Addiction: Part II. Identification and Management of the Drug-Seeking Patient

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This is Part II of a two-part article on addiction. Part I, “Benzodiazepines—Side Effects, Abuse Risk and Alternatives,” appeared in the previous issue. (Am Fam Physician 2000;61:2121–8).

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The medications most often implicated in prescription drug abuse are opioid analgesics, sedative-hypnotics and stimulants. Patients with acute or chronic pain, anxiety disorders and attention-deficit disorder are at increased risk of addiction comorbidity. It is important to ask patients about their substance-use history, including alcohol, illicit drugs and prescription drugs. Patients who abuse prescription drugs may exhibit certain patterns, such as escalating use, drug-seeking behavior and doctor shopping. A basic clinical survival skill in situations in which patients exert pressure on the physician to obtain a prescription drug is to say “no” and stick with it. Physicians who overprescribe can be characterized by the four “Ds”—dated, duped, dishonest and disabled. Maintaining a current knowledge base, documenting the decisions that guide the treatment process and seeking consultation are important risk-management strategies that improve clinical care and outcomes.

On one hand, physicians often undertreat certain patients because of concerns about the potential for drug abuse, while on the other hand physicians often fall prey to the manipulations of drug-seeking patients. Basic screening questions about drug abuse should be included when a patient's history is obtained. Physicians must also be aware of aspects of their own background that may make them susceptible to manipulation by drug-seeking patients.

Dilemma: Desire to Treat vs. Fear of Sanction

Most patients who take prescribed narcotic analgesics, sedative-hypnotics or stimulants use them responsibly, as directed. However, drugs of this type generate scrutiny from the U.S. Drug Enforcement Agency (DEA) and other authorities because of their abuse potential. Physicians' concerns about possible legal, regulatory, licensing or other third-party sanctions related to the prescription of controlled substances may contribute significantly to the undertreatment of pain syndromes and anxiety disorders.¹

Pain and somatic manifestations of anxiety are two of the most common reasons that people consult a physician, yet frequently these problems are inadequately treated. Failure to provide relief from pain and anxiety disorders exacts an enormous social cost from lost productivity, needless suffering and excessive health care expenditures. Numerous public policy groups and medical organizations, including the American Medical Association, have issued strong statements attesting that medical practice does not meet acceptable levels of quality when it comes to the diagnosis and management of conditions requiring treatment with a controlled substance.²,³

At the same time, reports from state medical boards indicate that allegations of controlled-substance overprescribing are the leading cause of investigations of physicians and of actions against physicians' licenses. In addition, the street value of controlled prescription drugs has been estimated by the DEA to be second only to the street value of cocaine, and greater than the street value of marijuana and heroin.³ This sets up an unfortunate paradox for physicians: the desire to relieve pain, anxiety and other discomfort must be weighed against the fear of creating addiction, of being investigated by law enforcement or licensing authorities, and of being "scammed" by the occasional patient who abuses opioid analgesics, sedative-hypnotics or psychostimulants. These competing concerns often leave physicians feeling ambivalent and uncomfortable about prescribing controlled substances, to the detriment of the majority of patients who suffer legitimate illnesses and are often left undertreated or feeling stigmatized.

Commonalities of Controlled Substances

The medications that are most often implicated in prescription drug abuse include opioid analgesics, benzodiazepines, stimulants, barbiturates and other sedative-hypnotic agents (Table 1). Although these drugs have different pharmacologic characteristics, they all share several important similarities, as follows:

- Self-administration is a universal attribute that allows patients with current or past addiction problems to avoid the need for a street drug supply.
- Drugs in each of these classes are “habit forming,” frequently causing a state of physiologic dependence if they are taken in large enough quantities for long enough periods of time. Thus, tapering the dosage may be required to prevent withdrawal symptoms.
- All scheduled drugs have psychoactive effects and may be abused and/or may have a “street value.”
- Drugs in these classes are scheduled by the DEA and require a special application for a DEA number and specific prescribing practice guidelines, laws and regulations.

### Characteristics of Drugs of Abuse

In general, mood-altering substances are more highly reinforcing to persons with addiction proclivity if the drug has a rapid onset of action, high potency, brief duration of action, high purity, water solubility (for intravenous use) or high volatility (ability to vaporize if smoked). Among benzodiazepines, for instance, highly lipophilic agents (those that cross the blood-brain barrier more rapidly), such as diazepam (Valium), and agents with a short half-life and high potency, such as lorazepam (Ativan) and alprazolam (Xanax), are the most reinforcing and, therefore, the most likely to be associated with abuse. Studies evaluating the abuse liability of various opioid medications clearly indicate that controlled-release formulations (e.g., MS Contin) and agents with a long half-life (e.g., methadone, LAAM) have lower abuse potential and less street value than high-peaking, rapid-onset opioid formulations (e.g., hydromorphone).

In addition, trade-name prescription drugs are routinely worth more on the street than their generic equivalents because the brand-name drugs are readily recognizable as the “real thing.” Generic pills do not enjoy this same status or “purchase power.”

Prescription drug abuse alone is uncommon, but a significant proportion of polydrug abusers start with street drugs and progress to prescription drugs as they become chronically ill. The prescription drugs may be from the same class as their street drug of preference (such as heroin and narcotic analgesics) or from different classes. Benzodiazepines, for example, have multiple uses for polydrug addicts: they are used to enhance the euphoriant effects of opioids, to alleviate withdrawal or abstinence syndromes between “fixes,” to temper cocaine highs, to augment the effects of alcohol (synergistically) or to ease withdrawal states. It is estimated that 80 percent of benzodiazepine abuse occurs within polydrug abuse, with the highest correlation occurring with concurrent addiction to opioids and alcohol.

### Definitions: Abuse, Dependence and Addiction

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**TABLE 1**

**U.S. Drug Enforcement Agency Classification for Scheduled Substances**

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Characteristics</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule I</td>
<td>No accepted medical use</td>
<td>heroin, marijuana, LSD</td>
</tr>
<tr>
<td>Schedule II</td>
<td>High abuse potential with severe dependence liability</td>
<td>morphine, methadone, oxycodone, amphetamines, secobarbital</td>
</tr>
<tr>
<td>Schedule III</td>
<td>Less abuse potential than schedule I and schedule II substances</td>
<td>acetaminophen that contains limited quantities of certain narcotic drugs</td>
</tr>
<tr>
<td>Schedule IV</td>
<td>Less abuse potential than schedule III substances</td>
<td>phenobarbital, benzodiazepines, propoxyphene, pentazocine, phentermine</td>
</tr>
<tr>
<td>Schedule V</td>
<td>Least abuse potential of scheduled substances</td>
<td>buprenorphine, propylhexedrine</td>
</tr>
</tbody>
</table>

LSD = lysergic acid diethylamide.
Between 10 and 12 percent of the population use benzodiazepines within the course of a year for a wide variety of reasons, ranging from psychiatric disorders, insomnia, anxiety or agitation to alcohol or drug detoxification. Use is significantly higher in larger frequency, for different indications or by different routes, usually resulting in adverse consequences.

"Abuse" refers to use in greater frequency, for different indications or by different routes, usually resulting in adverse consequences. "Addiction" is a further evolution of this preoccupation, with loss of control and acquisition of an obsessive-compulsive pattern that takes on a life of its own as a primary illness. Physiologic homeostatic changes leading to tolerance, withdrawal or sensitization may occur, and cognitive changes are common.

"Dependence" is a physiologic process, which is a predictable event in the prescription of opioids, benzodiazepines, barbiturates and, to some degree, stimulants. Dependence is dose-, time- and potency-related and may result in tolerance (to side effects and to therapeutic effects) and withdrawal. Physiologic dependence is not necessarily addiction.

Understanding the differences among these three terms helps the physician understand the liability risks and helps the patient overcome the stigma of getting "hooked" on a legitimately used controlled substance. In addition, understanding an addicted patient's history and clinical presentation comprehensively and over time is a critical part of the decision about whether to prescribe a medication as part of treatment and, if so, whether to risk the use of a medication with addiction potential.

### Screening for Addiction

Addiction disorders affect 20 to 50 percent of hospitalized patients, 15 to 30 percent of patients seen in primary care settings and up to 50 percent of patients with psychiatric illnesses, yet in most patients the addiction disorder remains undiagnosed and untreated. Patients with acute or chronic pain, anxiety disorders and attention-deficit disorder are at increased risk for addiction comorbidity. Physicians treating such patients must ask them about their substance-use history, including past patterns of alcohol, illicit drug and prescription drug use. Basic screening questions should be integrated into all histories and physical examinations.

The temporal onset of each disorder (alcohol and other drug abuse, medical disorders, psychiatric disorders) should be considered during the evaluation. Baseline medical or psychiatric status should be determined during periods of abstinence. The patient's family history and genetic risk factors should be taken into consideration, and the impact of other psychosocial stressors on the patient's life should be assessed. Finally, the patient's current state (intoxication or withdrawal) and stage (early or chronic) of addiction should be ascertained.

The physician should be especially wary of interactions with patients who are in a withdrawal state. Such patients often complain of pain or anxiety, leading to the perception of the need to prescribe an opiate or a benzodiazepine. Anxiety may also appear as a symptom of other psychiatric disorders, such as major depression, psychotic disorders and bipolar disorder. Numerous nonaddictive psychotropic medications may more appropriately treat these disorders. Similarly, the underlying illness or injury that is the cause of pain should be sought and treated whenever possible.

Most addiction medicine specialists feel that physicians should avoid prescribing potentially addictive controlled substances to patients with current or past addictions. However, if acute pain management is necessary, such medications should not be withheld. After appropriate dosage requirements are ascertained, medications should be administered on a schedule rather than on an as-needed regimen. If possible, alternatives to medications, such as biofeedback, relaxation techniques, transcutaneous electric nerve stimulation (TENS) units, physical therapy and psychotherapy, should be used. Newer procedures that may provide pain relief include spinal cord stimulation and intraspinal drug therapy. In addition, many nonaddictive medications have proved efficacious in the treatment of pain, anxiety disorders, insomnia and attention-deficit disorder (Table 2).

### TABLE 2

<table>
<thead>
<tr>
<th>Pharmacologic Alternatives to Controlled Drugs in Patients with Addictions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anxiety disorders</strong></td>
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<tr>
<td>Antidepressants (most)</td>
</tr>
<tr>
<td>Buspirone (Buspar)</td>
</tr>
<tr>
<td>Anticonvulsants (valproic acid [Depakene], gabapentin [Neurontin])</td>
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<tr>
<td>Selected antihypertensives (beta blockers)</td>
</tr>
<tr>
<td>Atypical neuroleptics (olanzapine [Zyprexa], quetiapine [Seroquel], risperidone [Risperdal])</td>
</tr>
<tr>
<td><strong>Insomnia</strong></td>
</tr>
<tr>
<td>Sedating antidepressants</td>
</tr>
<tr>
<td>Trazodone (Desyrel)</td>
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</tbody>
</table>

Patient Characteristics
Several behaviors tend to occur when patients who abuse prescription drugs interact with the medical care system: escalating-use patterns, drug-seeking behavior, doctor shopping and the use of “scams” to maintain and increase their supply of drugs.2

ESCALATING USE
Overuse of a prescribed medication can be the result of underprescribing or underestimating the magnitude of the symptoms. Indeed, many patients are undertreated because of the physician’s or patient’s misplaced fear of addiction or the physician’s lack of knowledge about pharmacokinetic properties such as half-life. However, if a pattern of overuse or escalation of use develops, and additional drug-seeking behaviors emerge, a more detailed addiction assessment is necessary.

DRUG-SEEKING BEHAVIOR
“Drug-seeking behavior” is a widely used, although poorly defined term that refers to a patient’s manipulative, demanding behavior to obtain medication. The patient may imply that the only possible solution to a medical problem is a prescription of a controlled (addictive) medication. For example, the patient may describe symptoms that markedly deviate from objective evidence or the physical examination findings. The patient may insist on receiving a controlled drug prescription on the first visit and claim that nonaddictive medications “don’t work.” The patient may claim that nonaddictive medications cannot be taken because of an allergy to them. The patient may make remarks about having a high tolerance to drugs, may lose prescriptions or run out of prescriptions “early.”

The patient may sell or forge prescriptions or may use the prescriptions of others, such as family members and friends. Some patients manipulate the situation by pitting one physician’s treatment opinions against another physician’s recommendations or by threatening to get the requested drug from “smarter” or “more caring” physicians. Nonpharmacologic treatment recommendations, such as behavioral training, psychotherapy and 12-step recovery programs, are resisted. The patient may offer bribes or sex, or may make outright threats of harm to person or property.

DOCTOR SHOPPING
“Doctor shopping” is a term that describes patients who use at least two and often multiple physicians in their attempt to obtain an adequate or increasing supply of controlled prescriptions. They often “role play” with a number of different well-intentioned but perhaps naive physicians to obtain multiple prescriptions, which are used personally or sold to support other drug habits. This type of behavior is most common in emergency department settings, where staff may not know the patient. Frequently, drug-addicted patients present “after hours” and claim to be from “out of town.”

Doctor shopping has historically been a difficult pattern to identify, but pharmacy networks and managed care companies are making this type of drug-seeking behavior an increasingly difficult option. Physicians should ally with their local pharmacists, who share the legal liability when a controlled drug prescription is filled. By working together, physicians and pharmacists can more effectively identify and monitor drug-abusing patients.

SCAMS
Scams are sometimes used to obtain additional medications, more potent or higher dosage formulations or brand-name drugs because of their higher street value. If patients encounter resistance to the scam, they are often willing to “push” the physician. Patient-generated pressure to prescribe in the face of the physician’s feeling of hesitancy is a classic indicator of a scam.

Patients rarely self-medicate with prescribed agents that do not produce a “high” or reward, and they are often quite adept at projecting their misery and helplessness onto “prospective prescribers.” An initial “no” (refusal to prescribe by the physician) that eventually is changed to a “yes” (willingness to prescribe) in the face of pressure from the patient is considered by some experts to be pathognomonic of prescription drug abuse. Once a scam has worked in a given practice,
that scam will likely continue to surface periodically in that office practice until the physician ceases to reinforce the scam. Dealing with scams consists of learning to recognize the common

Chemically dependent patients may effectively shift discomfort to the patient while refusing to prescribe by making statements such as "I'm feeling pushed by you to write a prescription today that is not medically indicated and thus I'm concerned about you, and we need to talk about your use of alcohol (or other substances)."

Although medical school education emphasizes clinical interviewing skills, communicating with patients and establishing a rapport in the physician-patient relationship, physicians are rarely, if ever, coached on how to say "no" and set limits with patients in precarious situations. Fear and avoidance of confrontation play into the hands of chemically dependent patients, who have a stronger relationship with the prescription than they do with the physician. In addition, in this age of managed care cost-consciousness, physicians are under increasing pressure to see more patients in shorter amounts of time and often would rather "write ("Rx") than fight."

**Characteristics of Overprescribing Physicians**

The American Medical Association describes four mechanisms—the four “Ds”—by which a physician becomes involved in overprescribing, as follows: dated, duped, dishonest and disabled.2,3

**DATED**

“Dated” refers to physicians who are out of date regarding knowledge of pharmacology and the differential diagnosis and management of chronic pain, anxiety, insomnia and addiction. Reports suggest that physicians are sometimes more out of date in their knowledge and less confident in their skills in these areas than they are in other areas of medical practice.

**DUPED**

Physicians may be duped by patients. Physicians are generally a caring, trusting group of professionals who are trying to help their patients in an open and honest relationship based on mutual respect. Thus, physicians may be vulnerable to a manipulative patient.

**DISHONEST**

Dishonest physicians are, thankfully, uncommon. There are a few physicians in every geographic area who are willing to write prescriptions for controlled substances in exchange for financial gain. Such physicians should be reported to the state medical board or other law enforcement agencies and appropriately investigated.

**DISABLED**

Disabled physicians are defined in this context as physicians with a medical or psychiatric disability, such as chemical dependency or a personality disorder. These physicians may be "loose" prescribers of controlled substances and may be less likely to confront patients who are abusing substances out of fear of turning suspicion on themselves.

**Countertransference and Physician Codependence**

Physicians who decide to prescribe controlled substances to patients with addictions should be aware that they may be drawn into the patient's own system of denial.2 The physician should pay attention to any atypical emotional responses in himself or herself. These include anger, guilt, wish to disengage, pity, revulsion and other emotions that diverge from their usual experiences of confidence and empathy in patient interactions.

Countertransference is a psychodynamic term that refers to feelings leading to the emotional response of a caregiver to a patient. It is only partially conscious, and it is always present. It is determined by the physician's own background, emotions, issues, etc.

Codependence may be thought of as a behavioral characteristic of persons who are involved in ostensibly helpful relationships with severely ill patients (for our purposes, ill with addictions). The relationship inadvertently results in harm to one or both persons because the "codependent" is unable to observe standard boundaries or limits in the relationship. A psychologic system of denial or identification is created around the relationship, perpetuating it despite the harm that ensues. Codependent persons unconsciously fear anger and potential abandonment if they refuse to gratify the patient's demands, no matter how unreasonable they are.

An example of codependence is a husband who wakes up hung over after a bout of uncontrolled drinking and asks his wife to call his office and explain that he is sick or will be late. In a healthy relationship, the wife will not make the call and will explain that he needs to take responsibility for his own actions. The codependent wife, on the other hand, will compromise her personal integrity and make the sick call for her husband.

Physicians are highly susceptible to being drawn into these compromising situations through the process of projective identification. Patients with addictions are notoriously prone to projecting onto physicians the message that "my problem is now your problem."

There is a fine line between empathy and codependence. In physicians, codependence involves overstepping one's boundaries and limits, combined with the fear that the patient will reject him or her if the desired prescription is not delivered. Exactly where the boundaries lie in prescribing controlled substances to patients with addictions is controversial, but heightening one's awareness of these issues can improve clinical outcomes and risk management.

**Risk Management**

Physicians prescribing controlled substances such as benzodiazepines, opioids and stimulants should review their pharmacology, including pharmacokinetic and pharmacodynamic properties, drug–drug interactions and signs of intoxication and withdrawal. They should also be aware of the epidemiology of abuse and appropriate treatment indications and contraindications, and they should be able to perform basic alcohol and drug addiction screening assessments.

‘WRITE (RX) RIGHT’

Careful charting and documentation habits are essential when initiating a controlled drug regimen. It is important to document clearly in progress notes the diagnosis, the clinical indications, the expected symptom end points and the treatment time course. A medication flow chart is useful to monitor refills, symptoms and time course, or chronicity of prescribing. Practice policies for calling in refills and cross-coverage prescribing are also essential. Writing prescriptions in a manner that decreases tampering and keeping prescription pads under close control are prudent precautions.

When writing prescriptions, physicians should make every effort to do the following:

1. Prescribe the exact amounts to carry through to the next appointment.
2. Write out the number dispensed, such as “fourteen” instead of using the number “14.”
3. Consider instituting a one-doctor/one-pharmacy treatment plan with the patient. Tell the patient that only one physician in the practice will prescribe medication, and prescriptions will be telephoned to only one pharmacy.

It is unlawful to provide maintenance or tapering prescriptions (including, but not limited to, methadone) for a narcotic to a patient who is addicted to controlled substances unless a patient is registered with the DEA in a treatment program. Most commonly, this refers to methadone clinics, but the rule applies to any addiction treatment situation.

CONSULTATION

Consultation with peers, supervisors and others with specialized expertise can clarify the decision-making process, thereby raising the level of clinical care and strengthening the physician's position in administrative or legal actions.13 In many cases, the consultation will be in a specialized clinical area such as addiction medicine, psychopharmacology, pain management or forensic psychiatry.

Legal Issues

The cardinal principles of risk management should be carefully applied when treatment involves the use of controlled substances.13

INFORMED CONSENT

Informed consent can be considered as an alliance-building process. When a controlled substance is being considered as a treatment option, patients should be informed of the potential for physical dependency and the possibility of mild to moderate rebound effects even with gradual tapering. The physician should carefully review the benefits and risks of the chosen medications, as well as other treatment choices.

DOCUMENTATION OF THE DECISION-MAKING PROCESS

When providing care to a patient who appears likely to sue, the physician should document not only what was done but also how that action was chosen. A record should be kept of the informed consent process, including assessment of the patient’s decision-making competence. Any treatment protocol that deviates from the community standard of care should be carefully considered and voluntarily chosen by the patient, and explicit documentation of this should be included in the medical record.

DUTY TO WARN AND THIRD-PARTY LIABILITY

The so-called “driving cases” are a special example of a specific “duty to warn.” Failure to inform patients of the risk of driving while taking a medication, such as a benzodiazepine, may lead to a claim of negligence against the prescribing doctor.14

An increased risk of driving errors occurs mainly after the initial dose of a benzodiazepine or following an increase in the dosage. Driving errors may occur with significantly increased frequency if a patient is also consuming alcohol.8 Whether chronic users of therapeutic dosages of benzodiazepines who are not using alcohol or other sedative-hypnotics are at increased risk for motor vehicle crashes remains a matter of debate. Given the liability risks, physicians should apprise patients of these concerns and document this in the medical record.

AVOID PRESCRIBING MEDICATIONS IN ISOLATION FROM OTHER THERAPIES

As with any other medications, controlled substances can be used most safely and effectively as part of an overall treatment plan that is carefully monitored. Other treatment modalities, such as physical therapy, behavioral therapy or psychotherapy, should be used conjointly when indicated. Periodic review of the course of treatment should occur at reasonable intervals and include input from multidisciplinary staff or consultants.

There is little doubt that narcotic analgesics, sedative-hypnotics and psychostimulants are effective and justified in a wide range of conditions. Being mindful of the potential for misuse and abuse of these agents is a key to avoiding the paradox of overprescribing them to high-risk patients and underprescribing them to the majority of patients with conditions that would be improved by their use.

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