

How to spot a drug seeking patient

March 3, 2010 [Dr. Pullen](#)

This is posted as a supplement to an earlier post, [Can't find a doctor to prescribe pain meds?](#) Here is an article in [Family Practice Management](#) with an approach to identify patients in the office to obtain drugs for other than legitimate causes of pain. This is a difficult problem, and no physician wants to be "used" as a source of pain meds to overtly abuse or sell. A still more difficult problem is to help patients with legitimate pain conditions manage their pain without developing a secondary problem with drug tolerance, subsequent overuse of the pain medication or a development of a [chronic pain syndrome](#). If anyone has a systematic approach that works for this? If so let me know.

From [Family Practice Management](#)

A Systematic Approach to Identifying Drug-Seeking Patients

Richard W. Pretorius, MD, MPH; Gina M. Zurick, PharmD, BCPS

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Introduction

A request for pain medication came from a 23-year-old male from New York City who showed up at a rural emergency room. He complained of two days of continuous pain in his left flank that radiated into his groin and was getting worse. Although suggestive of renal colic, the pain did not follow the natural history of obstructive nephropathy: It was not spasmodic and was nonspecific except for its purported severity. His physical exam, too, showed inconsistencies including diffuse guarding and generalized – rather than localized – tenderness to even light palpation. Although his urinalysis report showed red blood cells too numerous to count on the microscopic exam, the physician had her doubts and asked to see the urine specimen. While the urine was an amber color, there were small clots of blood on the bottom of the cup, which were more consistent with droplets of fresh blood from a pricked finger than from the microscopic ooze from a ureteral mucosa irritated from an entrapped stone. After the patient declined a request for a urine specimen via an in-and-out catheterization, non-narcotic analgesics were administered. A follow-up renal ultrasound was scheduled for the next day, an appointment – not surprisingly – that the patient did not keep.

As the misuse of prescription medications has increased dramatically in the past few years, particularly for opiates, it has become increasingly important to identify drug-seeking behavior, such as that depicted above. Currently, up to 30 percent of prescription narcotics are diverted for illegal use by someone other than the person for whom it was prescribed.^[1] Narcotics are not only shared with family and friends; they are often sold to strangers or exchanged for illegal substances.

This article describes the steps involved in a systematic approach to identifying drug-seeking patients.

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1 Involve Your Entire Team

A team approach allows input from multiple health care professionals, which is critical since inconsistencies in a patient's symptoms and signs are often the first clues of malingering. A patient who is experiencing pain should have the same difficulty with movement in the parking lot, the waiting room, the hallway and the exam room. If a patient comes to the office with a complaint of pain, the office staff should observe the patient's level of function from the moment of his or her arrival. This information should be reported from the front office staff to the back office staff and then to the physician. Similarly, upon completing the clinical visit, the physician and office staff should observe the patient walking to the discharge window as well as exiting the office.

Family members who have accompanied the patient to the office visit can also provide input into the patient's level of function through the use of simple questions about daily activities (e.g., Can the patient walk up and down the stairs or bend over to tie his or her shoes?). It is relatively easy for a family member to report that the patient has had pain throughout the day. It is more difficult to describe a level of function that is anatomically consistent with the pain. This can be even more difficult if the family member does not know what the patient has said to the physician.

Previous physicians can also provide crucial information. Since drug-seeking patients switch physicians frequently, a prescription for narcotics should not be written at a first visit in most cases. Offices should first obtain a copy of the patient's records from the previous physician to verify diagnoses and treatments. In addition, a simple phone call to the previous physician's office can be invaluable in understanding a patient's behavioral pattern.

Pharmacists can be valuable allies as well. Many pharmacies keep records about customers suspected of abusing the system. This includes patients who use multiple pharmacies, repeatedly submit refill requests too early, make excessive demands and offer to pay cash (to hide duplicate prescriptions from their insurance plans).

2 Recognize Suspicious Behavior

Patients often reveal their drug habits through their behavior. They tend to be obsessive and impatient, calling repeatedly both during and after office hours. They manage to find physicians' home phone and pager numbers. They often do not keep follow-up appointments and then call for an immediate appointment. They may request medications that are adjuvants to pain management, such as carisoprodol and hydroxyzine, as many of these patients have polysubstance abuse.

Upon receiving prescriptions for narcotics, many drug-seeking patients are excessive in their flattery. They may hug the physician and say, "You are the best physician I have ever had." On the other hand, repeated entreaties for controlled medications will often suddenly cease when the physician clearly and calmly states the treatment plan and explains that the patient's condition does not warrant the prescribing of narcotics. Most patients who are fabricating a story sense not only when the physician is indecisive (and, therefore, they press forward) but also when the physician has made a decision (and further efforts are futile).

3 Obtain a Thorough History of Present Illness

In obtaining a history of an injury from a patient, it is important to determine the mechanism of injury. What force was exerted on the body? What part of the body sustained the force? Was the force compressive or rotational? How did the body accommodate the force? A drug-seeking patient will often try to impress the physician with the severity of the initial injury, often several years old. However, acute injuries are not chronic conditions. Injured tissues heal. Fractured bones knit together. The subjective and objective information regarding the mechanism of injury and subsequent tissue repair should be internally consistent.

A patient who sits stiffly with percussion tenderness along the length of the thoracic or lumbar spine may be experiencing the sequelae of a torsional injury sustained a week ago, but almost certainly not from several years earlier. In the first two months following an acute injury, the rate of narcotic use is similar in all patients, regardless of prior history of addictions.^[2] After two months, however, the rate of narcotic use falls quickly in patients without a history of addictions, whereas it falls very slowly in those with such a history.

Pain, although often portrayed by patients as constant, should follow the natural history of the injury. While re-injuries and other exacerbations can occur, the level of pain should parallel the degree of injury and subsequent healing over time. Even over the course of a single day, the diurnal cycle is not constant but should reflect changes in sleep, activity and cortisol levels. Here again, careful questioning by the physician can uncover inconsistencies in the patient's story. This should include altering pain questions so the patient has less opportunity to give a planned response and including several questions that are spurious from a medical perspective. Indirect and open-ended questions (e.g., "Tell me about your eating" and "How did your last meal agree with you?") can force the drug-seeking patient to give an unscripted reply.

4 Look for Consistency in the Exam

All aspects of the physical exam should be internally consistent. Posture, point tenderness, percussion tenderness, passive and active range of motion as well as active resistance should tell the same story. Faking the injury in a consistent way is a relatively difficult task for most patients. This becomes even more difficult if the physician uses distraction techniques such as firmly palpating a non-injured extremity while gently palpating the injured extremity. The physician should move smoothly between the different components of the exam without giving the patient sufficient time to react to each one. While the physician should examine uninjured tissues first and avoid sudden movement, both essential for patient rapport, the exam of the injured tissue should not be scripted. Doing so would allow the malingering patient to plan out his or her responses.

Tissue injuries tend to be localized. Certain physical activities (but not all) will cause pain just as specific exam techniques (but not all) will produce tenderness. Patients who try to protect injured areas by tightening overlying muscles will have tenderness of the injured deeper tissue but not of the overlying muscle, a distinction that is rarely made by the feigning patient. Injured muscles that involuntarily spasm, on the other hand, will be tender while the voluntarily contracted muscle should not.

5 Conduct Appropriate Tests

Just as a patient with asthma needs a peak flow reading, a patient taking narcotic medications needs regular urine toxicology testing. While this is one of the most effective tests for monitoring patient behavior, it is underutilized. An office protocol can help ensure that all staff follow a consistent approach. The medical assistant can automatically obtain a urine specimen prior to taking pain patients to an exam room, particularly if several months have elapsed since the last test. Alternatively, a patient can be required to give a urine specimen at the end of the visit just prior to checkout.

Radiological images should be obtained for a patient with a new complaint of pain to ensure there is not a concomitant problem such as a bony metastasis. While X-rays provide information about structure, they do not verify the legitimacy of pain, which is a phenomenon of function. If the history, physical exam and mechanism of injury do not correlate with each other, the X-ray cannot independently substantiate the diagnosis of pain.

6 Prescribe Nonpharmacological Treatment

A patient genuinely seeking pain relief will understand that there is no “magic bullet” and be willing to use nonpharmacological treatment (physical therapy, home exercises, etc.) in conjunction with medications. A patient who is unwilling to try these therapies is unlikely to desire an improved level of function. Before adding a narcotic to the patient’s treatment plan, the physician should verify that the patient is willing to try – and continue to try – at least five nonpharmacological lifestyle interventions, some of which can be very simple. In addition, the physician should prescribe nonopioid analgesics such as acetaminophen and NSAIDs and document their failure prior to placing a patient on an opioid. Most narcotic prescriptions should be for acute or intermittent use. If opioids are needed, a legitimate sufferer will generally seek to limit their dose and frequency, balancing the need to relieve pain with the desire to avoid unpleasant side effects.

Since all narcotics bind to opioid receptors, a patient who names a specific narcotic and claims only that narcotic works may be seeking the medication itself rather than relief from pain. This is particularly true in a patient who insists on receiving a brand-name medication. Similarly, patients who claim to be allergic to multiple narcotics except for one are not likely being honest.

7 Proceed Cautiously

If you decide to prescribe a controlled substance, it is wise to limit the quantity of medication and the number of refills. Make sure the prescription is legible with all information clearly filled in so the patient cannot modify it. Document clearly in the patient record that a narcotic was prescribed, perhaps using a different color of paper from the rest of the chart to ensure this information will not be overlooked.

Frequent office visits should be scheduled for close monitoring of these patients, and drug contracts outlining expectations can be helpful. Keeping a list of patients who are on opioids may also be helpful in tracking them.

Above all, office staff and physicians should be consistent and diligent, as drug-seeking patients are experts at exploiting weak links in the system.

Send comments to fpmedit@aafp.org.

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Author Disclosure: nothing to disclose.

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17 Responses to How to spot a drug seeking patient

Micheal Lee Clark

November 28, 2012 | 1:17 PM

Thank you for this post!!! I suffer from Ankylosing Spondylitis which is a chronic inflammation of the spine and the early onset of Arthritis, three of my vertebrae show signs of darkening! Which leave me in constant pain. I've been prescribed ETODOLAC and something for my stomach because the pain medicine is a Nsaid medicine i have internal bleeding because of it!The ETODOLAC works fairly well for the Arthritis in my knees and hips and shoulders but it does nothing for my my Spinal pain.For a while i was buying my pain meds from a brother-in-law who get 300 10 milligram Vicodin a month and sells everyone of them.At first he just gave them to me then it was a nominal fee then as he saw he could make money he started strong arming me and charging 5 bucks a pill.Nice guy right? Dont get me wrong i know how this might sound but i really was using them for pain two in the morning one at night to sleep! Well he found people who would pay him upwards of 7 to 10 bucks a pill so i was shut out of his vicodin supply!! Well were there's a will there's a way! I found a lady who was prescribed Morphine Sulphate 15 milligrams! One pill at night and my pain was relieved all day long.She was only selling them for 3 bucks a piece!!! Wow i really lucked out!!! Well after about three months i started seeing that i was in more and more pain so i upped the dosage!Again i'm gonna tell you the truth i only used them to relieve the pain it wasn't because i wanted to have a good time or to party on.So now i was taking two a day and it worked very well but because i was taking more than she supply at the end of the month i was running out. Having to go to my brother in law and buy some at his price just not to be in pain! then the first of the month and I'd get my meds!This went on for two years.But the worst thing ever happened with out warning the lady passed away! I was genuinely sorry for her because she was a very nice woman and helped me very much! But now i was left with out an option.I refused to buy from my brother in law so i was in a lot of pain and also i was



getting sick and sneezing and throwing up! I thought i had caught a cold. Nastiness coming from every hole it was awe full. But it came out that i was coming off of the Morphine Sulphate. For two weeks i was in hell. Morphine is worse than heroin to stop doing! It was tough and i had found others who had the morphine but i had stopped using it and the pain was so great in quitting that I decided not to do it ever again. I've been free of narcotic pain meds for over 2 years now but I still live in constant pain. I one hand I'd love to be pain free but on the other hand i don't want to get hooked on morphine ever again. It truly is a slippery slope.

Dr. Pullen

August 27, 2012 | 8:41 PM

Dr Cynic: I also have been amazed at the number of comments wishing me horrible pain and suffering. I just pray for these souls as they clearly need them. DrP.



dr cynic

August 26, 2012 | 11:05 PM

It's strange how many people label us doctors as cold, cruel, heartless people who should be cursed with some disabling illness for our insolence. It strikes me that patients are more cruel than doctors, inasmuch as I have never wished anybody to have debilitating pain, regardless of what they have done.



Jodey Battles

August 25, 2012 | 7:58 PM

I am a 21 year old male who was diagnosed with HIV a year ago. About 4 months ago i started to experience an absurd amount of pain. I describe it as, "shooting", "burning" and even "stabing." I decided to go see a doctor when the pain began to affect my daily life. i started to have issues with my long time boy friend, i found my self unwilling to go to work, and i even started to seclude my self from my family. recently my doctor has decided to try and start me out on a low mg dosage, and it has helped a lot. I'm thankful for my doctor and his ability to prescribe medicine. Both me and my doctor have had long discussion about whether or not i wanted to go down this path, but i honestly believe palliative care is the best choice for me. The pain is ether a side effect of my hiv meds, or a side effect of the virus it self, we really dont know. He suggest at first that i talk to my other doctor about changing my hiv meds, but that was simply out of the question, once you get off a specific class of hiv meds, you can never come back to those, so we decided to start the up hill pain management battle. My point is simple, im lucky i was born in America with such a big medical infrastructure that can make these meds readily available to people like me who decided to go down this path. If a patient wants to treat his pain with narcotics, that should be his choice. I had to make this decision my self, and my doctor was their to provide me with educated information that i could trust. I stumbled on this thread because im constantly reading about pain management therapy.



Eileen

May 14, 2012 | 11:21 PM

See that is exactly what I was saying. the patients that really need the meds are treated like they are just druggies that just want to use excess pain meds and they are really not able to function without it. It actually raises their quality of life and without it they would not be able to get through each day. My husbands back has gotten much worse from when he was first diagnosed. He had an MRI and it was pretty bad then and that was almost 10 years ago. He refuses to have surgery because it is such a high risk surgery. There are days when he simply cannot get out of bed. Even days when he uses his meds and he is just in to much pain. I know what it is like to watch someone suffer a great deal from pain that he cannot do anything about. It is really unfair to lump everyone in together and treat people with a genuine condition as though they are just drug seekers. He hates the way the pain medication makes him feel most of the time. He is knocked out by it and he doesn't like the way it makes him non functional. SO there are many people who hate the way the meds make them feel but they are forced into using something that will allow them to continue on in daily life and keep going. Pain medication actually does work for its intended purpose believe it or not!! For those of you out there that just want to put it down and make it all out to be just about ppl getting high, you couldn't be more wrong for people who have been using these meds long term. The high is something that ends up long gone if you are on it for long enough and that is how people who have been on it for so long function on it well. They are not affected by it in that way anymore. If my husband avoids using it for a while just to take a break from it he will of course go through periods where he becomes somewhat more sensitive to it again but eventually that wears back off. That is just part of the cycle. That is when he hates feeling drowsy from his meds. He doesn't like the way pain meds make him feel either so it is just people jumping to automatic assumptions when they really do not know how someone who has to use the meds to work everyday feels. Ignorance is not the way to judge is what I keep saying. I know hat people think that they know but unless you are someone who is experienced at long time pain mgt, then you cannot understand what these people go through. A never ending cycle of pain and discomfort. And even for those people that may experience a certain amount of a "high" from their meds, for the ones that are in agonizing pain, who are we to say that this is a bad thing for them???? They are really the ones that are suffering here, not you or I. So.....why should we concern ourselves with people and their pain mgt unless they prove otherwise, really.....just leave these poor people alone. They suffer enough everyday without helping or adding to their pain/discomfort!!



Rather not say

May 14, 2012 | 8:06 PM

Dr. You are the problem. All you morons are scared to death of the DEA and they should not even be screwing with doctors. As if we don't have enough problems with illegal narcotics in this country, we have so called cops with no medical training screwing with doctors and what they do and the ones with the control have no medical license. I've never seen a DEA agent with a medical license. I had a bad accident in 05 and went off a single track cliff while mountain biking in the Rocky Mountains on a \$6,000 downhill mountain bike. One false move and my life has been forever changed. I've been through every treatment there is and they have not worked or have made the pain worse. I am fortunate to have a good Dr. But I have a genetic disorder that does not allow my body to allow opiates to attach to the receptors normally which means I require high doses of the medication. Between long and short acting morphine and oxycodone/oxycotin I take about 2,000mg of narcotics daily with muscle relaxants and benzo's to help the muscles relax. The injury has spread over time and will not stop. I have numerous bad discs, degenerative disc disease, degenerative facet disease, vertical and horizontal herniations and many are in the thoracic reigon from (-2 down to the sacrum. I've seen over 20 surgeons and all have said not to have surgery because all thoracic surgeries must go through the chest from the front and is very risky and will put tremendous strain on discs above and below and I have been told be all that if I have surgery to expect to have to fuse above and below about every 1-2 years until I'm totally fused. The alternative treatments I've tried have caused so many other health issues I can't begin to count. So not all injuries are self healing. The spine, discs, vertabre, etc don't just heal. I'm lucy to be able to walk and have fallen from my back and not only injured my head in the original accident but several times since in falls and now have seizures, and between the pinched nreves in the spinal cord and the seizures I lose bladder control several times a week, awake or asleep and I get treated like crap by other Dr's. I had a bad car accident, stopped breathing and heart stopped and I was dead and brought back and wish they had known I was a DNR but I was in critical ICU and 12 hours later discharges and told they could not help me and my pain and I needed to go home and treat myself. What a load of crap these Dr's are.



Eileen

April 5, 2012 | 2:59 AM

I know that there are a good number of ppl out there that are not actually in legitimate pain and are just seeking pain medication for other reasons. BUT..... that is not the case with MANY MANY other patients who legitimately need relief from pain. I don't understand why there is such a gnarly campaign all of the sudden to block anyone and everyone from receiving the pain medication that they so badly need. There are plenty of people out there that are truly unable to function without the pain meds that they need for real relief from pain. I have experienced the "treatment" that a suspicious Dr. will give you when they feel as though you are making up an ailment to get pain medication. It is not a good feeling. You walk away feeling as though you have done something terribly wrong and that is not how you should feel when you are truly looking for a relief from real pain.



I honestly think that Dr.'s can get caught up in a witch hunt for people who are seeking pain meds for other than pain related needs. But again, I feel that if a Dr. would listen to there patients and make time to really hear what it is that they are saying, that a lot of this would be avoided. Why are Dr.'s allowed to pretty much ignore

their patients and then jump to a conclusion that is far from what they should have concluded. Dr.'s are in such a hurry to "get to" the next patient that they are not hearing legitimate claims of pain and just being suspicious will keep them from hearing even more. We all know what it is like to start to formulate an opinion of someone while they are stating something about themselves or a situation that they are or have been in and basically your mind is wandering while calculation is going on. How much more of what this person was actually saying to you was absorbed?? Not much right? SO....with that said, if a Dr. can actually just hear out each patient and realize that what their patient is saying to them matters, then maybe that alone would stop the suspicion when it is not valid. I really do think that it is possible to hear those that actually need it and those that do not. Just like anything else in life, communication skill is required in life to solve any given problem. Dr.s who assume they know what is what before they have "heard" a patient out will more or less make a hypersensitive conclusion that is based on exactly what this Dr. wrote and many legitimate pain patients will be denied the meds that they actually "need." The world just needs to slow down a hair to hear what is real and what isn't! Make sense???

Tina Dillard

April 2, 2012 | 8:56 PM

I just want to be pain free or at least be able to have some normalcy in my life !!! I never thought I would see the day at 47 that it was all I could do to do everyday housework !!!Not to mention the problems I also have with my nerves due to all this mess !! Sometimes you have to have stronger medicine just to have a somewhat of a normal life !!



Tina Dillard

April 2, 2012 | 8:50 PM

I was injured at work 6 years ago ! Worked every day but when I got injured at work the comDoc said in my chart I was faking to get drugs and even went so far to put it in my chart that he prescribed me narcotics . Since it was a work injury I went to the pharmacy that my employer told me to and guess what NO NARCOTICS were filled ! Every doctor that I was sent to after that seen where I was accused of faking my injury to get drugs and was treated worse than an animal !! Now my back has gotten in bad shape due to one of the two injuries at work and now I have a compressed nerve at least 3 bulging disks that are starting to tear and a small hemangioma which is a small tumor on my spine. I have an appointment with a surgeon on the 6th of April and I know exactly how it feels to not have enough medicine to even begin to control my pain and due to the past doctors crap I am afraid to even ask for pain meds for fear they will think I am a pill head due to the mess from the past !!! The funny thing is even though I was faking with one of the injuries 2 weeks after an MRI was done surgery was scheduled !!! HEY DOCTORS, NOT EVERYONE WHO WALKS INTO THE E>R> OR YOUR OFFICE IS LOOKING FOR NARCOTICS !!!!



Angel

March 5, 2012 | 1:41 PM

I too have a problem with this post. My mother is 56 years old and was born with Alpha-1 Antitrypsen Deficiency...or do you not care to know what that is? My mother has never smoked, this was purely genetic. As she aged, her lungs got worse and she was constantly on steroids...30 years now shes been on steroids...naturally her bones are a mess from this...she has broken both hips and can no longer walk...she has severe pain due to her bones in her legs and back...how do you treat this?? She maybe has two years left (with her lungs) and you piece of crap doctors are just gonna let her live her last 2 years, if that, in pain because you no longer take patients in Pain clinics???. What the hell are you for???. I understand about drug-seekers...as both a police officer and and now a nurse, I have dealt with them. But what do you do for people like MY MOTHER!!!!!! Would you want someone treating your mother like this? My mother has been on the pain patch for 15 years now and has gone from 75mcg to 275 mcg in 15 years (and shes a drug seeker???)...she has done well and managed to live as much as she can on them...but now that her dr is no longer practicing, she is stuck without a dr and we cant find a pain clinic that is taking patients...he gave her a 3 month supply which is almost gone now and we still don't have a dr to write her. If she has to withdraw off of it, it will kill her...she can barely breath as it is...what she supposed to do? You doctors today are a joke and let me tell you something, I hope like hell you have to go through something like this...maybe that will wake you up. The health care system has gone to hell in a hand basket and even my mothers (retired) doctor said he was retiring because all of you current doctors are just poor picked on kids trying to play God and hes right...may God bless you now because KARMA is a bad thing! You are all a bunch of cowards and I hope one day that you wake up!



despicable

March 4, 2012 | 6:21 PM

yup, good job doc. 3 surgeries and 5 years later, after taking the meds they gave you for 3 crushed disks and Ti plates and fusions, they tell you you are an abuser. The opiate witch hunt means you can no longer work or even walk to the store. Time to leech off the government since you can't work. Disability, here I come. Thanks to the hypocritical oath. First, do not treat. Then prescribe tylenol.



No One (according to this 'doc')

February 3, 2012 | 6:07 PM

As I type this my husband is trying to find a way to ease his pain by building a nest of pillows on our couch. He went to his 40 yr old doc today due to severe nerve pain. Husband has Lyme disease, which we think is cause of the pain. (?) Of course since the doctor couldn't see an actual injury my husband was denied any medication....Can someone clue me in as to why companies even make pain meds if no one can get a script for legitimate reasons? So what do we do now? Go to downtown Hartford and buy some heroin from some thugs? Well that must be the solution cause we'd get shot in the head and therefore no more pain issues!



Linda Caldwell

December 18, 2011 | 1:59 AM

My guess is that "Dr." Pullen, nor any of his family suffer from life altering pain. If he/they did, they would be treated with respect, treated medically to relieve their pain and NEVER be branded as "pill seekers".



How DARE you? I was assaulted 20 years ago, and NO, soft tissue injuries do not "ALWAYS heal". I have extreme hyper-mobility of my upper neck, which results in excruciating headaches that have, many times, made me wish I was no longer in this life due to the relentless pain. Many times "opiates" don't even touch the pain.

Before I was assaulted and sustained the injuries (which I did not CHOOSE), I worked part time, earning over \$50k a year (in 1990, not too bad), was always at the top of the sales force, attended a high end university in NYC with a 3.9 GPA, played golf 4x a week, and was a championship swimmer. In 10 minutes my life was destroyed. I could no longer work, had to leave school because I could no longer carry the books, lost my place to live, ended up in a shelter...I went through HELL. Not to mention the excruciating pain. I waited 20 YEARS before I took pain medication, because I could not take the pain any longer.

I am now treated as a junkie, cannot even find a primary care provider because I found a doctor that is prescribing me pain medication, RESULT: I get pneumonia and can't get treated with antibiotics, I am ALWAYS disrespected, looked at with suspicion, when I am able to get to a specialist, when they "discover" (although their staff was told) that I am on opiate pain medication, my ailment is written off and dismissed as "psychiatric"...this is now my life. Let's see, would I rather have my life back, filled with production, activity and joy that I had as a Type "A" personality or a life filled with pain. You figure it out.

I never thought I would say this to anyone, but what I wish for you, "Dr.", is that you sustain a life altering injury, and THEN be refused any pain relief. My guess is that you would be on your knees crying like a little girl, then begging for someone to help you.

You are not fit to be a "caregiver"...you are a disgrace.

I think I will write an article on how to spot a "Dr." who claims to be in the business to help people, but is really there to pass judgement and surreptitiously prevent legitimate people from getting the help they need AND deserve.

Michele

December 13, 2011 | 12:35 AM



I cannot believe what I just read. You should be ASHAMED TO CALL YOURSELF A HEALER! You insensitive snob! I have been in pain my entire life. I had colic for the first half a year of my life, my mother said I cried & screamed as if I was being burned. My first memories are of pain at 3. Was called a hypochondriac at 6. At 8 was told after my mothers funeral, that I was squinting to get attention by my family Dr, I couldn't SEE! Same Dr told my parents to ignore my 'growing pains' & I would stop exaggerating them. By 13, I was great at hiding my pain. I even hid my 3-4 month long periods from everyone, until I passed out at school. The second time, the school refused to release me to my father until a Dr confirmed an appt. I was hemoraging (sp?) & severely anemic.

Now.

I'm 41. My diagnosis? Restless Leg Syndrome, Fibromyalgia, Severe Multi-chemical Allergies, Chronic Pain Syndrome, General Anxiety (paradoxical reactions to ALL benzodiazprines), Irritable Bowel & Bladder, and more fun fun chronic disorders.

My mother died from lupus & kidney failure. I used to be thankful I didn't develop lupus. Not so much now.

Since 1998, I have been on percocet 5-10mgs, aprox 30 , flexeril 10 mgs, 30-90 & oxycontin 10 mgs, 20-30 every 3-6 months. 13 years.

I now have no doctor who will treat me. My last Dr, whim I saw since 1995 dismissed me 6 mos ago over antibiotics. I can only take sulfa & the rest cause me to become violently ill. The PA insisted I continue taking meds that made me projectile vomit & pass out. My body refused to let it get past my stomach. I weigh 85 lbs. I cannot afford to lose weight. She insisted I break up the capsules & mix it with apple sauce.

I insisted on bactrim. I was refused based on the PAs insistence that its not indicated as use for an upper respiratory infection. WRONG. So. I was dismissed by my Dr. My pain is REAL.

What you, Mr Dr God Of Meds has written is an insult to chronic pain patients.

I know my body. I know what meds make me sick. I know what meds help me live. I cannot afford to play guinea pig with meds that make me sick.

My pain hasn't stopped since I ran out of all my meds.

My pain has worsened & my life is a mess.

I cannot clean or take care of my young child.

I am about to lose another job because I can't sleep or work exhausted & in pain.

The ER treated me as if I was a junkie when I slipped & fell, covered in blood & in shock. Found out later its because I said I have fibromyalgia & asked for muscle relaxers for my back spasms.

COME ON!!!!

I DON'T WANT A CURE! I JUST WANT RESPECT & TO HAVE MY PAIN UNDER CONTROL!!! I WANT MY LIFE BACK!!

THEN DRS LIKE YOU WRITE CRAP LIKE THIS!!!

One day. One day, either you, your wife or one of your silver spoon children will hurt. Badly. I hope they get a Dr like you to treat them like a junkie. But, then again, they always have YOU to write them a script for pain meds ..

Better watch them. They may just turn around & get high or sell them to a junkie like me, right?

Jerk.

Kicks the glorified chiropractor in the shins

Adrian

November 21, 2011 | 9:55 PM



What an insensitive doctor! One reason for the increase in patients who need strong narcotic pain medicine is the recent banning of darvocet which has been safe for 50 years! But a small group of individuals dedicated to getting rid of all pain medicine finally caused this.

Anyway its articles and opinions like this article that has caused people with legitimate pain to loose what little quality of life they have. Sure there are many addicts but there are also many legitimate pain patients who, when faced with the horrendous suspicious behaviors suggested above, wouldn't have a chance in getting the relief they need. Pain is the only disability where the patients are forced to endure suspicion and denial of medication because of doctors who don't have any empathy or any idea what living with terrible pain is like. Shame, shame on you for writing such a mean spirited article.

sarah

November 21, 2011 | 6:12 AM



You doctors are terrible. Do you ever really listen to yourselves talk? I have been on a low dose painkiller for awhile. The other types of meds make me feel loopy and sick to my stomach. But according to you, this would show that I am just a pill seeker! Some ppl really need help out there and not ignored! We come to you doctors for help and advice and all you do is accuse ppl of lying and send them away with no further help offered. It is because of you hard headed doctors that people are turning to the streets to get relief and overdosing because they didnt have a doctor to keep an eye on them if it was needed. You should be ashamed of the way you think and shouldnt be doctors anymore. Grow up and grow a concious! Might help you sleep better at night!

Eric Patterson

May 19, 2010 | 6:59 PM



ibuprofen is definitely the best OTC painkiller for me. It helps me a lot to deal with my muscular pain..:~

I generally give each patient the benefit of the doubt, before assuming s/he is a drug seeker. With most patients, it's not so much the behavior on one visit as it is a pattern of behavior over time. 6. These are the red flags for drug seeking patients that I have seen: Insistence on IV pain medication. Let's be honest, while that IV Dilaudid works wonderfully, it works briefly. How does a medical personnel (doctor, nurse) determine if a drug is inserted into the patient's body by injection in the upper arm, buttocks, or through an IV? Do doctors, anesthesiologists, and other hospital staffs get random drug tests? If not, should that be a requirement since they have access to prescription drugs and work on saving patients' lives? Why should we trust doctors? Prescription drug misuse. How to identify and manage drug seekers. Key reviewer: Dr Geoff Robinson, Chief Medical Officer, Capital and Coast DHB. Key concepts: The most sought after drugs are opioids and benzodiazepines. Identifying a drug seeker is sometimes difficult. GPs should routinely screen any patient who is prescribed a controlled drug. It is important not to withhold appropriate treatment when a drug seeker has a genuine need for pain relief. A usual patient/doctor relationship is based on mutual respect, however a drug seeker has a stronger relationship with the prescription than with the doctor. Some doctors who are pressured for time would rather "write than fight". 2. Indicators of drug misuse. Drug-seeking is often easier to spot in the emergency department and is more common in that setting but it's ill-advised to "walk into a patient's room and automatically assume they are drug-seeking," said Rebecca Loveless, a physician assistant in the emergency department at Washington University School of Medicine, St Louis, who also practices at a private orthopedic group. Some patients are legitimately in acute or chronic pain, but some are looking for pills to sell outside the hospital, Loveless tells Medscape. Loveless begins with a history and chart review to determine how many times a patient has visited her emergency department or others connected to the Washington University electronic medical record. She also looks for inconsistencies in exams. "Drug-seeking behavior" is merely a hallmark feature of the disease of addiction which is widely understood today as a chronic brain disease. What that means is that someone with an addiction may display certain compulsive or "drug-seeking" behaviors that are symptomatic of that underlying chronic brain disease. ADD_THIS_TEXT. An even more extreme drug-seeking behavior that I've had to deal with has involved a patient actually forging a doctor's prescription. In one particular instance that comes to mind, when I realized that a patient had forged another doctor's prescription, I had to alert that doctor. In such cases, we also had to alert law enforcement, because forging prescriptions is also illegal. More Content from this Author: The 10 Most Addictive Substances to Avoid. Find out about a drug-seeking behavior, also called doctor shopping, and how it is linked to the epidemic of opioid overdose deaths. Usually, a doctor will prescribe their patient a drug in the amount and dosage that is necessary for the legitimate treatment of their current medical condition. Double doctoring happens when some patients actively seek out additional doctors to obtain more of the same medication, or to obtain a different medication which has the same effect as the one they were prescribed originally. Double doctoring is a problem in the medical field because it is a type of dishonesty that makes it difficult for doctors to do their jobs properly. How to Spot the Signs of a Pain Killer Addiction. Heroin: Everything You've Been Afraid to Ask.