Drug Dealer, MD: How Doctors Were Duped, Patients Got Hooked, and Why It's So Hard to Stop

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Disclosures/conflicts of interest

- I have no conflicts to disclose.

Who is the compassionate doctor?

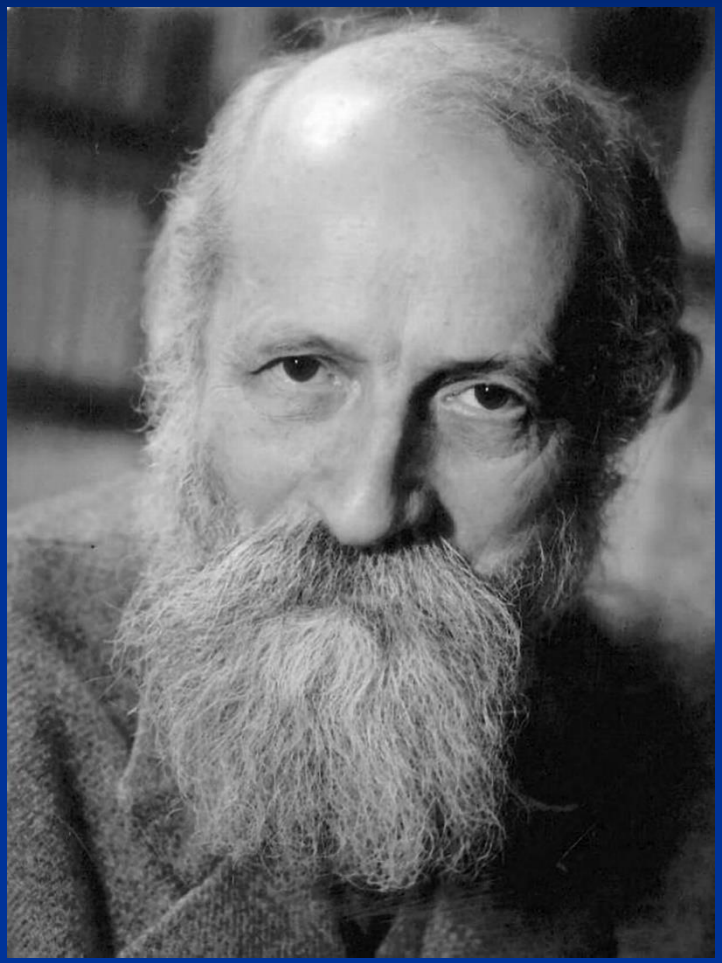
A pleaser

Responding to a ‘higher calling’

Socialized to empathize and believe patients

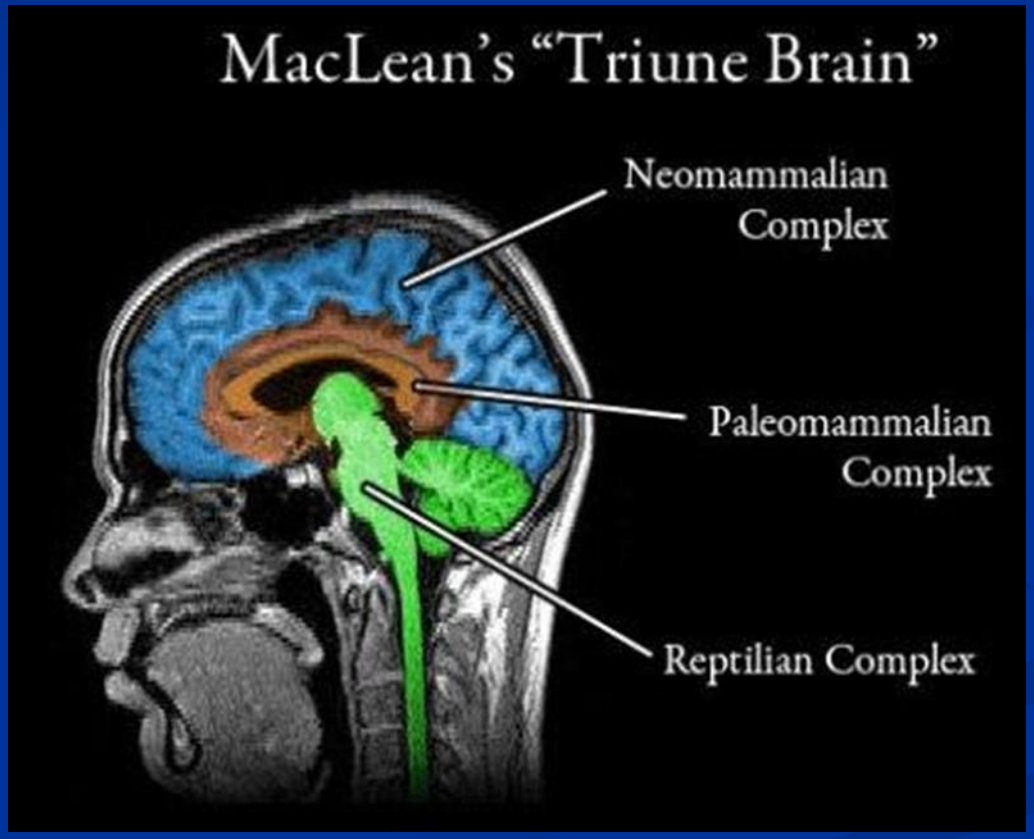
Motivated by mutually affectionate relationships

Martin Buber (1878-1965)



- "Man wishes to be confirmed in his being by man, and wishes to have a presence in the being of the other…. Secretly and bashfully he watches for a YES which allows him to be and which can come to him only from one human person to another."

What drives drug-seeking behavior?

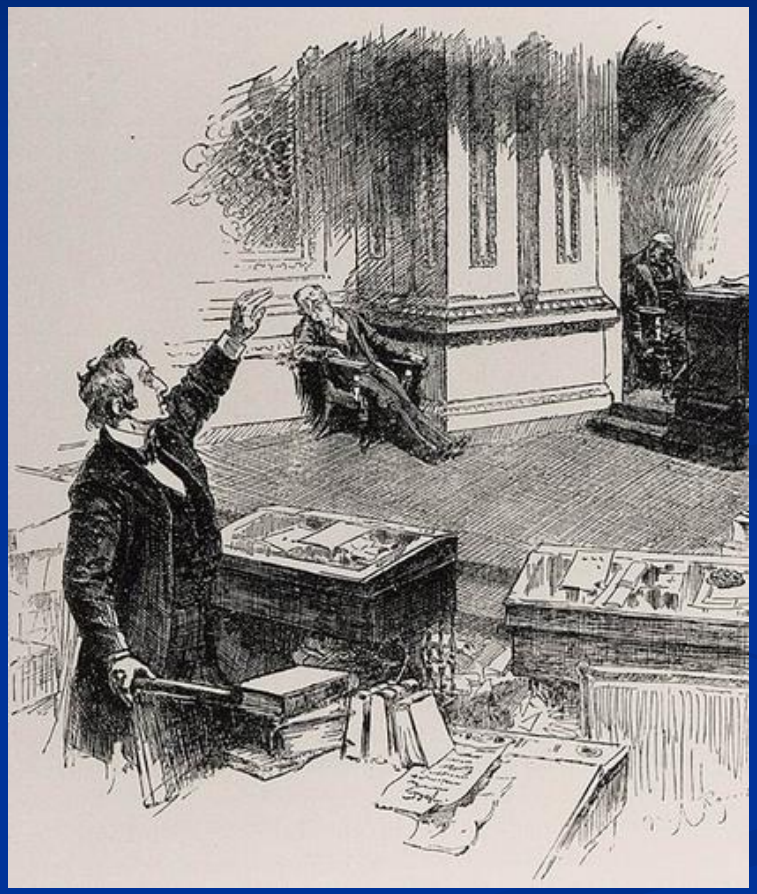


Neuroadaptation

Dysphoria Driven Relapse

(George Koob)

Filibustering

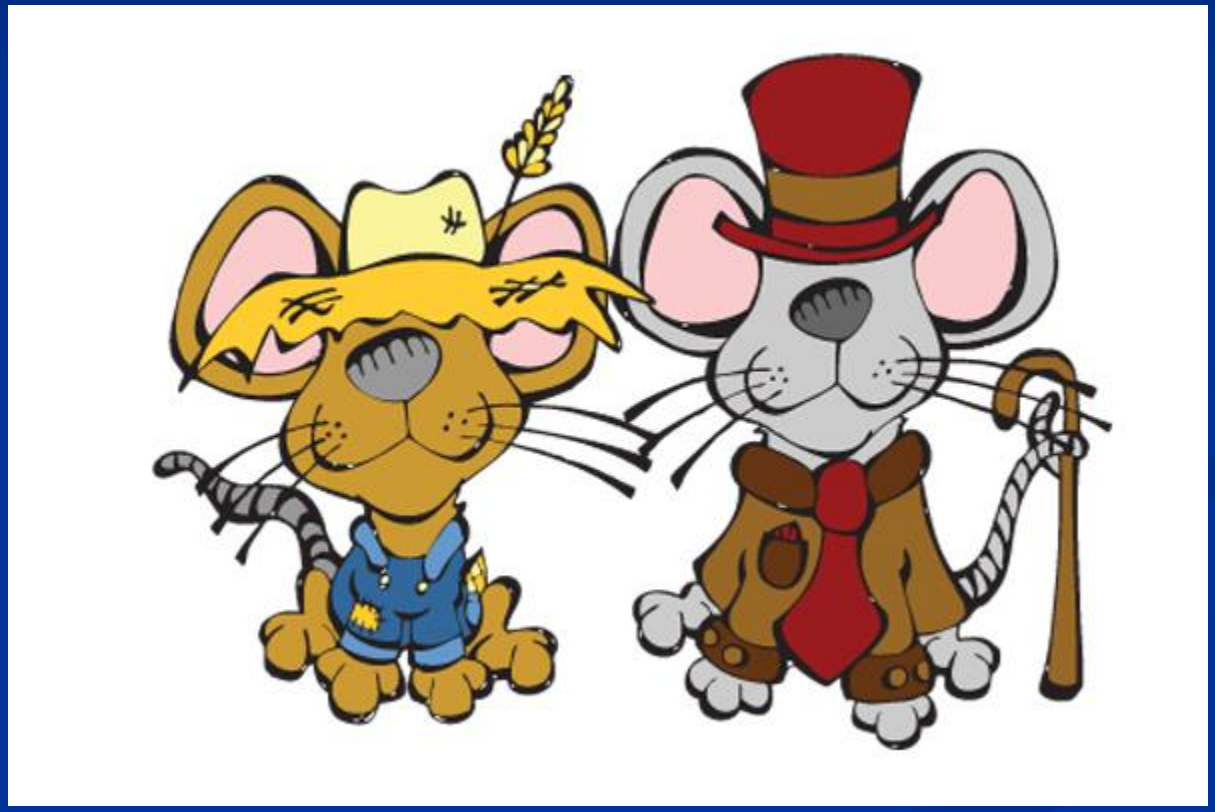


Flattering

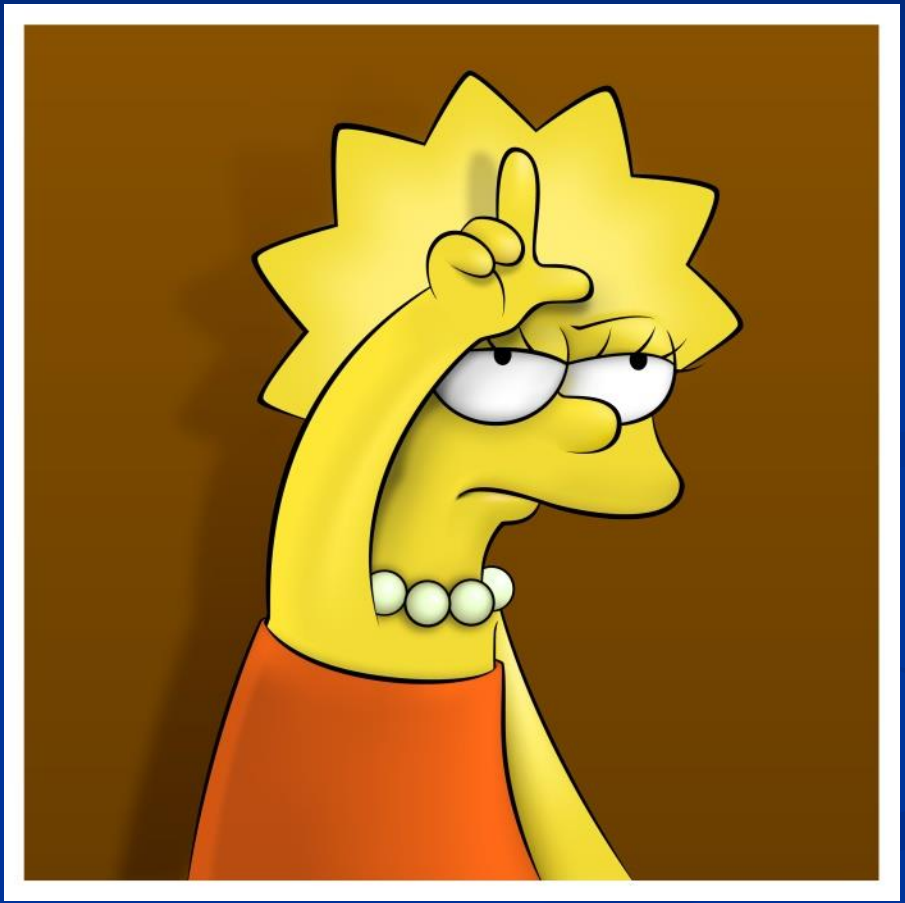
Demonstrating

Teaming Up

Being City Savvy or Country Naïve



Losing Meds



Calling Weekends and Evenings

Seeing a Mirror-Image

Doctor Shopping

Bullying

A deeper look

Opioids the solution …

The canary in the coal mine…

The Toyota-ization of medicine

The P-Paradigm

- Palliate Pain
- Prescribe Pills
- Perform Procedures
- Protect Privacy
- Please Patients

Lembke, A., *Why Doctors Prescribe Opioids to Known Opioid Abusers,* NEJM, 2012

Dr. Anna Lembke MD

3.0 Add your rating: ★★★★ ? / 4
2 reviews

Psychiatrist
15 years of experience
Video profile
✔ Accepting new patients

401 Quarry Rd
Palo Alto, CA 94304
Phone number & directions

Read Reviews | Check Insurance Plans

Summary | **Patient Reviews** | Credentials | Locations & Availability | Accepted Insurance | Schizophrenia

Patient Reviews

Write a Review

Overall Rating:	Total Ratings	Total Reviews
3.0 ★★★★	7	2

Ratings

4 stars	
3 stars	
2 stars	
1 star	

Ease of Appointment:	★★½★	Bedside Manner:	★★½★
Promptness:	★★½★	Spends Time with Me:	★★½★
Courteous Staff:	★★½★	Follows Up After Visit:	★★½★
Accurate Diagnosis:	★★½★	Average Wait:	5 minutes

Most recent

★★★★ | **Care that worsens your condition** | show details

by Corey on Jun 25th, 2013

Really wish I had seen this site's reviews before making an appointment with this physician. She provides the kind of care that will make you wish you had never sought help in the first place. Wrong diagnosis, wrong medication. In some cases this can be terrible. Seek help from someone else.

Archives of Internal Medicine
2012

ONLINE FIRST

The Cost of Satisfaction

A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality

Scan for Author Audio Interview

Joshua J. Fenton, MD, MPH; Anthony F. Jerant, MD; Klea D. Bertakis, MD, MPH; Peter Franks, MD

Background: Patient satisfaction is a widely used health care quality metric. However, the relationship between patient satisfaction and health care utilization, expenditures, and outcomes remains ill defined.

Methods: We conducted a prospective cohort study of adult respondents (N=51 946) to the 2000 through 2007 national Medical Expenditure Panel Survey, including 2 years of panel data for each patient and mortality follow-up data through December 31, 2006, for the 2000 through 2005 subsample (n=36 428). Year 1 patient satisfaction was assessed using 5 items from the Consumer Assessment of Health Plans Survey. We estimated the adjusted associations between year 1 patient satisfaction and year 2 health care utilization (any emergency department visits and any inpatient admissions), year 2 health care expenditures (total and for prescription drugs), and mortality during a mean follow-up duration of 3.9 years. After adjusting for demographic characteristics, disease burden, health status, and year 1 utilization and expenditures, respondents in the highest patient satisfaction quartile (relative to the lowest patient satisfaction quartile) had lower odds of any emergency department visit (adjusted odds ratio [aOR], 0.92; 95% CI, 0.84-1.00), higher odds of any inpatient admission (aOR, 1.12; 95% CI, 1.02-1.23), 8.8% (95% CI, 1.6%-16.6%) greater total expenditures, 9.1% (95% CI, 2.3%-16.4%) greater prescription drug expenditures, and higher mortality (adjusted hazard ratio, 1.26; 95% CI, 1.05-1.53).

Conclusion: In a nationally representative sample, higher patient satisfaction was associated with less emergency department use but with greater inpatient use, higher overall health care and prescription drug expenditures, and increased mortality.

Opioids as a proxy for the doctor patient relationship

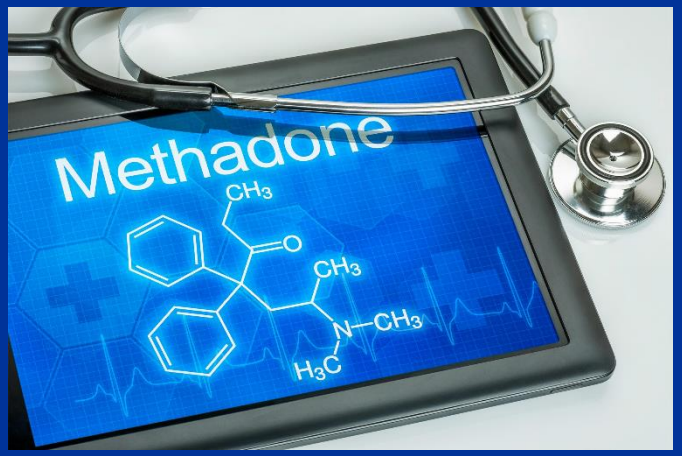
=

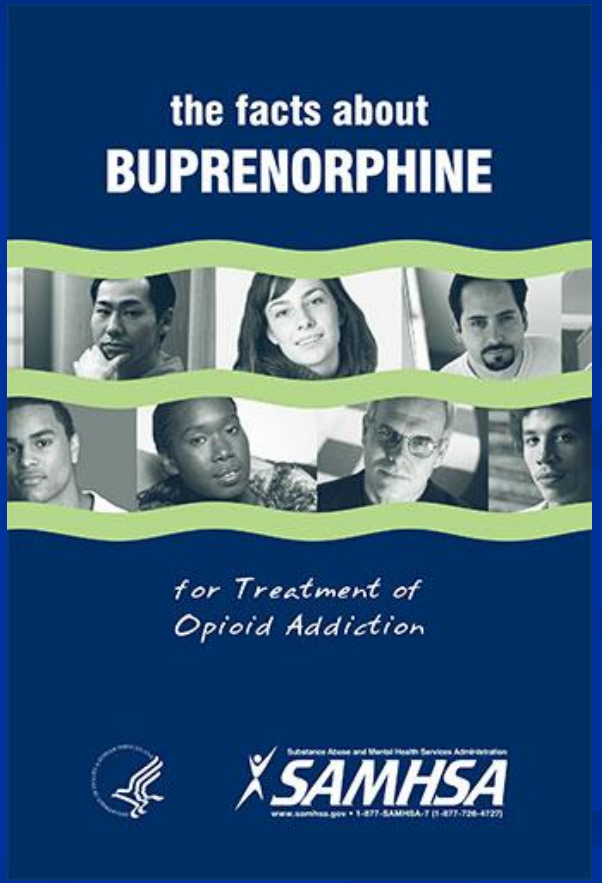
The tyranny of evidence-based medicine

4 Myths of opioid prescribing

- Myth #1: Opioids work for chronic pain
- Myth #2: No dose is too high
- Myth #3: Less than 1% get addicted if Rx'd
- Myth #4: Pseudo-addiction

What is evidence-based use of opioids?





Medicalization of poverty

Addiction not recognized as a disability … or a disease

Doctors are poorly trained in addiction medicine

No infrastructure to treat addiction

Opioids as a poor substitute for a social safety net

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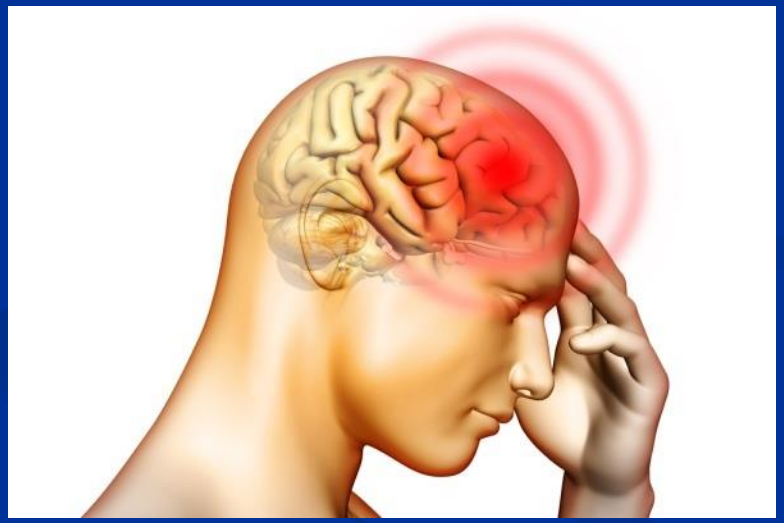
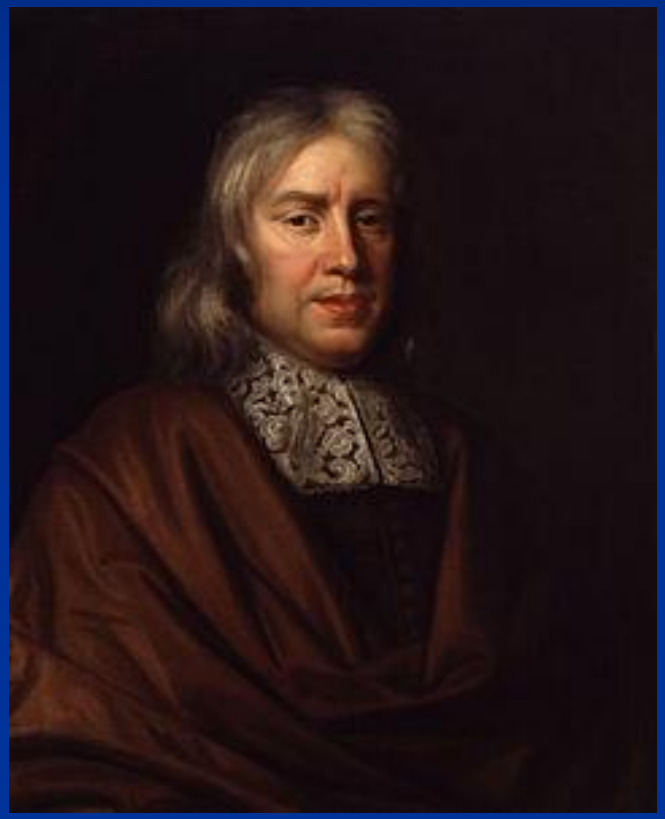
Cultural narratives

Pain is dangerous



Thomas Sydenham
1624-1689



"I look upon every … effort calculated totally to subdue that pain and inflammation dangerous in the extreme …. for certainty a moderate degree of pain and inflammation in the extremities are the instruments which nature makes use of for the wisest purposes."

People are fragile

The body cannot heal itself

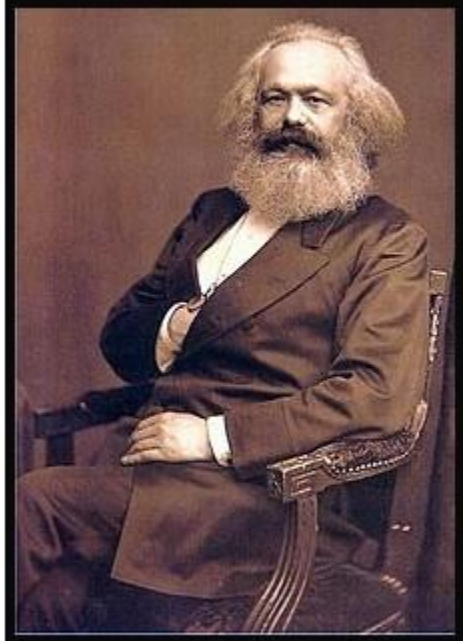
Doctors have superhuman abilities to heal

Victimhood is a right to be compensated

Opioids as a way to create identity

=

Karl Marx (1818-1883)



Religion is the opium of the masses.

(Karl Marx)

izquotes.com

Doctors (and patients) caught between a prescription and a hard place


ANXIETY
scared
chest
pho
ia
tensi
tense
panic
atta
ks
headache
trembling
stress
fear
sweating
feelings
w
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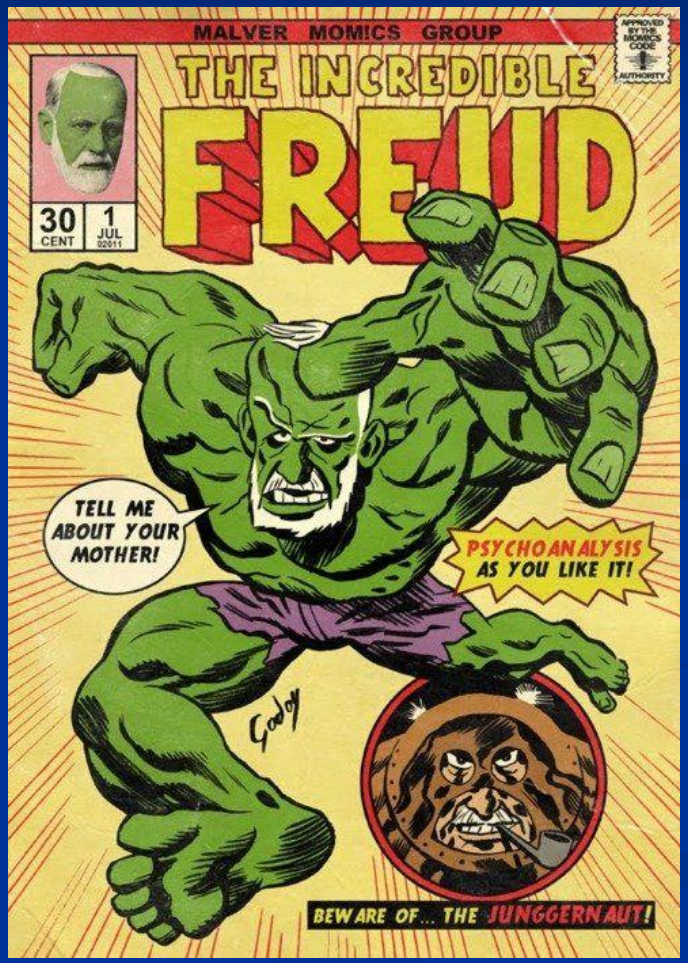
emotional
rest
ssness
disord
sympto
tension
angst
jumpy

Defense mechanisms to the rescue!



Defense mechanisms

Psychoanalytic concept

Unconscious, as oppose to coping strategies

How defense mechanisms work

Anxiety →

Defense Mechanisms →

DECREASED ANXIETY

Denial

Projection

Splitting

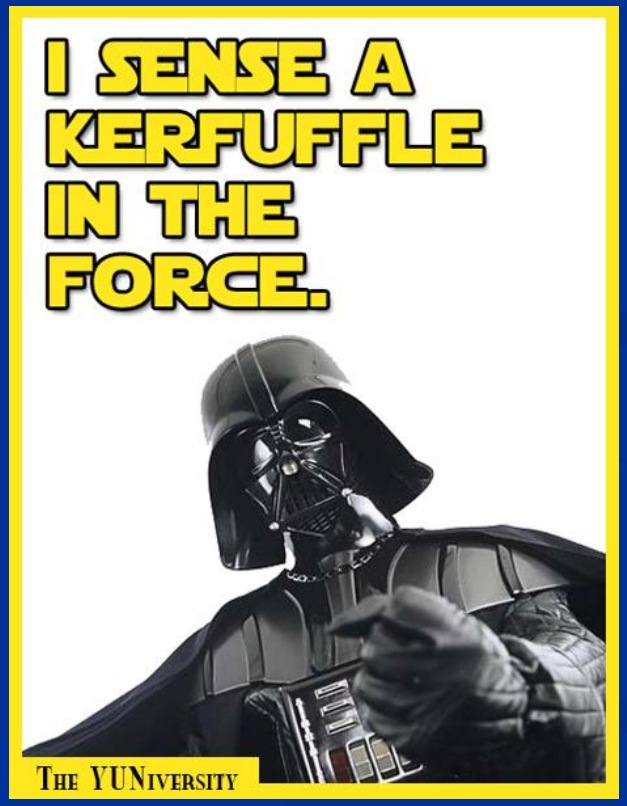
Passive aggression

What happens when the compassionate doctor and the drug-seeking patient get a room?

Doctor meets patient Take 1

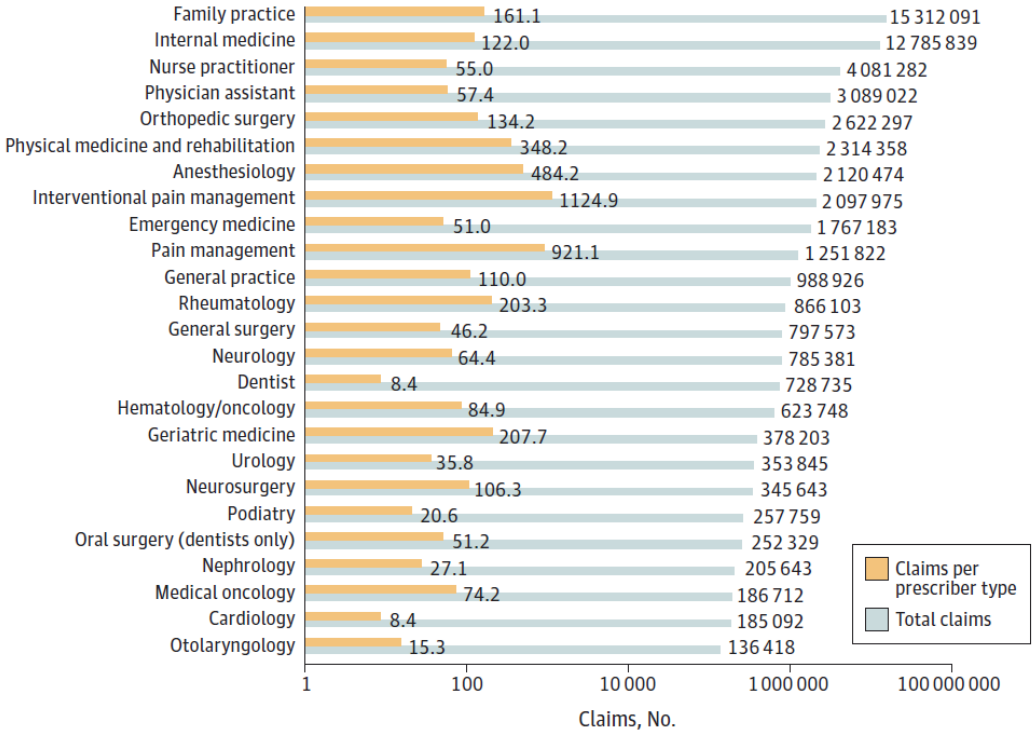
In other words …

- A Kerfuffle that perpetuates the problem …



We're ALL prescribing too many opioids

Figure 1. Top 25 Prescriber Specialties by Total Medicare Part D Claims for Schedule II Opioids in 2013



Values are reported on logarithmic scale.

jamainternalmedicine.com

JAMA Internal Medicine Published online December 14, 2015

Chen, J., Humphreys, K., Shah, N.H., Lembke, A. Distribution of Opioids by Different Types of Medicare Prescribers, *JAMA Internal Medicine*, December 14, 2015

What happens when primitive defenses no longer work?

- For example when the Prescription Drug Monitoring Database shows undeniable doctor-shopping

- Doctor is fully unmasked as a de facto drug dealer

A narcissistic injury

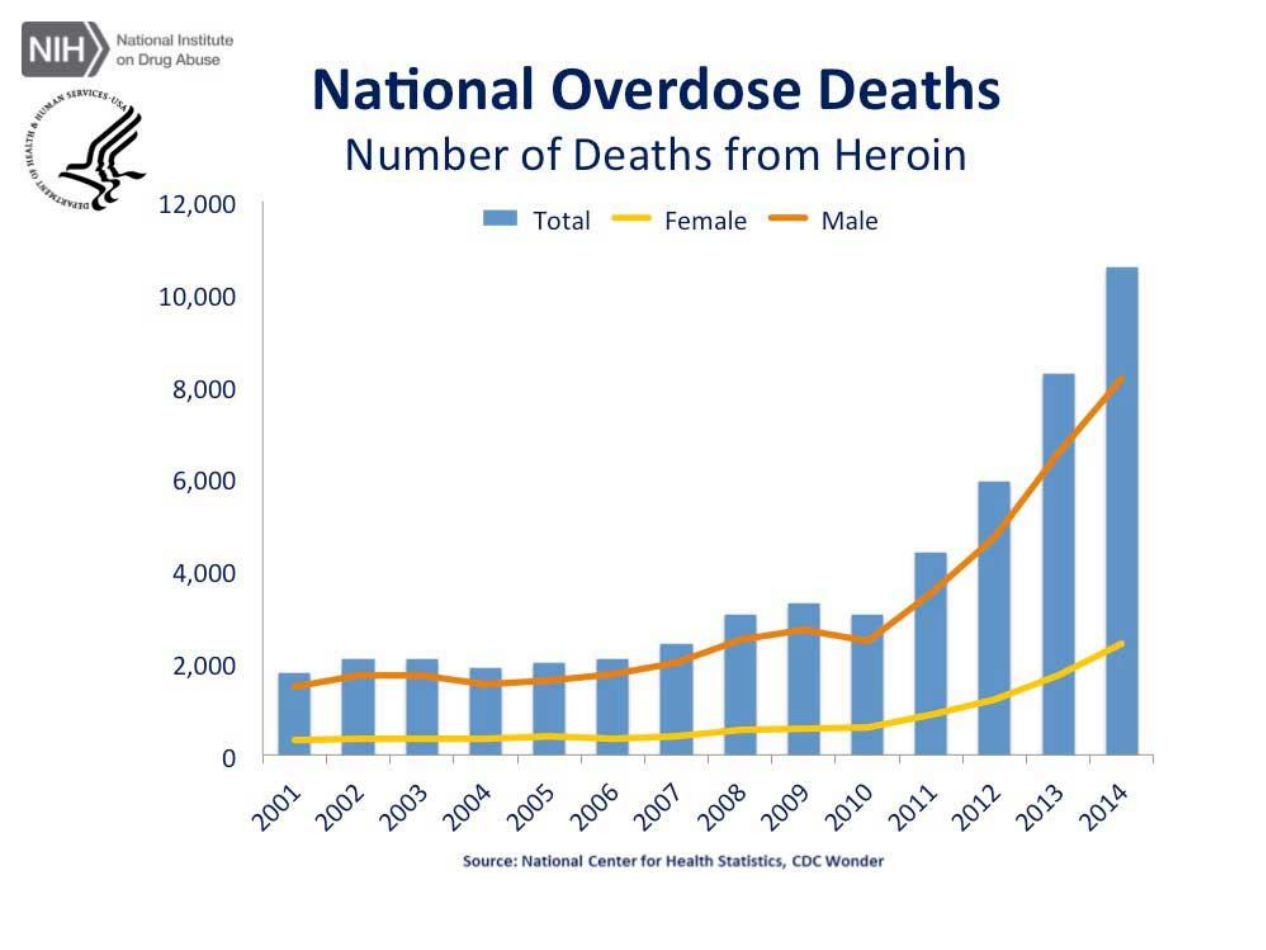
Healthy narcissism

Heinz Kohut, *The Kohut Seminars*, 1987

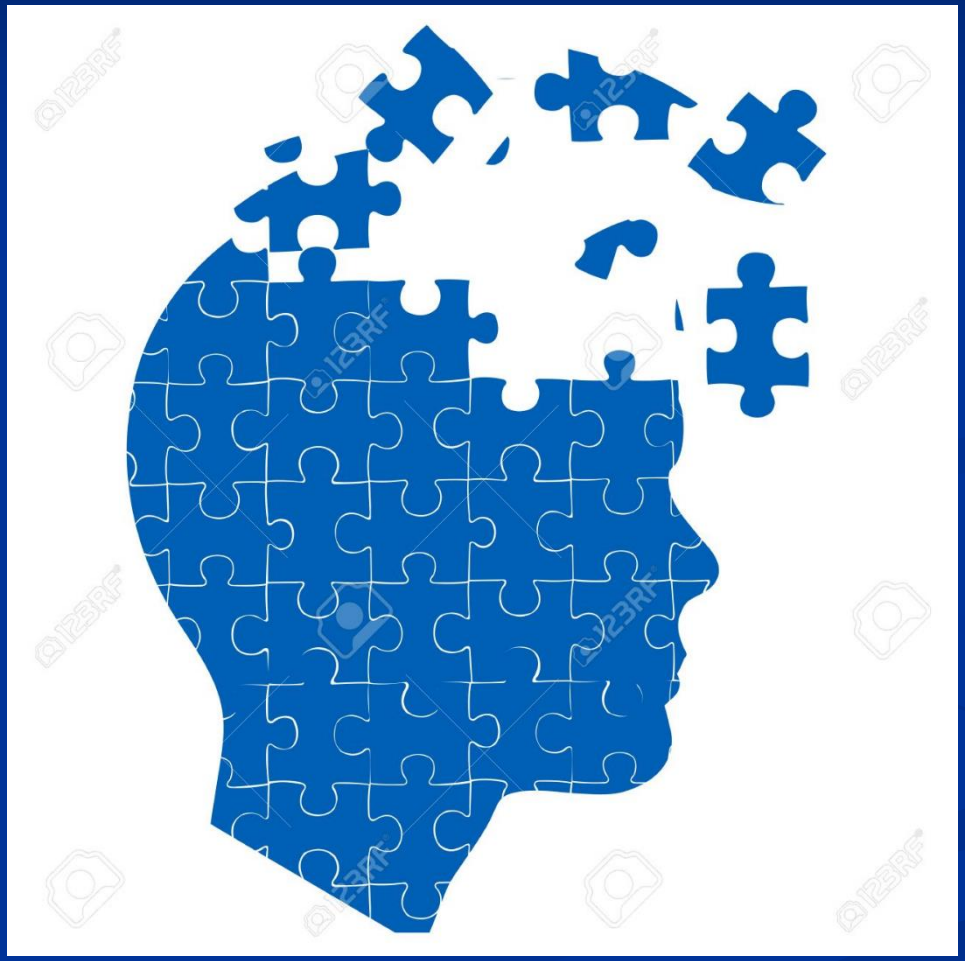
Narcissistic rage and retaliation

Doctor meets patient Take 2

Heroin overdose deaths rising

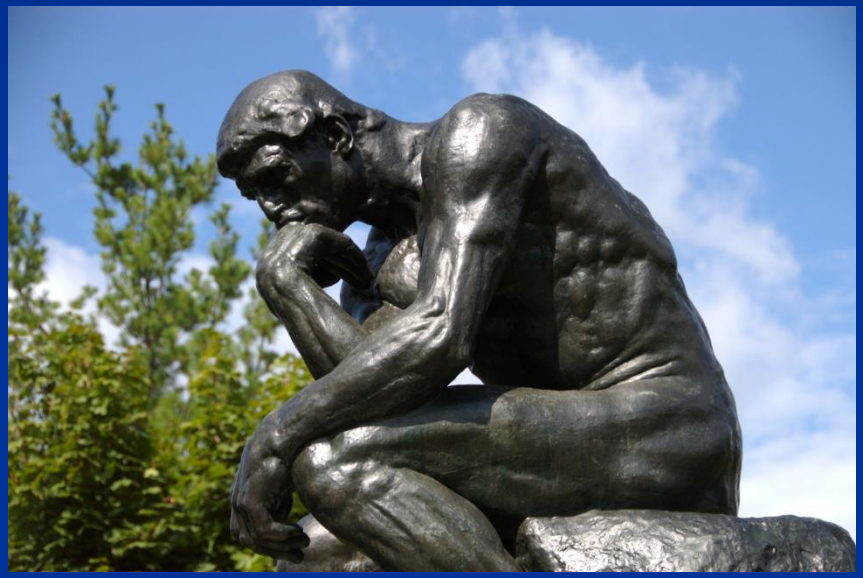


How can we do better?



When encountering addiction, don't do this …

Instead do this….



Think of addiction as a *chronic relapsing and remitting disease* EVEN IF YOU DON'T BELIEVE IT IS ONE

Initiate fewer opioid prescriptions

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose.

The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

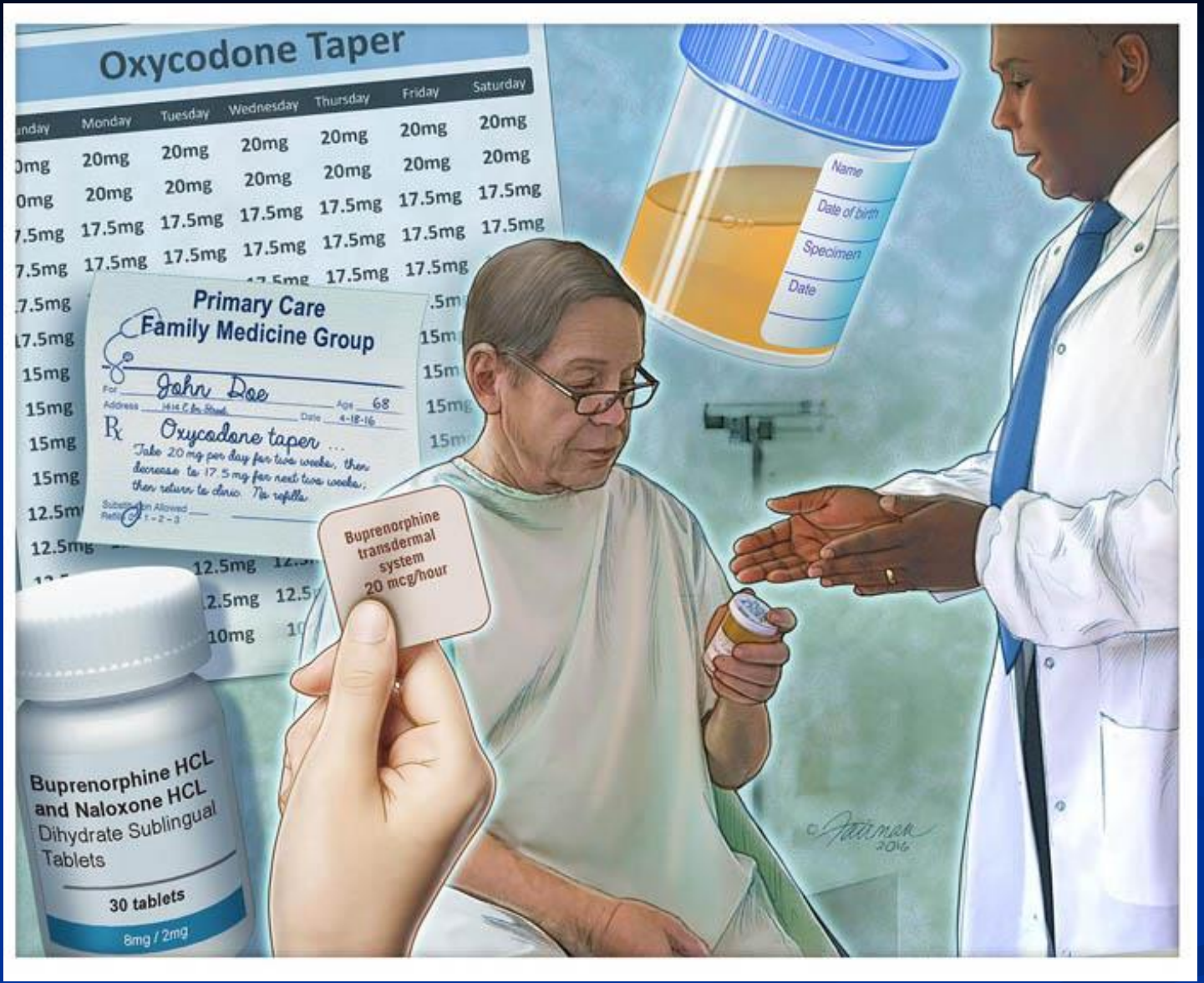
CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

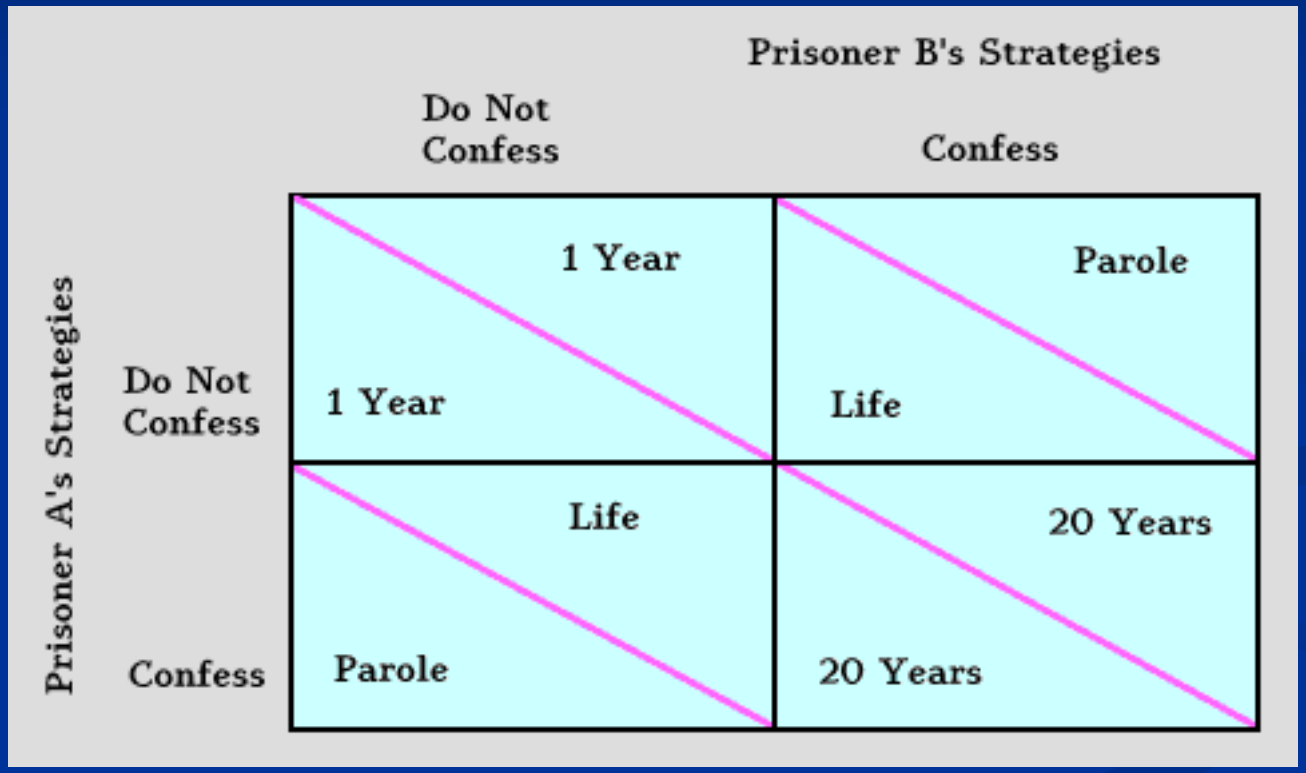
Taper patients off of opioids, when risks outweigh benefits



Am Fam Physician. 2016;93(12):982-990. Copyright © 2016 American Academy of Family Physicians.)

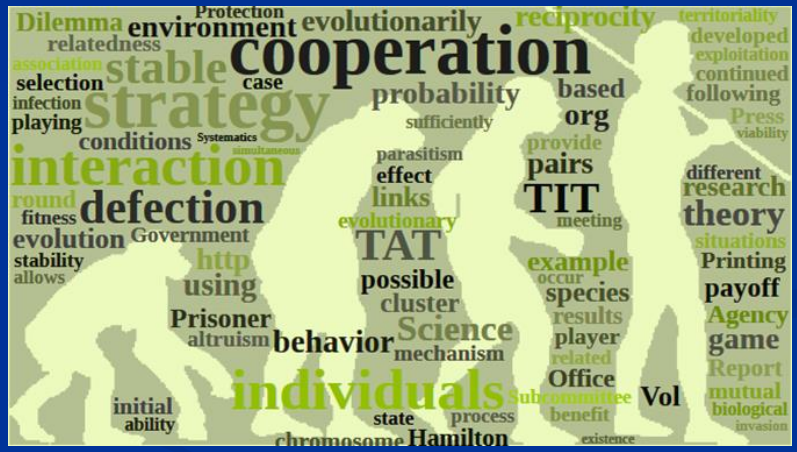
Use contingency management to manage chronic opioids

The *Prisoner's Dilemma*



Axelrod's computer simulation competition

- Strategies that did poorly?
  - "Nasty" strategies
  - "Always nice"
- The winning strategy?
  - Just four lines of BASIC
  - "Tit for tat"



Tit for Tat: cooperate, then repeat opponent's last move

- Doctor
  - Cooperate →
  - Cooperate →
  - Cooperate →
  - Defect →
  - Defect →
  - Cooperate →
- Patient
  - Cooperate
  - Cooperate
  - Defect
  - Defect
  - Cooperate
  - Cooperate

Respond to aberrant behavior with *Tit for Tat*

- Limit prescriptions to 1-2 weeks
- Increase visits
- Reduce the dose by 10%

Evidence for *Tit for Tat*?

- See the contingency management literature
- Contingency management
  - Punishment certainty > punishment severity
  - Immediate punishment > delayed punishment
  - Punishment = transgression
  - Rewards for good behavior
- South Dakota's "24/7 Sobriety Program" reduced both repeat DUI and domestic violence arrests at the county level (www.rand.org)

Stop flying blind

PDMP

Prescription Drug Transaction Details :

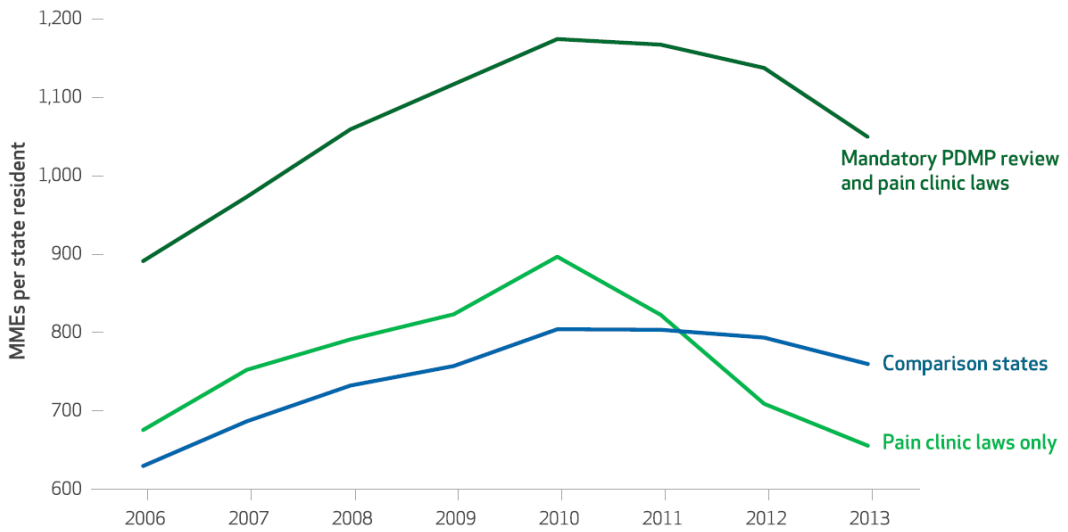
Number of Records: 37 **Start Date: 10/22/2013** **End Date: 10/22/2014**

Date Filled	First Name	Last Name	DOB	Address	Drug Name	Form	Str	Qty	PHY Name	PHY#	Dr.'s DEA #	Dr.'s Name	RX#	Refill#
10/22/2013					ZOLPIDEM TARTRATE	TAB	10 MG	45						2
10/30/2013					ZOLPIDEM TARTRATE	TAB	10 MG	45						2
11/01/2013					ZOLPIDEM TARTRATE	TAB	10 MG	30						0
11/01/2013					ZOLPIDEM TARTRATE	TAB	10 MG	30						1
11/01/2013					LORAZEPAM	TAB	0.5 MG	60						1
11/01/2013					ZOLPIDEM TARTRATE	TAB	10 MG	60						1
11/05/2013					ZOLPIDEM TARTRATE	TAB	10 MG	30						0
11/05/2013					ZOLPIDEM TARTRATE	TAB	10 MG	30						0
11/08/2013					ZOLPIDEM TARTRATE	TAB	10 MG	60						1
11/09/2013					ZOLPIDEM TARTRATE	TAB	10 MG	30						0
11/10/2013					ZOLPIDEM TARTRATE	TAB	10 MG	30						0
11/11/2013					ZOLPIDEM TARTRATE	TAB	10 MG	30						2
11/11/2013					ZOLPIDEM TARTRATE	TAB	10 MG	30						0

Check your PDMP!

EXHIBIT 1

Opioid prescribing rates by state policy category



SOURCES IMS Health's National Prescription Audit, 2006–13; state populations obtained from CDC WONDER (Wide-ranging Online Data for Epidemiologic Research), 2006–13. **NOTES** MME is morphine milligram equivalent. PDMP is prescription drug monitoring program.

Deborah Dowell, Kun Zhang, Rita K. Noonan and Jason M. Hockenberry; Mandatory Provider Review And Pain Clinic Laws Reduce The Amounts Of Opioids Prescribed And Overdose Death Rates; Health Affairs 35, no.10 (2016):1876-1883 10.1377/hlthaff.2016.0448

The future of medicine …

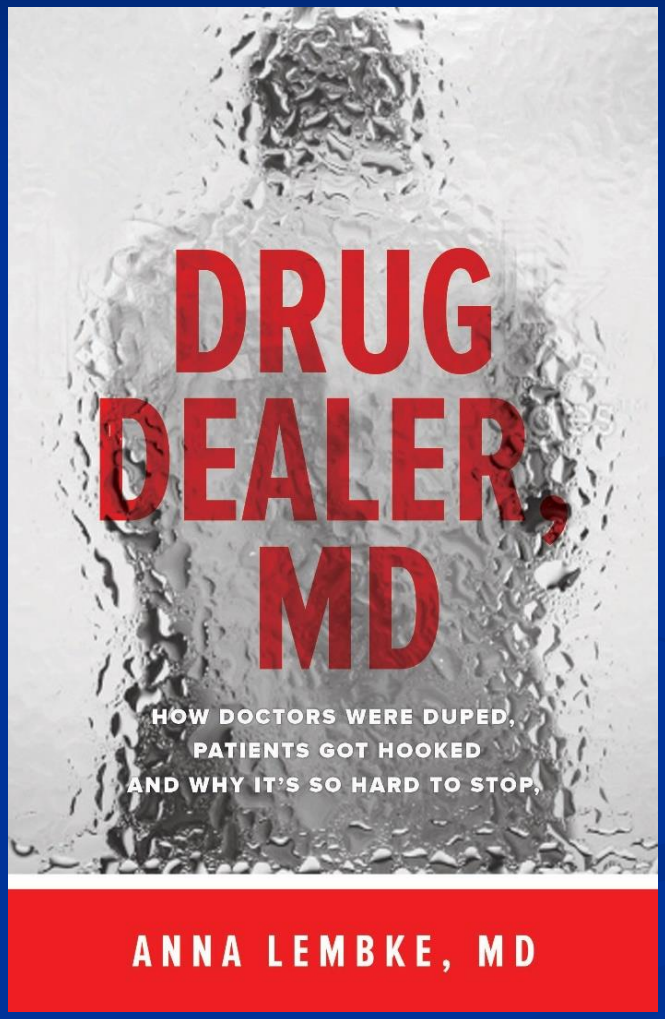
Reinhold Niebuhr (1892-1971)

"Ultimately evil is done not so much by evil people, but by good people who do not know themselves and who do not probe deeply."

Videos available free online

- Stanford University Online CME Courses https://med.stanford.edu/cme/learning-opportunities/online.html
- Youtube: Compassionate Doctor Meets Drug Seeking Patient: https://www.youtube.com/watch?v=SIJiMLxorkc
- Youtube: Drug Seeking Patient and Physician Interaction - Narcissistic Injury: https://www.youtube.com/watch?v=X9efr-5WAPc

Additional References



Thanks for listening!