

Physicians' Responsibility with Prescription Drug Abuse

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Abstract

The discharge of a patient found to be abusing their prescription represents a tragic outcome – that of a missed opportunity to provide appropriate continuity of care for a newly discovered (and recognized) medical problem of the substance use disorder. As physicians we need to realize (as with the acetaminophen case) that we have just as much medicine to practice to help our patients solve their substance use disorder as we practiced while accompanying them to that point of developing a substance use disorder.

Recently, I had the good fortune to be on a rather long flight to the Caribbean. Among the reading selections was the December 2011 issue of *Discover* magazine,¹ which had a brief summary of a *Journal of Pediatrics* September 2011 article² documenting a 101% increase in ER visits for accidental ingestions of medications by children under the age of five between 2001 and 2008, and which coincides with a near doubling of oxycodone prescriptions and a 559% rise in methadone prescriptions between 2000 and 2007.

It struck me that, as physicians, we are expected to get our patients to say “yes” to drugs ... at least to prescription drugs when appropriate. The pace of today's medical practice can be a challenge for us to do all the right things we learned in our last risk management seminar – such as getting an informed consent for medication. When prescribing a medication I typically tell the patient:

- 1) Take their medication as directed.
- 2) Let me know if they believe the dosage is insufficient to manage their problem.
- 3) Do not attempt to enhance the potency of their medica-

tion by “borrowing” the medication of a friend or family member (or by using alcohol and/or illicit drugs).

- 4) Tell each doctor they see which medications they are taking (including over-the-counter medications).
- 5) When using analgesics, they are not to use the medication to dull the pain enough to engage in physical activities that will only aggravate their condition. Furthermore, I monitor for use beyond the expected duration of the pain, the use of ever-larger amounts of medication, and reports of potential withdrawal symptoms when they try to stop taking their medication.

However, reality is very different. Every day I have patients react to my pursuit of informed consent for medications with surprise and suspicion because “I've never had any other doctor do this.” How often do we see non-compliance or find out that our patient believed “if a little is good, then more is better?” Even so, we generally trust our patients. We recognize them as a partner in their own health care – someone who has far more to lose than we do if they are not both forthcoming and compliant. If we tell a patient to use acetaminophen for pain, how often do we tell them about the potential consequences of taking more than four grams per day?³ When they show up in the clinic with elevated liver enzymes, what do we do? We treat them and we educate them. In other words, we recognized that there was more medicine to be practiced when we discovered the problem.

Why then do so many of us feel betrayed by the patient when we discover that they took a prescription for a scheduled drug and are now found to be abusing it? Granted, their presentation can be more devious (doctor shopping, lying, and manipulative behavior). Yet I see many patients who are denied any further prescription for scheduled medication or they are simply ter-

Table 1: Three Risk-Reduction Strategies.

Patient category	Urine drug tested	Made regular office visits	Restricted early refills
All patients	8.0%	49.8%	76.7%
Patients with drug use disorder	29.3%	52.9%	66.7%

minated from treatment altogether. Without exception, every physician I have ever spoken to about this regarding a mutual patient has cited liability concerns. I will be the first to say that I am not an attorney; however, it certainly seems to me that liability was an issue in the above described acetaminophen scenario as well. It is my opinion that to abruptly deny the refill of a scheduled medication or to terminate the doctor-patient relationship may well incur a greater liability. As physicians we need to realize (as with the acetaminophen case) that we have just as much medicine to practice to help our patient solve their substance use disorder as we practiced while accompanying them to that point of developing a substance use disorder.

The real reason for this article is to remind us to maintain the delivery of good patient care AFTER we find out that our patient now has a prescription substance abuse problem. In my experience, the majority of the time the patient is discharged from care without a specific referral. They are often left without prescriptions, treatment recommendations, or even an explanation of what to expect (such as what withdrawal symptoms may occur). This scenario often leads to the first illicit use of drugs and where they will buy it from other (as-of-yet undiscovered) abusing patients or they will find the street equivalent.⁴ The discharge of a patient found to be abusing their prescription represents a tragic outcome – that of a missed opportunity to provide appropriate continuity of care for a newly discovered (and recognized) medical problem of the substance use disorder. Furthermore, this tragic outcome (in my opinion) could be construed as patient abandonment in the face of the aforementioned newly discovered medical problem. As medical professionals we strive to provide the best care possible, and the reality is that the best care is often only as good as our documentation in the event of a poor outcome. For this reason, we all practice some degree of defensive medicine. This should not be overlooked in cases of prescription abuse. Obvious areas of potential liability in the event that the patient is simply “cut off” from treatment or their prescription would be when withdrawal can be life threatening (such as benzodiazepine withdrawal).⁶

“An ounce of prevention is worth a pound of cure.” Preventing prescription abuse is the goal, and three risk-reduction strategies identified by Joanna Starrels, M.D., at the Albert Einstein College of Medicine¹¹ as successful for prevention are:

- 1) Urine drug testing.
- 2) Regular face-to-face office visits at least every six months (and within 30 days of modifying treatment).
- 3) Restricted early refills.
- 4) The study included 1,612 patients which revealed the results in Table 1.

Apart from the urine testing, which was done more often in those patients with a substance use disorder, there was little difference in how often primary care clinicians saw the patient. Random urine testing is recommended along with face-to-face visits at least every six months (and within 30 days of a modification in the drug regimen). Of interest is that those with a substance abuse disorder were given early refills 10% more often. Early refills should require an explanation by the patient and be limited (e.g., once every two years). I also educate the patient about the abuse potential of the drug and how tolerance can manifest itself with specific prescriptions.

If there is suspicion of prescription abuse, any consideration of treatment options begins with defining the extent of the problem. The following table is used extensively on different sites on the internet, including the site for the California Society of Addiction Medicine. This simply and sufficiently summarizes the DSM IV criteria for dependence vs. abuse without the excessive detail included in the more recent DSM IV-TR:

DEPENDENCE

(3 or more in a 12-month period)

- Tolerance (marked increase in amount; marked decrease in effect)
- Characteristic withdrawal symptoms; substance taken to relieve withdrawal
- Substance taken in larger amount and for longer period than intended
- Persistent desire or repeated unsuccessful attempt to quit
- Much time/activity to obtain, use, recover
- Important social, occupational, or recreational activities given up or reduced
- Use continues despite knowledge of adverse consequences (e.g., failure to fulfill role obligation, use when physically hazardous)
- Recurrent use resulting in failure to fulfill major role obligation at work, home, or school

ABUSE

(1 or more in a 12-month period)

- Symptoms must never have met criteria for substance dependence for this class of substance
- Recurrent use in physically hazardous situations
- Recurrent substance related legal problems
- Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by substance

Certain medications, which are prone to abuse, create more complex clinical issues. One popular medication is Soma (carisoprodol). It is a non-controlled skeletal muscle relaxant whose active metabolite is meprobamate, a Schedule IV controlled substance.⁷ Although several case reports have shown that carisoprodol has abuse potential, it continues to be widely prescribed. Biopsychiatry.com reports that a significant percentage of the physician population is unaware of the potential of carisoprodol for abuse and of its metabolism to meprobamate, a controlled substance. Another popular medication is Ultram (tramadol). Withdrawal from tramadol includes both opiate withdrawal and SSRI (selective serotonin reuptake inhibitor) withdrawal.^{8,9,10}

Once you have defined the substance use disorder, then it is necessary to determine treatment. Begin with a contract between you and the patient. Any controlled medications should be monitored by one physician (preferably with access to a Bureau of Narcotics Enforcement database, such as the California Prescription Drug Monitoring Program). The three risk-prevention strategies discussed earlier should be applied, and appropriate laboratory studies should be obtained (e.g., LFTs). Patient accountability is paramount. Make specific referrals. Involve the family whenever possible. Depending on your area of expertise, you might elect to treat the problem on your own, but don't hesitate to refer at the first sign of a treatment failure. There are many treatment possibilities including (but certainly not limited to): Buprenorphine, Methadone, Naltrexone, benzodiazepine taper, barbiturate taper, non-narcotic detoxification, Cognitive Behavioral Therapy, 12-step programs, and residential treatment. What is most important is that you use interventions that you are comfortable with and deem to be the best course of action BUT collaborate with the many resources available to provide support services and accountability.

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References

1. Strong Medicine, Bitter Pills. *Discover*. Dec 2011 issue. Published online Feb 9, 2012.
2. Bond GR, Woodward RW, Ho M. The Growing Impact of Pediatric Pharmaceutical Poisoning. *The Journal of Pediatrics*. Vol. 160(Issue 2);pages 265-270.e1, February 2012.
3. Watkins PB, Kaplowitz N, Slattery JT, et al. Aminotransferase elevations in healthy adults receiving 4 grams of acetaminophen daily: a randomized controlled trial. *JAMA*. 2006;296(1):87-93.
4. Inciardi JA, Surratt HL, Cicero TJ, et al. Prescription Opioid Abuse and Diversion in an Urban Community: The Results of an Ultrarapid Assessment. *Pain Med*. 2009 April;10(3):537-548.
5. Retrieved August 14, 2012. www.esamasam.org/pdf/misc/dsm_criteria_for_diagnosis.doc.
6. The Merck Manual, 16th ed. 1992; p. 1560.
7. Reeves RR, Pinkofsky HB, Struve FA, Bennett DM. Carisoprodol (soma): abuse potential and physician unawareness. *J Addict Dis*. 1999;18(2):51-6.
8. Tartakovsky M. SSRI Discontinuation or Withdrawal Syndrome. Psych Central. Retrieved on August 10, 2012.
9. Senay EC, et al. Physical Dependence on Ultram (tramadol hydrochloride): both opioid-like and atypical withdrawal symptoms occur. *Drug and Alcohol Dependence*. 2003;69:233-241.
10. Physicians' Desk Reference, 66th ed. 2012; p. 2519.
11. Starrels JL, Becker WC, Weiner MG, et al. Low use of opioid risk reduction strategies in primary care even for high risk patients with chronic pain. *J Gen Intern Med*. 2011;Sep;26(9):958-64.