

Ethical, Legal, and Professional Challenges Posed By “Controlled Medication Seekers” to Healthcare Providers, Part 2

Ken Solis, MD, MA

Abstract

Abuse and diversion of controlled prescription medications is a large and growing problem in the U.S. The first of this two-part paper discussed the pragmatic, ethical, and legal issues that challenge healthcare professionals who must care for someone suspected or confirmed to be using deception to obtain controlled medications because of addiction to the medication, for resale, recreational use, or other reasons not sanctioned by the medical profession. The second part will focus on the pragmatic, legal, and especially ethical aspects of identifying and caring of patients who are suspected of controlled medication seeking behavior in the acute care setting. It is the hope of the author that this paper will be a catalyst for deeper and wider discussions and research on this difficult, multifaceted, and widespread healthcare issue.

Should the Diagnosis of “Controlled Medication Seeking Behavior” Ever be Made?

The pragmatic, ethical, and legal challenges that patients with known controlled medication seeking behavior pose to providers are perhaps dwarfed only by the challenge of making the determination that an individual *is* conclusively exhibiting seeking behavior on *this* presentation. For example, in cases of “pseudoaddiction” patients have been misdiagnosed as having “drug seeking behavior” because their undertreated pain led them to seek additional pain relief by going to various other providers.¹ Also, undoubtedly on some occasions patients will exhibit some of the warning flags of seeking behavior listed below because they are cognitively impaired, a friend *did* steal

their medications, they actually have a genuine condition on *this* presentation, and so forth. Thus, the provider often faces substantial challenges in ascertaining whether the patient before them is really seeking a controlled medication for a covert or illicit reason. As a caveat, most authors in the drug abuse literature believe that it is usually better to treat a suspected but unverified seeker’s complaint with a conservative amount of the controlled medication in question, if it is the only viable option, than it is to erroneously misdiagnose “controlled medication seeking behavior” and subsequently mislabel, dismiss, or under-treat a patient with genuine healthcare needs.^{2,3,4} In fact, The American Society for Pain Management Nurses believes that the diagnosis of “drug seeking” should be avoided all together because the diagnosis can create prejudice, bias, and barriers to care.⁵ These concerns are all legitimate and bear serious consideration. However, if the evidence is compelling that a patient is exhibiting controlled medication seeking behavior, it would be dishonest and inconsistent to avoid making this particular diagnosis to guide treatment while still being willing to make other stigmatizing diagnoses such as “cocaine abuse” or “Munchausen syndrome.” Furthermore, the potential harms from prejudice, bias, and barriers to care posed by this diagnosis must be weighed against the many potential harms to the individual and society in not recognizing, documenting, and properly addressing it as I discussed in part 1 of this article series. The U.S. Drug Enforcement Agency, state licensing agencies, and at least one state court have also concurred that substantial harms can occur and a provider held culpable for prescribing controlled medications to someone who is known to be abusing them.^{6,7,8} Similarly, patients and families have blamed emergency physicians for causing their addiction because they gave them narcotics every time they presented.⁹

Evaluating the Likelihood of Controlled Medication Seeking Behavior

Some providers protest that the evaluation typically needed to determine the likelihood of controlled medication seeking behavior amounts to police work and is, therefore, outside their scope of practice.¹⁰ However, the type and intent of evaluation of a patient with suspected controlled medication seeking behavior does not differ substantially from doing a careful evaluation of other unusual, suspicious, or potentially problematic patient presentations. If certain historical or exam findings raise suspicions of the patient being disingenuous, the provider should do an appropriate evaluation to try to confirm or assuage those suspicions. Additionally, if we are to accept the common assertion that psychological and physiological dependencies to various substances *are* diseases, that they are frequent motivations behind controlled medication seeking behavior,^{11,12} then doing an evaluation to make such a diagnosis is within the profession's province. Making an accurate diagnosis should also lead the provider to offer the correct treatment with greater confidence. For example, if the concerns about controlled medication seeking are assuaged, the provider can now treat the condition with less concern about medication abuse potential, or, conversely, if seeking behavior is confirmed, the provider can decide to avoid contributing to an underlying drug dependency and direct them to drug rehabilitation.

Some Warning Flags of Possible Controlled Medication Seeking Behavior

Studies which attempt to determine sensitive and specific signs or tools for detecting patients who are abusing controlled medications have been applied to chronic pain patients already on narcotics for treatment.^{13,14,15,16,17,18,19,20,21} Chou et al. systematically reviewed and critiqued this literature and determined that the nine relevant studies all had methodological shortcomings, and most of the results may not be applicable to primary care or other settings²² (nor, of course, to non-narcotic medications).

The warning flags listed below are *some* of the most commonly cited warning flags for seeking behavior derived from the two highest quality studies,^{16,19} as determined by Chou et al., and the opinions or observations by various experts in the field and drug enforcement agencies.^{23,24,25,26} Perhaps unsurprisingly, there appears to be general agreement in how controlled medication seekers tend to present or can be detected in both the more formal chronic pain research and the less formally determined assertions made by experts in other healthcare settings and drug enforcement agencies. Based on face value as well as extrapolating from the chronic pain literature, I have divided the different kinds of "controlled medication seeking" warning flags into those that are likely to have a high probability of indicating controlled medication seeking behavior ("red flags") from those that have a lesser probability of indicating seeking behavior ("yellow flags"). These warning flags might be detected from historical information gleaned from nurses, other personnel such as paramedics, past medical records, or

the provider's own interview with the patient. The detection of a warning flag(s) should often prompt the provider to look for other flags, particularly if it is a flag that is a strong indicator of seeking behavior in that patient's particular context.

Red flags of controlled medication behavior (strong evidence):

- Patient believes that he/she is addicted to medications or has undergone narcotic detoxification in the past.
- Patient frequents different providers, institutions, or pharmacies in a short time period to obtain controlled medications (especially if patient denies the practice).
- Steals or diverts prescriptions from family members, e.g., brings a dependent family member in for an alleged condition, but then takes the medication for themselves.
- Obtains controlled medications from non-medical sources, such as the "street."
- Steals medical goods, such as prescription pads or syringes.
- Forges or alters a prescription for a controlled medication.
- Frequently loses the controlled medication by misplacing it, having it stolen, etc.
- Notification by another provider, institution, or a family member that the patient is addicted to controlled medications.
- Has drug-related deterioration in work performance, family relationships, or other social dynamics.
- Concurrently abuses illicit drugs, e.g., positive urine drug screen for illicit drugs.
- Asserts that they take a controlled medication regularly and recently for their condition, but the urine drug screen is negative; are they diverting the medication for resale? (Caution: check with your laboratory to determine their screen's sensitivity in detecting the medication in question.)
- Patient gives false identification information.
- Patient injects an oral formulation of the controlled medication.

Yellow flags for possible drug seeking behavior (less strong evidence):

- Patient frequently visits or contacts your facility with requests for refills of the controlled medication or has multiple unsanctioned escalations in the dose. (Caution: evaluate to determine if symptoms are genuine and they simply are not being adequately managed.)
- The patient is away from home or has passed by closer healthcare facilities and presents with a subjective condition that typically requires controlled medications.
- Gives an improbable story for running out of a medication, e.g., "I accidentally flushed them down the toilet," "my dog ate them . . ."

- States that they are allergic or intolerant of every other class of relevant medication besides the directly or indirectly requested controlled medication or its class.
- Has an unusual amount of knowledge about the controlled medication in question or requests a particular controlled medication by name. (Caution: the patient might also simply be familiar with their condition and knows what works from past experience.)
- Has little interest in the diagnosis or alternative treatments.
- Fails to keep appointments with other providers who are necessary for referral or continuity of care.
- Uses the controlled medication for purposes other than for which it was prescribed, e.g., using a narcotic to decrease anxiety.
- Other healthcare professionals have terminated care of the patient due to concern of controlled medication abuse.
- History of abuse of other substances, such as alcohol or recreational drugs.

Again, although multiple red and yellow flags might strongly suggest that a patient has at least a history of controlled medication seeking behavior, they do not guarantee that a patient does not have a genuine condition on *this* presentation; thus, a careful evaluation and treatment decision must still be made each time – seekers are also mortal and, thus, will eventually become genuinely ill or injured like everyone else.

Additional Historical Elements

Chronic pain patients, at least, often significantly underreport their medication use.^{27,28} Nevertheless, providers should obtain a detailed history of recent controlled medication use, including the last time that they have had them administered or prescribed, the amount, by whom, and the approximate frequency of use. If the provider is concerned about a particular class of medications, they should recount the various names of medications within that class to the patient rather than just naming one or using medical jargon. Some individuals will later state that they did not understand what the provider meant if they ask, “Have you had any narcotics or benzodiazepines lately?” Also, consider asking questions that might be relevant from the list of warning flags listed above, e.g., “do you have a past history of addiction or dependency to any substance, such as alcohol, cocaine, or other recreational drug?”

If the patient reports being intolerant or allergic to multiple medications, the provider should determine the exact nature of those past reactions. Some drug reactions can be addressed, and the patient might be willing to try a non-controlled medication again if proper precautions can be taken, e.g., giving diphenhydramine *before* prochlorperazine for a migraine headache to decrease the risk of akathisia. Similarly, the provider will need to determine if the patient is taking other medications or substances that can adversely interact with many controlled medications and preclude, or at least mitigate, their use. For

example, an alcoholic who is taking a benzodiazepine for anxiety should not be prescribed narcotics due to the increased risk of causing apnea when combined with the other sedating substances that they already use.

Exam Elements

If an objective exam or diagnostic test finding corroborates a patient’s complaint (e.g., the presence of a tooth abscess on exam), the provider should generally offer the most effective medication, even if the patient has a history of controlled prescription medication seeking behavior. Of course, measures to try and limit the risk of reinforcing a tendency towards addictive behavior should be taken, such as counseling, prompt definitive treatment of the problem, limited prescription of the medication in question, and avoiding medications with high abuse potential, such as meperidine.²⁶ Conversely, if an exam finding or witnessed patient behavior is fully out of character with a presenting complaint that has no objective corroboration, the observation should be documented, discussed with the patient, and considered in the overall evaluation.

Medical Records

The provider should check for a patient’s local medical records, even if the patient claims to have never been at the clinic or institution previously. The patient might have forgotten or wish to conceal previous visits to your institution that could demonstrate a pattern consistent with controlled medication seeking behavior. Many emergency departments also have a separate in-department file of patients that habitually frequent them.²⁹ The usual purpose of these files, which are separate from routine medical records, is to help a provider determine if a patient has habitually used the emergency department to obtain controlled medications for non-therapeutic reasons.³⁰ In many, if not most, institutions, these files are not created and maintained via a formal, consistent process³¹ and, therefore, could present ethical, legal, and practical problems for the provider and the healthcare institution alike as opined by Doctor Geiderman of the Cedar-Sinai Center for Health Care Ethics, Burns and Allen Research Institute. Nevertheless, he also believes that “habitual patient files” can be pragmatically, ethically, and legally defensible if at least the following precautions are taken: 1) obtain legal counsel to determine if and how such a file can be created and managed within federal and state laws; 2) avoid pejorative terms, such as “kook book” or “frequent flyers” for naming the file and avoid pejorative terms in regards to the patient; 3) there should be a formal and rigorous process for creating, maintaining, and accessing the file; 4) the information should not be shared with other parties without the patient’s consent; and 5) the file should be used as a tool only and not as the final arbiter for making a decision about a patient’s diagnosis or treatment. In addition, these files can also be used for the purpose of describing typical presentations, treatment plans, or other important information for patients who present with some frequency to your service with known recurrent medical conditions, such as sickle cell disease, seizures, and the like.³²

Another source of information of possible past controlled medication seeking behavior is the patient's medical records from other providers or healthcare institutions. Healthcare information can legally be shared with other healthcare professionals *for treatment purposes* according to the Health Insurance Portability and Accountability Act (HIPAA) and does not necessitate a patient's consent.³³ However, state patient privacy laws³⁴ or institutional regulations might require a patient's written consent before you can obtain medical records from another party. Hence, in many cases the patient will have to be willing to sign a "release of medical information" form before you can receive confidential information from another institution or provider, even though it is not required by federal law.

Other Sources of Information

Pharmacy records are another frequently helpful resource for determining a patient's history of controlled medication use. Some retail chains, such as Walgreen's® and CVS®, have proprietary national databases that include the prescriptions filled for an individual anywhere within the chain and is accessible by contacting any of their stores.^{35,36} Also, with internet search engines, such as Google Map®, it is easy to quickly find the phone number of various pharmacies close to a patient's address by simply typing in their address followed by the word "pharmacy" in the search box.

Additionally, currently 34 states have legislatively authorized databases called "prescription drug monitoring programs" (PDMPs) that record various prescription information for different scheduled medications (the exact information recorded varies by state). Ten more states have either enacted legislation or are considering legislation to initiate PDMPs.³⁷ Many state PDMPs allow providers to access these databases to help achieve their major stated goals that include "to help identify and deter or prevent drug abuse and diversion; and to facilitate and encourage the identification, intervention with and treatment of persons addicted to prescription drugs."³⁸ Admittedly, PDMPs are not without their detractors who express concern that the databases compromise patient privacy and might at times deter providers from prescribing controlled medications, even when it is indicated.³⁹ As with any medical record, it is preferable professionally and ethically to ask a patient for their permission to call pharmacies or state databanks for prescription information, even if not required by federal law.

What to Do?! A Generalized Approach to Patients Suspected of Controlled Medication Seeking Behavior

Determining how best to *specifically* manage a particular individual that a provider suspects or confirms of controlled medication seeking behavior is beyond the scope of this paper. Available resources, local medical norms, various laws or institutional policies, and especially the patient's particular situation will often constrain or even dictate a provider's options. The

following general approach attempts to maximize beneficence or "doing good" for the patient while minimizing the potential for maleficence or "doing harm" and attempts to preserve or restore a functional patient-provider relationship. This approach also hopes to improve the future likelihood of attaining these ideals as well. The autonomy of the patient is also respected within the framework of the law, unless it is determined that they are very likely or conclusively illicitly seeking controlled prescription medications. Finally, even though confirmed controlled medication seekers are typically acting criminally due to their violation of laws surrounding the procurement of controlled medications, the proposed approach avoids compelling the provider to contact legal authorities unless the patient is egregiously breaking the law, is a potential harm to others or imminently to themselves. In the end, the potential harms to the individual and society that could be mitigated by reporting controlled medication abuse to legal authorities must be weighed against the potential harms of compromising the patient-provider relationship from the loss of patient confidentiality and fidelity. The proposed approach first relies on the provider's determination of the likelihood that the patient is inappropriately seeking controlled medications.

Controlled Medication Seeking Unlikely or Inconclusive

If the evaluation reveals that controlled medication seeking is unlikely or inconclusive, the provider should treat the patient's condition as appropriate. In general, narcotics and other controlled substances should be used only if other more specific or less potentially harmful approaches have been tried and failed, e.g., bupivacaine dental block for a toothache, acetaminophen for a backache. The provider should also consider having the patient "help you help them" so that the warning flags that popped up during their evaluation pose less of a problem for them with future encounters with the healthcare system. For example, the provider should encourage them to work with their primary provider or specialist as much as possible, minimize the use of emergency or urgent care centers where the efficacy and side effects, including the development of dependency of controlled medications, are difficult to monitor; they should anticipate if they will run short of the medication before the pharmacies are closed, etc. In many cases, the provider will find it helpful to contact the primary provider or specialist during office hours to develop a complimentary and perhaps formal written treatment plan for the patient. If the patient does not have a primary provider due to their financial situation or other circumstances, the provider or another staff person (e.g., social worker) might be able to help the patient find one at an affordable or charitable clinic.

The provider can also consider more formally informing the patient regarding the limits of what they can and cannot do for them according to what they believe is both effective and safe. As an example, some primary providers and pain specialists develop and utilize a "pain management contract" which de-

lineates the boundaries of who, what, how much, and how controlled medications will be prescribed; states that compliance is expected with treatment plans, tests, referrals, and the law; and spells out the consequences of departure from the contract.⁴⁰

Controlled Medication Seeking Behavior Very Likely or Conclusive

If the provider has determined that a patient is very likely or conclusively exhibiting controlled medication seeking behavior, it is preferable to address the problem appropriately rather than “giving them a few pills to get them out the door.” This tactic only ensures that they will likely return at another time, contributes to potential harms, and does not address the underlying problem. In a similar vein, a provider would not provide an alcoholic with a few beers just to get them out the door. Obviously, it is preferable for the patient to admit to a drug-related problem and get appropriate help rather than to just go away. However, until they are willing to admit to the problem and accept help, there usually is little that a provider can do other than to avoid continuing to contribute to the controlled medication seeking and attendant behaviors. Instead, offer your determination to the individual, preferably with a chaperone at your side because you might need their support and to be a witness during this sometimes difficult “confrontation.”

A particularly challenging situation is the patient who exhibits various conclusive warning flags of controlled medication seeking behavior, but also is believed to have a genuine chronic or recurrent condition that warrants the use of the medication that is being abused. The many psychological and physiological changes that occur with conditions such as chronic pain, anxiety, and the use of narcotics or other medications that affect the nervous system is far beyond the scope of this paper – and is a rapidly evolving area of healthcare science. Nevertheless, in this situation, a thorough assessment and frank discussion is needed to determine why the patient is exhibiting these behaviors. If the symptom is simply not being adequately treated, then perhaps a different treatment regimen or referral to an appropriate specialist should be considered. If the patient has become addicted to the psychological effects of the drug, then a referral to a multidisciplinary team with an addiction specialist, specialist of the underlying medical condition, and perhaps other disciplines might be in order. In either case, the benefits of symptom control must be carefully weighed and guarded against the potential harms from the potential abuse of the controlled medication. As noted above, a “pain management contract” can also be a helpful tool for steering the patient towards a regimen which strives to meet their needs for symptom control and dissuades abuse of the medication(s) in question.

When the provider gives the evidence to the patient that supports the conclusion that they cannot in good conscience provide them with a controlled medication and offers to help them seek more appropriate alternative care, I have received several responses that seem to be most common:

1. *“Okay, I have a problem with drugs and I would like to get help.”* While this response is not as common as we would like, when it does occur, the provider now has, and hopefully will continue to have, a patient that has become a truthful, genuine, and licit patient with whom the provider can work to get the proper treatment. If the patient agrees to rehabilitation, but also requests controlled medications to prevent withdrawal, it is important to note the constraints dictated by federal DEA regulation [21 CFR 1306.07(b)], which only allows a provider who does not have a special license to treat for drug dependency or addiction to administer (and not prescribe) enough medication to prevent withdrawal on three separate days and in lieu of arranging rehabilitation.

2. *“That’s not me you’re talking about, it’s someone else.”* This response typically occurs when the provider presents the individual with evidence that a call to a pharmacy or state prescription drug monitoring program reveals a pattern of controlled medication use that is substantially inconsistent with the history that they offered earlier. In this case, the individual is alleging either a mistaken identity or identity theft. Therefore, the provider should double-check the spelling of the patient’s full name and birth date with their informational resource. If mistaken identity is ruled out, the individual has the option of contacting the police, so that the alleged “identity theft” can be investigated. Given the frequency that this objection has been given to me compared to the actual likelihood that identity theft is being practiced at the very pharmacies or other healthcare institutions in their locale, I’ve been reluctant to accept their allegation and prescribe the controlled medication in question. Furthermore, I have never learned of a patient who actually involved the police to address the alleged identity theft.

3. *“I don’t want any controlled prescription drug; but what are you going to do for my symptoms!”* In this scenario, the patient is indicating that the provider has misunderstood their true intention, and the provider may very well have to be sure that they *have* seriously evaluated their stated problem rather than just focusing on possible controlled medication seeking behavior. Nevertheless, in many cases the patient will already have typically stated or implied that every non-controlled medication is ineffective or causes side effects, and various other warning flags of seeking behavior have also been discovered. Therefore, the provider is often left with the option of trying a different non-controlled medication that they might not have tried in the past or simply stating that they do not have anything to offer the individual with which they are comfortable administering or prescribing. If the evidence of controlled medication seeking behavior is not incontestable and the provider believes that it is possible that the patient is being honest, then the provider will have to use his/her judgment to decide if and how liberally they will treat them until the issue can be fully resolved.

4. *“I’m not a drug abuser, you #@!%*&!” (or worse).* This is a situation in which a chaperone is particularly helpful to act as visible support for the provider and as a witness. If the patient could react violently, the provider should also take precautionary measures, such as having extra personnel close by, keeping

themselves between the patient and the door, etc. The provider should also try to distance themselves emotionally from the confrontation as much as possible and try to de-escalate the situation by indicating that they are here to help them, but only in a way that they believe is medically safe and appropriate. If necessary, the provider should indicate that this behavior is not conducive for a working relationship and will not persuade them to change their mind. If past encounters with the patient indicate that he or she is potentially violent or particularly malicious, the provider should consider having security or law enforcement close at hand for everyone's safety when they confront them. Note that HIPAA does allow for contacting law enforcement when an individual commits a crime on the premises of a healthcare provider⁴¹ and Wisconsin Statute 940.20 (7) makes it a felony to assault emergency healthcare workers.

Contacting Law Enforcement

Besides concerns for personal safety or the disruption of the healthcare setting noted above, there are other circumstances where the provider might consider contacting law enforcement: (1) the drug seeking behavior is egregious (e.g., theft or tampering of prescriptions or other medical goods, witnessed to be reselling the drug); (2) the patient poses an imminent threat to public safety, such as driving away in a vehicle after getting a medication despite your warning that they must have somebody else drive them home; and (3) if the patient is an imminent threat to themselves. The final criterion is perhaps the most unlikely and difficult for a provider to make. Contacting legal authorities due to the concern of self-harm is theoretically defensible because controlled medications are involved in about 30% of drug-related deaths.⁴² However, this situation should only occur if a provider discovers that the patient has a serious problem with controlled medications *after* they have been discharged, because a provider should not logically have provided the medication otherwise. The rarity of being compelled to contact legal authorities for fear of patient self-harm is compounded by the fact that, while controlled medications are involved in a substantial percentage of drug-related deaths, the odds of any single drug use event causing substantial harm is undoubtedly substantially smaller. Therefore, the decision that a recent encounter warrants contacting law enforcement because of the potential for patient self-harm requires considered judgment.

Conclusion

Individuals who feign or exaggerate medical conditions to obtain controlled medications from the healthcare system are a large and growing problem. The duty that providers have to treat patients' pain, anxiety, or other conditions that are often treated with controlled medications adds to the various ethical, legal, and professional challenges posed by individuals suspected of seeking behavior. Before diagnosing an individual with "controlled medication seeking behavior," the provider must gather enough reliable supporting information to achieve the high evidentiary standards needed to make this diagnosis,

which carries the attendant stigmatizing label of "drug seeker" and could bias future medical evaluations of the patient. Additionally, even in patients with a definite history of controlled medication seeking behavior, the provider must do a careful and thorough evaluation and not presume that their presenting condition is non-genuine yet again. If the provider determines that he has enough evidence to be certain that a patient is exhibiting controlled medication seeking behavior, then a professional approach, honesty, moral courage, and perhaps support staff are required to guide the patient in the right direction.

Exactly how providers should best relate to and manage controlled medication seekers while still meeting their own ethical, legal, and professional duties requires more reflection, perspectives, and empirical research. For example, the University of Wisconsin Hospital emergency department reported remarkable success in decreasing the *apparent* use of narcotics of patients who had greater than ten annual visits to their ER for nonmalignant pain and no co-morbidities, by sending them and their primary provider a letter that stated that they would no longer receive narcotics for their subjective pain and why. However, given the study design limitations, it is not clear if the patients truly dramatically decreased their use of narcotics or simply obtained them from other sources. More discussions are also needed to decide:

- How reliable are the warning flags of controlled medication seeking behavior listed by the DEA and other authorities?
- At what threshold and what kind of controlled medication seeking behavior should a physician report a verified seeker to legal authorities?
- How effective and accurate are existing state prescription drug monitoring programs in assisting providers to better detect controlled medication seekers, and are patient privacy rights still adequately protected?
- Which strategies are most effective at persuading controlled medication seekers to get the true treatment that they need – assuming that they are dependent or addicted to the medication and not simply obtaining them for resale or for a recreational "high."

In conclusion, the healthcare professions need to come to a consensus on how providers with aspirations of maintaining various duties to the patient and the community at large can most effectively detect, relate to, diagnose, and treat patients who are harming themselves and the very system that is supposed to help them with their genuine healthcare needs.

Ken Solis, MD, MA, BCCEM certified, holds a Master's degree in bioethics and is currently completing a residency at Aurora Sinai Internal Medicine Program in Milwaukee.

Potential Financial Conflicts of Interest: By AJCM® policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article that might create any potential conflict of interest. The author has stated that no such relationships exist.

References

- Weissman DE, Haddox JD. Opioid pseudoaddiction – an iatrogenic syndrome. *Pain*. 1989,36(3):363-6.
- Millard, WB. Grounding frequent flyers, not abandoning them: Drug seekers in the ED. *Ann Emerg Med*. 2007,49(4):482-86.
- Geiderman JM. Sympathetic dystrophy. *Ann Emerg Med*. 2001,37(4):412-14.
- Geiderman JM. Geiderman's rules for emergency physicians. *Top Emerg Med*. 1986,8:viii.
- McCaffery M, Grimm, M, Pasero C, et al. On the meaning of "drug seeking." *Pain Manag Nurs*. 2005,6(4):122-36.
- "Cases Against Doctors" web page, U.S. Drug Enforcement Agency Office of Diversion Control web site, Available at: http://www.deadiversion.usdoj.gov/crim_admin_actions/index.html. Accessed February 9, 2010.
- Chapter VI. "Controlling diversion and abuse: What are the gaps in current efforts?" Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the U.S., New York, NY, The National Center on Addiction and Substance Abuse at Columbia University, 2005, p 79.
- Fishman SM, Bandman TB, Edwards A, et al. The opioid contract in the management of chronic pain. *J Pain Symptom Manage*. 1999,18(1):27-37.
- MacLeod DB, Swanson R. A new approach to chronic pain in the ED. *AM J Emerg Med*. 1996,14(3):323-6.
- Chapter IV. The Mechanisms of Diversion, Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the U.S., New York, NY, The National Center on Addiction and Substance Abuse at Columbia University, 2005, p 57.
- Fishbain DA, Rosomoff HL, Rosomoff RS. Drug abuse, dependence, and addiction in chronic pain patients. *Clin J Pain*. 1992,8(2):77-85.
- Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the U.S., New York, NY, The National Center on Addiction and Substance Abuse at Columbia University, 2005.
- Adams LL, Gatchel RJ, Robinson RC, Polatin P, et al. Development of a self-report screening instrument for assessing potential opioid medication misuse in chronic pain patients. *J Pain Symptom Manage*. 2004,27(5):440-59.
- Atiuri SL, Sudarshan G. Development of a screening tool to detect the risk of inappropriate prescription opioid use in patients with chronic pain. *Pain Physician*. 2004,7(3):333-8.
- Butler SF, Budman SH, Fernandez K, et al. Development and validation of the current opioid misuse measure. *Pain*. 2007,130:144-56.
- Compton P, Darakjian J, Miotto K. Screening for addiction in patients with chronic pain and problematic substance use: evaluation of a pilot assessment tool. *J Pain Symptom Manage*. 16(6):355-63.
- Hojsted J, Sjogren P. Addiction to opioids in chronic pain patients: a literature review. *Eur J Pain*. 2007,11(5):490-518.
- Manchikanti L, Pampati V, Damron KS et al. Evaluation of variable in illicit drug use: does a controlled substance abuse screening tool identify illicit drug use? *Pain Physician*. 2004,7:71-5.
- Michna E, Ross EL, Hynes WL, et al. Predicting aberrant drug behavior in patients treated for chronic pain: importance of abuse history. *J Pain Symptom Manage*. 2004,28(3):250-8.
- Wasan AD, Davar G, Jamison R. The association between negative affect and opioid analgesia in patients with discogenic low back pain. *Pain*. 2005,117(3):450-61.
- Wu SM, Compton P, Bolus R, et al. The addiction behaviors checklist: validation of a new clinician-based measure of inappropriate opioid use in chronic pain. *J Pain Symptom Manage*. 2006,32(4):342-51.
- Chou R, Gilbert FJ, Fine PG, et al. Opioids for chronic noncancer pain: prediction and identification of aberrant drug-related behaviors: a review of the evidence for an American Pain Society and American Academy of Pain Medicine clinical practice guideline. *J of Pain*. 2009,10(2):131-146.
- Chapter IV. The Mechanisms of Diversion, Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the U.S., New York, NY, The National Center on Addiction and Substance Abuse at Columbia University, 2005, pp 56,57.
- "Don't be Scammed by a Drug Abuser" web page. U.S. Drug Enforcement Administration Office of Diversion Control Web site. Available at: <http://www.deadiversion.usdoj.gov/pubs/brochures/drugabuser.htm>. Accessed on February 14, 2010.
- Pretorius RW, Zurick GM. A systematic approach to identifying drug-seeking patients. *Family Practice Management*. 2008,15:A3-A6.
- Hansen GR. The drug-seeking patient in the emergency room. *Emerg Med Clin N Am*. 2005,23(2):349-65.
- Fishbain DA, Cutler RB, Rosomoff HL, et al. Validity of self reported drug use in chronic pain patients. *Clin J Pain*. 1999,15:184-91.
- Ready LB, Sarkis E, Turner JA. Self-reported vs. actual use of medications in chronic pain patients. *Pain*. 1982,12(3):285-94.
- Graber MA, Gjerda C, Bergus G, et al. The use of unofficial "problem patient" files and interinstitutional information transfer in emergency medicine in Iowa. *Am J Emerg Med*. 1995,13:509-11.
- Longo Lp, Parran T, Johnson B, et al. Identification and management of the drug-seeking patient. *Am Fam Physician*. 2000,61:2401-8.
- Zechnich D, Hedges JR. Community-wide emergency department visits by patients suspected of drug-seeking behavior. *Acad Emerg Med*. 1996,3(4):312-7.
- Geiderman, JM. Keeping lists and naming names: Habitual patient files for suspected nontherapeutic drug-seeking patients. *Ann Emerg Med*. 2003,41(6):873-881.
- "Can a physician's office Fax patient medical information to another physician's office?" web page, U.S. Department of Health and Human Services web site. Available at: <http://www.hhs.gov/hipaafaq/providers/smaller/356.html>. Accessed February 6, 2010.
- "Patient Confidentiality" web page. American Medical Association web site. Available at <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/patient-confidentiality.shtml>. Accessed February 14, 2010.
- "About Walgreens Health Services" web page. Walgreens Health Services web site. Available at http://www.walgreenshealth.com/whc/clientPortal/companyInfo/jsp/about_us.jsp. Accessed February 14, 2010.
- "Drug Information Center" web page, CVS pharmacy web site. Available at: http://www.cvs.com/CVSApp/health/drug_information_center.jsp. Accessed February 14, 2010.
- "Questions and answers for state prescription drug monitoring programs" web page. U.S. Department of Justice Drug Enforcement Agency Office of Diversion Control web site. Available at: http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm#4. Accessed February 6, 2010.
- "Prescription drug monitoring programs: A brief overview" web page. National Alliance for Model State Drug Laws web site, Available at: <http://www.namsdl.org/documents/PDMPsBriefOverview7-31-09.pdf>. Accessed February 14, 2010.
- Chapter VI. Controlling diversion and abuse: What are the gaps in current efforts? Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the U.S., New York, NY, The National Center on Addiction and Substance Abuse at Columbia University 2005, p 83.
- Hariharan, J, Lamb GC, Neuner JM. Long-Term Opioid Contract Use for Chronic Pain Management in Primary Care Practice. A Five Year Experience. *J Gen Intern Med*. 2007,22(4):485-90.
- Federal statute: 45 C.F.R. § 164.512(f).
- Chapter III. How big is the problem of controlled prescription drug abuse? Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the U.S., New York, NY, The National Center on Addiction and Substance Abuse at Columbia University 2005:p 40.
- Svenson JE, Meyer TD. Effectiveness of nonnarcotic protocol for the treatment of acute exacerbations of chronic nonmalignant pain. *Am J Emerg Med*. 2007,25(4):445-49.