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Psychiatric Prescribers' Experiences With Doctor Shoppers

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Abstract

Doctor shopping is a primary method of prescription medication diversion. After opioids, benzodiazepines and stimulants are the next most common prescription medications used nonmedically. Studies have shown that patients who engage in doctor shopping find it fun, exciting, and easy to do. There is a lack of research on the prescriber's perspective on the phenomenon of doctor shopping. This study investigates the experiences of prescribers in psychiatry with patients who engage in doctor shopping. Fifteen prescribers including psychiatrists and psychiatric nurse practitioners working in outpatient psychiatry were interviewed to elicit detailed information about their experiences with patients who engage in doctor shopping. Themes found throughout the interview were that psychiatric prescribers' experience with patients who engage in doctor shopping includes (a) detecting red flags, (b) negative emotional responding, (c) addressing the patient and the problem, and (d) inconsistently implementing precautions. When red flags were detected when prescribing controlled drugs, prescribers in psychiatry experienced both their own negative emotional responses such as disappointment and resentment as well as the negative emotions of the patients such as anger and other extreme emotional responses. Psychiatric prescribers responded to patient's doctor shopping in a variety of ways such as changing their practice, discharging the patients or taking steps to not accept certain patients identified as being at risk for doctor shopping, as well as by talking to the patient and trying to offer them help. Despite experiencing doctor shopping, the prescribers inconsistently implemented precautionary measures such as checking prescription drug monitoring programs.

Keywords

prescription drug abuse, doctor shopping, drug use disorders

Introduction

Substance use disorders related to controlled prescription medications are a worldwide problem. According to the U.N. Office on Drug Rates and Crime (2012), nonmedical use of prescription medications is second only to marijuana in many countries. In the United States, the annual cost of opioid use disorders alone is estimated to be $53 billion (Drug Enforcement Administration, 2014). In 2013, six and a half million Americans aged 12 years and older admitted to illicit use of controlled prescription medications. Within this group, 4.5 million used pain relievers, 1.7 million used tranquilizers, and 1.4 million used stimulants (Substance Abuse and Mental Health Services Administration, 2014). From 1999 to 2011, deaths resulting from opioid overdoses quadrupled and nearly surpassed the rate of accidental traffic deaths (Chen, Hedegaard, & Warner, 2013). And from 2000 to 2010 there was a 570% increase in the concurrent abuse of opioids and benzodiazepines (Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2012). In 2008, doctor shopping cost Medicare $148 million and Medicaid $63 million (Civic Federation, 2009; U.S. Government Accountability Office, 2011).

Background

The term *doctor shopping* refers to a known method patients engage in to obtain controlled medications for nonmedical use (Cicero et al., 2011; Inciardi et al., 2009; Rigg, Kurtz, & Surratt, 2012). Patients who doctor shop use multiple prescribers to obtain controlled prescription medications without reporting to the prescriber that they have obtained similar prescriptions from other prescribers,

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fill the prescriptions at more than one pharmacy, and use the medication in a way that was not intended when prescribed (Worley & Hall, 2012). In a study of 146 million opioid prescriptions filled during 2008 by 37,000 pharmacies, 359,000 patients had obtained their opioid prescriptions from at least five different providers and 135,000 patients obtained an average of 32 unique prescriptions from an average of 10 different prescribers (McDonald & Carlson, 2013).

Doctor shopping is an important concern in psychiatry for several reasons. First, benzodiazepines and stimulants are the second and third most common prescription medication (opioids are most common) used illicitly in the United States (Amari, Rehm, Goldner, & Fischer, 2011; Substance Abuse and Mental Health Services Administration, 2014). Over a 1-year period, the rate of doctor shopping for all benzodiazepine prescriptions was 3.6%, accounting for 361,428 daily doses (Pradel, Delga, Rouby, Micallef, & Lapeyre-Mestre, 2010). Second, overlapping prescriptions for benzodiazepines and opioids have been found to be predictive of doctor shopping (Cepeda, Fife, Chow, Mastrogiovanni, & Henderson, 2012b). Third, patients who visit outpatient mental health facilities are associated with an increased risk for prescription opioid abuse (White, Birnbaum, Schiller, Tang, & Katz, 2009). Prescription data collected on 314 new patients in a psychiatric residency outpatient clinic of an academic medical center in Virginia revealed that 42% of patients met at least one criterion for prescription drug misuse, defined as two or more prescriptions for controlled substances, prescriptions from two or more providers, refilling prescriptions early, filling prescriptions at three or more pharmacies, or differences between the patient's report and the report from the state prescription drug monitoring program (PDMP). When compared with patients who do not meet criteria for prescription drug misuse, patients who misuse prescriptions have a higher incidence of prior benzodiazepine or opioid use, a personality disorder or chronic pain (Sowa et al., 2014). Last, there are potentially serious consequences to doctor shopping, including overdoses, seizures, loss of custody of children, incarceration (Worley & Thomas, 2014), and drug-related death (Peirce, Smith, Abate, & Halverson, 2012). In one study of the cause of drug-related deaths over a 1-year period, the benzodiazepine, alprazolam, contributed to 17% of all the drug-related deaths. In 97% of the drug related deaths where alprazolam was a contributing factor, an opioid was also identified as a cause of death (Shah et al., 2012).

Relatively few studies have been conducted with people who engage in doctor shopping, but findings from these studies indicate that doctor shopping is most prevalent in the South and Northeastern United Sates. Patients often cross state lines and often pay with cash (Cepeda et al., 2012a; McDonald & Carlson, 2014). Additionally, more women than men doctor shop and those who doctor shop tend to have a history of physical or sexual abuse, mental illness, and polysubstance abuse (Amari et al., 2011; Jamison, Butler, Budman, Edwards, & Wasan, 2010; McLarnon, Monaghan, Stewart, & Barrett, 2011). Other studies have shown that individuals who engage in doctor shopping often have an addiction to the substance. They may network with others who doctor shop, use abnormal diagnostic tests such as magnetic resonance imaging scans or X-rays shared from other people, use fraudulent names, provide false information, and/or travel long distances to obtain prescriptions. They report that doctor shopping is "fun" and that it is easy to obtain the prescriptions from prescribers (Green et al., 2013; Rigg et al., 2012; Worley & Thomas, 2014).

To date, the only studies conducted to examine prescriber characteristics or experiences related to the phenomenon of doctor shopping have focused on prescribers' use of PDMPs, which are online databases that can be used to access information about patients who have filled prescriptions for controlled medications. Although PDMPs have been shown to be effective in detecting doctor shopping, they are not universally used (Worley, 2012). Since the responsibility for the choice of medication and the treatment offered the patient relies solely on the prescriber, it is important to understand prescribers' experiences identifying and responding to patients who doctor shop. Gaining a greater understanding of providers' experiences could lead to the development of more uniform responses to doctor shopping and potential changes to health care policy. The purpose of this study was to understand the psychiatric prescribers' experience with patients who engage in doctor shopping.

Method

The methodology underpinning this study was existential phenomenology, which is grounded in the philosophy of Merleau-Ponty (Pollio, Henley, & Thompson, 1997; Thomas & Pollio, 2002). The central premises of existential phenomenology are (a) the uniqueness of each person's perception and (b) the description of a participant's experience as reflected on by the participant (Pollio et al., 1997). Phenomenological research is useful when there is a paucity of research because it focuses on understanding the wholeness of the human experience as seen through the participant's eyes (Merleau-Ponty, 1945/2005; Mottern, 2013). In phenomenological research, the interviews are conceptualized as a dialogue between the researcher and the participant. The interview will begin with one or two open-ended questions and subsequent questions are not predetermined but rather flow from the dialogue and are aimed at obtaining

a clear description of the phenomenon from the participant's perspective (Pollio et al., 1997).

Since the aim of phenomenology is to obtain the participant's perspective of a phenomenon, the danger is that the researcher will impose his or her own biases on the interpretation of the data (Pollio et al., 1997). To minimize bias, the first two authors independently analyzed the interviews and then met to discuss the findings, reconcile differences, and come to consensus. Once consensus was achieved the findings were shared with the third author to ensure that the major themes reflected providers' common experiences of doctor shopping. Approval for this study was obtained from the university's institutional review board.

Participants

Participants for this study were recruited from professional listserves through an online posting and by word of mouth. Inclusion criteria included psychiatrists and psychiatric nurse practitioners working in outpatient psychiatry who prescribe controlled medications as part of their normal practice and who self-reported as having had experience with patients who engage in doctor shopping. Demographic information was collected following the interview on age, state, type of practice, and years in practice. Participants were given a $100 gift card at the conclusion of the interview.

The participants were seven psychiatrists and eight psychiatric nurse practitioners ($N = 15$), all of whom were prescribers. They ranged in age from 35 to 67 years (mean age = 53; $SD = 11.1$). Their years of experience ranged from 4 to 30 (mean years = 14; $SD = 9.46$). Ten of the participants were female and five were male. The participants practiced in the West, Midwest, South, and Northeast United States and the majority worked in private practice. Recruitment was terminated when new interviews did not reveal any new findings but rather repeated what was found in prior interviews.

Data Collection

Interviews were conducted by the first author in a private location either by Skype or in person. The type and location of the interview was determined by the geographical location and the preference of the participant. Participants faxed or mailed their written consent to the first author prior to the interview. The questions asked of participants included, "Tell me what your experience has been with patients who were engaging in doctor shopping?" and "What stands out to you about your experience with patients who were engaged in doctor shopping?" These questions were followed by specific questions to elicit greater specificity about the participant's experience and with open-ended questions such as, "Is there anything else you would like to share?" or "Are there any other experiences that stand out for you?" If the participants did not address safeguards they used to detect doctor shopping, they were asked about safeguards. There was no time frame set for the interviews. The average length of the interviews was 33 minutes. The interviews were digitally recorded.

Data Analysis

The interviews were professionally transcribed. The transcripts were initially reviewed independently by the first two authors to identify short phrases and meaning units. The research team (the three authors) met to compare the initial analysis. Differences were discussed and consensus achieved. The short phrases and meaning units were then grouped into categories. New codes were added as necessary in light of emerging findings. The first two authors then independently reread and coded the transcripts, followed by additional team meetings to ensure consistency. In the team meetings, the codes were further analyzed for the presence of common themes and interrelationships. Global themes, which were present across interviews, were developed and were supported with verbatim quotes from the participants. The final themes were shared with the third author to ensure that the findings were consistent with the third author's knowledge of and experience with doctor shoppers. All participants were assigned pseudonyms.

Findings

The analysis of the interviews of psychiatric prescribers' experience with patients who engage in doctor shopping revealed three themes that were common to all the participants: *detecting red flags, negative emotional responding*, and *addressing the patient and the problem*. In addition, the findings revealed that participants were *inconsistently implementing precautions*. The relationship among the major themes is depicted in Figure 1. The prescribers' experience of doctor shopping is a fluid process often moving from one theme to another back and forth. At some point, the provider would become aware that something was not right. Many participants labeled the signs as red flags. Negative emotional responding refers to the negative responses from the prescriber to the patient and the patient to the provider when confronted with his or her behavior. Last, at some point in the process, all the prescribers attempted to address the problem.

Detecting Red Flags

Detecting Doctor Shopping. For most of the participants, their experience of doctor shopping began with a case

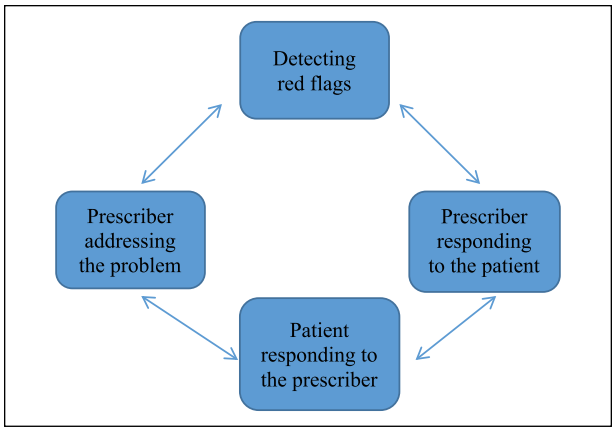

Figure 1. Providers' experience of doctor shopping.

that stood out in their minds that changed their practice. It was often this case that taught them they needed to be careful when prescribing certain medications. It was from these experiences that the participants developed a constellation of behaviors that they often called "red flags"; these are warning signs that a patient might be engaging in doctor shopping. For example, Dr. Cleveland described the situation that led to changes in how he screened patients and how he prescribed controlled medications:

> We started with that when we asked the patients to tell us who is their provider or information about their pharmacy so we can verify their medications. We were shocked to find out that when we get the report from the pharmacy they have three, four, five different prescribers.

Nurse practitioner Franks described the point in time when he found out that a patient of his was doctor shopping:

> I've been burned before. I had a patient that ended up in jail with several prescriptions from different prescribers. I got a call from the jail stating that my name was on one of the prescription bottles. He [the patient] told me that he had no history of drug abuse, so all of that was very new information to me. I think that incident probably stands out in my mind the most as changing the way I practice.

Dr. Delacruz discussed a case that stood out for him in regard to doctor shopping:

> I remember a long time ago, a patient came in that I guess kind of got me off guard and I ended up writing her a prescription. I mean, I'm not sure she even had a psychiatric problem, and the story was that she had moved or something—some reason she just needed somebody to give her another month's worth or whatever. I did it, and then afterwards I really, I felt like I'd been had. I didn't think this was really a legitimate patient coming for help. I never let that happen again.

Sometimes the prescribers discovered their patient was engaging in doctor shopping when they were notified by another prescriber or a pharmacist. NP Gonzalez recounted her discovery that one of her patients was doctor shopping:

> She [the patient] was seeing me for the same disorder, seeing him [the psychiatrist] for the disorder, prescribing almost identical medications. We didn't know until a pharmacist called us and said, "Hey, do you realize this patient . . ."

Based on their experience with patients who doctor shop, all the participants described patient behaviors that they saw as red flags, or indications that a particular patient may be engaging in doctor shopping. At times the behavior was reminiscent of other patients whom they had discovered were doctor shopping. These red flags included patients who asked for medication prior to or during their first visit, came to see them from out of town, became "pushy" for more medications, ask for specific medications, switched from one prescriber to another, tried to cajole, "bully," or "guilt-trip" them, or described symptoms that can only be treated with a controlled prescription medication. NP Wong, who works in private practice, described his experience with a patient who raised a red flag: "There's websites that describe exactly what to say to get the prescriptions, and I've had patients come in and deliver it to me in that order. It always makes me suspicious."

Many participants described patient's tactics that were easy to recognize, such as asking for a specific controlled prescription medication by name, saying that other noncontrolled medications had already been tried and were not effective, stating they were allergic to noncontrolled medications or that they were in desperate need of a controlled medication to treat their symptoms. Dr. Boyle described his experience:

> Patients come in with symptoms such as anxiety; run through symptom criteria; will name medications; say it's the only thing that works for them; they want distance between follow ups; ask for refills or lose refills. Patients try to bully me or intimidate me or tell me they need the medication and I'm the one that can give it to them.

The prescribers perceived that the patients were quite skilled and well versed when it came to engaging in doctor shopping. Dr. Lee described behaviors that were not only red flags, but made her feel uncomfortable: "They can be kind of pushy for prescriptions. They have various convoluted reasons. They are slick. They have been furious and angry. I have thought, no, you're not going to

bully me." NP Gonzalez described her experiences that signaled the patient may be doctor shopping:

> If they're requesting a benzodiazepine or a stimulant that's usually a red flag. They're real adamant about getting that prescription. They want what they want and become angry if you don't prescribe them what they want. They can get very hostile. I've had people throw chairs and I've been called names.

Negative Emotional Responding

The participants described their own negative responses toward patients who doctor shop and the patients' negative reactions when the patient's actions were not successful and the provider confronted the patient. The prescribers' emotional responses included disappointment, frustration, and resentment toward the situation, the patient, and other prescribers. These negative emotional responses played a significant role in their experience of the phenomenon of doctor shopping. When patients were not prescribed the controlled medications they were seeking, the patients who were engaging in doctor shopping responded by becoming distraught, argumentative, or angry.

Prescriber Responses. For the participants, their emotional responses to patients who were doctor shopping included feeling overwhelmed, disheartened, discouraged, and resentful. The experience with the patients who were engaging in doctor shopping was one that was contrary to what they had been trained to do, which was establish a trusting relationship with their patients and to work together with them in formulating a treatment plan. Situations that were particularly difficult for the participants included overt threats to report the prescriber or writing disparaging online reviews about the prescribers when they were not prescribed controlled medications. The participants in the study related fears that their medical license could be in jeopardy if they prescribed a controlled medication to a patient who would use it for an illicit purpose. NP Wong described his responses to dealing with patients who were engaging in doctor shopping.

> It's extremely frustrating. It's easy to feel frustrated and even resentful toward the patient. It's frustrating because you feel like you are wasting your time, it's time taken away from other people. Resources are being consumed and wasted. Them manipulating the situation to try to get drug is very frustrating and disheartening. My score online always goes down.

NP Gonzalez also discussed her negative emotional responses to patients engaging in doctor shopping:

> It's frustrating, so frustrating. It's a waste of my time. It's discouraging to try to help and to know that they're using you for an ulterior motive. It depletes our energy as providers to go through that. It's exhausting and draining.

These participants, who wanted and expected to engage in a therapeutic relationship with their patients, did not expect that they would be feeling resentment toward the patient. NP Levine described the impact on her: "It's created a lot of negative experience. I've been really affected. I would become very resentful. It's all very uncomfortable." Dr. Kidd also talked about feeling resentful, "I would become very resentful. It's pretty awful."

Some of the participants' frustration was toward other providers whom they perceived as colluding (both willingly and unwillingly) with the patients. These participants saw the system and other prescribers as part of the problem. In some cases, participants felt that certain prescribers were unknowingly complicit but they also thought there were prescribers who were unscrupulous and willing to bend the rules. Dr. Kidd stated, "I think it's our fault on the physician's side or the prescriber's side for filling the prescriptions." Dr. Cleveland discussed his frustration with other prescribers, "We're making them impulsive and criminal by prescribing medication. What is frustrating to me is the indifference of my colleagues. That naïve attitude in doctors is harming our image because he is the one prescribing the pills." NP Patel recounted:

> It also makes you not have any respect for your colleagues. One of mine is the worse with the benzo's and Ambien, even if someone's on pain meds. I'll talk to him about it, and he just kinda smiles and says, "Yeah, well, he's been on it for years."

Patient Responses. The participants recounted the negative ways patients reacted when doctor shopping was detected, including patients becoming distraught, angry, or hostile. At times the patients would raise their voice, make accusations, walk out, file negative reports about the prescriber, make excuses, or try to coerce the prescriber. NP Wong stated, "I've had people be angry. I've had people storm out." NP Gonzalez discussed a variety of negative responses she has experienced from patients who were doctor shopping:

> When you confront them, they get very, very hostile, I had one that threw a chair in the room when I confronted him. Or they won't come back if they don't get what they want, they just pick up and move on. Patients have fired me, they have become angry and said "I'm going to report you to the board. You're never going to work in this town again."

Some of the participants stated that in addition to becoming emotionally distraught, patients would walk out without paying for the visit when controlled medications were not prescribed. Dr. Fry stated:

> They would usually start escalating. They get angry. 'I think I'm gonna kill myself. I'm gonna kill you.' I've had people rip up the money they were giving me, the check that they wrote, because I didn't give them stimulants in the end.

Addressing the Patient and the Problem

Participants varied in the way they addressed the patient and the problem of doctor shopping. Some participants screened patients prior to the first visit; their perception was that patients who came to the first visit were now "theirs," so they tried to screen doctor shoppers out before they came into the office. Others terminated the relationship with the patient. At times the discontinuation of care was abrupt once behaviors related to doctor shopping were detected. In other cases, participants made an effort to confront the patient in a matter-of-fact way and offer help for them to be weaned off the medication.

Screening Out Doctor Shoppers. Some participants took steps to avoid seeing patients who were engaging in doctor shopping. Patients were screened and if the patient asked for a certain controlled medication or described a symptom that likely would result in treatment with a controlled medication, the patients were told that they do not prescribe benzodiazepines and were referred elsewhere. In some cases, PDMPs were checked and if it was determined that the patient had seen other prescribers for controlled medications in the past, they would not be accepted as a new patient. Dr. Delacruz stated, "I screen every patient, so a lot never come in. I screen them out ahead of time." Dr. Boyle also described screening patients by phone, "I screen the patients and tell them I can't guarantee I'll fill that medication."

Ending the Relationship. Ending the relationship with patients who were engaging in doctor shopping was common among the participants and took place through a variety of mechanisms. At times this was abrupt with little or no prior notice to the patient. NP Olinsky spoke about discharging the patients she encountered who were engaged in doctor shopping:

> We just discharge 'em. If they lie about their medicine we just won't see 'em again. Once they've lied to us that's when we're done with 'em. We just don't see 'em anymore after that. If they prove us wrong one time then it's pretty much over.

Ending the relationship was not always done in person or over the phone. At times patients would be sent a termination letter as Dr. Fry stated, "I've ended up sending them a termination letter. I mean, I don't feel like there's an obligation if I've been lied to." Dr. Delacruz spoke about taking measures to screen patients who may be engaging in doctor shopping:

> Sometimes I'll actually cancel the evaluation and tell them I think they should find someone else cuz I don't want to be in that, playing that game. One patient I found out she was getting a benzo from someone else and I discharged her. I eliminate a lot of patients that way.

Offering to Help. In some cases, prescribers did make attempts to address the problem and to offer help. Despite negative responses from the patients when they were confronted, a few of the prescribers related that they were able to remain nonjudgmental and supportive in this process. These prescribers were able to channel frustration or negative emotions into a more neutral approach with the goal of helping the patients. They related that although they may have initially taken the patients' behavior personally, they were now able to recognize doctor shopping as indicative of a substance use disorder and focus their attention on trying to help the patient. NP Franks described handling confrontations with patients engaging in doctor shopping:

> They usually respond with anger or indignation or accusing me of judging them. I just say "I'm sorry you feel that way. This is my clinical opinion, this is my assessment. You are welcome to go elsewhere." I usually show them they have options if this isn't working for them.

Some participants tried to find opportunities to let the patient be open and honest about what they were doing before there was evidence to the contrary. These prescribers took a more subtle and gentle approach versus the indignant and adversarial approach taken by other prescribers. Dr. Boyle shared his strategy of dealing with patients who engage in doctor shopping:

> I call it gentle confrontation. I'll give them a chance to tell me if I'm going to find something on the database. Then I'll ask, "Are you tired of this? Are you tired of doing it like this?" A lot of them leave. I tell them, "I'm here to help the part of you that wants to get better."

In some cases, prescribers tried to warn the patients of the dangers involved in doctor shopping and expressed their empathy and concern. Dr. Cleveland also talked about confronting patients who were engaging in doctor shopping:

> I say, "Okay, is there anything else that you should tell me that you haven't told me?" Then I will confront them. I know there's drugs involved. They tried to make a living with it. I

> tell them, "What has become of you? This is what you plan to do? You don't want to do this for long."

Those who took a more concerned approach with the patient recognized the need to separate their own emotional responses from the situation and to acknowledge that their negative emotional responding was not therapeutic for the patient. NP Puckett discussed a straightforward approach to dealing with addiction related to doctor shopping as well as an attempt to deal with negative emotional responses:

> They all present with a similar profile. They are resistant to trying to treat the problem they are saying they have. I think it has to be confronted and addressed directly. "Listen I think you're withdrawing." If I get irritated that's countertransference. You can be good professionally and not have that emotional reactiveness.

A variety of ways of addressing the problem were reported by the participants. Most expressed a desire to not have contact with the patients who were engaging in doctor shopping. This was accomplished either by discharging patients or not accepting them as patients for care. Some prescribers took the time to address the problem by bringing it up with the patient in a nonjudgmental way. Even when this approach was often met with indignation by the patient, these prescribers felt it was their professional duty to address the problem and to try to offer the patient help. These prescribers reacted to the experience of caring for patients who were doctor shopping with a more neutral less personal response.

Inconsistently Implementing Safeguards

Participants in this study detected red flags that signaled a patient might be engaging in doctor shopping. Experience with these patients led to changes in their practice. Many prescribers discharged patients or took measures to screen patients before accepting them as patients in an effort to not engage with them. Some prescribers were reluctant to prescribe controlled medications at all. A few prescribers had begun to change their practice by taking safeguards with all their patients. A few of the participants stated that they had begun checking the PDMP all the time. However, most of the participants reported checking the PDMP only if there were doubts or if they had reason to suspect a patient when prescribing controlled medications. NP Levine discussed her use of the PDMP: "There may be a sense that you are being manipulated, certain cues that may cause you to say, 'Yeah, I think I wanna check this out.' I've not been consistent about checking it (PDMP)."

Some of the participants described their inner struggle and conflict because of their belief that some patients did really need the medications. They described how difficult it can be to discern who really needed the medication and who was trying to obtain them to use for nonmedical purposes. NP Levine stated, "Because obviously, there are patients who need these drugs, and we want those patients who meet criteria, and who would benefit from them to be able to have access. We just want to do it safely."

Often, despite recognition that doctor shopping was an ongoing problem, prescribers expressed that they believed it was only necessary to check the PDMP in certain circumstances. Dr. Sosa reported not regularly checking the PDMP, "I don't check it regularly except for people that have been pushing to get them [prescriptions] early." Dr. Boyle also reported not checking the PDMP consistently: "If you see five patients an hour there's no way to check. That's just ten minutes a visit. There's just no way to do all that."

One reason participants gave for not checking the PDMP or taking precautionary measures was that it was too time-consuming. NP Wong also reported inconsistent measures taken to detect doctor shopping: "I check it (PDMP) when I have a new patient or if I have a patient I'm concerned about. I don't do urine drug screens on everyone. If there are concerns or issues I have, I do." One participant reported that there was not an operational PDMP available for use in her state of practice.

For most prescribers there was not a set plan or policy in place to manage the phenomenon of doctor shopping. Inconsistent use of treatment contracts and urine drug screens was also reported by NP Hahn: "Depending on the person I may not put them on that (treatment contract). We don't have a consistent policy on drug testing." Often participants seemed to second guess themselves and question if they were doing the right thing when they did or did not take precautions. Uncertainty about what was the right approach was often expressed. Dr. Lee also stated she checked the PDMP and used treatment contracts infrequently: "Maybe I should be checking it more frequently (PDMP). I haven't had any reason to use a treatment contract. I use it if I have suspicions."

Frustration with the PDMP programs was often discussed. At times the system was cumbersome and difficult to log on to. Additionally the information was not in real time and there was a lag in time when prescriptions would be available. Even the participants who stated that they did regularly check the PDMP complained that states did not share information, which allowed patients to cross state lines to obtain prescriptions and go undetected. NP Levine expressed frustration with the PDMP: "They can get it from multiple states. They can be going back and forth. If we had a national database that would clean that up pretty quickly."

While the participants were aware that they were seeing patients who were doctor shopping, inconsistencies were noted regarding implementing safeguards to identify doctor shopping. Often the participants reported that they relied on their judgment and only took precautions when they were suspicious of a patient or when a patient gave them a reason to do so. Many participants seemed uneasy and unsure of what precautions they should be taking and how often to take them. Even when precautions were taken, there were issues with the measures such as not having a nationwide PDMP in real time and a lack of policies.

Discussion

Psychiatric prescribers' experience of patients who are engaging in doctor shopping begins when they detect one or more red flags. Once the red flags are detected, the prescriber and the patient experienced a variety of negative emotional responses. The patient's negative emotional responses created an environment to which the prescriber had to respond. Once doctor shopping was identified, the prescribers were put in a position to address the patients and the problem. Addressing the problem often involved ending the professional relationship with the patient through a variety of mechanisms. Other prescriber's chose to talk to the patients about substance use and offered treatment. The participants reported a change in their practice as a result of their experience with patients who were doctor shopping including being more judicious with prescribing controlled medications and checking PDMP reports. However, most participants reported inconsistent implementation of safeguards when prescribing controlled medications. The findings from this study show that there were commonalities and differences among the prescribing practices. Commonalities were detecting red flags and the subsequent response toward the patient. There were various ways of responding to the patient, which then elicited responses from the patient, which then led to changes in practice or putting certain safeguards into practice. Although there were differences in each participant's experience, the participants as a collective provided a full picture of the experience, which included constant learning over time.

Findings from this study show that prescribers often have a negative response to dealing with patients who are doctor shopping, which often results in terminating these patients from their practices. In some cases the, frustration and resentment experienced toward the patients seemed to overshadow the desire to provide help and care for the patient. In this case, there may be a missed opportunity to identify and manage patients with substance use disorders. Patients who are discharged from care rather than offered treatment may end up simply going on to the next prescriber and propitiating the doctor shopping phenomenon. Because we know of the significant risk that patients who engage in doctor shopping take, patients who do not receive treatment may go on to suffer serious health issues or death.

Limitations of this study include that the sample was recruited from a professional listserve. By joining this group, the providers have shown initiative and a proactive approach to practice through engaging in dialogue with other professionals about current issues. Therefore, the results may not be generalizable for all prescribers. Additionally, volunteering for the study involved recognition by the participant of having provided care for patients who were doctor shopping and this may make them different from other prescribers who do not have this recognition.

Conclusion

Findings from this study indicate that there is a need for prescriber education about measures that can be taken to identify doctor shopping and strategies to effectively manage these patients, such as identifying the red flags, consistently using the PDMPs, responding to patients who doctor shop, and understanding the nature of addiction. This information could be used to develop institutional and agency policies that are implemented when controlled medications are prescribed. The use of motivational interviewing and other deescalating techniques could arm prescribers with the tools they need to manage difficult situations and conversations with patients. If prescribers have an increased knowledge about measures to detect doctor shopping as well as ways to manage the situation when doctor shopping is detected, it could result in a decrease in frustration and more of a willingness to provide care for these patients. Finally, there needs to be a national conversation about the use of PDMPs, so providers have that resource available to them in all states and could potentially detect patients who cross state lines to obtain their medication.

Patterns of doctor shoppers identified by the prescribers in this study such as traveling out of town to see prescribers, describing symptoms that can only be treated with controlled medications, and exhibiting extreme emotional responses are similar to those of other studies and can be used to develop interventions and policies that can be implemented when controlled medications are prescribed (Green et al., 2013; Rigg et al., 2012; Worley & Thomas, 2014).

Not all the participants expressed recognition that addiction was driving this behavior and many did not report offering help for the patient. With increased understanding about substance use disorders and how to manage them, prescribers may be able to show more empathy

toward these patients as well as to take steps to refer patients to treatment which would result in improved patient outcomes. In light of the societal and personal cost of substance use disorders, there is a need for all prescribers to accurately identify and manage substance use disorders.

Author Roles

Dr. Worley was the PI for the study and along with Dr. Johnson and Dr Karnik who were Co-Is in the study, were involved in the design, analysis and interpretation of the study. Dr. Worley was involved in the conception and implementation of the study and drafted the article. Dr. Johnson participated in article revisions. Dr. Karnik participated in article review.

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References

Amari, E., Rehm, J., Goldner, E., & Fischer, B. (2011). Nonmedical prescription opioid use and mental health and pain comorbidities: A narrative review. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *56*, 495-502.

Cepeda, M. S., Fife, D., Chow, W., Mastrogiovanni, G., & Henderson, S. C. (2012a). Opioid shopping behavior: How often, how soon, which drugs, and what payment method. *Journal of Clinical Pharmacology*, *20*(10), 1-4.

Cepeda, M. S., Fife, D., Chow, W., Mastrogiovanni, G., & Henderson, S. C. (2012b). Assessing opioid shopping behaviour. *Drug Safety*, *35*, 325-334.

Chen, L. H., Hedegaard, H., & Warner, M. (2013). Quick stats: Number of deaths from poisoning, drug poisoning involving opioid analgesics—United States 1999-2010. *Morbidity and Mortality Weekly Report*, *62*(12), 234-235.

Cicero, T. J., Kurtz, S. P., Surratt, H. L., Ibanez, G. E., Ellis, M. S., Levi-Minzi, M. A., & Inciardi, J. A. (2011). Multiple determinants of specific modes of prescription opioid diversion. *Journal of Drug Issues*, *41*, 283-304.

Civic Federation. (2009, October 5). *Medicaid prescription drug abuse alleged in Illinois and other states*. Retrieved from https://www.civicfed.org/iifs/blog/medicaid-prescription-drug-abuse-alleged-illinois-and-other-states

Drug Enforcement Administration. (2014, November). *National drug assessment threat summary*. Retrieved from http://www.dea.gov/resource-center/dir-ndta-unclass.pdf

Green, T. C., Bowman, S. E., Ray, M., Zaller, N., Heimer, R., & Case, P. (2013). Collaboration or coercion? Partnering to divert prescription opioid medications. *Journal of Urban Health*, *90*, 758-767.

Inciardi, J. A., Surratt, H. L., Cicero, T. J., Kurtz, S. P., Martin, S. S., & Parrino, M. W. (2009). The "black box" of prescription drug diversion. *Journal of Addictive Diseases*, *28*, 332-347.

Jamison, R. N., Butler, S. F., Budman, S. H., Edwards, R. R., & Wasan, A. D. (2010). Gender differences in risk factors for aberrant prescription opioid use. *Journal of Pain*, *11*, 312-320.

McDonald, D. C., & Carlson, K. E. (2013). Estimating the prevalence of opiod diversion by "doctor shoppers" in the United States. *PLoS One*, *8*(7), e69241. doi:10.1371/journal.pone.0069241

McDonald, D. C., & Carlson, K. E. (2014). The ecology of prescription opioid abuse in the USA: Geographic variations in patients' use of multiple prescribers ("doctor shopping"). *Pharmacoepidemiology & Drug Safety*, *23*, 1258-1267.

McLarnon, M. E., Monaghan, T. L., Stewart, S. H., & Barrett, S. P. (2011). Drug misuse and diversion in adults prescribed anxiolytics and sedatives. *Pharmacotherapy*, *31*, 262-272.

Merleau-Ponty, M. (2005). *Phenomenology of perception* [Kindle version]. New York, NY: Routledge Classics. (Original work published in 1945)

Mottern, R. (2013). Teacher-student relationships in court-mandated adult education: A phenomenological study. *Qualitative Report*, *18*(7), 1-40.

Peirce, G. L., Smith, M. J., Abate, M. A., & Halverson, J. (2012). Doctor and pharmacy shopping for controlled substances. *Medical Care*, *50*, 494-500.

Pollio, H. R., Henley, T. B., & Thompson, C. J. (1997). *The phenomenology of everyday life*. Cambridge, England: Cambridge University Press.

Pradel, V., Delga, C., Rouby, F., Micallef, J., & Lapeyre-Mestre, M. (2010). Assessment of abuse potential of benzodiazepines from a prescription database using "doctor shopping" as an indicator. *CNS Drugs*, *24*, 611-620.

Rigg, K. K., Kurtz, S. P., & Surratt, H. L. (2012). Patterns of prescription medication diversion among drug dealers. *Drugs: Education, Prevention and Policy*, *19*, 145-155.

Shah, N. A., Abate, M. A., Smith, M. J., Kaplan, J. A., Kraner, J. C., & Clay, D. J. (2012). Characteristics of alprazolam-related deaths compiled by a centralized state medical examiner. *American Journal on Addictions*, *21*(Suppl 1), S27-S34.

Sowa, E. M., Fellers, J. C., Raisinghani, R. S., Santa Cruz, M. R., Hidalgo, P. C., Lee, M. S., . . . Clayton, A. H. (2014). Prevalence of substance misuse in new patients in an outpatient psychiatry clinic using a prescription monitoring program. *Primary Care Companion for CNS Disorders*, *16*(1). doi:10.4088/PCC.13m01566

Substance Abuse and Mental Health Services Administration. (2014, September). *Results from the 2013 National Survey on Drug Use and Health: Summary of national findings*. Rockville, MD: Author. Retrieved from http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2012).

The TEDS report admissions reporting benzodiazepines and narcotic pain reliever abuse at treatment entry. Rockville, MD: Author.

Thomas, S. P., & Pollio, H. R. (2002). *Listening to patients: A phenomenological approach to nursing research and practice*. New York, NY: Springer.

U.N. Office on Drugs and Crime. (2012, June 26). *2012 World drug report launches as general assembly debates impact of drugs and crime on development*. Retrieved from http://www.unodc.org/unodc/en/frontpage/2012/June/2012-world-drug-report-launched-as-general-assembly-debates-the-impact-of-drugs-and-crime-on-development.html

U.S. Government Accountability Office. (2011). *Medicare part D: Instances of questionable access to prescription drugs*. Retrieved from http://www.scribd.com/doc/67614641/GAO-Report-on-Medicare-Part-D

White, A. G., Birnbaum, H. G., Schiller, M., Tang, J., & Katz, N. P. (2009). Analytic models to identify patients at risk for prescription opioid abuse. *American Journal of Managed Care*, *15*, 897-906.

Worley, J. (2012). Prescription drug monitoring programs, a response to doctor shopping: purpose, effectiveness, and directions for future research. *Issues in Mental Health Nursing*, *33*, 319-328.

Worley, J., & Hall, J. M. (2012). Doctor shopping: A concept analysis. *Research in Theory and Practice*, *26*, 262-278.

Worley, J., & Thomas, S. P. (2014). Women who doctor shop for prescription drugs. *Western Journal of Nursing Research*, *36*, 456-474.