How Can You Tell Medication Use From Medication Abuse?

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Accepting the gatekeeper role requires scrutinizing and sometimes confronting the patient at the gate; it's getting a lot more complicated.

**Being a medication gatekeeper is getting more and more complicated**

Opioid painkillers, such as Vicodin (hydrocodone) and OxyContin (oxycodone), are crucial medical tools that are addictive and widely abused. Tranquilizers and sleeping pills of the benzodiazepine class, like Xanax (alprazolam), Ativan (lorazepam), and Klonopin (clonazepam), are safe and effective in limited, short-term use, but are often taken too freely, leading to drug tolerance and withdrawal risks. Stimulants such as Ritalin (methylphenidate) and Adderall (amphetamine) ease the burden of ADHD but are also widely used as college study aids as well as recreationally.

All of these medications are available only by prescription. This means prescribers serve as gatekeepers, permitting access for medical needs and denying it otherwise.

This gatekeeping can be difficult. Doctors are imperfect lie detectors and can be fooled with a plausible story. Pain, anxiety, insomnia, and inattention are mostly invisible. The internet offers quick lessons in how to fake a medical history. Beyond the initial assessment, every physician has patients who repeatedly "lose" bottles of painkillers or tranquilizers and request more.

Secretly seeing multiple doctors to obtain the same drug remains fairly easy. While a few doctors run illegal "pill mills" and flout the gatekeeper role, many more are simply too overworked to be vigilant with every patient.

None of us became physicians to fight the war on drugs. On the contrary, most of us are uncomfortable doubting our patients' honesty. It's stressful to worry about being too suspicious or too gullible, and it's a waste of valuable time.

The possibility of tranquilizer abuse arose with a new patient of mine recently. My concern led to multiple phone calls to pharmacies and to consulting California's CURES database online. I was convinced enough that something was amiss that I confronted my patient, who responded by calling me names, making vague threats and leaving in a huff without paying for the appointment (and, of course, never coming back).

Although the reaction seemed confirmatory, in truth I'm still not certain my suspicions were correct. Why did I put my patient and myself through such grief? Because I wanted to "do no harm."

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Let's consider other drugs that are used both medically and recreationally -- but unlike those mentioned above, do not involve a physician gatekeeper.

The best candidate may be cannabis. Currently legal in 28 states, medical marijuana requires a doctor's authorization but not a prescription that specifies dosage, frequency, and duration of treatment or route of administration. By definition, a Schedule 1 drug, like marijuana, is not "FDA approved" for any medical use. Yet cannabis is very much like the Schedule 2 drug Adderall: it has a few solid medical uses, a much larger set of dubious or controversial ones, and a sea of mostly illegal recreational use.

A lot of medical marijuana is used for relaxation or sleep, blurring the medical-recreational distinction in much the way Adderall does when used for studying. Purely recreational use is legal in four states as of this writing.

I have never authorized medical marijuana, although several of my patients were approved by other physicians and use it regularly. Once a patient tells me he or she uses marijuana, whether doctor-approved or (for now) illegally, I can act in my preferred role as adviser. We can discuss risks and benefits, sativa versus indica, THC and CBD, all without me having to second-guess my patient's story, make a paternalistic decision about whether to authorize access, or even cast judgment on the decision to use it.

In states where recreational cannabis is newly legal, it joins the three drugs already native to our
cultural landscape. Adults consume alcohol, caffeine, and nicotine with nary a prescription, gatekeeper, or hoop to jump through. And although we rarely think about it, all three have medicinal effects. Alcohol can reduce stress, aid sleep, and may promote health in a number of other ways. Caffeine treats fatigue, migraine headaches and possibly obesity. Nicotine eases Parkinson's disease and perhaps schizophrenia, and helps with weight loss.

While smoking rates are declining in the U.S., most Americans continue to use alcohol and caffeine often for a complex mixture of reasons: taste, psychoactive effects, social custom, and sometimes for plainly medicinal purposes. Widespread use also leads to addiction in a significant subset of the population: caffeine becomes necessary and not just optional, and we go to extraordinary efforts to manage alcoholism. As tragic as this is, nearly everyone agrees that Prohibition was the greater evil. I like that I'm an adviser, not a gatekeeper, for marijuana and the (other) legal vices. I also reject the gatekeeper role for stimulants by telling callers I don't treat ADHD. This is trickier, my refusal to treat a legitimate psychiatric disorder is arguably too finicky. It can be hard for an earnest sufferer to obtain a thorough evaluation and treatment, even if, paradoxically, it is all too easy for a drug abuser to tell a sob story and score a prescription. Nonetheless, with stimulants, as with medical marijuana, I'm uncomfortable making Solomonic distinctions where medical and non-medical uses lie so closely on a continuum.

In any event, I draw the line there. I continue to prescribe tranquilizers and sleeping pills for my patients who seem to need them. I may unwittingly abet substance abuse in some cases, but the alternative is to not prescribe any abusable medication, a stance that feels far too finicky. After all, medication gatekeeping is the norm for many physicians. Oncologists, surgeons and ER doctors can't tell patients they don't treat pain. Surgeon General Vivek Murthy sent a letter to every U.S. physician in August, urging us to help fight the "opioid epidemic" by limiting dosages and durations of opioid prescriptions and by substituting non-narcotic alternatives -- in essence, by being better gatekeepers.

The only way to avoid doctor-as-gatekeeper entirely is to make all drugs available without a prescription. The prospect of narcotics and amphetamines on the open market strikes most of us as extremely foolish, even though Prohibition and the failed war on drugs should give us pause. Another strategy is to embrace gatekeeping even more seriously, as Dr. Murthy advises. Careful comprehensive evaluation, "start low and go slow" prescribing, close monitoring using a system like CURES, and strictly limiting refills should drive down prescription drug abuse. Unfortunately, this takes more clinical time, one thing most physicians can't spare, and trades away doctor-patient collaboration for something more wary and legalistic.

As usual, physicians are asked to erode the traditional doctor-patient relationship and do more work to keep the system afloat. Meanwhile, patients suffer further small indignities and colder encounters. Alternatively, we could wait it out. The line between medical treatment and personal enhancement or optimization gets fuzzier all the time. Society may soon fail to distinguish treating an anxiety disorder and taking something to relax in the evening, or treating ADHD and simply maximizing one's mental sharpness. The medical-recreational divide already looks more like a continuum for marijuana and stimulants, and it is essentially gone with respect to alcohol, caffeine, and nicotine. If this trend continues, physicians may no longer be called upon to distinguish legitimate from illegitimate drug use. Our focus as medication gatekeepers may shift from the purpose of the prescription to its safety, making us more like pharmacists than judges.

Steven Reidbord is a psychiatrist who blogs at Reidbord's Reflections. This post appeared on KevinMD.com.

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