

The Drug-Seeking Patient in the Emergency Room

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It has been estimated that an emergency department with 75,000 patients per year can expect up to 262 monthly visits from fabricating drug-seeking patients. Distinguishing drug seekers from patients who have a legitimate therapeutic need is not always possible in the acute care setting, yet physicians have the dual obligation to relieve pain and to protect susceptible patients from the consequences of abusing or becoming addicted to drugs [1]. Problems associated with frequent opioid use—for either recreational abuse or for pain control—make it imperative that physicians understand and appropriately manage patients who request psychoactive drugs.

In this article, the psychoactive properties of opioids, abuse, addiction, and pseudoaddiction are discussed, and various strategies for managing them are reviewed.

Psychoactive properties of opioids

The role of opioid medications in the treatment of pain, along with their physiologic and psychosocial limitations, is discussed in detail in other articles in this issue. Opioids, particularly mu-receptor agonists, produce psychological effects that cannot be separated from their analgesic properties. There are more mu-receptors in the brain than in the spinal cord, reflecting the role they play in the psychological aspects of pain and pain-control [2]. Euphoria and reward produced by mu-agonists and other addictive drugs are mediated through the stimulation of dopaminergic neurons in the ventral tegmental area in the midbrain. Experimental animals will rapidly learn to press a lever to inject morphine into this area [3], or electrically self-stimulate it to the point of ignoring their needs for food and water [4]. The reward and reinforcement properties of opioids persist even in the presence of analgesic tolerance, which is mediated through different parts of the central nervous system [5].

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When taken by normal patients at analgesic doses, opioids produce a change in mood and feeling typically described as decreased anxiety, drowsiness, and a sense of tranquility [6]. They “dull general discomfort” [7], or produce “a feeling of detachment from the responsibilities of the world” [8], even when they are not effective at relieving pain. Former addict volunteers usually report an elevation in mood and self-esteem. When taken intravenously (IV), some liken the opioid “rush” to sexual orgasm [6].

Prescription strength opioids are highly sought as drugs of abuse. The street value of prescription narcotics is greater than marijuana and heroin, and second only to cocaine [9]. The Drug Enforcement Administration (DEA) estimates that a third of illegal drug traffic is in the form of diverted prescriptions [10]. In drug treatment facilities, the principal drug abused is a prescription drug 9.4% of the time; the vast majority of these are obtained legally by prescription [11]. More than half of the patients who sought treatment or died of drug-related medical problems were abusing prescription drugs [12]. Short-acting, rapid-onset drugs produce a greater rush or “high,” and therefore have a greater tendency to be abused [13,14]. Not all patients get high after taking moderate doses of opioids. A placebo-controlled study in which healthy volunteers were given moderate doses of various mu-receptor agonists revealed that equal numbers of subjects report disliking the effects as liking them [15]. Nonetheless, half the population does feel some degree of euphoria, and predisposed individuals will abuse opioids if given the opportunity.

Self-reinforcing properties of opioids

In addition to producing pleasant sensations or euphoria in many patients, opioids are intrinsically self-reinforcing. When the drug is paired with actions or other stimuli, it produces rapid and entrenched learning or conditioning. Repeated drug administration may produce permanent changes in the ventral tegmental area of the midbrain [4]. Furthermore, opioids reinforce behavior that leads to their administration [16], and can diminish other unrelated behaviors that have been learned or reinforced previously [17]. When opioids are given in response to the patient’s complaint of pain, this self-reinforcing property may induce the patient to take the medication again, even if the patient’s pain responds poorly to opioids, or even in the presence of adverse consequences [7].

Reinforcement is rarely a problem in patients who have acute pain or cancer [18], but may be more prominent among chronic nonmalignant pain patients [19]. When used for chronic pain, opioids can reinforce behavior that leads to their administration, while failing to reinforce behaviors that are supposed to decrease pain or improve function [20]. Moreover, when opioid use is made contingent on the experience of pain, opioids may reinforce the perception of pain at a level high enough to justify their use [21]. This has been observed in many patients whose pain is actually

maintained by opioids [22], leading to a lifestyle that is “opioid centered” in addition to being pain centered [20]. Rapid-onset opioids, paired with the experience of pain, are greater reinforcers for pain and medication-taking than are slow-onset medications, and are more likely to increase the patient’s perception of pain [21].

Abuse

The American Medical Association’s Council of Scientific Affairs Panel on Alcoholism and Drug Abuse Task Force defines substance abuse as “use of a psychoactive substance in a manner detrimental to individual or society, but not meeting criteria for substance or drug dependence” [23]. This definition can be expanded to include use of an opioid for recreational purposes or for reasons other than pain control, whether or not the patient has a painful condition. Predisposing factors include chronic disease (possibly including chronic pain), an unhealthy lifestyle, lack of social support, and depression [24].

Drug abusers may insist on specific medications, claiming no other medications work [9], or may claim to be allergic to all pain medications except their drug of choice [25]. A preoccupation with opioids during the visit also tends to be associated with abuse [26]. Abusers may engage in various scams, such as faking kidney stones, to obtain narcotics [27]. Abusers tend to be younger. One study [28] reported that patients over age 65 were 10 times less likely to abuse drugs than those aged 18 to 44. In a study of drug-seeking patients that presented to an emergency room [11], the mean age was 34.3 years. These patients also averaged 12.6 visits per year, presenting to an average of 4.1 different hospitals, and used an average of 2.2 different aliases.

The prevalence of substance abuse among the general population in the United States is 6.1% in people aged 12 and older, and 9.9% among those 12 to 17 years old [29]; 9.3 million people used opioids nonmedically in 1999, including 1.6 million people who used them for the first time. This was increased from 500,000 in the 1980s [30]. Another study [31] found that 1.6% of the general population abuses pain medications.

The true prevalence of drug abuse among patients who complain of pain is difficult to determine, owing to problems distinguishing those who purely seek pain relief from those who seek the psychological effects [9]. In studies of chronic pain patients, the prevalence of abuse ranges from 2% [32] to 41% [33]. Much of the variation results from differences in the populations being studied, how abuse is defined, and at what point in time the researchers were looking for it. It has been shown that abusers tend to leave pain management programs early, and thus may not show up in reports of the prevalence of abuse in chronic pain patients [34].

The controversy over opioid abuse by chronic pain patients has been complicated further through inappropriate comparisons with acute pain and

cancer patients [35], whose use is less likely to be problematic. Acute pain is more responsive to treatment with opioids than is chronic pain, and it generally lacks chronic pain's complex psychological and social issues, as noted in other articles in this issue. Cancer patients tend to be older, and older patients are less likely to abuse drugs [11,36,37]. Cancer patients also show little dose escalation (even when not explicitly prohibited) compared with patients who have nonmalignant pain [38]. Consequently, observations about low levels of narcotic abuse in acute pain or cancer patients cannot be applied to chronic nonmalignant pain patients.

Problematic use and dose escalation have been attributed to undertreated or increasing pain [18,39–43]; however, alcohol abuse has been found in up to 40.5% of chronic pain patients [44]. This, along with the known prevalence of drug abuse among non-pain patients, suggests that it is highly likely that a significant number of chronic pain patients abuse their medications, probably at a rate at least as high as the general population.

Screening for abuse

Screening for a history or predisposition for substance abuse is difficult even when the clinician has a large amount of time and resources to gather information [26]. Substance abusers present with complaints of pain, but there is no way to test for or confirm its presence or severity. Self-reporting of pain has been advocated as the only way to validate and determine a patient's pain level [45]; however, if you rely solely on self-report, you cannot distinguish those who have real pain from those who are lying or exaggerating to obtain opioids for psychological or recreational purposes. As noted previously with the operant conditioning of pain behavior and perception, giving opioids (particularly rapid-onset opioids) in response to patients' self-reports of pain can result in some patients exaggerating their complaints, and possibly worsen their perception of their pain [46].

Self-report of the amount of medication used has been found to be inaccurate. In an inpatient pain treatment program, chronic pain patients were found to be using 1.85 times more medication than their self-reported use. The discrepancy between self-reported and actual use was found to be substantially less for patients over 55 [36]. At a pain clinic in which patients were screened and selected for having no history of abuse (and were chosen as good candidates for long-term treatment by both the primary physician and a psychiatrist), 27% consistently took much more than prescribed [47]. Patients have been noted to have a greater tendency to overuse short-acting opioids [48].

A prior history of drug or alcohol abuse helps to identify patients at risk for the problematic use of opioids, but a lack of a history of abuse does not reliably exclude them [26,34]. Substance abusers tend not to be forthcoming about their histories. In a study of 244 consecutive chronic pain patients presenting to a pain clinic [49], 8.8% were proven to have lied about illicit

drug use. In the emergency room, 90% of the patients who abuse opioids deny it [28].

Problems caused by drug abuse

There are many problems associated with the abuse of opioids, including those obtained by prescription. More than half of the patients who sought treatment for or died of drug-related medical problems in 1989 were abusing prescription drugs [12]. There are case reports of chronic pain patients biting and swallowing their transdermal fentanyl patches [50], including one patient who initially claimed to be medicating his pain, but later admitted to abusing the medication to get high. Despite being given a lower dose, he ultimately overdosed and died [51].

The cost of drug abuse on the American workplace was estimated at \$100 billion in 1992, and is thought to be double that more recently [25]. Drug seekers account for a disproportionate share of emergency department services. One study found drug-seeking behavior (identified by the use of aliases, frequenting multiple hospitals for narcotics, and so on) in 2.3% of emergency room and urgent care patients. These patients accounted for 20% of the total visits, adding to the crowding and confusion already present in many emergency departments [11].

Recreational or psychologically motivated use of opioids, if allowed to occur with any degree of frequency, will result in physiologic dependence. There are few data that specifically address how often or frequently abuse must occur to substantially harm a patient; however, even short-term opioid infusions have been found to produce paradoxical opioid-induced pain, and longer exposures induce long-lasting adverse neuroplastic changes [52]. These are reviewed in greater detail in the article “[The Psychology of Pain](#)” by Hansen elsewhere in this issue.

Side effects, such as sedation, may interfere with the patient’s quality of life. Some patients seek opioids to treat depression, anxiety, sleep disturbances, and other psychological problems, and misrepresent this to the prescribing physician [6,21]. Patients may then develop tolerance to the psychological effects they were seeking, increase the dose, and incur greater dependence.

For people who desire opioids for their psychological effects, pain is a socially acceptable stimulus that allows their use [8]. This may lead them to manipulate others in order to convince them that they are in pain, and they may adversely change their lifestyles for this purpose.

In those patients who have a real chronic pain condition and also abuse opioids for psychological or recreational purposes, it is important to note that opioid tolerance can increase chronic pain [52]. Most chronic pain problems will not improve significantly while the patient is actively abusing alcohol or illicit drugs [38,53]. Opioids have very little analgesic benefit for many chronic pain patients, and what little benefit they have gets lost due to

tolerance, making the patients' condition worse. This also is reviewed in greater detail in the article "[The Psychology of Pain](#)" by Hansen.

There are liability issues regarding the unrestricted and poorly managed prescription of opioids. A physician in Massachusetts was found liable for being lenient and refilling an opioid prescription despite the patient having a contract that prohibited it. The patient had a known history of non-compliance, and overdosed [54].

It is important to consider that overt drug abuse for recreational purposes represents only one end of the spectrum. Although overt recreational abuse of opioids can lead to problems for the patient and should be discouraged, recreational drug abusers represent a relatively small percentage of the population. The greatest problem lies with those chronic pain patients who take opioids for their psychological effects. The intrinsically self-reinforcing aspect of opioids and the associated physiologic dependence contribute to their compulsive use, even when they provide little pain relief, and can result in worsening pain.

The meperidine problem

Meperidine, an opioid mu-receptor agonist, possesses the worst attributes of opioids. Parenteral meperidine has an onset within minutes of injection, but produces clinical analgesia for only 2 to 3 hours. This is not improved by giving it intramuscularly, but only made less predictable. It has a toxic metabolite, normeperidine, which causes central nervous system (CNS) excitation and seizures, and lasts 15 to 30 hours [55]. Like other rapid-onset opioid medications, when meperidine is paired with the complaint of pain, it reinforces pain and drug taking, and may consequently result in an increased perception of pain [21].

Meperidine has been shown to be the most "intoxicating" of the opioids, with the largest mean peak ratings of feeling "high," "floating," "confused," "drunk," "coasting," or "difficulty concentrating." It produced 67% more drug high than morphine at equivalent doses. Meperidine also produced more nausea [15]. Parenteral meperidine has been studied in hospitalized patients. One patient developed a mild degree of dependence after 21 doses of 75 mg over 16 days, and demonstrated craving on discontinuation. Another developed psychological dependence after just 4 doses of 100 mg [56].

Despite these limitations, meperidine is frequently given by physicians, and is very popular with many patients, presumably for its tendency to make them feel high; however, some nonopioid medications have been found to be as good or better for pain relief in migraine headaches [57,58], renal colic [59], and chronic pain [60].

There have been many studies comparing meperidine to morphine. Meperidine has not been found to be better for biliary or ureteral spasm—both drugs mildly increase biliary spasm, and there is no clinically significant difference between them [61]. Morphine has been shown to

provide as good or better analgesia in a variety of other conditions [62–65]. In general, morphine is a better agent for most situations in emergency medicine that require a parenteral opioid analgesic [61]. In “idiopathic pain,” however, there was only a minimal reduction in pain (compared with placebo) with either 20 mg morphine or 100 mg meperidine given intravenously [66].

Drug-seeking behavior and abuse can be reduced significantly if physicians limit the use of meperidine to special circumstances. Some facilities, such as Cedars-Sinai Medical Center in Los Angeles, prohibit the use of meperidine for any reason other than amphotericin-induced rigors or for documented intolerance to alternative narcotics [67]; however, despite the analgesic equivalence between meperidine and morphine, and the CNS side effects associated with meperidine, meperidine has been given to 60% of acute pain patients, and to 20% of chronic pain patients [57].

For those patients who cannot tolerate morphine but still require a parenteral mu-agonist opioid, methadone is an effective alternative [68].

Addiction

The tendency for opioids to cause addiction is well known. At the beginning of the 20th century, 1% of the population was addicted to opioids, leading opioids to be made controlled substances in 1914 [69]. Currently, addictive disorders affect 6% to 17% of the general population [70].

Opioid addiction has been defined as persistent dysfunctional opioid use with adverse consequences, or loss of control, or preoccupation, despite adequate analgesia [70]. The presence of physiologic dependence and tolerance, which are inherent in the long term use of opioids, do not necessarily mean that the patient is addicted [21,71]. They may be contributing factors, but are not required for a person to exhibit compulsive use or abuse of a drug. Physiologic dependence, tolerance, and withdrawal are discussed in detail in the chapter “[Management of Chronic Pain in the Acute Care Setting](#)” by Hansen elsewhere in this issue.

Psychological dependence, defined as an emotional craving for the positive effects of substance or to avoid negative effects, may be present without the presence of physiologic dependence [23]. It is associated with compulsive drug-seeking behavior leading to overwhelming involvement in drug use and to obtaining drugs [72]. Psychological dependence on kappa agonists has been observed, even though there are no physical withdrawal symptoms [73].

The signs of addiction overlap with those of abuse. They differ in that addiction involves persistent compulsive use, whereas abuse may be defined as the use of drugs for recreational or psychological purposes for which they were not intended. Addiction may arise from either abuse or from poorly managed medical use. In the latter instance, the prescribing physician is at least partially responsible.

Addiction in chronic pain patients

There is considerable controversy surrounding the issue of addiction in chronic pain patients. Behaviors associated with addiction include an inability to restrict medications or take them on an agreed-upon schedule, taking multiple medications together, doctor shopping, isolation from friends and family, the use of nonprescribed psychoactive drugs in addition to prescribed medications, inability to recognize psychosocial and psychological aspects of chronic pain, noncompliance with recommended non-opioid treatments or evaluations, a preoccupation with opioids, insistence on rapid-onset formulations and routes of administration, and reports of allergy or no relief whatsoever by any nonopioid treatments [13,21,74]. The frequent loss of prescriptions, concurrent abuse of other drugs, forgery, and selling, stealing, or getting drugs from the street are more strongly indicative of addiction [38].

Addiction is associated with loss of control or overwhelming involvement in obtaining opioids; however, mild psychological dependence may be present without evidence of overwhelming involvement. Because of the risk of psychological dependence, some authors recommend against the use of opioids for chronic pain, particularly parenteral opioids [75].

The presence or absence of tolerance does not reliably distinguish addicts from nonaddicted chronic opioid users. Patients may require moderate increases in dose as a normal result of tolerance. On the other hand, addiction can be present even when the dose has stabilized. Heroin addicts and experimental animals that self-administer narcotics ultimately reach a stable dose [19], similar to alcoholics who reach a stable intake level.

Rapid dose escalation, however, does imply addiction. Tolerance to the euphoric side effects of opioids develops faster than tolerance to the analgesic effects. Consequently, rapidly developing tolerance suggests that the patient is primarily seeking the drug's psychological effects [53].

Dose escalations have been attributed to worsening of the underlying condition or complications of the disease [42]; however, most of the patients in the study were taking codeine. Even at high doses, true analgesia from codeine is so poor that by itself it would not be an inducement for dose escalation [76]. Moreover, most forms of chronic pain have no objective evidence by which one can attribute worsening of the condition.

Because of confusion about the definition of opioid addiction in chronic pain patients, and the difficulty in distinguishing those who seek opioids for recreational or psychological purposes from those who are purely trying to relieve pain, it is difficult to determine the true prevalence of addiction among chronic pain patients. The prevalence of "psychological dependence and compulsive use" of substances by chronic pain patients has been found to be 3.2% to 16.5% [72]. The risk of addiction should be much lower for patients taking slow-onset, long-acting forms of opioids, but even among a group of patients taking sustained-release morphine, up to 120 mg/day,

4.3% reported craving [77]. The risk of addiction approaches 50% in chronic pain patients in patients who have contact with the “street culture,” and who are actively abusing illicit drugs, are not in a recovery program, and have poor social support [78].

One report states that addiction is rare in patients treated with narcotics [79]; however, this was in fact only a brief follow-up report of a proposed surveillance system for adverse drug reactions [80], in which hospitalized patients received as little as a single dose, and no information was provided as to how they defined or identified addicts. Moreover, it is inconsistent with studies of true addicts, whose first exposure to opioids was medical use in 9% to 27% of cases [21]. It furthermore fails to address the chronic use of opioids for nonmalignant pain.

Because of the small but significant prevalence of true addiction among chronic pain patients, it is important to consider a dual diagnosis of chronic pain and addiction when patients demonstrate a preoccupation with opioid medications [20].

Screening for addiction

Screening for addiction is no easier than screening for abuse. One study found that the best predictor for “problematic use” is admission by the patient. Determining that the patient has an addictive disorder generally requires information from the personal physician and the family [70].

Problems with addiction

Addiction has serious consequences for both drug abusers and chronic pain patients. Even subtle addiction or psychological dependency may result in persistent sedation or intoxication due to overuse, functional impairment, irritability, apathy, anxiety, depression, and adverse legal, economic, and social consequences [74]. An example of this can be seen in the \$5.2 billion class-action lawsuit filed against Perdue Pharma for pushing OxyContin, which caused addiction in some patients when used “exactly as their doctors prescribed it.” One of the plaintiffs is a patient who abandoned her children “in the haze of her Oxy addiction” [81].

Other problems have been demonstrated in heroin addicts. They have been found to have a proneness to overreact, and be overly concerned about personal comfort, which improves with abstinence [82]. Their pain tolerance has been found to be lower than normal, as demonstrated by cold pressor tolerance [83]. Their pain threshold and tolerance remain abnormal even when they are maintained on methadone [84]. When addicts are in withdrawal, they suffer from hypochondriasis, depression, and lethargy [82].

It has been found that pain cannot be adequately managed, and may be made worse, when complicated by addictive disease [70]. On the other hand, treating opioid addiction in chronic pain patients has been shown to

improve pain and well-being in the majority of patients, and they can return to work. Psychiatric illness cannot be treated until substance use is under control [85].

The problems with opioid addiction are worse with short-acting drugs, similar to the problem with abuse. These problems may resolve when the patient is switched to a long-acting drug [10].

There is a high relapse rate for patients that have been addicted [4,86]. It has been found that even a small quantity of drug similar to what they were abusing produces craving and relapse, even after 2 years of abstinence [86]. Consequently, caution should be used in prescribing small doses or weak opioids, or even agonist-antagonists, in patients who have been addicted to opioids in the past.

Patients and their families have blamed emergency physicians for their addiction, because they give them opioids every time they present [87]. There is concern that, since the Joint Commission on the Accreditation of Health care Organizations (JCAHO) has begun including checks on pain management for accreditation, physicians have become more liberal in their opioid prescription practices, resulting in an increase in the prevalence of addiction [25].

It is important to consider that overt addiction, like abuse, represents only a small part of the spectrum of problematic use. Many more patients have subtle psychological dependence that is not obvious to the physician or even to the patient. Although addiction and abuse are problems in themselves, the greatest threats to most patients are opioids' adverse effects on psychosocial function and pain control.

Pseudoaddiction

The term "pseudoaddiction" has been used to describe behavior similar to addiction that results from poorly managed pain. Pseudoaddicted patients may be overly focused on obtaining medications, "clock-watch," and appear to be drug-seeking. They may be deceptive and even use illicit drugs [74]. The natural progression of pseudoaddiction may include escalating analgesic demands associated with behavioral changes to convince others of the pain's severity [88].

It can be nearly impossible to distinguish pseudoaddiction from true addiction, particularly in the acute care setting. True addiction is probably present if the patient's function is deteriorating or if he is injecting oral formulations of narcotics [53]. Problematic use of poor analgesics such as codeine or propoxyphene probably represents addiction, because their psychological effects provide a far greater inducement for their use than their analgesic effects.

In pseudoaddicts, drug-seeking behaviors resolve when pain is effectively treated [74]. Pseudoaddicts demonstrate an improved level of function with appropriately managed opioids [21], particularly if they are switched to adequate doses of long-acting opioids [53].

The prevalence of pseudoaddiction among drug-seeking patients is not known. It is important to note that this concept was developed based on the behavior of a single cancer patient who was being under-treated with parenteral opioids [34]. For the acute care physician, it is important to understand that some patients who manifest drug-seeking behavior might actually be pseudoaddicts whose behavior may improve with better management of their pain; however, these patients need appropriate multidisciplinary care for their pain as much or more than any other pain patients. Prescribing higher doses of short-acting or injectable opioids may not only fail to help them, but may contribute to a true narcotic problem in addition to their poorly managed pain.

Managing drug-seeking patients in the acute care setting

Patients at risk for problems with opioids

Patients at risk for problems with opioids include anyone who frequently uses the emergency department or urgent care clinic to obtain opioids, whether it is for abuse or because his pain is not being appropriately managed as an outpatient. This is particularly important for patients who have psychosocial dysfunction. Some physicians believe it is better to give these patients the benefit of the doubt, and prefer to administer opioids to possible recreational drug abusers so as to avoid the risk of withholding them from patients who have legitimate pain [1]; however, physicians are also responsible for protecting patients from complications that arise from inappropriate or poorly managed opioid use [53,89].

Distinguishing patients as being either “legitimate” or “drug-seeking” is valuable only if the distinction is used to guide appropriate treatment. In designating patients as being legitimate, physicians should be careful not to imply that the emergency department is where they should be getting their treatment. Rather, they should reinforce that these patients are best served by having their pain managed comprehensively as outpatients [89].

True drug abusers and addicts should also be identified so that they might be given the help that they need. Studies have shown that although up to 27% of emergency room patients need drug or alcohol treatment, the problem is documented in only 1% [31]. The emergency department is in fact an excellent setting for the identification and referral of drug and alcohol abuse. The patient is already in a medical setting, and does not need to muster the additional motivation to seek help. The patient may also have had a drug-related accident, or be in some form of crisis involving use or supply, at which time he is most likely to consider change [90].

Habitual patient files

Some physicians will not prescribe an opioid until records from previous physicians are obtained and reviewed [53]. Such records are not always

available, or they may be incomplete. An alternative is to keep a habitual patient file. Such files are allowed under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), by the JCAHO, and by various state regulations, such as the Confidentiality of Medical Information Act in California. Patients should be selected in an appropriate and systematic manner. Information should be limited to what is necessary for the diagnosis or treatment of the patient, and should not contain any wording that is judgmental, demeaning or discriminating [1].

Management strategies

The treatment of drug addiction is beyond the scope of this article; however, various strategies are available to identify patients at risk for complications of frequent opioid use, and to improve their care. Some emergency departments use “narcotic contracts” or pain management letters that refuse narcotics to selected frequent users unless they have a detailed letter from their personal physician. One facility reports a tracking and management system for patients who request narcotics frequently. In this system, a “care manager” helps direct patients who have drug problems toward treatment programs, while assisting the department in providing optimal care for those who are therapeutic users. Systems such as these can help legitimate pain patients access optimal pain management, direct drug abusers and addicts to appropriate therapy, and improve emergency department use and staff morale [91].

A study was done [92] that identified frequent users of the emergency department, in an attempt to encourage them to use community services, where they can be managed more effectively. Denying a narcotic prescription in the emergency room, restricting prescriptions to one pharmacy, and supportive and addiction counseling for certain patients resulted in a 72% decrease in the use of the emergency department by the frequent users overall, from 26.5 visits to 6.5 visits per patient per year, with no increased use of other local hospitals.

Compassionate refusal

Some patients demand opioids when they are not appropriate. In such cases, the physician should express compassion for their condition while explaining that opioids, particularly those that are short-acting and rapid-onset, may do more harm than good for their long-term pain control. If they persist in their demands, the physician may “turn the tables.” While expressing appropriate concern for their pain, the physician should review with them again that they are requesting a form of medication that may be harmful to them, and that there is a need to discuss issues of physiological and psychological dependence [9]. Many patients, particularly those who present with the expectation that they will be given an opioid, are highly

resistant to any other recommendations. These expectations are not likely to change until multiple physicians have denied them narcotics.

If the physician decides to give an opioid for the patient's pain, methadone and long-acting morphine are considered good choices, and are less likely to reinforce drug-seeking behavior [93]. These drugs are particularly useful for patients who complain of pain and may be at risk for opioid withdrawal if they are not given an opioid. When prescribing methadone, documenting that it is being used for treating pain will avoid issues surrounding the treatment of addiction.

Summary

Drug-seeking patients include recreational drug abusers, addicts whose dependence occurred through abuse or the injudicious prescription of narcotics, and pseudoaddicts who have chronic pain that has not been appropriately managed. Opioids produce euphoria in some patients, providing the motivation for abuse, which can be detrimental even with occasional use. Even in the absence of overt euphoria, opioids are highly self-reinforcing and can be problematic in a large number of patients, requiring that acute care physicians exercise caution in whom they are administered. Habitual patient files, narcotic contracts, pain management letters, and patient tracking and management programs can be used for the benefit of both drug seeking-patients and chronic pain patients. For many patients, drug-seekers and chronic pain patients alike, withholding opioids may be an important part of their long-term management. For others, long-acting opioids such as long-acting morphine or methadone are a reasonable option.

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