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

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 spasmoidic and was nonspecific except for its purported severity. His physical exam, too, showed inconsistencies in both the physical and the patient’s story 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 oozes of 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.

1 Involves 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 pain. 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 malingerer 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 readout, 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.

References


Authors and Disclosures

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Author Disclosure: nothing to disclose.

17 Comments - Leave a comment!

Thank you for this post!!! I suffer from Ankaloising Spongilitis which is a chronic inflammation of the spine and the early onset of Arthritis,three of my vertebrea show signs of darkening! Which leave 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 them 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? Don’t 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 Sulphate15 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 Morphone Sulpurate. For two weeks i was in hell. Morphone 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 the other hand i don't want to get hooked on morphone ever again.It truly is a slippery slope.

Dr. Pullen
August 27, 2012 | 8:41 PM

Dr Cynic: I 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 insolvency. 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.

Jodye 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 "stabbing". 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 either a side effect of my hiv medication, 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 myself, and my doctor was their to provide me with educicated 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 refusets 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 knobked 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. 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 mg, 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 mg? if they are the choice, 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 the DEA. Taking away the ability to treat patients for pain is just another high handed move that the DEA thinks will help them catch "drug dealers". The pain management field is already filled with people who would rather provide pain relief than treat the underlying cause of the pain.

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 garaely campaign all 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 alientment 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! Bulging disks that are starting to tear and a small hemangimata 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 if not to 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>RR> 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 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…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…she 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.

Angel
March 5, 2012 | 1:41 PM

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 their hands on it. My guess is that “Dr.” Pullen, nor any of his family suffer from life altering pain. 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 their hands on it. My guess is that “Dr.” Pullen, nor any of his family suffer from life altering pain.

Tina Dillard
April 2, 2012 | 8:56 PM

you figure it out.

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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”.

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Linda Caldwell
December 18, 2011 | 11:59 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 aiment 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!

Michele
December 13, 2011 | 12:35 AM

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 apt. 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 & oxycotin 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 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 shouldn’t be doctors anymore. Grow up and grow a conscious! 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...~