline surgical incision wound in the abdomen was active for 1591 days; a dorsal wound on her fourth right finger was active for 1338 days; and a non-pressure ulcer on her left anterior leg was active for 1177 days.

Besides the narcotic-seeking behavior that indicated the presence of opiate use disorder, the patient was diagnosed and treated at age 50 as an inpatient for alcohol abuse. There was no subsequent evidence of sobriety such as regular attendance at Alcoholics Anonymous meetings, and the patient often claimed to her health care providers that she did not consume alcohol. Other signs and conditions associated with the patient's alcohol use disorder included unstable family history (son committed suicide, separation from husband who died shortly thereafter) and dementia characterized as "alcoholic."

The patient was morbidly obese with a history of gastric bypass and had a diagnosis of poorly controlled diabetes for decades. She was also diagnosed with chronic obstructive pulmonary disease associated with her 1 pack a day smoking habit for over 45 years. The patient experienced an ischemic stroke at age 69 and had cardiovascular conditions including myocardial infarction, cardiomegaly, diastolic dysfunction, paroxysmal atrial fibrillation, hypertension, peripheral vascular disease, dyspnea, pitting edema of the lower extremities, generalized weakness and fatigue.

The patient was noncompliant with her non-opiate medications, indicating at various times that she did not have money to pay for them; she could not afford medication anymore and would not like a refill; she is only taking over-the-counter and iron pills because she has to pay down her pharmacy bill; she forgot to take them; she admits she is behind on her medications; she did not take her prescription medications because she took cold medication; she substituted over the counter medications for her prescription medications; and she doesn't always take her medications as prescribed because she gets up at 3 a.m. to deliver newspapers and her schedule gets mixed up.

The patient had refused to see her health care providers and refused to remain in hospital when she needed further care, even to the point of refusing to review discharge instructions so she could leave quickly. She had declined the examination of her wounds, had changed her wound dressings before the home visiting nurse had a chance to inspect and change the wound dressings, and had declined social worker visits as part of her home-based care.

For her severe medical conditions, many times the patient had been advised to go to skilled nursing facilities as an inpatient, but she and her daughter (who is a RN) insisted that the patient remain at home with visiting care. The patient's physical conditions deteriorated as a result, likely establishing the medical necessity of the continued use of opiates for pain. The patient's records show that her symptoms were controlled with difficulty, affecting daily functioning, and needed ongoing monitoring.

The patient and an accomplice (most likely her daughter) defied her doctors' orders to put her physical safety at risk in at least one instance after her stroke left her with swallowing difficulties (dysphagia). To prevent aspiration when drinking fluids while recovering from her dysphagia, liquids were ordered to be thickened until the patient regained full ability to swallow thin liquids. However, the patient was found in her hospital room with a 20 oz bottle of diet soda, stating "I've been sneaking diet coke, but I got caught."

She had been sneaking thin liquids against the doctor's orders and threatened to leave the

hospital unless the liquids were upgraded. An accomplice would have been necessary to help the patient obtain the forbidden soda while the patient was in the hospital recovering from her stroke, increasing the patient's risk of choking despite her health care providers' precautions.

An underwriting impression was formed that the patient was a narcotic-seeker, malingerer, and engaged in deceptive self-injury behavior with the assistance of her nurse daughter as an accomplice.

## DISCUSSION

Red flags for malingering in a medical setting have been well established and are consistent with practical experience.[7] No case has the exact same red flags as another, but in general all these malingerers share one or more of these red flags in common. Having 3 cases to compare in this report shows which aspects appear to be shared and which aspects appear to be unique to a case. As more cases of malingering are underwritten, more detailed patterns of red flags can be further identified.

Health care providers are in the untenable position of needing to intervene in narcotic-seeking behavior and malingering in their clinical practice yet risk the patient immediately leaving their care for a more lax provider. "Doctor shopping" is a well-established red flag for identifying narcotic-seeking and malingering patients. Moreover, once a patient leaves the clinical practice, the income sent on behalf of that patient to the clinical practice goes elsewhere. Such conflict between the service and economic imperatives for health care providers promotes opportunities for narcotic-seeking behavior and malingering to flourish.

None of the 3 cases in this report had any explicit notation in the records by a health care provider that narcotic-seeking behavior and malingering by the patient was suspected or acknowledged. No other case that has been underwritten for life expectancies in one expert practice has ever had an explicit notation in the records that narcotic-seeking behavior and malingering by the patient was suspected or acknowledged.

For the cases where it appeared obvious to the health care providers that the patient was narcotic seeking and malingering, what was actually noted in the records were simply the objective detailed facts of an event or direct quote from the patient that supports a clear conclusion of narcotic-seeking behavior and malingering. It appears that it is up to the reader of a patient's records to make their own interpretation and conclusion about the sophisticated patient's narcotic-seeking behavior and malingering directly from the facts and quotes in those records.

Traditionally it has been health claims adjudicators who are in the best position to have oversight over patient care and thus have the ability to clearly identify and acknowledge any narcotic-seeking behavior and malingering from the records. Health claims adjudicators have the authority, resources and anti-fraud skills to identify narcotic-seeking behavior and malingering in the network of clinical practices they administer.

However, in an era of single-payer health care and government-mandated health care, health claims adjudicators do not necessarily have the opportunity to perform their oversight duties. The concept of "doctor shopping" also applies to health care networks, so the likelihood of a narcotic-seeking and malingering patient leaving a diligent health care network for a more lax network is greatly increased. None of the 3 cases in this report experienced any intervention from health claims adjudication or oversight.

## CONCLUSION

The effects of opioid crisis-related restrictions on prescription opiates reach beyond what can be seen in statistics of black market opiate overdose deaths. What is unseen is the enormous apparent cost to the health care system from sophisticated narcotic

seeking manifested through deceptive self-injury behavior. Health insurers, medical malpractice insurers, the legal system, and taxpayers also bear excessive costs associated with these malingerers.

When given the authority and resources they need, life underwriters have the advanced medical knowledge and anti-fraud skills to explicitly identify deception, malingering, and sophisticated narcotic-seeking patients to begin the process of containing these excessive costs. If health claims adjudicators are not in a position to routinely identify and acknowledge such patients, life underwriters are a good alternative when addressing individual cases of malingering across different health care providers and networks over long periods. Life underwriters can be engaged in nontraditional ways to contain excessive costs for the most egregious cases of sophisticated narcotic-seeking behavior and self-injury like the ones in this report.

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