Commentary on Jung and Reidenberg’s “Physicians Being Deceived”: Aberrant Drug-Taking Behaviors: What Pain Physicians Can Know (or Should Know)

Jung and Reidenberg have once again touched a nerve in their piece: *Physicians Being Deceived*. Always with a knack for highlighting key controversies in the medico-legal arena, they are to be applauded for this contribution that brings data to bear on an issue that has heretofore been subject to changing legal and regulatory currents without being informed by science. Physicians have more and more been given back the responsibility for ferreting out addicted and drug dealing patients. Early intractable pain laws offered pain physicians protections when they prescribed opioids, but limited these protections by excluding known substance abusers or those who should be known to be substance abusers [1]. It was considered progress by the pain management community when the wording of such laws began changing, coinciding with the recognition that pain management with opioids in those with substance abuse is feasible, can be safe, and is an ethical imperative in some situations. However, with the growth of prescription drug abuse, the pressure to detect lying has been rising for prescribing physicians.

And these patients do lie. Jung and Reidenberg point out that this lying is nearly impossible to detect given most physicians’ truth bias. Physicians are taught that patients come in seeking help and are approaching them in a good faith fashion to enlist such help. When people lie to doctors to obtain more opioids, not all lying is created equally nor are they equal in terms of the bad faith they represent. To our observation, addicted patients lie in a fashion that is somewhat distinct from diverters. Addicted patients engage not just in other-deception but also in self-deception (i.e., volitional on the one hand and almost dissociative on the other). The act of lying to their physicians is often an extension of lies they tell themselves (i.e., “I am not overusing; I am not out of control; It is all pain related and if I only had more relief I wouldn’t use like this”). They lie while their life spirals out of control; they run out early and lie about why.

The diverter, on the other hand, lies without self-deception. Diverters lie to procure drugs for sale and are motivated by profit. Unless greed gets the better of them, they will not run out early. They will often abide by the rules while secretly doctor shopping. Both can be skilled actors and experts at hiding their deception. The difference lies in the fact that the addicted patient’s lying is a private, psychiatric matter between the patient and the physician. The diverter’s trail of lies effect kids in playgrounds that might end up with access to the drugs they divert. The pain doctor can treat the abuser and, with psychiatric, motivational, and pain management expertise, end the self-deception and help move the patient’s life forward. The diverter, however, does not seek treatment and is not amenable to therapeutic interventions aimed at ending the deceit.

The current situation could, of course, be changed. Medical schools could be transformed into police academies. Physicians could learn interrogation techniques. Insurance companies can be convinced to pay for extended visits, wherein interrogations could be carried out for hours and eventually the truth will come out. Of course, to have a zero tolerance of undetected lying, we would sacrifice any progress that has been made in the treatment of pain. The doctor–patient relationship would further deteriorate. Another possibility is to avoid prescribing opioids all together. These ideas are silly, ridiculous, and inhumane “solutions.” We have to look for rational approaches that assess and manage risk and balance this risk against the need to not lose ground in the treatment of pain.

The science and clinical experience with aberrant drug-taking behaviors suggests that, while it is an important stream of data available to clinicians, these behaviors are not in and of themselves sufficient to detect drug abuse or diversion. The interpretation of aberrant drug-taking is complex, inexact, and can even be misleading. Jung and Reidenberg suggest that clinicians’ monitoring of aberrant drug-taking behaviors is a way to offset the misleading impact of lying. They add that the categorization of behaviors as either more or less predictive of addiction as suggested by Portenoy and Payne [2], and refined over the years by Passik
et al. [3–6], can be taken almost at face value. This ignores the clinical reality that the more obvious behaviors (i.e., stealing a prescription pad, for example) are opaque to clinicians and certainly are not elicited in the clinical exam or in self-report. The aberrant behaviors that are more frequent, more often observed in clinical situations and more readily elicited by self-report are also the most ambiguous ones (i.e., a patient who reports taking their medication at night to induce sleep rather than strictly for pain). These more ambiguous aberrant behaviors might be signs of addiction, but they could also be signs of untreated pain (i.e., pseudo-addiction), stress and poor coping (i.e., chemical coping and self-medication), other psychiatric disorders, and finally, diversion [7,8]. Not only is this differential diagnosis difficult and time-consuming, it is also longitudinal [9,10]. The self-deceiving addicted pain patient’s self-report will not help the pain physician; they will inevitably tell a pseudo-addiction tale when queried about why they are out of their medication early. The skilled diverter will up their pain report and not even have any overt aberrant behavior. Thus far, very little science has been able to parse aberrant drug-taking behaviors along etiologic lines. The work of Elander et al. [11] in sickle cell patients does suggest that certain behaviors can be used to differentiate addiction from pseudo-addiction. Our work [5,6] has suggested that behavior that is frequent and does not respond to limit-setting is potentially linked to addiction. We are still a long way, however, from having a behaviorally based way to sort out whether pain patients are being truthful.

Katz and Fanciullo [12] showed that urine toxicology screens for people on opioids for chronic pain are an important adjunct to clinicians’ assessments of drug-taking behavior. In their work, one in five chronic pain patients on opioids under expert care who had no evidence of aberrant drug-taking behaviors had a positive urine screen (defined as the presence of an illicit drug, the presence of an opioid not prescribed by their pain physician, and/or the absence of opioids prescribed by their pain physicians). Thus, it is clear that physicians need other data, urine screens (or a low-tech alternative such as pill counts), or reports from prescription monitoring programs and the like to augment the typical clinical information that is available to them via observations of aberrant drug-taking behaviors. They also need the time and reimbursement to be able to gather all of this data and integrate it before deriving a treatment plan. The creativity and ingenuity needed to treat the patient in trouble takes time and expertise.

Expecting physicians to take some reasonable steps to detect lying is reasonable. Risk assessment, triage, and gathering/integrating multiple sources of data are reasonable if time and reimbursement are provided (and if not, we should make sure the guilt for continued addiction and diversion is shared with third-party payors). In the end, interrogation, zero tolerance, and avoidance of opioids are neither reasonable nor humane solutions.

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References