

# Ethical, Legal, and Professional Challenges Posed by “Controlled Medication Seekers” to Healthcare Providers - Part 1

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## Abstract

Abuse and diversion of controlled prescription medications is a large and growing problem in the U.S. In fact, individuals abusing controlled medications outnumber the abusers of cocaine, heroin, hallucinogens, and inhalants combined. The first of this two-part paper focuses on the pragmatic, ethical, and legal issues that challenge physicians and other providers who must care for someone suspected or confirmed to be using deception to obtain controlled medications for resale, personal recreational use, or other reasons not sanctioned by the medical profession. The second part will focus on a general approach that attempts to minimize potential harms while still addressing legitimate medical needs of these challenging patients. It is hoped that this paper will be a catalyst for deeper and wider discussions and research on this difficult healthcare-related issue.

## Introduction

The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations-JCAHO) and other medical authorities have strongly encouraged healthcare providers to more aggressively treat pain after a wave of research indicated that many patients were not having their pain adequately managed.<sup>1,2,3,4</sup> Alas, the sword of aggressive pain control might be double edged. Although correlation does not mean causation, providers have simultaneously also witnessed

an increase in the percentage of individuals feigning or exaggerating medical conditions to obtain controlled prescription medications, especially narcotics, for ulterior purposes. For example, according to a 2005 report by the National Center on Addiction and Substance Abuse at Columbia University:<sup>5</sup>

There has been a 94% increase in people abusing prescription drugs between 1992 and 2003 (from 7.8 million to 15.1 million).

In the same time period, there has been a self-reported 140.5% increase in abuse of prescription opioids, a 44.5% increase in abuse of central nervous system prescription depressants, and a 41.5% increase in abuse of prescription central nervous system stimulants.

In 2003, approximately 6% of the U.S. population admitted to abusing controlled prescription drugs, 23% more than the combined number abusing cocaine, hallucinogens, inhalants, and heroin.

Teens have had an especially rapid rise in controlled prescription drug abuse, increasing 542% from 1992 to 2002; and 2.3 million teens (9.3%) admitted to abusing them in 2003.

Statistics available up to 2007 indicate that the trend of increasing abuse of controlled prescription medications has not abated, at least in those aged 18-25.<sup>6</sup> Importantly, the harms from controlled prescription medication abuse are also substantial because of their potential to cause physical or psychological dependency,

**Table 1:** Characterizing genuine patients versus different types of malingering.

|  | Has a medical condition? | Truthful? | Legal Behavior? |
|--|--------------------------|-----------|-----------------|
| <b>PATIENT TYPE</b>  |                          |           |                 |
| <b>Genuine</b>   | yes                      | yes       | yes             |
| <b>Malingers</b>   |                          |           |                 |
| Feigns/exaggerates a condition to obtain medication due to drug dependency.                          | yes                      | no        | no              |
| Feigns/exaggerates a condition to obtain medication for monetary profit or for its euphoric effects. | no                       | no        | no              |
| Feigns/exaggerates a condition to obtain monetary compensation.                                      | no                       | no        | no              |
| Feigns/exaggerates a condition to avoid a work day.  | no                       | no        | yes             |

add burdens to an already stressed healthcare system, and, especially, because it is estimated that they contribute to nearly 30% of all reported deaths and injuries from drug abuse.<sup>7</sup>

### Defining the Problem

“Drug seeking (behavior)” and “drug seeker” are phrases commonly found in the medical literature and in common medical parlance, and multiple definitions of “drug seeking” exist in the literature<sup>8</sup> and medical dictionaries.<sup>9,10</sup> Although some definitions list various behaviors commonly associated with drug seeking, at least one only focuses on a single illicit intent for the sought drug – selling it for profit.<sup>11</sup> However, for the purposes of this paper, “drug seeking” will include both the *general* behavior as well as the intent that is compelling the behavior. Additionally, this paper proposes to use the more precise phrases “controlled medication seeking” and “controlled medication seeker” to avoid including those who might seek an illicit drug, such as heroin, on the street, or even the parent who seeks a non-controlled drug like amoxicillin for their child’s viral respiratory infection. This paper defines “controlled medication seeking” as: intentionally feigning or exaggerating a medical condition, or otherwise using deception (e.g., prescription tampering) to obtain a controlled medication (medications that are classified as being schedule II-V of the U.S. “Controlled Substances Act”) from the healthcare system for purposes not sanctioned by the medical profession and provider.

### What Type(s) of Patients are Controlled Medication Seekers?

According to the U.S. Centers for Medicare & Medicaid Services (CMS), a “patient” is an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement or protection of health or lessening of illness, disability or pain.<sup>12</sup> An individual who intends to procure controlled medications from a

provider solely for its recreational effects (e.g., euphoria) or for monetary profit, fails to qualify as a genuine patient. Seekers who have an underlying physical dependency to the controlled medication or also have an underlying condition such as chronic pain are genuine patients by CMS’s definition – even if their behavior obscures a valid underlying medical condition(s).

Controlled medication seekers can also be categorized as a subset of a “maligner”: those who intentionally produce false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding work or military duty; obtaining drugs for financial compensation; or evading criminal prosecution.<sup>13</sup> While all forms of malingering are unethical at face value, some forms are not illegal, e.g., pretending to have back pain to avoid a day at work. Other forms of malingering such as faking a back injury to obtain an insurance claim and drug seeking are illegal, fraudulent acts.

Hence, drug seekers and maligners are not a homogeneous class of patients, which further complicates their characterization. Table 1 parses how genuine patients and several subsets of maligners can be categorized in regards to having a genuine medical condition, their truthfulness, and the legality of their behavior. Whether patients who are definitively involved in illegal activity should be reported to law enforcement authorities will be explored in the second part of this article.

### Roles and Responsibilities of Patients

Physicians and other healthcare providers have substantial “power” over their patients due to their mastery of special knowledge and skill sets, the healthcare setting which is intimidating or at least often confusing to patients, and the patients’ vulnerability when they are ill or injured, to name a few reasons. Therefore, tradition and a great deal of literature rightfully propounds upon the fiduciary duties that providers have to their patients. Perhaps less well known, or at least less publicized, is the caveat that patients also have duties to providers as well. One of the most important duties that a patient has to

providers is to be honest or “candid in discussing their medical problems,” as proposed since at least the 1700s by Doctor Benjamin Rush.<sup>14</sup> This assertion is echoed in contemporary times as well by the American Medical Association’s Code of Medical Ethics. Section 10.02 of the Code lists eleven patient responsibilities, the first two of which require the patient to be truthful and to give a complete medical history, and the last one that admonishes the patient from initiating or participating in fraudulent health care.<sup>15</sup>

According to the definition given above, controlled medication seekers use deception to obtain a particular medication from providers for ulterior purposes. Of course, besides the immediate breach in ethical decorum and responsibility, lack of patient honesty leads to pragmatic medical problems as well. For instance, even a careful exam and extensive tests cannot definitively refute a patient’s complaint of a severe headache – we must ultimately rely on their report of experiencing pain. Even though evaluations exist to help discern some genuine conditions from feigned conditions (e.g., a physical therapy evaluation of low back pain), in many settings such as the emergency department or a busy private practice, a provider might not have the time or the resources to quickly and confidently disprove a patient’s claim that they have the alleged condition. In other words, seekers take advantage of the indeterminacy and uncertainty inherent to the practice of healthcare.

Second, the exchange of adequate and honest information between the patient and provider is required for the development of mutual trust necessary for a well functioning patient-provider relationship. If the provider suspects or discovers a ruse, mutual trust is compromised and the seeker risks assuming the role of the “Boy Who Cried Wolf” with the same potential, eventual outcome. Third, the provider is also well aware of the parable’s outcome and now must not only wrestle with the uncertainty inherent to medical practice but also the added uncertainty imposed by the unreliable individual: “Is my patient with a history of controlled medication seeking telling the truth *this* time?!” Pursuing the spiraling descent of mistrust even further, sometimes seekers, who know that they are considered to be dishonest by their provider, local emergency department, etc., might decide to delay or forego genuinely needed medical treatment due to fear of disbelief or disdain from the provider. In the final analysis, if an individual is known to use deception to obtain controlled medications for ulterior purposes, the mutual trust critical for developing a well-functioning patient-provider relationship and to practice safe, effective medicine has been seriously undermined.

Importantly from the provider’s perspective, seekers also violate the interpersonal rule to not “use” another individual for their own hidden agenda. Controlled medication seekers understand and take advantage of providers’ professed duty to help others.<sup>16</sup> Because emergency departments are subject to the federal Emergency Medical Treatment and Active Labor Act (EMTALA), emergency providers also have a *legal* duty to provide at least “stabilizing” care for the complaints with which seekers typically present.<sup>17</sup> Hence, to the healthcare provider’s chagrin,

seekers try to take advantage of our ethical and legal duty to provide relief from suffering and medical “stabilization.”

## How Controlled Medication Seekers Compromise Medical Ethical Principles and Duties

Beauchamp and Childress’s book, *Principles of Biomedical Ethics*, provides one of the most commonly cited frameworks for contemporary medical ethical discourse.<sup>18</sup> According to their work, determining the ethically correct course of action to make within the healthcare context typically requires that four “mid-level” principles be considered and weighed: autonomy, beneficence, non-maleficence, and justice. Controlled medication seekers can pose significant challenges to the provider’s deliberation of all these principles.

### Autonomy

Autonomy, or the right of a competent person to make one’s choices without coercion, is necessary for the realization of one of the fundamental propositions of a liberal society: no one substantive perspective should be given a “privileged” position,<sup>19</sup> i.e., no person, including a healthcare provider, has the unabridged power to decide what is the “good” for another person. Thus, temporarily, autonomy has ascended over the older healthcare norm of the physician almost solely determining the best interests of a patient (a.k.a. physician paternalism). Nevertheless, a patient’s autonomy is not absolute and can still be overruled by concerns a provider might have that a requested treatment is ineffective, can cause harm to the patient or others, or is contrary to existing laws. Controlled medications have the potential to cause harm to their users via physiological and psychological dependency, compromised cognitive or judgmental abilities, and other serious side effects including death. Controlled medications also have the potential to directly or indirectly impel users to harm others via crime, child neglect, motor vehicle accidents, work absenteeism, and other negative behaviors. Therefore, the state has reduced an individual’s autonomy to obtain and use controlled medications via laws that limit how they can be accessed and punish those who irresponsibly prescribe them, obtain them by illegal means, resell them for profit, and so on.

In the state of Wisconsin, the law applicable to controlled medication seeking behavior is quite explicit. According to the Wisconsin Uniform Controlled Substances Act (961.43c): “It is unlawful for any person: To acquire or obtain possession of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge.” Also, physicians can have their license revoked or be charged criminally for improperly prescribing controlled prescription drugs per the U.S. Controlled Substances Act.<sup>20</sup> However, such indictments rarely occur against physicians (fewer than 1 in 10,000) and only for egregious controlled medication prescribing practices - not for being duped by drug seekers.<sup>21</sup> Additionally, at least one physician was found liable for refilling a narcotic prescription – despite the patient having

a “pain contract” that prohibited it – and the patient subsequently overdosed.<sup>22</sup> In the end analysis, there are legal in addition to ethical reasons to override the autonomy of an individual who uses deception to try to obtain controlled medications.

## Beneficence and Non-maleficence

The intent to maximize benefits (beneficence) for and minimize harms (non-maleficence) against patients is perhaps *the* core ethical principle and professed duty of healthcare providers. The seeker most immediately corrupts beneficence by duping the provider into trying to alleviate a condition that does not exist or at least is exaggerated. If a provider suspects controlled medication seeking behavior, the provider will typically be in a quandary to try to steer between the potential harms caused by giving a controlled medication for inappropriate reasons versus the harms of not addressing what might be a genuine condition with the best available agent. If the provider confirms that seeking behavior exists, then he may understandably be reluctant to prescribe the controlled medication to help that patient in the future, even when the problem is genuine – unless perhaps there is objective evidence that the condition does indeed exist (e.g., a bone fracture confirmed by radiography).

The potential to cause harm exists even independent from the side effects of the controlled prescription medication. Many feigned complaints prompt the provider to recommend or institute other medical treatments, diagnostics, or referrals, nearly all of which have some risks – at the very least, financial. Furthermore, because the provider is working with misinformation provided by the drug seeker, he will not be able to accurately weigh the benefits versus the risk of harm for various diagnostic and treatment modalities that need to consider.

## Justice

The theories of justice in medical ethics typically refer to the ideals of ensuring equitable distribution of resources (distributive justice) and the avoidance of discrimination.<sup>23</sup> Controlled medication seekers compromise distributive justice by impelling the misdirection of limited material, financial, temporal, and personnel resources away from those with legitimate needs. For example, a drug seeker complaining loudly and disrupting the emergency department because of feigned back pain might receive care before those with genuine, serious medical conditions.

Also, controlled medication seekers cause the misdirection of limited health care financial resources. For example, it would not make financial sense for a seeker without insurance to pay for an emergency department visit, even if they intend to sell the medication because the medical care bills are typically much more expensive than the drug’s street value. To illustrate, the street value of hydrocodone is approximately \$4-6 per pill and oxycodone is \$4-8 per pill.<sup>24</sup> A patient with a headache or back pain will usually incur a “level 2 to 3” charge which is typically more than \$500 in a Wisconsin emergency department for both facility and professional fees. If the physician prescribes the

typical 10-30 tablets of oxycodone, the subsequent street value would be \$40-240 – a loss of \$260 or more. If the patient *does* have insurance, the misuse of medical care still causes distributive injustice by contributing to the potential raising of premiums for everyone in the insurance pool.

## Conclusion

The growing number of individuals that use deception to try to obtain controlled prescription medications causes numerous pragmatic, ethical, and legal dilemmas to healthcare providers – and potential dangers to the individuals themselves, since the misuse of controlled medications are fraught with many dangers. This paper’s review of the major challenges and dilemmas posed by controlled medication seekers undoubtedly will not relieve the angst and frustration experienced by providers that face the difficulties of managing these patients. However, it is hoped that their articulation will at least help us to understand the many sources of that angst and frustration. The next part of this paper will examine the more pragmatic aspects of this difficult healthcare issue and review some of indications that the patient before you might be inappropriately seeking a controlled medication. The second part will also suggest a general approach to managing patients suspected of controlled medication seeking behavior that strives to minimize potential harms while also minimizing the risk of not treating legitimate medical needs.

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