

## Addiction Medicine and the Primary Care Physician

# Prescription Drug Abuse Patient, Physician, and Cultural Responsibilities

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*The abuse of prescription drugs is one facet of America's drug problem that is particularly complex because access to prescription drugs must be maintained for some purposes and contained for others. The American Medical Association has sponsored two national conferences to grapple with the confluence of the medical access to prescription drugs and a national drug abuse control policy. One result has been a classification of misprescribing physicians that blames physicians for prescription drug abuse. The conceptualization and public policy response to prescription drug abuse have been largely shaped by the emotional response to the epidemic of crack cocaine and other nonprescription drug abuse. A new perspective is needed—one that accommodates the evolving role of physicians in society, the lifestyle choices that physicians enable in their patients, and the respective responsibilities of both physicians and patients in physician-patient transactions.*

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In 1980 the American Medical Association (AMA) sponsored a White House Conference on Prescription Drug Abuse that drew attention to the abuse of prescription drugs as one facet of the nation's growing drug problem. In the intervening ten years, the Drug Enforcement Administration, state medical licensing boards, and local drug abuse agencies have expended great efforts to curb prescription drug abuse, and, as shown in Figure 1, many regulatory agencies oversee the manufacture and distribution of prescription psychotropic medications that have abuse potential. Despite triplicate prescriptions, new laws, and an increasing web of regulations designed to control prescription medications, the abuse of prescription drugs has continued.

In December 1988, the AMA's Department of Substance Abuse, headed by Ms Bonnie Wilford, sponsored a second national conference on prescription drug abuse. The conference—which included plenary sessions and workshops covering clinical and epidemiologic aspects of prescription drug abuse and regulatory strategies for curbing prescription drug abuse—brought together speakers from drug law enforcement, organized medicine, medical practice regulatory bodies, and a representative from the Narcolepsy Foundation representing the patients' perspective.

The basic positions of medicine and regulatory agencies have changed little in the years between conferences. The patients' perspective was a superb anchor to discussions of prescription drug abuse in which the legitimate need some patients have for access to the medication is often overlooked.

But the conference was also remarkable by what was missing. There were no discussions of the many underlying assumptions that shape attitudes and ideas about prescription

drug abuse. Prescription drug abuse is more difficult to conceptualize than the abuse of cocaine, marijuana, or even alcohol because there is the need for a balance between restricting access and maintaining availability in drug control policy.

### What Is Prescription Drug Abuse?

Prescription drug abuse is a nebulous construct whose common denominator is that medicinals manufactured by the pharmaceutical industry are being used in ways that were not intended by regulatory agencies and in ways that are not approved by the mainstream culture. Lumped together is a range of patient, physician, and addict behaviors. At one end are those physicians who, for personal profit, sell prescriptions to drug addicts who will use the medications to "get high." At the other are patients being treated for a medical condition who take more of a medication than an addiction specialist deems appropriate. Epidemiologists describe occurrences of drug-correlated adversities that appear in emergency departments as prescription drug abuse, clinicians describe cases of addiction to prescribed medication, and enforcement officers speak of physicians who deal drugs—all trying to communicate with one another without a common frame of reference. What is needed to design more effective intervention strategies for prescription drug abuse is a better operational definition of physician, patient, or addict behaviors that relates to prescription drug abuse.

### Why Is Prescription Drug Abuse So Abhorrent?

Participants in both AMA conferences uniformly condemned prescription drug abuse—however they defined it. The common view is that medicinals are intended to treat

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disease and that physicians should prescribe medications only to treat disease. Any other use of their medicinals is unethical, criminal, or both.

This definition of physicians' role in society does not reflect the reality of physicians' range of practice. For example, birth control, abortions, and cosmetic surgical reconstructions—accepted medical practices that have to do with enabling personal choices rather than treating illness—involve the prescription of “medications” for purposes other than the treatment of disease. Physicians are uniquely restricted in their prescription of psychotropic medications.

The question is why physicians' prescribing of psychotropic medication for nonmedical purposes is so vehemently abhorred in this culture. Clearly, the prohibition of prescription psychotropic drugs is an extension of the dominant culture's selection of alcohol as the permissible social-psychoactive drug and its prohibition of all other drugs.

Many people now point out that the cultural enabling of alcohol use and the concomitant prohibition of the recreational use of other drugs is determined more by cultural tradition than pharmacology. Without question, the toxicity of many prescription psychotropic drugs does not exceed that of alcohol. Many laypeople and some physicians think that the responsible use of prescription medications for purposes other than the treatment of disease should be permissible and that access through physicians and pharmacies would be preferable to illicit, unregulated, and uncontrolled black-market access.

**Why Is the Physician Blamed?**

When a patient abuses a psychoactive medication that a physician has prescribed, it is usually the physician, not the patient, who is held legally and morally responsible. This

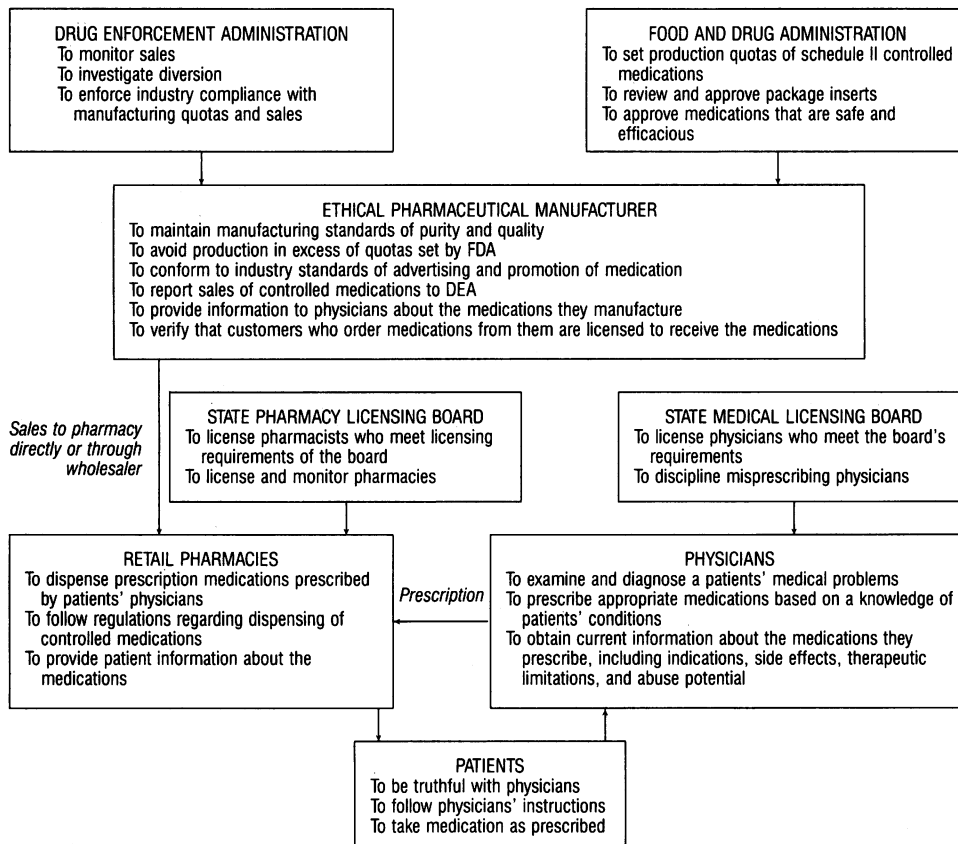
physician-at-fault theme permeates both medical and legal discussions of prescription drug abuse and was generally echoed by speakers at both AMA-sponsored conferences. The AMA itself has adopted a categorization of physician misprescribers—the dated, the disabled, the dishonest, and the duped (the four “D's”)—that assigns fault to physicians. The category-wide assignment of fault by the AMA seems particularly incongruent. An understanding requires a knowledge of how the classification system arose.

The four-D classification—conceived and developed by one of us (D.E.S.)—was first presented at the White House Conference on Prescription Drug Abuse in 1980.<sup>1</sup> Smith and Seymore's intent was to stimulate educational alternatives for the dated or duped physicians, who at that time were either being prosecuted in the same manner as dishonest physicians or were allowed to continue misprescribing because there was no alternative to disciplinary intervention. The four-D classification was pragmatically useful, and several state medical licensing boards subsequently initiated prescribing practice educational alternatives to discipline.

After the White House Conference, Emanuel Steindler, who was on the AMA staff, incorporated the four-D classification into an AMA position paper, which was subsequently adopted as an official stance of the AMA.<sup>2</sup> The AMA took a leadership role in advancing a pluralistic approach to physician misprescribers.

Although Drug Enforcement Administration and other regulatory agencies also adopted the classification, they often perceived an overlap between dishonest physicians and dated or duped physicians and they viewed physicians disabled by personal addiction as “willful misprescribers” who should be prosecuted.

Thus, the classification, which started as an educational



**Figure 1.**—The diagram shows the responsibilities of those involved in the manufacture and distribution of prescription psychotropic medications with abuse potential.

device, has taken on institutional and legal meanings far beyond its original intent. Its association with fault and moral responsibility is entangled in the tradition of medicine and the history of popular antidrug sentiment. Releasing it requires that it be gently disentangled through a realistic understanding of the responsibilities of physicians and patients in a physician-patient relationship and then reframed with anti-drug sentiment in the background.

The physician-patient interaction involves respective responsibilities that are part of our culture. The salient responsibilities, summarized in Table 1, are so much a part of our cultural tradition that they are rarely made explicit, and we can generally assume that most physicians and patients know their respective responsibilities. Physicians are responsible for having as their primary concern their patients' well-being and for providing the time, skill, and knowledge to diagnose and treat their patients' disease or condition. Patients are responsible for seeking medical attention for diseases or conditions that they believe a physician can cure or ameliorate, for providing their physicians with the best information possible, and for following their physicians' directions.

The physician-patient relationship is seriously distorted when either party fails to abide by his or her responsibilities. Thus, the breach of responsibility should be the basis for assigning fault.

#### Dated Physicians

Some physicians misprescribe psychoactive drugs because the information on which they base their therapeutic choices is obsolete, incomplete, or wrong. Such physicians have violated their responsibility to their patients by not keeping abreast of current prescribing practices and of abuse patterns of psychoactive drugs. Thus, they cannot meet their responsibility to practice medicine at the same standard as other practitioners in the community.

Prescribing practices change over time as new medications become available or as new clinical information becomes established by scientific study. In the absence of reasonable clinical certainty established by well-conducted clinical trials, prescribing standards for psychotropic medications are established primarily by clinical consensus. The consensus is influenced by many factors, among them societal values, the schedule of the medication, reports of toxicity, and current abuse patterns involving the medication.

The use of amphetamines for weight control is illustrative. The balance has shifted against their use for weight control, not because more efficacious medications have been developed but rather because of the view that their potential for abuse outweighs their therapeutic benefit in controlling weight. Physicians who prescribe amphetamines for weight loss today would be hard-pressed to justify their prescriptions; yet, in the 1950s this was accepted medical practice. Physicians have the responsibility to follow current prescribing practices. Outdated physicians have failed in their responsibility to keep current on prescribing information.

#### Disabled Physicians

Physicians whose judgment is impaired by mental illness or by their own use of psychoactive drugs may prescribe psychotropic medications at variance with accepted practices. A few impaired physicians prescribe excessive amounts of the psychoactive medication or medications that they themselves are taking. More often, however, such physi-

cians may withhold from patients medications that are medically indicated because these physicians fear drawing attention to themselves. In either case, they breach their responsibility to their patients because they do not bring to the physician-patient relationship their best judgment, attention, and skill.

#### Dishonest Physicians

Dishonest physicians are those who use their medical license to deal drugs. When drug addicts consult a dishonest physician, the physician does not have his or her patient's well-being as the primary concern. Such physicians are not treating illness; they are perpetuating addiction while creating the illusion of medical practice to avoid prosecution.

The identification of such physicians pivots on determining their motive. Unfortunately, their motive is not directly observable and must be inferred from their behavior. The motive is obvious when a physician's behavior matches the classic profile of the "script doc"—a physician whose fees

TABLE 1.—The Responsibilities of Physicians and Patients in the Physician-Patient Interaction

Physician	Patient
To have the patient's well-being as his or her primary concern	To seek medical attention for conditions that he or she believes that a physician can cure or ameliorate
To formulate a working diagnosis of the patient's problem based on the patient's history and examination	To be truthful in relating historical information and to cooperate with the physical examination
To obtain appropriate laboratory tests—or consultations with specialists—to clarify diagnosis	To cooperate in obtaining the laboratory tests—or consultations—requested by the physician
To prescribe appropriate therapy (assumes that the physician is acting within his or her scope of expertise and that the physician possesses about the same level of knowledge as other practitioners in the community)	To comply with the physician's instructions, such as taking medications as prescribed and avoiding activities that would complicate or aggravate the disease
To monitor the effect of treatment, including monitoring for side effects or toxicity	To report symptoms accurately
To continue follow-up until the condition is resolved or the patient's care is assumed by another physician	To follow through with follow-up appointments until discharged by the physician

TABLE 2.—The Physician and Patient Contribution in Each of the American Medical Association's Categories of Misprescribing Physicians

AMA Physician Category	Physician's Contribution	Patient's Contribution
Dated . . . . .	Fails to keep current with prescribing practices or knowledge about current drug abuse patterns	...
Disabled . . . . .	Fails to exercise optimal judgment because of impairment	...
Dishonest . . . . .	Subverts medical practice for personal financial gain	Uses physician as drug dealer, not for medical care
Duped . . . . .	Fails to detect deception Allows himself or herself to be manipulated into prescribing at variance with accepted medical practices	Falsifies or withholds information

are dependent on the quantity and type of drug prescribed. It is less so when a dishonest physician closely simulates in his or her office procedures legitimate medical practice. But the identification of dishonest physicians should not be difficult for ethical physicians. Dishonest physicians fail to meet every physician responsibility.

### *Duped Physicians*

A duped physician is one who inadvertently supplies drugs to a drug abuser because the physician has been deceived by a drug abuser posing as a patient. As noted in Table 2, it is primarily the "patient" who has failed to meet his or her responsibility.

Drug abusers who do not want their drug dependence treated but rather want access to the medications for which a physician is the gatekeeper may create the illusion for physicians that they are seeking medical attention for a disease or illness for which the desired drug would be appropriate. Scams for medications can be quite sophisticated, innovative, and impossible to unravel in the time available for the physician-patient interaction.

The term "duped" is not always appropriate in these situations because it implies that a physician is careless, easily deceived, or foolish. It has an implied converse: that careful, competent physicians would not have been duped because they would have recognized the deception. Many who work with such patients have been victims of deception on occasion and suspect that, given the right circumstances, any physician who would undertake the care of such patients could be deceived for a period of time. Why should physicians be at fault when they are the victims of deception?

This question should be of considerable concern to physicians because the issue has been the substance of malpractice suits, disciplinary proceedings, and criminal charges against physicians.

Important dynamics make physicians vulnerable to being held at fault, even when the fault should reasonably rest with the patient. First is the concept of drug addiction as a disease. Many people misunderstand the disease concept and reason that because patients are not at fault for having a disease, they should not be held accountable for their behavior when it is caused by their disease. People who hold this position are understandably reluctant to hold patients at fault. Because someone must be at fault, a physician is blamed. But when patients have used deception to obtain medications or use them in ways other than those prescribed by their physicians, they have violated their responsibility in the physician-patient relationship.

### **Conclusion**

The efforts of the AMA and the four-D classification of misprescribing physicians have helped state medical licensing boards and enforcement agencies develop ways of intervening with misprescribing physicians sooner and with a broader range of options. The next step is to further refine the application of this system.

Physicians who fail in their responsibilities to patients should be censured, but the current tendency to assign fault to physicians when patients have violated their responsibility is unreasonable and unfair to physicians. When patients are dishonest in the physician-patient relationship and deceive their physicians, or when patients use their medications other than as prescribed, society should hold the patients, not the physicians, accountable for the inevitable adverse consequences.

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