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Dealing with Drug-Seeking Patients in the Emergency Department

Authors: **Larissa I. Velez, MD**, Assistant Professor, Assistant Director of Emergency Medicine Residency Program, University of Texas Southwestern Medical Center, Dallas; **Wilfredo Rivera, MD**, Assistant Professor, Emergency Medicine, University of Texas Southwestern Medical Center, Dallas; Associate Medical Director, North Texas Poison Center; **John Marcucci, MD**, Clinical Instructor, Emergency Medicine, University of Texas Southwestern Medical Center, Dallas; Medical Director, Emergency Department, Baylor Regional Medical Center, Plano, TX; and **Fernando Benitez, MD,** Assistant Professor, Emergency Medicine, University of Texas Southwestern Medical Center, Dallas.

Peer Reviewers: **Sandra Schneider, MD, FACEP**, Professor and Chair, Department of Emergency Medicine, University of Rochester, Rochester, NY; and **Gregory A. Volturo, MD, FACEP**, Associate Professor of Emergency Medicine and Medicine, Vice-Chairman, Department of Emergency Medicine, University of Massachusetts Medical School, Worcester, MA.

Drug-seeking behaviors are commonplace in emergency departments (EDs). Many physicians have faced patients with multiple alleged allergies to narcotics who are asking for a medication that the physician never would have initially thought of prescribing, whose medications were stolen, and who become angry, threatening, and agitated upon refusal to refill the stolen prescription. This article defines various terms used in the drug-seeking literature, provides an overview of drug-seeking behaviors, and proposes some techniques to manage these patients both at the individual and at the institutional levels.

—The Editor

Definitions

A drug seeker is defined as a patient who requests the prescription of a legal drug for resale, personal use, and/or family use. Generally, these are non-medical uses of the prescription drug, which refers to a use pattern that exceeds the recommended dose in amount or frequency. Non-medical uses also include the use of prescription medications not prescribed to that patient.[1] This is in contrast to appropriate use, in which the medication is used only as prescribed and only for the condition indicated by the physician.[2]

Inappropriate use refers to the use of a medication for a reason other than for which it was prescribed, or at doses or frequencies other than prescribed.[2] It can be intentional or unintentional. If the inappropriate use results in a negative consequence, such as divorce or job loss, it is termed abuse.[3] The Drug Abuse Warning Network (DAWN) defines drug abuse as the "non-medical use of a substance for psychic effects, dependence, or suicide attempt."[1] DAWN collects data from approximately 1000 EDs and medical examiners' offices in the United States, and pro-

duces statistics on drugs implicated in morbidity and mortality.[4] Abuse usually is associated with loss of control over the use of the drug and preoccupation about the drug.[2] Tolerance and physical dependence are not necessary to make the diagnosis of abuse. Drug tolerance is a decreasing response to repeated constant doses of a drug or the need for increasing doses to maintain a constant response. Physical dependence is indicated by the development of withdrawal symptoms on reduction or cessation of the drug. It does not, in itself, represent abuse.[2,3]

The drug-seeking patients obtain prescription drugs in multiple ways: Some do so illegally through pharmacy theft, prescription forgery, diversion at wholesale level and street sales.[5-7] Internet sales without a prescription also have become popular.[8] Several authors describe one of the legal ways of obtaining prescription drugs as the ones received from friends and family who have stockpiles. However, it is estimated that 80-90% of misused prescription drugs are obtained by legal means.[2,6] Some of the drugs with the highest abuse potential, such as the benzodiazepines, are among the most commonly prescribed drugs in the United States.[2]

Doctor shopping or drug-seeking behavior is defined as "a fraudulent presentation of disease to multiple doctors and pharmacies" in an attempt to obtain prescription drugs for use, trade, or sale.[6,9] This definition avoids the controversy of addiction or dependence. Focus is on patient activities that have the potential for harm.[6] A more specific definition by the Health Insurance Commission (HIC) defines a doctor shopper as someone who has seen more than 15 different general practitioners (GPs) in one year, has had 30 or more Medicare consultations, and has obtained more prescriptions than appear to be clinically necessary.

Population at Risk

The National Health Survey from 1985 found that 15.7% of the U.S. household population older that 12 years reported misuse of at least one drug type in their lifetime.[1] The National Household Survey on Drug Abuse from 1990 showed that 8.5 million people 12 years or older had used controlled tranquilizers, stimulants, or analgesics for non-medical reasons at least once in the year preceding the survey.[5] These numbers do not include information regarding alcohol consumption. About 2.7 million people in the United States have abused a prescription drug in the past month, compared to 14.5 million who have done the same with an illegal drug.[7] The four most common abused prescription drug groups include sedatives (barbiturates), tranquilizers (benzodiazepines), analgesics (opiates), and stimulants (amphetamines and anorectic agents).[1,3,9,10] Pharmacologic properties of a drug that make it more likely to be abused include having mood-altering properties, rapid onset of action, high potency, short duration, high water solubility, and high volatility.[10] In general, all Drug Enforcement Agency (DEA) number-requiring drugs have significant abuse potential when prescribed to a patient with an underlying chemical dependence.[10]

Prescription drugs are more desirable than illicit drugs for several reasons. For one, their possession is not illegal.[11] They often have a better market value than illegal drugs, with cocaine being the only drug with a higher street value than prescription drugs.[10] It is estimated that trade name drugs, since they are easily recognizable as the real thing, are worth double the price when sold on the streets.[10] Also, the quality, dosage, and effect of the drug are ensured, since they are manufactured under strict federal regulations.[6] This is in contrast to illegally manufactured drugs, where the identity, safety, and quality of the drug are questionable. Prescription drugs are available on the street.[6] Finally, cost also is an issue. If the patient has medical insurance, the pre-

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Editorial Group Head: Valerie Loner
Specialty Editor: Shelly Morrow Mark
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scribed drugs are free, or the cost is significantly decreased, making this the preferred drug over other illegal drugs.[11]

Prescription drugs are involved in almost 60% of all ED visits and in 70% of drug-related deaths in the United States.[4,5,9,12] There also are many secondary effects of prescription drug abuse, such as absenteeism, occupational injury, traffic collisions, and crime.[5] Most importantly, the overall medical care of these patients is inconsistent and not adequate.

There are multiple target sites for drug seeking behavior: it can occur in clinics, EDs, and private offices. The three groups of physicians that generate the most number of prescriptions include family physicians, internists, and psychiatrists.[2,13] For several reasons, ED physicians often are the target of drug-seeking patients. For one, there is brief contact with patient, so there may not be an attempt to find out much about the past history of the patient (limited access to medical and pharmacy records), and a lower likelihood of remembering multiple visits by the same individual. The ED also is available 24 hours a day, 7 days a week, which is convenient, since prescription drug use escalates over time.[5,9]

The health care resources consumed by drug-seeking patients are enormous.[5,14] Zechnich and colleagues published data on 379 visits by 30 patients. Of those, 85.5% were to the ED, 9.8% to urgent care, and 4.7% resulted in admissions. In this report, there was a mean of 12.6 visits per patient per year.[5] Schaulis and Snoey published a case of the "ultimate frequent flyer": a patient with 1000 ED visits over three years.[15] It has been estimated that an ED serving a base population of 75,000 will have up to 262 monthly visits from drug-seeking patients.[16,17]

The most common age group for drug seekers is 24-36 years, followed by those 18-25 years. This pattern follows that of illicit drug abuse in the United States.[1] In a recent study, 50% of the drug seekers were men, with a mean age 34.3 +/- 7.52 years.[5]

In terms of ethnicity, whites have twice the rate of prescription drug abuse as blacks or Hispanics.[1]

Asking about substance abuse before prescribing psychoactive substances is just as important as asking about allergies before prescribing an antibiotic.[2] Any patient with a past history of substance abuse, including alcohol, and family history of substance abuse is at risk for new or recurrent medication abuse and misuse.[2] The elderly also are at increased risk of medication misuse because they use more prescription drugs, such as anti-anxiety and anti-insomniacs; polypharmacy is more common in this age group; cognitive and visual impairments can lead to erratic compliance; and they often use over-the-counter medications that can interact with prescription medicines.[2,4] Additionally, drug abuse and misuse can be misdiagnosed or overlooked in the elderly. It can present with non-specific behavioral changes such as depression, anxiety, agitation, and insomnia. Misuse and abuse also can present with trauma, poor hygiene, poor attention, and a host of other symptoms that may be confused with dementia. Finally, the elderly have fewer social contacts (they usually don't work, may not drive, etc), which makes the symptoms less likely to be noticed by others.[2]

Some behaviors have been associated with a higher likelihood of drug seeking. Many of these drug-seeking patients are known to use aliases. In one study, the mean number of different names for every drug-seeking patient was 2.2 (range 1-6).[5] These patients ask for specific medications, report multiple drug allergies, and often request to be seen by different or specific physicians.[2,18] Many drug-seeking patients will visit several EDs in the same city or region.[19] If the old charts or pharmacy profiles are searched, one can find an unusual number of prescriptions for one patient, large quantities prescribed over a short amount of time, and multiple providers writing the prescriptions.[12] The past medical history often will reveal a history of drug or alcohol abuse.[2] These patients often have frequent unscheduled visits to their primary doctors, do not keep scheduled appointments, and often only visit the ED for their primary care. Reports of stolen, lost, or damaged medications also should be viewed as suspicious.[2,6,10,12] The chart may reflect that the individual appears intoxicated.[2,6,10] These patients also may report that they have needed to use higher doses of medications than indicated on label, leading to premature requests for refills (i.e., "I ran short").[6] Finally, they often exhibit threatening or abusive behavior when denied a prescription.[2,6,10]

Several diagnoses put patients at risk of drug abuse and drug-seeking behaviors. These include back pain, pelvic pain, head-ache, extremity pain or injury, medication refill, dental pain, seizure, and abdominal pain.[5,18,20] Ill-defined symptoms of pain, anxiety or insomnia also are suspects.[12,13] One case reports a patient who received more than 4000 hydromorphone tablets after visiting approximately 11 Veteran's Administration hospitals with the story that he was a cancer patient on vacation and he ran out of pills and was scheduled for surgery upon his return.[6]

Some observed behaviors of drug-seeking patients include searching through drawers when left alone and stealing needles and syringes from the hospital.[3,10,16] In the office setting, it may be common to get third party requests ("I am calling for my mom, she cannot go herself").[21]

However, remember that these are suspicious, not proven, behaviors. Do not base a decision to deny a prescription solely on the number of visits or the chronic use of some prescription drugs. Remember there are many patients with true chronic pain who need adequate pain control, such as those with sickle cell disease, terminal cancer, multiple sclerosis, and others.

Parran describes one behavior that is virtually pathognomonic of substance abuse: When the initial refusal (initial "no") to prescribe is met by the patient's resistance, the physician feels pushed by the patient to prescribe, and finally accedes (subsequent "yes") to writing a prescription.[10] If the physician feels uneasy about prescribing controlled substances for a particular diagnosis, extreme caution is indicated. Sometimes, the decision to not prescribe is difficult because it can escalate to arguments with the patient. However, the physician should be firm when setting limits to the treatment he or she is willing to give. Coercion is a method used by drug seekers, and physicians must learn to identify the attempt at coercion and not give in to a request they don't feel comfortable with. The physician should

be compassionate but firm, and should not take it personally or react with anger.[10]

An Encounter with the Drug-Seeking Patient

Drug-seeking patients use physicians to give them the medicines, and they are extremely skilled at describing symptoms of pain, anxiety, and insomnia.[22] In addition to this, medical graduates are poorly prepared to deal with these patients and their requests, finding it uncomfortable to deny a request that may be legitimate.[15,22] For many, it is problematic to determine the legitimacy of the patient's requests.[22] Finally, when a physician prescribes liberally, the word spreads.[11]

The patients also take advantage of the fact that many physicians are unaware of frequent/multiple visits—very often there is no tracking system.[18] They also are aware of the lack of inter-hospital consistency in care.[5] Drug seekers are very persistent, and often know ED shift change hours for the hospitals they visit regularly. Sometimes, they play on the physician's sympathy by self-inflicting injury or not caring for wounds so they don't heal.[21]

When their requests are denied, they often resort to confrontation, using threats and having abusive outbursts. These behaviors also make health care practitioners very uncomfortable.

Drug abuse is almost never admitted by the patient, and educational interventions often are ineffective.[6] This makes any help difficult to impossible. Just saying "no" does not help with the true disease, addiction. Furthermore, these patients, when pressed, often move to a different town or simply change providers.

Prevention

As with many behaviors, it is easier to prevent than to treat substance abuse. There are several things ED physicians can do to decrease the probability that a patient will become a prescription drug abuser and a drug seeker. First, identify patients at risk. Physicians often lack thorough knowledge on how to identify patients at risk for drug abuse.[21,22] Once those patients have been identified, attempt to use non-narcotic analgesics instead of narcotics to treat pain, non-benzodiazepine agents to treat anxiety (i.e., valproic acid, buspirone), and non-benzodiazepine agents to treat insomnia (i.e., trazodone and nefazodone).[2,23]

Stay up-to-date in methods to manage chronic pain, anxiety, and insomnia.[21] All prescriptions from the ED must have a clear indication and a therapeutic end point. Also, tell the patient the expected clinical course and make sure that he or she has appropriate follow-up.[2] Since chemical dependence often involves poly-substance abuse, try to avoid polypharmacy.[10]

Physicians should be extremely careful when prescribing for a co-worker. The act of prescribing a medication requires the establishment of a physician-patient relationship that must be documented by means of a chart or other type of written record.

What To Do with the Drug Seeking Patient?

Some physicians and health care providers are more vulnerable to these requests.[2,6,13] It may be that they are new in town and don't know which patients are doctor shopping and drug-seeking. Some get tired of the same behavior and the multiple visits, and a decision is made to prescribe without much resistance. Time constraints also are an issue, particularly in busy EDs: Physicians can see more patients if they give up, and a long discussion at the end of a long shift is not something to look forward to.[11] Threats of reporting the physician to the hospital's administration also play a role: Health care providers want patient satisfaction and job security.

The American Medical Association published the four Ds on why some physicians over-prescribe:

• Dated: They have outdated knowledge on drugs, pharmacology, and pain management. They have lax prescription practices.[7]

• Duped: They trust a deceptive or manipulative patient. This is the reason for the highest percentage of inappropriate prescriptions.[7]

• Dishonest: Physicians who prescribe for profit. These should be reported to the respective medical boards.

• Disabled: Physicians themselves have a psychiatric or substance abuse problem.[3,24]

Another author uses the concept of the "pseudobenevolent overprescriber." Physicians who over-prescribe have a strong need to help; a touch of grandiosity and omnipotence; an orientation toward immediate symptom relief; and an inability to handle personal feelings if treatment is withheld.[13]

One study looked at cases of inappropriate prescribing being investigated by the Oregon Board of Medical Examiners between 1981 and 1986. They found that 51% (154/300) of the complaints resulting in an investigation were due to inappropriate prescribing. Forty percent were originated by their investigative staff; 39% by other physicians, insurance companies and other regulatory agencies; and 5% were initiated by a family member.[13] However, it is the minority of physicians who account for most of the inappropriate prescribing. In a study by Maronde, 4% of a hospital's staff accounted for 50% of inappropriate prescriptions.[13,25]

Some of these problems do not have an easy answer. How do physicians adequately treat pain without freely prescribing medications to those who have a chief complaint of pain? The fact is that, very often, physicians under-treat acute or malignant pain and that there is a widespread tendency to prescribe subtherapeutic doses of non-optimal opioid analgesics.[10] Parran advises physicians to "relax and don't worry about prescription writing for legitimate prescriptions."[10] The majority of the patients will, in fact, use the medications as prescribed and will not have a drug abuse or misuse problem.[7]

However, there are a few things physicians can do to prevent falling in the prescription drug trap. First, educate the patient. Some patients may not be aware of the dangers of using the medication other than the way it was prescribed. If the patient insists on receiving a prescription, clearly explain why it is inappropriate. Then, give alternatives to treat their complaint, such as non-

Table 1. Steps to Identifying and Treating the Suspected Drug Seeker

STEPS TO IDENTIFYING AND TREATING THE SUSPECTED DRUG SEEKER	EXAMPLE
Is there misuse?	• Educate patient. • Simplify prescription regime. • Include family and caregivers in discussion.
Is there abuse?	• Identify the patients at risk (past substance or alcohol abuse, family history of substance or alcohol use). • Identify suspicious behaviors (see text). • State concern in direct, empathetic, and non-judgmental way: "I want to help you with your pain, but I am concerned about the pain medication you are using…" • Present specific behaviors that make you concerned: multiple refills, not following up with primary doctor, multiple ED visits for same problem, etc.
Give alternatives to treat their complaint	• Non-narcotic analgesics • Non-benzodiazepine anxiolytics • Trazodone (Desyrel) and nefazodone (Serzone) for insomnia • Syrups that do not contain ethanol • Non-pharmacologic techniques
Say "no" and mean it	
Refer for substance abuse help; intervene with the problem	• ED counseling • Primary doctor • Clinic • Rehabilitation center
Assess for withdrawal risk	• Different classes of medications cause a different withdrawal picture. Some general signs may include anxiety, irritability, sweating, or confusion.

narcotic analgesics for pain. Finally, for those obviously exhibiting abuse and drug-seeking behaviors, explain in an emphatic, direct, and non-judgmental way the concern that the medication may be causing problems to the patient, and that you want the patient to seek help.[2] It is important to say "no" to the patient, but this needs to be coupled with feedback and appropriate referral.[2] (*See Table 1.*)

Alternatives: What Can Be Done?

Improve your knowledge about pain management, chemical dependence, acute and chronic pain, anxiety and insomnia.[10] This is an essential first step. Changing the use of some readily abusable drugs to others less prone to abuse can be helpful in treating acute pain. When possible, use mixed agonists antagonists such as nalbuphine (Nubain) and butorphanol (Stadol, Stadol NS). These agents cause no euphoria and thus less addiction. Some of the negative aspects of these agents are that they are more costly, cause more dysphoria, and the incidence of withdrawal reactions is common.[26] An alternative to opiates is the short-term use of parenteral non-steroidal anti-inflammatory drugs (NSAIDs), such as ketorolac (Toradol).[26] For those who report multiple allergies, choose agents that don't release histamine, such as fentanyl (Duragesic, Actiq), hydrocodone (Lortab, Lorcet, Norco), and oxycodone (Roxicodone, OxyContin, Percolone, Percocet, Percodan). OxyContin, however, is associated with a high incidence of abuse due to its sustained release properties and the amount of drug contained per tablet. Most of the "allergies" reported by patients are not true allergies.[26] In the case of insomnia, trazodone (Desyrel) and nefazodone (Serzone), coupled with education about better sleeping habits, should be used instead of the benzodiazepines.[23]

Write tamper-resistant prescriptions to avoid forgery. Some of the most important aspects include prescribing the exact amount needed until the next scheduled appointment and writing out (spelling out) the number of pills ordered.[3] Additionally, prescription pads must not be left in places where they can be stolen.[2]

Although sometimes difficult to do in a busy ED, make attempts to improve communication with the patient's primary doctor, when possible. Often, they are not aware of the patient's frequent or multiple ED visits.[20]

Besides these individual efforts, many institutions have attempted to curtail inappropriate prescription writing. The efforts likely will decrease drug-seeking behaviors, although there are no data to support this statement.

Patient Alert Lists. Some hospitals have created lists of drug-seeking patients. They can be hospitalwide or community-wide.[6,16,20,27] Centralized, or communitywide efforts are best, since many patients visit multiple locations and multiple providers. In Zechnich's publication, the mean number of institutions visited by every patient was 4.1 out of the 7 hospitals surveyed.[5] The Calgary system is an example of the community-wide approach. It involves the four major hospitals in the city. A committee reviews the charts of all patients with 10 or more ED visits in a year who have a complaint of chronic pain. The committee, when appropriate, asks the patient to register in a chronic pain registry. This registry requires that the patient identify a primary physician and one ED that will provide all the necessary management. The primary physician is responsible for effective communication with the ED.[20]

Informal and Formal Chart Flagging. Some hospitals have established drug-seeking behavior committees that review charts of probable abusers. The committees look for evidence of document fraud, forgeries, non-compliance with appointments, substance abuse history, and personality disorders, and recommend flagging those charts of patients who have suspicious or proven drug seeking behaviors.[5,6,14] This system allows physicians to be more confident in refusing to prescribe medications. Drug-seeking status and recommendations are highlighted in the computer system. The system also can assign a sole physician as the one allowed to prescribe narcotic medications for that patient.[6]

Tutorials. Hospitals have developed programs for medical students and physicians that train them in identifying drug-seeking behaviors and give advice as to how to better deal with requests for prescriptions.[22]

Computerized Patient Care Plans. Each patient is assigned a care plan, which is highlighted in the computer system. This plan tells the physician which health care provider is the primary doctor and what medicines are included in the plan.[18]

The Tripler Army Medical Program, also called the sole provider program, is very comprehensive. It identifies drug seekers, assigns them a sole provider, offers rehabilitation, and regularly monitors prescriptions given to these patients.[12]

Legal Implications and Drug-Seeking Behavior

There are several international, national, and state laws that attempt to regulate prescription drugs and decrease drug diversion. International treaties have been enacted since 1912. They restrict the production, trade, and consumption of several drugs.[7]

HIPAA. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides federally protected privacy provisions for health information. Physicians, nurses, hospitals, nursing homes, pharmacies, and other health care providers are covered by this statute. HIPAA provides regulations over sharing of health information among physicians, health care agencies, and third-party payors. Patients have the right to know who their medical information will be shared with, and also can ask for a list of entities that their medical information has been shared with. HIPAA does allow for the sharing of medical information among physicians for treatment purposes. Several states also have implemented health information privacy statutes that exceed the statutes of HIPAA.[16] While keeping health information confidential remains a physician's duty, ethically and legally, there are precedents set in law where it is the physician's obligation to breach this confidentiality.[28] Most commonly, confidentiality may be broken when disclosure may prevent harm to the patient or others, and when disclosure is required by law.[28]

Drug Enforcement Agency (DEA). While the Food and Drug Administration (FDA) regulates safety of medications and drugs that are brought to the market, the agency has no authority over how these drugs are prescribed by physicians. Regulation of controlled substances and misuse in prescribing these substances is overseen by the DEA.[1] The DEA and the FDA have established drug schedules. (*See Table 2.*) All scheduled drugs require a DEA number for prescribing.[10]

The Federal Controlled Substances Act (CSA) provides criminal statutes for inappropriate use and prescribing of controlled substances. It also created a system for classifying prescription drugs according to their importance in medical use and their potential for abuse.[7] The DEA is the agency that ensures compliance with the CSA statutes. Among the statutes is a provision regarding prescribing controlled substances to addicts. It is not illegal to prescribe controlled substances to a

Table 2. Scheduled Drugs[10]

SCHEDULE I
- No accepted medical use
- Marijuana, LSD, heroin

SCHEDULE II
- High abuse potential with severe dependence liability
- Morphine, methadone (Dolophine, Methadose), oxycodone (OxyContin, Oxydose, OxyFast), amphetamines, secobarbital (Seconal)

SCHEDULE III
- Less abuse potential than Schedule I or II
- Acetaminophen/narcotic combinations (Lortab, Lorcet)

SCHEDULE IV
- Less abuse potential than Schedule III
- Phenobarbital, benzodiazepines (Xanax, Valium), propoxyphene (Darvon, Darvon-N), pentazocine (Talwin), phentermine (Adipex-P)

SCHEDULE V
- Least abuse potential
- Buprenorphine (Buprenex, Subutex), propylhexedrine

known addict for the purposes of controlling pain; it is, however, illegal to treat addiction with opioids for the purpose of detoxifying or maintaining an addict outside a licensed Narcotic Treatment Program. The exception to this is physicians who obtain a waiver under the recent Drug Addiction Treatment Act of 2000 (DATA 2000).[3,29] These physicians can then treat opiate addiction with schedule III, IV, and V opioid medications. To qualify for a waiver, the physician has to meet very strict requirements, including subspecialty training in addiction management. The physicians also must attest that they have the capacity to refer addiction treatment patients for appropriate counseling and other non-pharmacologic therapies. Every state also has its own form of a CSA, which can be more restrictive than the federal law.[7] The major differences between state CSAs involve differences in fines and jail time for specific violations. Allegations of over-prescribing controlled substances are the leading cause of physician investigation and actions taken against physicians, which, some argue, has led to the general widespread under-treatment of patients with acute and chronic pain.[7,10]

Some states go further and have set limits on a physician's ability to prescribe certain schedule II drugs. Alabama, Arizona, Florida, Michigan, New York, and Ohio are among the states that have statutes that strictly regulate prescribing amphetamines and sympathomimetic amines.[1] Many states have implemented triplicate prescriptions for schedule II narcotics.[1] The DEA and individual states have not implemented strict guidelines regarding Schedule III, IV, or V drugs, such as acetaminophen/narcotic combinations and benzodiazepines, which are commonly requested by and/or prescribed to drug-seeking patients in the ED.

Each state has specific laws for the implementation of sanctions and limitations of physician overprescribers. These sanctions can range from obtaining hours of continued medical education (CME) to the suspension of a state medical license. 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.[3]

EMTALA. The Emergency Medical Treatment and Labor Act (EMTALA) statute was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). The EMTALA statute provides that patients presenting to an ED for treatment must be provided with "an appropriate medical screening examination" to determine if they are suffering from an "emergency medical condition." If an emergency medical condition is found to exist, then the hospital is obligated to either provide the patient with treatment until he or she is stable or to transfer the patient to another hospital in conformance with the statute's directives. If no emergency medical condition exists, the statute imposes no further obligation on the hospital. It is essential to remember that any flagging system or habitual patient files must not interfere with the patient's ability to access emergency care.[16]

EMTALA defines an emergency medical condition as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." There is no provision in EMTALA that requires treatment with opioids; it is left to the health care professional to determine how to best treat the patient.[16]

JCAHO. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has recognized pain as a public health problem. JCAHO has developed standards and expectations of hospitals, including EDs, for managing pain in accredited hospitals. JCAHO also has established that appropriate assessment and management of pain is a patient right.[16,30]

Other Regulations and Monitoring Systems. The DEA has a monitoring system, the Automated Reports and Consolidated Orders System (ARCOS), which tracks all Schedule II and III drugs from the point of manufacture to the point of sale. This system tries to decrease drug diversion.[4,7] Medicaid has a similar system, called the Medicaid Abuse Drug Audit System (MADAS). In New York, MADAS identified 800 patients who are potential doctor shoppers every month, and assigns them one practitioner and one pharmacy.[7] Private insurance companies have drug utilization reviews (DUR), which try to determine whether drugs are being prescribed appropriately and cost-effectively.[7]

Habitual Patient Files. There is no clear legal position or precedent regarding frequent-flyer files in the ED to discourage and/or prevent patient drug-seeking behavior. As of June 2003, there had been no reported legal cases involving the use of these files in the ED.[16] Regulatory agencies and governing legislation appear to be conflicting, as outlined above. Creating patient files and maintaining them in the ED may violate HIPAA provisions for sharing patient information, but it can be argued that if these patient files are used for treatment purposes, they may be not be covered by HIPAA.[27,28] No statute or regulatory agency dictates which medications a physician should use to treat a patient, and there are no requirements for giving patients prescriptions. The only requirements are that a patient's pain be addressed and treated, but treatment options are up to the clinician, and non-narcotic agents can be used. Informal patient files, however, should be avoided. A well developed plan for the establishment of a habitual patient file should be in place if one is to be used. A multidisciplinary team should be assembled to establish criteria for the following:

- Who will be able to access the information;
- Criteria for placing patient information in the file;
- Data to be entered into the file;
- How the data will be safeguarded against inappropriate access; and
- Recommended treatment plan for patients presenting with pain complaints.

It can be argued that the use of a formal system may be used to establish a hospital's commitment to treating patient's pain per JCAHO requirements if implemented effectively.[16] Because

different states also have passed laws regarding patient confidentiality, a health care attorney should review the plan for a habitual patient file to ensure compliance with all federal, state, and local laws.[16] Individual hospitals and physician groups have implemented various types of habitual patient files in their EDs in the United States. The authors have been unable to locate any studies that show the effectiveness in using this type of patient file, and have not been able to identify how prevalent this practice is. A citywide approach, as in Calgary, appears to be a better strategy over instituting individual plans because it also will take doctor shopping or ED shopping into account. However, this approach may be difficult, at best, to institute in the United States because hospitals are not willing to share patient information readily in the face of HIPAA and EMTALA regulations. To date, no follow-up studies have been reported to support this approach.[20]

Ethics and Drug-Seeking Behaviors

Confidentiality makes the physician responsible for protecting the information entrusted by a patient.[28] However, as discussed previously, confidentiality is not absolute, and there are instances in which it can be breached. One of these instances is when drug-seeking behavior is obvious, since danger to the patient and others may ensue.

With regard to pain management, some ethical concepts must be considered. The term beneficence urges physicians to treat every patient appropriately. When in doubt about the reality of the pain, it is always better to administer analgesia to a patient who may not need it than to withhold or delay a treatment for one who really needs treatment.[16] EDs remain some of the few places where basic human needs are addressed, and some patients come to the EDs to get some temporary shelter and to get some sense of society. Some patients will have a vague complaint only because society forces them to have one to enter the ED.[15,16] Non-maleficence refers to making sure that harm does not come due to under-treatment or inappropriate labeling as a drug seeker and protects patients from the consequences of abusing or becoming addicted to drugs.

Veracity refers to the fact that the patient should tell the physician the truth about the reason for visit, but the physician also should tell the truth about the reason for denying prescription and the intention to enter drug-seeking behavior status into the file.[16] Finally, with professionalism, physicians must remember that these patients should be treated with dignity at all times, despite their complaints, habits, demeanor, or hygiene.[16]

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Physician CME Questions

1. The definition of a drug seeker is:
   A. a patient who requests a prescription for back pain when his primary care physician is not available.
   B. a patient who requests a prescription for treatment of a toothache.
   C. a patient who requests the prescription for treatment of chest pain.
   D. a patient who requests a prescription for resale, personal use, and/or family use.

2. Which of the following methods may drug seekers use to obtain a prescription medication?
   A. Pharmacy theft
   B. Prescription forgery
   C. Street sales
   D. Internet sites
   E. All of the above

3. The Health Insurance Commission defines a doctor shopper as someone who has seen:
   A. more than 5 different general practitioners (GP) in one year.
   B. more than 10 different general practitioners (GP) in one year.
   C. more than 15 different general practitioners (GP) in one year.
   D. more than 20 different general practitioners (GP) in one year.
   E. more than 25 different general practitioners (GP) in one year.

4. The most common abused prescription drugs include which of the following?
   A. Sedatives
   B. Tranquilizers
   C. Analgesics (opiates)
   D. Stimulants
   E. All of the above

5. Which of the following statements is true?
   A. Illicit drugs are more desirable than prescription drugs.
   B. Possession of prescription drugs is illegal.
   C. Prescription drugs may have a higher street value than illicit drugs.
   D. The quality, dosage, and effect of illicit drugs usually are better than for prescription drugs.

6. Physicians may encounter which of the following behaviors when a drug seeker requests a prescription?
   A. Confrontation
   B. Threats
   C. Self-inflicting injury or not caring for wounds
   D. All of the above

7. Which of the following may be characteristics of an overprescribing physician?
   A. Outdated knowledge of drugs
   B. Trusting a deceptive patient
   C. Dishonest physicians who will prescribe for profit
   D. A physician who has a psychiatric or substance abuse problem
   E. All of the above

8. Which of the following strategies may help with the drug-seeking patient?
   A. Do not treat pain for any patient.
   B. Prescribe anything the patient asks so that you can see more patients per hour.
   C. Prescribe the exact amount needed until the next visit to the primary physician.

D. Never contact the patient's primary physician.
E. Always prescribe opioids for the treatment of pain.

9. Which of the following statements is true regarding DEA statutes?
   A. It is not illegal to prescribe controlled substances to a known addict for the purpose of controlling pain.
   B. It is illegal to prescribe controlled substances to a known addict for the purpose of controlling pain.
   C. It is not illegal to treat addiction with opioids for the purpose of detoxifying.
   D. It is not illegal to prescribe medications for the intent of selling.

10. Patient confidentiality is absolute and never can be breached.
   A. True
   B. False

In Future Issues: **Sinusitis**

CME Answer Key

1. D	6. D
2. E	7. E
3. C	8. C
4. E	9. A
5. C	10. B

Emergency Medicine Reports CME Objectives

To help physicians:

- quickly recognize or increase index of suspicion for specific conditions;
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- apply state-of-the-art diagnostic and therapeutic techniques (including the implications of pharmaceutical therapy discussed) to patients with the particular medical problems discussed;
- understand the differential diagnosis of the entity discussed;
- understand both likely and rare complications that may occur.

CME Instructions

Physicians participate in this continuing medical education program by reading the article, using the provided references for further research, and studying the questions at the end of the article. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to evaluate their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. *After completing this activity, you must complete the evaluation form that will be provided at the end of the semester and return it in the reply envelope provided to receive a certificate of completion.* When your evaluation is received, a certificate will be mailed to you.

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Drug-Seeking Patients in the ED

Steps to Identifying and Treating the Suspected Drug Seeker

STEPS TO IDENTIFYING AND TREATING THE SUSPECTED DRUG SEEKER	EXAMPLE
Is there misuse?	• Educate patient. • Simplify prescription regime. • Include family and caregivers in discussion.
Is there abuse?	• Identify the patients at risk (past substance or alcohol abuse, family history of substance or alcohol use). • Identify suspicious behaviors (see text). • State concern in direct, empathetic, and non-judgmental way: "I want to help you with your pain, but I am concerned about the pain medication you are using…" • Present specific behaviors that make you concerned: multiple refills, not following up with primary doctor, multiple ED visits for same problem, etc.
Give alternatives to treat their complaint	• Non-narcotic analgesics • Non-benzodiazepine anxiolytics • Trazodone (Desyrel) and nefazodone (Serzone) for insomnia • Syrups that do not contain ethanol • Non-pharmacologic techniques
Say "no" and mean it	
Refer for substance abuse help; intervene with the problem	• ED counseling • Primary doctor • Clinic • Rehabilitation center
Assess for withdrawal risk	• Different classes of medications cause a different withdrawal picture. Some general signs may include anxiety, irritability, sweating, or confusion.

Scheduled Drugs

SCHEDULE I
- No accepted medical use
- Marijuana, LSD, heroin

SCHEDULE II
- High abuse potential with severe dependence liability
- Morphine, methadone (Dolophine, Methadose), oxycodone (OxyContin, Oxydose, OxyFast), amphetamines, secobarbital (Seconal)

SCHEDULE III
- Less abuse potential than Schedule I or II
- Acetaminophen/narcotic combinations (Lortab, Lorcet)

SCHEDULE IV
- Less abuse potential than Schedule III
- Phenobarbital, benzodiazepines (Xanax, Valium), propoxyphene (Darvon, Darvon-N), pentazocine (Talwin), phentermine (Adipex-P)

SCHEDULE V
- Least abuse potential
- Buprenorphine (Buprenex, Subutex), propylhexedrine

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Authors: **Larissa I. Velez, MD,** Assistant Professor, Assistant Director of Emergency Medicine Residency Program, University of Texas Southwestern Medical Center, Dallas; **Wilfredo Rivera, MD**, Assistant Professor, Emergency Medicine, University of Texas Southwestern Medical Center, Dallas; Associate Medical Director, North Texas Poison Center; **John Marcucci, MD**, Clinical Instructor, Emergency Medicine, University of Texas Southwestern Medical Center, Dallas; Medical Director, Emergency Department, Baylor Regional Medical Center, Plano, TX; and **Fernando Benitez, MD**, Assistant Professor, Emergency Medicine, University of Texas Southwestern Medical Center, Dallas.