



# Acute pain and opioid seeking behaviour



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This is the ninth and final article in a series of case files from general practice that explore treatment issues around substance use and commonly encountered general practice presentations.

## BACKGROUND

Acute pain is a common presentation associated with opioid seeking behaviour.

## OBJECTIVE

This case study provides a practical approach for general practitioners seeing patients with acute pain whom they suspect of seeking opioids because of dependence.

## DISCUSSION

Acute pain commonly presents as an emergency appointment 'squeezed in' between booked appointments. General practitioners have to make a rapid assessment of the possible underlying causes, relieve pain, and establish a plan for further investigation and management. Furthermore, some opioid dependent people can and do effectively feign acute pain in order to obtain opioid medication.

## Case history – Bill

Bill, 49 years of age, presents to the practice for the first time one Monday morning, clearly in discomfort and complaining of pain from kidney stones. Your receptionist arranges for him to lie down in a spare room and 'squeezes' this consultation in between appointments.

## Initial assessment

You walk in to find Bill in a crumpled and ill-fitting suit, sitting at the edge of the bed clutching his side. Sweaty and apparently in considerable pain, he tells you it's exactly the same pain he had 10 years ago when he first developed kidney stones and again 2 years ago. He describes passing the stone on both occasions and experiencing the worst pain imaginable. Bill describes his pain as 'coming in waves', which is consistent with the colicky pain that occurs with renal stones. Bill reports good health apart from an appendectomy years ago. He asks if he can have something for the pain, to which you respond

that you first need to examine him.

Bill's mucous membranes look dry, his pulse is 92 and regular, and his blood pressure is 156/90. He is tender in the left iliac fossa and left flank. A urine sample confirms the presence of microscopic haematuria. After checking his drug history and allergies you administer 100 mg of pethidine intramuscularly.

When you inform Bill of your wish to investigate further, he replies, 'That's what they wanted to do last time but I passed the stone before I got there'. Bill agrees to have a plain abdominal X-ray today and to return immediately after. His pain appears to settle and he looks considerably better, at which point he uses his mobile phone to call his wife to pick him up.

## The story unfolds

Later that day you notice that he hasn't returned and your receptionist contacts the radiology clinic, only to discover that he never attended. As the reception staff had expected Bill to return later that day they had agreed to let him settle the account that afternoon. The practice tries to contact Bill but his telephone

number is invalid. Given your description of events, your local department of health confirms what you have now surmised, that Bill fits the description of a 'doctor shopper' who has been successful in obtaining opioids from many colleagues. (A 'doctor shopper' is a person who visits multiple doctors in order to obtain drugs of dependence, most commonly opioids or benzodiazepines, under false pretences).

You feel tricked and used. Bill deceived you to obtain opioid medication. You had acted in good faith and with compassion to relieve his pain after your history and examination led to the provisional diagnosis of renal colic. You contemplate what other options you may have in such a situation. To insist that a full diagnosis including radiological confirmation is required before any pain relief would delay compassionate and appropriate treatment to a legitimate pain sufferer. You have to balance the need to assess and treat on face value while being aware that some patients will use elaborate deceptions to obtain opioid based medications.

In your experience, 'doctor shoppers' have been easier to detect because they looked more like the stereotype of a 'drug addict'. Not only was Bill older, well dressed, apparently employed, polite and well spoken, he also had a very plausible story and physical signs that were consistent with a condition requiring opioid analgesia.

In retrospect there was something about Bill that didn't quite fit. Was it his shabby suit with the well polished story? Was it the fact that everything just seemed to fit together so well, with the exact description and behaviour of colicky pain in exactly the right place and the presence of microscopic haematuria? But he appeared to be genuinely in pain, with sweating, tachycardia, hypertension and haematuria. However, pricking one's own finger to add to a urine sample is easy, and all the other symptoms are consistent with opioid withdrawal.<sup>1</sup>

### Finding other stories

You discuss this case with your colleagues, Sue and George, at the next practice meeting, and they relate a number of other clinical scenarios they have experienced.

#### Martin – 35 years of age

Sue recounts the story of Martin, who having recently returned from 2 years in the United Kingdom where his wife, a nurse, was studying at university, was the 'house husband' caring for 1 year old twins. Martin requested a swab and repeat antibiotics for a recurring knee infection, the result of an operation that went wrong in the UK. He went on to knowledgeably explain the complicated regimen of antibiotic combinations and regular wound swabs. He demonstrated a sinus in his knee, which from the look of the dressing had been oozing serous material. When Sue prepared to swab it he said that it was deep and his wife normally had to administer pethidine by injection before taking the swab at home. At that point he told her he had nearly forgotten that he needed another script of pethidine. By this time Sue had spent 20 minutes getting a detailed history, checking the availability of the antibiotics concerned and organising the pathology form. She was now running late and anxious to finish the consultation as the twins were getting restless. While there was a brief moment of hesitation for Sue, Martin and his story seemed genuine. At the reception desk Martin said he hadn't yet had time to organise his Medicare card since his arrival back in Australia but would pay the fee privately. When the bill was presented however, he 'discovered' that he had left his wallet at home, and promised to return in 10 minutes. He didn't return and the home address provided was of course false. A subsequent phone call to her local jurisdictional authority for S8 medication revealed that Sue, together with many other local GPs had been manipulated to provide pethidine prescriptions.

#### Karen – 42 years of age

George tells you about Karen who had presented with 'migraine' for the second time at a previous practice. On the first occasion she had appeared happy with his treatment of parenteral prochlorperazine and NSAIDs. This time she appeared with her boyfriend who has holding a bucket in case she vomited. She wore dark glasses and was promptly given a place to lie down in the treatment room. Once again she seemed happy with the treatment but George later discovered that while waiting in the treatment room the couple had stolen the supplies of opioid medication. George deduced that her previous presentation was an opportunity to observe where medication supplies were kept.

### Searching for a management solution

You suggest to your partners that in future, perhaps you will not provide opioid based medications to anyone without proof of diagnosis and definitely never to a person with a history of opioid dependence. George however, cautions you about withholding treatment where a patient's condition could be considered legitimate. He confesses that when he was younger he had long hair and a goatee, much to your disbelief. He tells of his post-graduation

experience while visiting his family in another part of Australia, a holiday during which he developed renal colic. The cause was very quickly obvious to him. He attended an emergency department (ED) at 3 am and tried to tell them that he knew this was renal colic because he was a doctor. This was met with scepticism and he was left to suffer in pain, as the ED was unable to confirm his credentials at this hour. Fortunately for him, an abdominal X-ray did confirm the diagnosis and he was given analgesia.

### Miriam – 38 years of age

Sue reinforces George's point and tells you about Miriam, a friend of her daughter's. Miriam has been on the methadone program for opioid dependence since she was 22 years of age. Now 38 years of age, she has worked as a secretary in the same job for the past 10 years. Previous attempts to come off methadone were unsuccessful and precipitated depression. Miriam has chronic back pain which she does not seek extra opioids for, but you would like her to get a consultant's opinion in a public hospital. However, Miriam is absolutely terrified of the hospital knowing she is on methadone treatment as she knows from her friends that she will be treated differently if this information is on her file. Her greatest fear is that if she should need appropriate pain relief for an acute condition that this will be denied to her. This is a common and justified fear as health professionals do sometimes deny pain relief where dependence is suspected, even when opioid analgesia is appropriate for the condition.<sup>2</sup>

## Lessons

So what were the lessons from these cases? The practice discusses the well known warning signs of 'doctor shoppers' (Table 1). However, these are neither always present nor reliable. As a result of the practice meeting, some principles emerge:

- we should never assume that people who seek opioids illegitimately will fit stereotypes. Some people are well dressed, employed, well spoken, have extremely plausible stories
- drug withdrawal is associated with physical signs that can be confused with other causes such as infection and pain<sup>1</sup>
- if treatment for pain and discomfort is withheld until a definite diagnosis

is made, some people who are in legitimate pain risk not receiving appropriate treatment

- opioid dependent persons are not exempt from experiencing legitimate pain and may require additional opioid analgesia during these periods, and
- we have to accept that in order to provide compassionate and credible service to pain sufferers, we will be open to abuse by those wishing to exploit this.

## Resources

You discover that each Australian state and territory has access to two levels of resources for information about 'doctor shoppers' (Table 2). The level of information available is influenced by the Federal Privacy Act.<sup>3</sup> There is variation in preference in the practice about when to use these resources. George points out that making contact with the patient in attendance provides a clear

**Table 1. Warning signs**

### Reception and appointment

- New patient, often 'recently moved'
- Walk in presentation with no appointment
- Last minute presentation when the surgery is almost at closing time

### History

- Very knowledgeable about condition and drugs requested, often requests drug by name
- Previous doctor unavailable to corroborate story
- Multiple 'allergies' or drug reactions to nonaddictive medications
- Carries letters from other doctors confirming treatment which appear to have dubious rationale (eg. high dose opioids or benzodiazepines)

### Examination

- Exaggerated appearance of pain
- Inconsistent behaviour with pain or other symptoms including variation between different movements, and increasing behaviour when aware of being observed

**Table 2. Resources**

### Health Insurance Commission (HIC)

- Has data limited to consultations subsidised by Medicare and medications subsidised by the Pharmaceutical Benefits Scheme (PBS)
- Under the Prescription Shopping Project which seeks to identify and reduce the obtaining of PBS medication in excess of therapeutic need, the HIC has the legislative authority to disclose PBS information about a person identified under the project to their doctor without patient consent. The HIC may write to advise a doctor of suspicion or contact a doctor to request a meeting to discuss PBS information about one or more of their patients who appear to be obtaining PBS medicines in excess of therapeutic need, often by visiting a number of doctors

### State and territory jurisdictions: drug of dependence branches

- Control S8 drugs and will commonly provide information about people who have visited multiple doctors and used clinical scenarios to obtain medication
- Notwithstanding privacy laws, which have resulted in limitations as to what personal information can be disclosed, where there are clinical reasons for seeking this information assistance will be given

**Table 3. Practice policy in acute pain management with opioids where doubt about legitimacy is present****Being prepared**

- Make sure you know the number of your local jurisdictional S8 authority and can access it easily. For a list of telephone numbers in your state/territory, refer to the article *Back pain and opioid seeking behaviour*, AFP June 2004<sup>4</sup>
- Be aware of the need to monitor anyone in the treatment room, especially if drugs are kept there. If continual staff supervision is not possible, leave the door open and ask the reception staff to periodically visit the patient

**Checking**

- If possible, call your local jurisdictional S8 authority at the time of consultation to enquire if the patient and the story are familiar to them
- If unable to call at the time, make a habit of checking when it is possible. This will help the practice to better manage this patient next time

**Treating**

- If you decide that analgesia should be given immediately, prescribe in an appropriate quantity. Do not repeat analgesia until you are able to confirm that it is warranted. State/jurisdictional legislations vary and it is best to check local information. As a general rule they do not permit prescribing medication to people who are suspected or known to be drug dependent but permit the administration of acute analgesia for pain, as the patient is not being given a script or medication to take away with them
- Be careful that the source of medications is not visible and that your script pads and other belongings are secure. Both computer generated and hand written scripts are easily reproduced with today's technology and pharmacists are not as familiar with individual GP's handwriting as they were in the days before computerised generated scripts became the norm

**Confronting**

- If you decide not to give opioids, be open about the problem. Explain that you would like to treat with analgesia but are limited in what you can use immediately. Offer nonopioid alternatives
- Explain to the patient that it is not about them, but because of 'doctor shoppers' who are committing fraud and making it harder for people with genuine pain to get immediate treatment. In this way you are not the adversary (since it is 'doctor shoppers' who have created the barrier and not you) but their advocate who will help them establish a diagnosis quickly so that they can get appropriate treatment<sup>5</sup>

**Recording**

- Record the consultation accurately, including all drugs prescribed and any advice given
- Any statement that you made about what will or will not be done at the practice in the future (eg. we will not prescribe this drug) needs to be clearly marked so that all doctors have a plan for acting consistently
- Record any follow up consultations and make sure that information is clearly visible for all doctors who might see the patient in the practice

**Discussing and debriefing**

- Talk to colleagues. While we cannot discuss private details of our patients, it is easy to feel cheated and abused when you have spent time and effort with people who have lied to you, and then not paid their bill
- The stories are valuable and most doctor shoppers use similar stories when they visit multiple doctors. You can therefore alert colleagues in this way. Some divisions of general practice publish de-identified information about these scenarios to help GPs recognise these cases
- Remember that while people may use deception to get the drug they want, not everything is a lie. People who are dependent on opioids do feel pain and withdrawal is uncomfortable<sup>1</sup>

message that you are open in your dealings and aware of how to contact the authorities. However, Sue feels more comfortable checking without the patient present.

**Setting a plan**

As a result of these discussions, the practice decides to draft a policy to help manage such situations in the future where pain may be an entry for a 'doctor shopper' (Table 3).

**Conclusion**

Acute pain can be the entry point for 'doctor shoppers' and in the absence of enough information in the short term, doctors have to use clinical judgment to balance giving opioids inappropriately and appropriately treating pain. Being prepared, knowing your resources and how to access them, checking, recording and discussing the scenarios is a strategy for these challenging cases.

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