

Diagnosing Addiction and Drug-seeking Behavior in Chronic Pain Patients

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EDUCATIONAL OBJECTIVES

The aim of this course is to help the pain clinician distinguish between legitimate patients with chronic pain and individuals engaged in non-therapeutic drug seeking behavior. Drugs sought by addicted patients and criminal drug seekers will be listed, along with current information on the illicit market for opioid analgesics and other controlled substances. The characteristics of addicted patients and criminal drug seekers will be discussed, along with typical feigned illnesses and scams. Drug seeking behaviors that are more suspicious of addiction or criminal intent will be contrasted with those that merit less suspicion. A system to help the clinician distinguish between legitimate patients and drug seekers will be presented. Finally, this course will present methods to prevent itinerant drug seekers from scamming the pain clinician.

CASE PRESENTATION

J.D. is a 28 year old financial employee with chronic low back pain. A CT scan showed a moderate-sized left posterolateral disc herniation at L5-S1 and a bulge to the left at L4-5, but no neurological symptoms or signs at the time. Following an attempted laparoscopic discectomy plus fusion at L4-5 and L5-S1, he underwent an open posterior decompression and fusion from L4 to S1, which did not relieve his pain. The patient's pain is treated with controlled release morphine 480 mg per day, a bulk forming laxative, and nabumetone, COX-2 inhibitor. On this regime, he is able to work full time as a bank employee. He has a supportive spouse, and has one child.

One day, while distracted, the patient accidentally swallowed the contents of a pharmacy stock bottle containing 42 tablets (1280 mg) of controlled-release morphine. He was transported to the nearest hospital, where he was treated with activated charcoal. A drug screen was positive for morphine but no other drugs. When the emergency physician who took the history saw the stock bottle, he accused the patient of being a drug seeker, and contacted the police. Although charges were not laid, the attending pain clinician was now concerned that he was being duped by the patient.

INTRODUCTION

Physicians have increasingly recognized the value of opioid analgesics in relieving chronic pain. Unfortunately, opioid analgesics may also be diverted by drug seekers from legitimate sources. Drug seekers are individuals who knowingly break the law by seeking and obtaining controlled drugs in order to sell them on the street. They do this by feigning illnesses, seeking controlled substances from multiple prescribers and by forging prescriptions. Some drug seeking individuals meet the criteria for chemical dependency. Others seek to profit from drug seeking by obtaining prescription drugs that they in turn sell to drug dealers. As shown in the above case, drug seekers may be difficult to distinguish from bona fide chronic pain sufferers.

THE ILLICIT MARKET FOR OPIOID ANALGESICS

The scale of prescription drug diversion is unknown. There are few sources of reliable information on criminal drug seeking behavior, such as controlled trials. Most of the existing knowledge on drug seeking comes from anecdotal clinical as well as law enforcement reports (Cooper et al. 1992). A new system of drug surveillance is emerging that may increasingly provide useful data. Known as Electronic Data Transfer (EDT), the system requires that dispensing information on a target set of controlled and (in some cases) non-controlled substances be entered at point of sale and uploaded to a centralized database which is at the disposal of the State Board of Medical Examiners as well as law enforcement authorities (Dodd 1993).

One advantage of such a system is that it's invisible to the prescriber and to the patient. Another is that computerized record-keeping greatly speeds up the generation of reports. Data on drug use and diversion have yet to be published from states with EDT systems. However, there are concerns that such a system might result in a decline in the prescribing of controlled substances tracked on EDT systems, with a corresponding increase in the prescribing of drugs not on EDT.

In general, drug seekers prefer illicit drugs such as heroin and cocaine over prescription pharmaceuticals.

Nevertheless, prescription drugs have several theoretical advantages over illicit drugs. First, they have guaranteed safety and strength. Second, unless injected, oral and transdermal opioid analgesics can be used without risk of Human Immunovirus infection (HIV). Third, the cost of licitly-obtained pharmaceuticals is less than the cost on the street; moreover, such drugs may be paid for by third-party insurers or welfare-entitlement programs. Fourth, prescription pharmaceuticals are obtained in the safety of the physician's office, as opposed to drug dealers and undercover police officers on the street (Goldman 1993). Prescription drugs obtained from licit sources may be used by the drug seeker, or may be bartered to obtain an illicit drug of choice.

Controlled drugs such as opioid analgesics can be diverted anywhere along the supply and distribution chain. According to a report by the Virginia State Police, the number one source of diversion is prescription forgery, followed by telephone fraud, internal theft, drug seeking from doctors and dentists, indiscriminate prescribing, and external theft (Personal communication 1994)(Table 1).

Table 1. Sources of prescription drug diversion.

1.	Prescription forgery
2.	Telephone fraud
3.	Internal theft
4.	Multiple doctoring
5.	Indiscriminate prescribing
6.	External theft

Source: Unpublished survey by the Virginia State Police, 1994.

PREFERRED DRUGS

Pain clinicians who prescribe chronic opioid therapy should be aware that there is an illicit market for opioid analgesics. According to a published survey, a wide variety of opioid analgesics have an established street value. These include acetaminophen with codeine 15mg, acetaminophen with codeine 30, anileridine, combination products containing oxycodone, meperidine, hydromorphone, combination products containing a mixture of ASA, caffeine, butalbital, and codeine, as well as controlled release morphine products (Sajan et al. 1998) (Table 2). As shown by the survey data, opioids with a higher abuse potential tend to have higher street values than those with a lower abuse potential. Thus, products containing hydromorphone are sold on the street for higher amounts than products containing codeine.

The high street value for controlled-release morphine was somewhat surprising. At least one previous report suggested that drug abusing patients were less

Table 2. Street value of selected prescription opioid analgesics in Vancouver's Downtown Eastside.

Drug	Street name	Pharmacy cost per tablet (\$)*	Street price per tablet (\$)*	
			Min	Max
Acetaminophen + 30 mg codeine	T3	0.03	.50	1.50
Anileridine	Leritines	0.35	2.00	5.00
Oxycodone +acetaminophen	Percs	0.11	3.00	6.00
Oxycodone +ASA	Percs	0.13	3.00	6.00
Meperidine	Demerol	0.11	2.50	6.00
Hydro-morphone 2mg	Red dids	0.22	5.00	20.00
Hydro-morphone 4mg	Yellow dids	0.32	12.00	32.00
MSContin 15mg	Green peelers	0.64	15.00	30.00
MSContin 30mg	Purple peelers	0.96	20.00	40.00
MSContin 60mg	Orange peelers	1.70	25.00	50.00
MSContin 100mg	Grey peelers	2.59	35.00	60.00
MSContin 200mg	Red peelers	4.90	45.00	75.00

* Prices expressed in Canadian dollars (\$1 Can approximately equals 0.65 \$ U.S.) Adapted from: Sajan A, Corneil T, Grzybowski S. The street value of prescription drugs. CMAJ 1998; 159: 139-142.

likely to abuse controlled-release opioid analgesics (Brookoff 1993). However, the previous report did not specify the preferred method of self-administration. While controlled-release drugs may not be preferred by drug abusers for oral administration, recent reports have suggested that controlled-release tablets are prepared for intravenous administration using crude street methods (Montauk and Martin 1997; Welch 1997; Goldman 1998). Such methods carry a risk of local tissue necrosis and pulmonary granulomas (Goldman 1998).

Other opioids that have reportedly been diverted include intranasal butorphanol as well as opioid antitussive syrups. A street value for transdermal fentanyl patches has not been reported. Nevertheless, such drugs likely have a high street value. A pharmacokinetic analysis indicated that 28-84.4% of the original contents

of the patch may remain inside used patches following 3 days of continuous use; this represents a potentially lethal dose of fentanyl (Marquardt et al. 1995).

Non-opioid drugs also have a street value. The following benzodiazepines and other sedatives have a street value, in descending order of street price: alprazolam, oxazepam, lorazepam, imovane, clonazepam, triazolam and diazepam (Sajan 1998). Flunitrazepam has also reportedly been diverted (Personal communication 1997). Clonazepam is commonly-prescribed to patients with chronic pain.

Other prescription drugs that are diverted include barbiturates, stimulants, and anabolic steroids. In addition, there is also a street market for expensive non-controlled prescriptions drugs that are paid for by third party coverage. These include antiretroviral therapy for HIV.

CHARACTERISTICS OF DRUG SEEKERS

There are three categories of drug seekers. The largest category consists of individuals suffering from chemical dependency. Definitions of addiction and dependence are described elsewhere. Chemically dependent drug seekers sometimes use techniques that are similar to those of criminal drug seekers. These include feigning illnesses and forging prescriptions. However, their primary motivation is to seek drugs for their own use, not to sell them to others. On occasion, chemically dependent drug seekers may seek drugs to barter for their drug of choice.

Most chemically dependent drug seekers do not present with a stereotypic appearance. They tend to be middle aged, and tend to come from middle class backgrounds. They may present to unfamiliar physicians with acute recurrent pain such as migraine headaches or back pain. More often, the patient is well-known to the physician. There is no chronic pain condition per se that is highly likely to lead to addiction. However, many such patients tend to suffer from recurrent headaches, craniofacial pains, atypical chronic pain syndromes and fibromyalgia.

Although the diagnosis may be difficult, there are several useful indicators of chemical dependency. These include compulsive use, loss of control over use, and use despite consequences. Uncontrolled use may be evidenced by signs and symptoms of intoxication, such as lethargy, slurred speech, poor concentration, and staggering gait. Signs and symptoms of withdrawal, such as chills, lacrimation, salivation, rhinorrhea, diaphoresis, nausea, gooseflesh, abdominal cramps, and diarrhea must be interpreted with caution. Acute withdrawal and other manifestations of physical dependency are not diagnostic of addiction. Chemically dependent patients in acute withdrawal tend to be more likely than legitimate patients to become extremely agitated, tearful, and violent if they cannot obtain their drug of choice or a

substitute. Chronic pain patients tolerate acute withdrawal syndrome well, and sometimes test their ability to withstand it.

The second category is the criminal drug seeker. Unlike those with chemical dependency, they primarily seek drugs to sell on the street. They tend to use the drugs they obtain for recreational purposes only. They are well-versed in street terminology. They often visit several prescribers per day, and travel from town to town, posing as unfamiliar patients. Unlike chemically dependent individuals, those engaged in covert criminal activity have a stereotypical appearance. They range in age from twenty to forty, and dress scrupulously to avoid the stereotypical skid row appearance. They tend to seek out chemically dependent physicians and those who have a reputation for prescribing opioid analgesics without taking a detailed history. They often test new graduates.

Chemically dependent drug seekers tend to seek out physicians for long term prescribing. By contrast, criminal drug seekers tend to shift from physician to physician, often posing as a patient from out of town. The disorder feigned by the criminal drug seeker depends on the drug desired. For example, the drug seeker in search of an opioid antitussive may pretend to have a chronic cough.

Criminal drug seekers attempting to obtain drugs from pain clinicians tend to feign conditions such as chronic low back pain, fibromyalgia, recurrent headaches and temporomandibular joint disorders. A surgical scar may be used to bolster the credibility of the complaint. Sometimes, the wounds are self-inflicted. Sometimes, they present with a well-developed story, backed by documentation such as corroborating health records that have been pilfered by an accomplice from another patient. Or, they may present with corroborating letters from so-called consultants who are in fact their accomplices.

Criminal drug seekers may augment their medical knowledge by reading medical reference books. They learn which drugs may be prescribed as alternatives to opioid analgesics. That way, they can incorporate contraindications to the drugs they don't want. Thus, drug seekers frequently claim to be 'allergic' to NSAIDs, codeine, or local anesthetics.

Criminal drug seekers often employ psychological pressure tactics. They may often look and act like important individuals. They may create a false sense of urgency by pretending to have a severe symptom that cannot wait. To discourage close questioning, they often present a ready-made diagnosis. In fact, drug seekers become angry when the prudent physician tries to take a detailed history. They may take umbrage with any attempt to verify their story by contacting corroborating sources.

The criminal drug seeker may initially succeed in obtaining a prescription from a pain clinician. The clini-

cian may attempt to give the drug seeker the benefit of the doubt while carrying out investigations or seeking corroborating information. At this point, it is not uncommon for the criminal drug seeker to fail to show up for scheduled investigations.

In addition, those engaged in criminal activity may use elaborate ruses or scams.

1. 'The Phony Bank Inspector:' a confederate who plays a law enforcement officer telephones the physician's office claiming a known drug seeker is about to visit. The 'officer' urges the physician to play along the scam and write a prescription, promising to apprehend the drug seeker after he or she leaves the office. The arrest never takes place.
2. 'Inside job:' one of the physician's employees acts as a confederate for the criminal drug seeker, providing blank prescriptions, samples, and patient records. The employee may also intercept telephone calls from pharmacists wishing to verify suspicious prescriptions.
3. 'Telephone scams:' typically the criminal drug seeker claims to be a patient of one of the other physicians in the on-call group, and asks for a prescription for an analgesic to last until they can see their regular physician. Sometimes, the drug seeker uses a telephone to impersonate a practicing physician. There are also reports of drug seekers tapping into telephone lines outside the physician's office in order to impersonate them when the pharmacist calls to verify a script.

A third kind of drug seeker is known as a 'professional patient.' This individual possesses an obvious physical deformity that can be used to justify a request for an opioid analgesic. Examples include paraplegics, amputees, and individuals with numerous surgical scars. Professional patients do not obtain drugs to sell on the street. They are 'hired' by drug dealers, and are paid a flat fee for each prescription they obtain.

PRESCRIPTION FORGERY

Prescription forgery is a common activity among drug seekers of all kinds. Entrepreneurial drug seekers often modify a legitimate prescription to increase the dosage or quantity of a controlled substance. The easiest method is to increase the number of tablets. For example, the number '10' can easily be altered to '100' or '40.' Prescriptions in which the dispensing number has been written in longhand can also be altered, albeit not as easily as those written in Arabic or Roman numerals. Another way of modifying a prescription is to add a controlled drug at the bottom of a bona fide prescription, a practice permitted for unscheduled drugs with the po-

tential for diversion, such as intranasal butorphanol. For example, the drug seeker diagnosed with a sinus infection who receives a prescription for an antibiotic might add an opioid analgesic underneath it.

Using a photocopier, it is possible to reproduce prescriptions or to forge new ones by blanking out parts of the script. Some drug seekers steal prescription pads from the prescriber's office. Using desktop publishing and an optical scanner, it is possible to create impressive-looking forgeries from scratch, including the prescriber's signature.

HOW LEGITIMATE PATIENTS DIFFER FROM DRUG SEEKERS

The vast majority of people whom pain clinicians are likely to encounter are legitimate patients. It is relatively easy to distinguish the criminal drug seeker from the legitimate patient. Legitimate patients lack many if not all of the features suspicious of drug seeking behavior. They tend to be well known to the physician. If unfamiliar to the doctor, they cooperate with attempts to verify their history. They don't become defensive when questioned about their symptoms. They don't possess a hidden agenda. They don't act as if they're in a hurry.

It is more difficult for the pain clinician to detect the established patient who is chemically dependent. In general, long term opioid patients at risk of addiction are preoccupied with both the use of and the seeking of opioids. They are unwilling to try to taper opioids when other treatments are offered. They report no relief with any modalities other than opioids. They exhibit a strong preference for short-acting or injectible opioids. They tend to reject controlled release preparations out of hand or claim that they are ineffective. They frequently obtain drugs in non-emergency situations from multiple source. They are non-compliant with treatment recommendations (Sees and Clark 1993; Savage 1996).

The patient with chemical dependency loses control over drug taking. The patient cannot take medications as prescribed, and repeatedly reports lost or stolen medications. Thus, the dependent patient frequently requests early renewals of prescriptions. In addition, the dependent patient insists on using opioid analgesics despite adverse consequences such as decreased function, intoxication, as well as social, emotional, and economic upheaval.

By contrast, non-dependent patients use opioid analgesics as instructed by their physician. They don't enter the therapeutic alliance with a strong preference for short-acting opioid analgesics. When used appropriately, the opioid analgesics clearly result in improved function. Such patients are generally far more reluctant to continue the use of opioid analgesics in the face of serious consequences. For example, they are reluctant to increase or even to maintain the opioid dosage in the presence of significant adverse effects.

Some drug-related behaviors are less indicative of addiction. Aggressive complaining about the need for more drug may indicate inadequate pain management. A request for a specific drug may reflect the patient's wealth of experience of which drugs work and which do not. Drug hoarding may be an appropriate strategy for a chronic pain patient who is consistently undermedicated. Occasional dose escalations may reflect the patient's experience with the waxing and waning of the pain condition (Portenoy 1994) (Table 3).

Other behaviors are more aberrant and thus more predictive of addiction. They include prescription forgery, the selling of prescription drugs, stealing or borrowing drugs from others, injecting oral formulations, obtaining drugs from non-medical sources, as well as the concurrent use of illicit drugs. Multiple episodes of non-compliance despite warnings should raise alarm bells, as well as multiple episodes of prescription loss (Portenoy 1994) (see Table 3).

STOPPING THE DRUG SEEKER: THE NEED FOR A BALANCED APPROACH

In dealing with the problem of prescription drug abuse and diversion, one approach is to make it more difficult to obtain opioid analgesics. This approach is generally undesirable, since it tends to compromise the ability of legitimate patients to obtain drugs when programs have been shown to result in a decrease in appropriate prescribing to bona fide patients (Portenoy 1991; Zulich 1992). There is also evidence that increased controls over opioid analgesics can result in the prescribing and the consumption of less desirable agents such as nonsteroidal anti-inflammatory drugs (Goldman 1998).

Thus, an approach is required which balances society's desire to reduce the risk of drug abuse with the individual's desire for pain management. It is possible to continue prescribing opioid analgesics to appropriate patients while maintaining vigilance against the risk of abuse and against criminal drug seekers. There is some evidence that this approach is effective. Zenz has demonstrated that European nations with more liberal drug legislation do not have a greater problem with diversion than those nations with more stringent laws (Zenz 1994).

With a balanced approach, it is inevitable that some drug seekers will succeed in obtaining drugs. Thus, it is reassuring that the American Society of Addiction Medicine has included the following in a recent public policy statement (American Society of Addiction Medicine 1997): "Physicians who are practicing medicine in good faith and who use reasonable medical judgement regarding the prescription of opioids for the treatment of pain shall not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for non-medical purposes."

Table 3. Representative aberrant drug-related behaviors

Probably more predictive of addiction

- Selling prescription drugs
- Prescription forgery
- Stealing or 'borrowing' drugs from others
- Injecting oral formulations
- Obtaining prescription drugs from nonmedical sources
- Concurrent abuse of alcohol or illicit drugs
- Multiple dose escalations or other noncompliance with therapy despite warnings
- Multiple episodes of prescription 'loss'
- Repeatedly seeking prescriptions from other clinicians or from emergency rooms without informing prescriber or after warnings to desist
- Evidence of deterioration in the ability to function at work, in the family or socially that appears to be related to drug use
- Repeated resistance to changes in therapy despite clear evidence of adverse physical or psychological effects of the drug

Probably less predictive of addiction

- Aggressive complaining about the need for more drug
- Drug hoarding during periods of reduced symptoms
- Requesting specific drugs
- Openly acquiring similar drugs from other medical sources
- Unsanctioned dose escalation or other noncompliance with therapy on one or two occasions
- Unapproved use of the drug to treat another symptom
- Reporting psychic effects not intended by the clinician
- Resistance to a change in therapy associated with 'tolerable' adverse effects with expressions of anxiety related to the return of severe symptoms

DETECTING THE CRIMINAL DRUG SEEKER: UNFAMILIAR 'PATIENTS'

The majority of criminal drug seekers present as unfamiliar patients seeking treatment for the first time. The following strategies will help the pain clinician distinguish the drug seeker from the legitimate patient without compromising patient care (Table 4):

Table 4. Detecting the criminal drug seeker.

1. Identify the patient
 2. Verify the presenting complaint and observe for drug seeking behavior
 3. Talk to the patient's regular practitioner
 4. Use safe prescribing guidelines: consider not prescribing opioid analgesics on the first visit
 5. Prevent prescription forgery
 6. Use 'partial fill' prescriptions
 7. Develop strategies to deal with telephone scams
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1. Accept patients by referral only. A criminal drug seeker must gain access to the physician in order to

make a pitch for opioid analgesics. The only way to make that pitch is by obtaining an appointment. Thus, a sensible way of preventing drug seekers from gaining access to the pain clinician is to make appointments by referral only. Physicians should bear in mind that some drug seekers use bogus referring letters and employ confederates to pose as referring physicians. In some cases, it may be necessary to independently verify the referral.

2. Identify the patient. Since many drug seekers present as unfamiliar patients, ask all new patients ask for several pieces of identification, such as a driver's license and Social Security Number. Criminal drug seekers are often reluctant to present corroborating identification, since they are trying to avoid being identified as part of a criminal investigation. In addition, many drug seekers use aliases and thus lack corroborating identification.
3. Verify the presenting complaint and observe for drug seeking behavior. Since drug seekers like to present a well-developed story that seems to justify a prescription for an opioid analgesic, it's useful to take control of the encounter. Take an independent history, and observe closely for evasiveness. If inconsistencies are detected in the history, ask about them. In addition, know the features that suggest drug-seeking behavior (Tables 5 and 6). No matter how late in the day a suspected drug seeker appears, a detailed physical examination is essential, although not always helpful. Note that personal hygiene and dress are not useful in distinguishing drug seekers from legitimate patients.

Obtain corroborating tests such as xrays if indicated. Make certain that abnormalities in diagnostic imaging being passed off as new (such as bulging discs seen on magnetic resonance imaging) are clinically significant. Be suspicious of patients who refuse appropriate confirmatory tests.

4. Talk to the patient's regular physician. Ask the patient to provide the name and address. Once obtained, verify that the practitioner exists, that the physician's bonafide address matches the one provided by the patient, and that the physician is treating the patient. If a patient furnishes a consultant's letter, verify its authenticity in the same way.
5. Use safe prescribing strategies. It is useful to bear in mind that there is no legal obligation to prescribe opioid analgesics on demand. Thus, a reasonable precaution with unfamiliar patients is to establish a policy of not prescribing opioid analgesics pending a complete assessment including corroboration of the patient's history.

Table 5. Diseases feigned by criminal drug seekers

Drug Sought	Diseases
opioid analgesics	migraine headaches back pain dental pain fibromyalgia renal colic craniofacial pain trigeminal neuralgia
opioid anti-tussives	bronchitis chronic cough

Table 6. Behaviors possibly suspicious of criminal drug seeking.

Refuses or is reluctant to present identification
Out of town patient
Cash-paying patients
Telephone (on-call) requests for narcotics
Allergy to codeine, NSAIDs, or local anesthetics
Appears to be in a hurry
Presents at times when the regular physician cannot be reached (evenings, night, and weekends)
Does not show up for follow up appointments, investigations, or consultations
Well versed in clinical terminology
Maintains constant eye contact with the physician

If prescribing an opioid analgesic on the first visit, it may be prudent to limit the duration to more than 3-5 days. Another strategy is to dispense several tablets instead of writing a prescription. Note that this strategy is not appropriate for pain clinicians in solo practice; it is only appropriate for clinics that are staffed 24 hours a day, with security staff on the premises.

6. Prevent prescription forgery and telephone scams. Prescriptions should be written so as to make them difficult to alter. Do not leave blank spaces in the prescription; instead, fill the unused portion of the script with a pen stroke. To prevent a forger from altering the strength of the dosage, do not leave a space between the number and dosage unit. To prevent any alteration in the number of dosage units, write the number of dispensed dosages in longhand, followed by the corresponding Arabic numeral written in parentheses. For further protection, write the word 'only' immediately following the Arabic numeral, without leaving a space. For example, to request that 8 tablets be dispensed, write the following: mitte:#eight(8only)

7. Use 'partial fill' prescriptions. With a partial fill, the prescriber instructs the pharmacist to dispense a fixed number of tablets per day. Travelling con artists will invariably ask the pharmacist to fill the entire prescription at one time, thus raising suspicions.
8. Develop specific strategies to deal with telephone scams. Do not telephone prescriptions for unfamiliar patients. Instead, insist that the patient come to the office for an assessment. As a precaution, do not arrange to see unfamiliar patients alone. Make certain that support staff or security are available if needed. When this isn't possible, refer the patient to the nearest emergency department. In addition, do not permit office staff to authorize renewals of controlled drug prescriptions.

DETECTING THE CHEMICALLY DEPENDENT DRUG SEEKER

The detection and management of chemically dependent patients are discussed elsewhere. However, several the steps should be considered whenever suspicions are raised. Suspicions may be raised by reports from pharmacists, members of the patient's family, consulting physicians, and others, as well as patient behaviors as shown in Table III. Pain clinicians should be aware that investigations by regulatory authorities often begin with an accusation by a colleague or by a patient or family member that the physician is prescribing addicting substances. The following steps should help allay patient concerns while protecting the pain clinician from regulatory sanctions:

1. Obtain collateral information. It is useful to reassess the patient, and interview the patient's partner if necessary.
2. Review the patient agreement. If the patient has signed a patient agreement, it is useful to review and invoke relevant sanctions.
3. Reduce the prescription interval. If the patient receives prescriptions every month, consider changing the prescription interval to once weekly in order to closely monitor the patient.
4. Obtain random body fluid testing for alcohol and other drugs.
5. Consider referring the patient to a specialist in addiction medicine.
6. Document the actions taken. The risk of regulatory sanctions for prescribing opioid analgesics inappropriately is highest where concerns of addiction

are raised. Thorough documentation of all steps taken demonstrates compliance with local regulations and guidelines.

CONTACTING AUTHORITIES

There is no positive duty to contact the police regarding a suspected criminal drug seeker. However, the more certain the diagnosis, the more advisable it is to do so. In many jurisdictions, it is unlawful to knowingly prescribe controlled drugs for anything other than a 'legitimate medical purpose.'

It is also helpful to contact pharmacies and other physicians. However, there is a theoretical risk of being cited for violating patient confidentiality. Physicians should contact their local regulatory authorities for more information.

A minority of drug seekers, particularly those who are chemically dependent, may resort to verbal abuse or acts of violence. Contact the authorities if threatened in any way. If necessary, have a prearranged signal with the secretary for doing so.

CASE RESOLUTION

Upon discharge from hospital, the pain clinician scheduled an urgent appointment with the patient. Meanwhile, corroborating information was obtained. The dispensing pharmacist confirmed that the patient had received controlled release morphine in stock bottles. After discussion, the pharmacist agreed to dispense the medication in an appropriately labeled dispensing bottle in the future. The patient was closely questioned about the incident, and admonished not to take medications while distracted. The patient's drug taking history was reviewed. Since the patient had had 1 prior episode in which an early renewal of the prescription was required, issues of addiction were raised in some detail. The patient continued to have improved function as the result of taking opioid analgesics. Nevertheless, the patient was referred to a specialist in addiction medicine for an assessment. The specialist was not concerned about addiction, but recommended that the prescribing interval be reduced from every 2 months to every 2 weeks. The patient agreement was reassessed. The episode was thoroughly documented in the patient record. There have been no subsequent episodes arousing suspicion.

SUMMARY

Opioid analgesics are powerful tools in the armamentarium of the pain clinician. Criminal and chemically-dependent drug seekers may attempt to obtain such drugs from the physician. Nevertheless, it is possible to continue to make opioid analgesics available to

appropriate patients while being vigilant to the drug seeker.

REFERENCES

- Brookoff D. Abuse potential of various opioid medications. *J Gen Intern Med* 1993;12:688-690.
- Colorado Prescription Drug Abuse Task Force presents Drug Diversion Scenarios: Scams, 3rd ed. Denver: Alcohol & Drug Abuse Division, Colorado Dept. of Human Services, 1995.
- Cooper JR, Czechowicz DJ, Petersen RC, Molinari SP. Prescription drug diversion control and medical practice. *JAMA* 1992;268:1306-1310.
- Dodd E. OSTAR-Oklahoma Schedule II abuse reduction: an electronic point of sale diversion control system. *NIDA Research Monograph* 1993;131:151-158.
- Goldman B. Use and Abuse of opioid analgesics in chronic pain. *Canadian Family Physician* 1993;39:571-576.
- Goldman B. The news on the street: prescription drugs on the black market. *CMAJ* 1998;159:149-150.
- Marquardt KA, Tharratt RS, Musallam NA. Fentanyl remaining in a transdermal system following three days of continuous use. *Ann Pharmacother* 1995;10:969-971.
- Montauk SL, Martin J. Treating chronic pain. *Am Fam Physician* 1997;55:1151-1160.
- Portenoy RK: The effect of drug regulation on the management of cancer pain. *New York State J Med* 1991;91(Suppl):13S-18S.
- Portenoy RK. Opioid therapy chronic nonmalignant pain: current status. In: Fields HL, Liebeskind JC (Eds). *Pharmacological Approaches to the Treatment of Chronic Pain*. Progress in Pain Research and Management, Vol. 2. Seattle: IASP Press 1994, pp 247-287.
- Public Policy Statement on the Rights and Responsibilities of Physicians in the use of Opioids for the Treatment of Pain. American Society of Addiction Medicine, 1997.
- Sajan A, Comeil T, Grzybowski S. The street value of prescription drugs. *CMAJ* 1998;159:139-142.
- Savage SR. Long term opioid therapy: assessment of consequences and risks. *J Pain Symptom Manage* 1996;11:274-286.
- Sees KL, Clark HW. Opioid use in the treatment of chronic pain: assessment of addiction. *J Pain Symptom Manage* 1993;8:257-264.
- Welch JS. Risk of intravenous drug abuse of oral morphine sulfate (letter). *Am Fam Physician* 1997;56:1307.
- Zenz M, Wilweber-Strumpf A. Opiophobia and cancer pain in Europe. *Lancet* 1993;341:1075-1076.
- Zulich SG, Grasela TH, Fiedler-Kelly JB, Gengo FM. Impact of triplicate prescription program on psychotropic prescribing patterns in long-term care facilities, *Ann Pharmacother* 1992;26:39-46.

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