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An Investigative Hearing entitled "To Do No Harm: Strategies for Preventing Prescription Drug Abuse."

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**A Pharmacist's Perspective on Prescription Drug Diversion and Abuse**

presented by:

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Good Morning, Ladies and Gentlemen. My name is Paul Doering and I am Distinguished Service Professor of Pharmacy Practice at the College of Pharmacy, University of Florida, in Gainesville, Florida. I am honored to be here this morning.

I went to pharmacy school in the late 1960's and early 1970's and came to the stark realization that the very same drugs we were learning in the classroom (the ones that can ease pain and suffering and cure disease) could just as easily cause severe injury and death if used inappropriately. This reality really hit home when I volunteered my time to assist in a methadone maintenance program for heroin addicts, a program being run out of Shands Hospital in Gainesville. In a strange sort of way, we as pharmacists are in denial: we don't like to admit that the very same pharmaceutical drugs that might be the answer for one person's problem *is* the problem for the next person.

Working with heroin addicts and focusing on the drugs they used, I suddenly realized, like a light bulb suddenly lighting up, that as a pharmacist I do know something about drug abuse after all. Since that time I have spent a substantial part of my career helping people understand that downside risks that accompany the use of all drugs, but especially the recreational use of prescription drugs. After all, morphine is morphine is morphine, whether it is used to get high or used to relieve the pain of surgery. Its dangers are the same, its bad effects when combined with alcohol or other drugs, and the risks associated with taking more medicine than prescribed.

Today, there has been a shift away from the abuse of so-called "street drugs," more towards the pharmaceutical drugs. Although abuse of over-the-counter (OTC) drugs is a growing problem, it is the problem of prescription drug diversion that is wreaking havoc all across our nation. Data from the Drug Abuse Warning Network (DAWN) suggest

that prescription drugs account for about 25-30% of all drug abuse. As the dispensers of most prescription drugs, pharmacists are unwittingly finding themselves smack dab in the middle of the problem. Let me tell you why.

The Code of Ethics of the American Pharmacists Association states, among other things, the following:

**A pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner.** A pharmacist places concern for the well-being of the patient at the center of professional practice. In doing so, a pharmacist considers needs stated by the patient as well as those defined by health science. A pharmacist is dedicated to protecting the dignity of the patient. With a caring attitude and a compassionate spirit, a pharmacist focuses on serving the patient in a private and confidential manner.

Unfortunately, we spend an inordinate amount of our time trying to sort out the patient presenting a narcotic prescription for some *legitimate* purpose from the patient who has obtained the prescription under *false pretenses* or who alters or outright forges the prescription for the purpose of abuse or resale. Unfortunately, most of us as pharmacists are not experts at handwriting analysis nor have we gone to the police academy to hone our skills at conducting an investigation. We are taught to trust the patients we serve and to be “caring and compassionate” as our Code of Ethics requires. Image our shock and frustration when a vial of pills from our pharmacy is found at the scene of a death investigation where a young adult has died from injecting pills crushed up and injected. Ours is a careful balancing act: while we want to keep drugs out of the hands of those who have no business having them, we must provide them with the caring attitude and compassionate spirit that patients so rightly deserve.

One of the most valuable tools that we, as pharmacists, have to combat the problem of drug diversion is open and honest communication. This includes communication between the pharmacist and the patient, the pharmacist and the doctor, the pharmacist and the law enforcement community, and the pharmacist and the regulatory boards of the other health professions. While there are laws in place to guide the pharmacist, sometimes law can be difficult to apply on a daily basis. For example, under federal law [21 CFR 1306.04 (a)], the tenets of lawful prescribing dictate that, to be lawful, a prescription for a controlled substance must be:

1. issued for a legitimate medical purpose
2. by an individual practitioner acting in the usual course of his professional practice
3. documented in the medical records

Although this may sound straightforward, as pharmacists we sometimes have difficulty determining if the medication is ordered for a “legitimate medical purpose.” Furthermore, we may not know what constitutes the “usual course of professional practice” of a particular physician and we almost never have access to the medical record. One of the daunting aspects of this federal law is the chilling reminder that “...corresponding responsibility rests with the pharmacist who fills the prescription.”

This strikes the fear in some pharmacists that they may be arrested or disciplined if they fill a prescription that turns out to be issued not in accordance with the definition of a lawful prescription. So, what ends up happening? Sometimes patients who really need the medicine suffer needlessly or are inconvenienced because the pharmacist has doubt about the authenticity of the prescription.

On the other end of the spectrum, sometimes drugs wind up in the hand of those who have no legitimate medical need for the drugs and are simply obtaining the drugs for illegal purposes. The tools we currently have available to separate out one from the other are minimal. Good judgment, open communications, and a healthy dose of common sense are not enough to prevent errors being made in both directions.

Looking at the problem from the patient's perspective, *The Therapeutic Imperative* would likely prevail. This theory compels the pharmacist to "Always dispense opioid analgesics when they are appropriate for a patient." On the other hand, The Regulatory Imperative commands us to "Never dispense opioid analgesics when they are inappropriate for a patient." No matter how hard we try, no pharmacist can be faithful to both imperatives. What we need are better tools to help us determine who is an abuser and who is a patient in legitimate need of the drug.

Some have proposed stronger regulation of certain drugs or drug categories. While this may seem to be a giant step in the right direction, my 30-plus years of experience in teaching drug prevention tells me that this is simply a stop-gap measure. If these hearing were being held 25 years ago, we wouldn't be debating whether Oxycontin or Percocet should be removed from the market or more tightly controlled. Instead, we would be talking about "714s" or Quaalude as this popular drug of abuse was called. If this were 15 years ago, we would be talking about Dilaudid, a potent drug of abuse that is experiencing somewhat of a resurgence in popularity. I suppose if we go back even farther, we would be focusing on the drugs Milltown and Equanil. None of these are, in and of themselves, particularly bad drugs. Instead they are reasonable drugs that are being used in an unreasonable way.

I am a member of an organization called the National Association of Drug Diversion Investigators (or NADDI for short). The position of this organization is clear-cut: Legitimate patients with pain should not suffer because practitioners are fearful of law enforcement. Unfortunately, this is sometimes easier said than done. I fear that there are patients out there that are suffering needlessly because their doctors are afraid to prescribe narcotic pain killers. With increasing evidence that drug diversion is growing and not diminishing, this trend will likely continue. So what should be do about it?

First, I believe that we need to increase the amount of education and training given to health professionals on the subject of drug abuse, in general, and drug diversion, in specific. We must re-double our efforts with young people as it pertains to drug education, beginning with the earliest grades in school. We must figure out a way to make technology work to our advantage. I am sure that pharmacists would embrace any tools that could be used to identify known drug abusers and keep from filling their

prescriptions. However, we must respect the right of confidentiality that is crucial to our health care system. It would be wonderful if we could simply ask a patient to touch their thumb to an electronic pad and instantly know if they are passing bad 'scripts all over town. I'm afraid it's not that simple. Whatever tracking systems are developed, we must insure that the patient's right to privacy is protected and that inputting data into the system is practical. Whereas one may expect to hear differing opinions among the 190,000 pharmacists in our country, all would agree that we need help in carrying out our job. Most pharmacists that I know are hard working, honest, caring, and sincere people who only want the best for the patients we serve. It is my hope that we can all work together to better control who has access to our prescription drugs and how that access is obtained.

Thank you very much for your kind attention to these comment.

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