

The Lived Experience of Female Doctor Shoppers

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The Doctor of Philosophy Degree
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DEDICATION

To my father Bob Soule who has always believed in me.

I also dedicate this work to all those people and their families who suffer from the devastating effects of prescription drug abuse.

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Abstract

Prescription drug abuse is a significant problem in the United States with huge societal and financial cost. The 2010 National Survey on Drug Use and Health indicated that in 2009 there were 12.4 million non-medical users of prescription opioids, indicating a 10% increase from 2002. According to the Drug Enforcement Administration (DEA), the financial cost of prescription drug diversion is approximately \$72 billion per year. According to the Department of Justice, doctor shopping is the primary method of diversion of prescription drugs. Doctor shopping occurs when patients visit numerous prescribers and pharmacies to obtain prescriptions for controlled drugs for illicit use, such as opiates, stimulants and benzodiazepines for illicit use or sale. In many cases females are noted to be doctor shoppers, perhaps because they are perceived more sympathetically by prescribers. The purpose of this study was to examine the experiences of female doctor shoppers through a phenomenological study guided by the philosophy of Merleau-Ponty. Participants were recruited through a flyer placed at a location where a Narcotics Anonymous group met, as well as by personal invitation of the researcher. The sample included 14 women ranging in age from 27 to 51. Participants were asked to share their experience of doctor shopping. Data from the interviews was coded and thematically analyzed. A thematic structure of the meaning of doctor shopping was developed which encompassed four themes: (1) *“feeding the addiction”* (2) *“networking with addicts”* (3) *“playing the system”* and (4) *“baiting the doctors.”* Recommendations for future research include instrument development to measure doctor shopping and prescribing behaviors, intervention development for the treatment and support of women who engage in doctor shopping and interventions to increase responsible prescribing. Recommendations for

systematic changes include improved methods to determine patients identity and insurance status, eliminating cash payments for controlled drug prescriptions and visits, advanced use of the prescription drug monitoring system, developing advanced assessment instruments and tests, and an external auditing program to ensure responsible prescribing.

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Chapter 1

Introduction

The use of substances to achieve a psychoactive effect such as a feeling of euphoria or of being “high” has been recorded since early civilizations. Initially the discovery of fermentation led to the use of alcohol to achieve a psychoactive effect. Other natural substances such as cocoa beans, peyote and mescaline have also been used (Naegle, 1988b). Psychoactive substances, including medications, are regulated in this country by the Drug Enforcement Administration (DEA). Some psychoactive substances used for abuse are illegal or illicit such as cocaine and heroin. Other psychoactive substances are used legally to treat conditions such as pain, anxiety, or attention deficit disorder and require a prescription. Some people abuse psychoactive prescription drugs by obtaining them through methods of diversion, including theft, forgery, and doctor shopping. This study focuses on the diversion method of doctor shopping as a means of obtaining prescription drugs for abuse.

Prescription drug abuse is a serious and significant problem in the United States (Worley, 2012b). The United States Department of Health and Human Services (2012) lists reducing non-medical use of prescription drugs as a priority in the *Healthy People 2020* report. Doctor shopping has been identified as a primary source of prescription drug diversion and occurs when patients visit numerous prescribers for prescriptions of controlled drugs and have them filled at numerous pharmacies. Few research studies have been done on the phenomenon of doctor shopping. No instruments have been developed to measure doctor shopping or prescriber experiences and decision making when prescribing controlled drugs. Additionally no interventions have been developed for prescribers or patients to reduce the incidence of doctor shopping. Differences in gender have been noted between men and women in studies on illicit

and prescription drug abuse as well as in tactics and sources of diversion. To date, no research study has been done specifically with women related to prescription drug diversion or doctor shopping. In order to understand the experience of doctor shopping for women, a phenomenological study was proposed.

A greater understanding of doctor shoppers will help prescribers, including advanced practice nurses (APNs), to make more appropriate decisions when prescribing controlled drugs. This information may also guide in the development of instruments and interventions to measure and improve appropriate prescribing decision making.

Scope of the Problem

In 2009, seven million Americans age 12 and older used prescription drugs non-medically (Drug Enforcement Administration, n.d.). Prescription drugs are diverted for illicit use through a variety of methods such as theft, forgery, and doctor shopping (Wang & Christo, 2009). Several studies have confirmed that diversion of controlled substances for non-medical use often involves doctor shopping (Pradel, Delga, Rouby, Micallef, & Lapeyre-Mestre, 2010; Wilsey et al., 2010; Wilsey et al., 2011). Diversion of prescription drugs by doctor shopping is a major contributor to prescription drug abuse (United States Government Accountability Office, 2011). The United States National Drug Intelligence Center (2004) defines doctor shopping as occurring when individuals visit numerous doctors in an attempt to obtain multiple prescriptions for drugs, often falsify or exaggerate symptoms in order to receive these prescriptions, and typically have their prescriptions filled at multiple pharmacies in order to avoid detection.

A 2008 report by the Government Accountability Office (GAO) found that 170,000 Medicare beneficiaries engaged in doctor shopping at a cost of \$148 million (United States Government Accountability Office, 2011). Another study conducted in 2008, found that 65,000

Medicaid recipients from just four states engaged in doctor shopping at a cost of \$63 million (Civic Federation, 2009). Despite the increasing incidence of doctor shopping, prescribing rates of controlled drugs have increased dramatically, 127% between 1997 and 2006 (Manchikanti & Singh, 2008). This increase has occurred despite the development of prescription drug monitoring programs (PDMPs), which are electronic databases run by individual states so that prescribers can access information on controlled drug prescription histories of patients (Worley, 2012b).

The financial cost of prescription drug diversion has been estimated at \$72 billion per year (United States Department of Justice, 2009). This reflects overall healthcare and law enforcement costs. A study evaluating claims data found that the societal cost of abuse, dependence and misuse of one type of prescription pain reliever: opioids, was estimated to be \$55.7 billion in 2007 which included workplace, healthcare and criminal justice costs (Birnbaum et al., 2011). Further evidence of the seriousness of the problem is the fact that deaths from opioid poisoning or overdoses have tripled from 1997 to 2007 (United States Center for Disease Control Morbidity and Mortality Weekly Reports, 2010). Another study found that people who engage in doctor shopping had twice the odds of a drug related death (Pierce, Smith, Abate & Halverson, 2012). Additionally, the proportion of substance abuse treatment admissions in people age 12 and older who reported prescription pain reliever abuse increased more than fourfold between 1998 and 2008 from 2.2% to 9.8% (Treatment Episode Data Set Report, 2010). From 1999 to 2006 hospitalizations from poisonings by prescription opioids, sedatives and tranquilizers increased a total of 65% (Coben et al. 2010).

Few studies have been done on prescription drug diversion and doctor shopping. Consistently in research conducted with people who abuse prescription drugs, doctor shopping is

stated as one of the primary methods by which the drugs are obtained (Cicero et al., 2011; Inciardi et al., 2009; Rigg, Kurtz & Surratt, 2012). Tactics described by buyers and sellers of prescription drugs in London when obtaining prescriptions from health care professionals included feigning symptoms, gaining sympathy, and exaggerating (Fountain, Griffiths, Farrell, Gossop, & Strang, 1998). Other studies have found that people who sell prescription drugs often visit numerous clinics to obtain large amounts of prescription drugs, sponsor others to obtain prescription drugs, and buy prescription drugs from vulnerable people such as veterans, the elderly, people on Medicare or Medicaid, or those with HIV/AIDS (Inciardi et al., 2009; Rigg, Kurtz, & Surratt, 2012).

Philosophical Basis for the Study

Existential Phenomenology of Merleau-Ponty

Philosophy can be described as the search for origins and foundations (Schrag, 1985). This study will be conducted using the existential phenomenology lens of Merleau-Ponty. Existentialism is a form of philosophy that focuses on who we are and how we come to live authentically (Thomas & Pollio, 2002). The study focuses on experience as seen through the participants' eyes in order to discover their perceptions of their lived experience (Thomas, 2005). According to Merleau-Ponty, figural aspects of perceived things are only understood against the backdrop of existential grounds, which include: body, time, other people and the world (Thomas, 2005; Thomas & Pollio, 2002). This view describes human experience on its own terms through perception, which reveals interconnectedness between ourselves and the world in the situational context of personhood and being in the world (Thomas & Pollio, 2002). Our relationship to the world we live and interact within plays an integral role in our experience. According to Merleau-Ponty (1945/2005), "Truth does not 'inhabit' only 'the inner man', or more accurately,

there is no inner man, man is in the world, and only in the world does he know himself” (p. 25). Additionally he (1945/2005) states that man is “nothing but a view of the world” (p. 1413). This existential phenomenology philosophy guides this study to provide an understanding of the meaning of the participant’s experience of doctor shopping, relative to the world, time, their body, and interactions with others.

Purpose of the Study

In this and the following sections I will detail the purpose of the study as well as the research questions and key definitions. The purpose of this study was to describe the meaning of the lived experience of women who engage in doctor shopping.

Research Question

The research question for this study was: what is the experience of female doctor shoppers?

Definitions

Illicit Drug Abuse

Illicit drug abuse is defined as any use of drugs that have no accepted medical or legal use as designated by the United States government.

Prescription Drug Abuse

Prescription drug abuse is defined as any non-medical use, misuse, or abuse, of controlled prescription drugs (Worley, 2012a).

Controlled Prescription Drugs

Controlled prescription drugs are medications that have abuse potential and are classified in the United States as Schedule I thru V with I being the most addicting or having the greatest

abuse potential (U.S. Department of Justice Drug Enforcement Administration Office of Diversion Control, n.d.; Worley, 2012b).

Prescription Drug Diversion

Prescription drug diversion is any diversion or deviation of prescription drugs from medical use to the illegal market including: doctor shopping, illegal Internet pharmacies, drug theft, prescription forgery, and illicit prescribing (Council of State Governments, 2004).

Prescription Drug Monitoring Programs

Prescription drug monitoring programs are electronic databases run by individual states that collect data on controlled drug prescription substances so health care providers can access the data and deter abuse, doctor shopping, and diversion (Worley, 2012b).

Prescriber

A healthcare professional who has legal authority to prescribe medication in the United States, which includes APNs, dentists, ophthalmologists, physicians, physician assistants, and podiatrists.

Doctor Shopping

Doctor shopping occurs when, a) a patient receives a prescription for the same or similar controlled drug for illicit use, from more than one prescriber within a 30-day day period, b) from three or more pharmacies, c) wherein the patient does not inform the prescriber of previous controlled prescriptions or the prescriber is aware and unscrupulously prescribes, as well as or when, d) a patient visits five or more prescribers within a one-year period for controlled drugs for illicit use (Worley & Hall, 2012).

Delimitations

My study focused on doctor shopping, which is a facet of prescription, rather than illicit drug abuse. There are two key players in the act of doctor shopping, patients and prescribers. This study focused on the experience of the patient. Specifically I am interested in the experience of adult women who engage in doctor shopping. The participants self-identified as doctor shoppers based on their common knowledge of the term and/or the definition provided when they inquired about the study. I included women who were enrolled in outpatient substance abuse in my study as well as those who were not in treatment. Women in the study may or may not have had legal charges related to substance abuse and may or may not have been on probation. Women who were current or former patients of the researcher were not included in the study.

Assumptions

Assumptions for this study were: a) substance abuse is a complex psycho-social problem, b) prescription drugs are a source of substance abuse, c) prescribers are a source of controlled drugs for doctor shoppers, whether through ignorance, complacency, or collusion.

Significance of the Study

In these sections on the significance of the study I will focus on the overall significance of the study for the nursing profession and for women. Prescription drug abuse results in the tragedy of lost lives and huge societal costs. Through doctor shopping, patients are obtaining prescription drugs to abuse or sell. Patients, through clever tactics or fraudulent methods, are able to deceive and manipulate prescribers to prescribe medication that is being misused. Since APNs are prescribers in this country and nurses in many fields interact with patients who abuse prescription drugs regularly, this topic is significant to nursing. Research has shown women's

experience of prescription drug abuse and diversion differs from men's. For this reason, it is important to understand women's experience of doctor shopping.

Significance of the Problem for Nursing

Nurse practitioners, nurse anesthetists, nurse midwives, and clinical nurse specialists are nursing professionals with advanced education who are designated as APNs (American Nurse Association, 2012). The majority of APNs are nurse practitioners, who comprise a significant percentage of prescribers in the United States. Nurse practitioners are registered nurses with advanced degrees who are prepared through advanced graduate courses to provide health care services including the diagnosis and treatment of medical conditions, which includes prescribing medication (American College of Nurse Practitioners, n.d.). Nurse practitioners must hold a master's or doctoral degree and be board certified by a national accrediting agency. Certification is achieved through taking a national exam in their specialty area. Specialty areas for nurse practitioners include family practice, pediatrics, geriatrics, women's health and psychiatry.

The Kaiser Family Foundation (2011) reported in 2010 there were 167,857 nurse practitioners in the United States. During the same year, the American Medical Association (2010) reported there were 638,661 physicians in office based practice. Prescribers have a legal and ethical obligation to prescribe medication responsibly. Legitimate reasons for prescribing controlled drugs must exist according to the American Nurses' Association (2001) Code of Ethics. The DEA also designates that a prescription is only lawful when issued for legitimate medical purposes and that willfully not doing so subjects prescribers to penalties (U.S. Department of Justice, n.d.).

In addition to being significant to APNs, the problem of prescription drug abuse, which often involves doctor shopping, is significant to nurses in many specialty areas. People who

abuse substances interact with nurses in the healthcare system at all levels including substance abuse treatment centers, mental health clinics, family practice, obstetrics, public health, and inpatient psychiatry units. Nurses are often on the forefront of providing screening and implementing treatment for patients who abuse prescription drugs. While APNs may be the ones writing the prescriptions, office nurses are often the first people that doctor shoppers interact with when they call or are received for an appointment. Nurses play a crucial role in partnering with prescribers to detect and intervene when doctor shopping is suspected.

Significance of the Problem for Women

Historically, controlled prescription drugs have been targeted at women for conditions such as menopause and stress, which will be covered more in depth in Chapter Two. Gender differences have been identified in research on people who abuse prescription drugs and engage in diversion tactics. For example, studies have shown that when compared to men, women have a greater incidence of mental health problems associated with illicit and prescription drug abuse (Back, Payne, Simpson & Brady; 2010, Grella & Lovinger, 2012; Jamison, Butler, Budman, Edwards, & Wasan, 2010; Pant & Bagrodia, 2003), a greater incidence of physical health problems (Grella & Lovinger, 2012), a greater incidence of a history of being physically or sexually abused (Jamison et al., 2010; McCauley, 2009; Tracy, et al., 2012), and a greater incidence of polysubstance abuse (Back, et al., 2010; Green, Grimes-Serrano, Licari, Budman, & Butler, 2009; McCauley, 2009). There are also differences between men and women in regards to the tactics and means of diversion of prescription drugs. Studies have found that women are more likely to use doctors' prescriptions for abuse (Cicero et al., 2011) and/or engage in doctor shopping than men (Hall et al., 2008).

This study may help shed light on why women engage in doctor shopping, for instance for abuse due to an addiction, for recreational use, or to sell the drugs for profit. It may be that women are more likely to engage in doctor shopping because they are perceived more sympathetically by prescribers. If this is the case, this study may uncover the fact that women are in some way being coerced by others to obtain medications. In addition, interventions may be developed based on the results of this study, which may help women who engage in doctor shopping to improve coping skills and adopt healthier lifestyles that do not include prescription drug abuse.

Personal Interest in the Study

Having worked as a family nurse practitioner for 10 years and then as a psychiatric nurse practitioner for close to 10 years, I have repeatedly seen patients who are drug seeking. My experience has been that in family practice, opioid narcotic pain medications are primarily sought, followed by benzodiazepines for anxiety. In psychiatry, benzodiazepines and stimulants used to treat attention deficit disorder are sought. I have listened to numerous suspicious stories and requests for controlled drugs and have been concerned about potential prescription drug abuse. With the onset of a PDMP, I have been able to confirm doctor shopping in close to 100 patients. Often a patient's PDMP reports are several pages long, indicating many controlled drugs prescribed and filled. While certain prescribers are known for overprescribing, I believe that most would not willingly prescribe controlled drugs to people who are doctor shopping. I have wondered why prescribers are not using the PDMP or verifying patients' information through other methods. I have been very concerned and surprised that so many patients are able to obtain so many controlled drugs from so many prescribers.

I have also seen the damaging effects of prescription drug abuse in patients who have told me that the drugs have ruined their lives. Routinely I see teenagers who report they have taken prescription drugs from their parents or other family members' medicine cabinets, some of whom are known to engage in doctor shopping. I see many patients whose lives have been detrimentally affected by prescription drug abuse including those who have gone through treatment numerous times, to no avail. Several months after I started on my path researching this topic, one of my patients died unexpectedly of a prescription drug overdose. Her PDMP report revealed she had gotten numerous prescriptions from numerous prescribers filled at numerous pharmacies in the days before her death.

Summary

Doctor shopping is a problem of epidemic proportions in the United States which often involves patients engaging in doctor shopping to divert controlled prescription drugs which are then abused or sold for profit. Little is known about doctor shoppers. Women have unique differences from men in regard to prescription drug abuse and doctor shopping. Currently there are no instruments to measure doctor shopping or prescriber decision making when prescribing controlled drugs and no interventions to decrease its incidence. There is no understanding of the motives or uses of the prescription drugs that are obtained. It is not known if doctor shoppers primarily act independently or if other people are involved in the act of doctor shopping. Specific tactics of doctor shoppers are not understood, and there are many questions, such as if and how certain prescribers are targeted for doctor shopping. An understanding of the experience of doctor shopping can be used to help prescribers make better decisions about prescribing. This understanding can also lead to the development of a theory of doctor shopping as well as instruments and interventions to decrease its incidence. The needs of women who

engage in doctor shopping may be identified and used to develop interventions to decrease the incidence of their prescription drug abuse.

Doctor shopping is a problem for patients, as it has the potential to ruin lives. Doctor shopping is also a significant problem for prescribers who have an ethical and legal obligation to prescribe controlled drugs responsibly. This proposed research on the experience of doctor shoppers can be used to help prevent or reduce the incidence of doctor shopping. The results of this study can be used for benefit for the people engaging in doctor shopping and the prescribers who care for them.

Chapter 2

Review of the Literature

In this section I provide a historical perspective of substance abuse in the United States as well as pertinent laws pertaining to the regulation of substances. I also discuss historical aspect of substance abuse in the lives of women. This is followed by an examination of theoretical frameworks that have been used to examine substance abuse as well as noted leaders and researchers in the field of substance abuse. The new construct of doctor shopping is discussed as well as a historical perspective of prescription drug monitoring programs. This chapter concludes with a thorough review of the empirical literature on doctor shopping.

Historical Perspective of Substance Abuse

In order to understand and appreciate the current phenomenon of prescription drug abuse, it is important to reflect on a historical perspective of substance abuse. Substances have been abused to achieve a psychoactive effect for centuries. Use of psychoactive substances causes an alteration in a person's mental status such as a feeling of calm, relaxation, euphoria, excitement, or dulled sensation. Large amounts of psychoactive substances can lead to the impairment of functioning of speech, motor skills, memory and judgment. The physiological effect of drug abuse is hypothesized to occur in the mesolimbic dopamine pathway in the brain which is considered the "pleasure center" (Stahl, 2008). Other activities such as intellectual accomplishments or sport participation can increase the brains natural pleasurable neurotransmitters. This has been referred to as a "natural high." When drugs are abused, they bypass the brain's own neurotransmitters and stimulate the brain's receptors in the mesolimbic reward system which results in the release of dopamine resulting in an "artificial high" (Stahl, 2008).

Initially, in early civilizations, there was the discovery of the process of fermentation led to alcohol consumption, which can be abused in large amounts. Some psychoactive drugs are derived from naturally occurring substances such as cocaine from cocoa beans, and opium or heroin from poppy plants. Other natural substance such as peyote, certain mushrooms and mescaline can also cause mind altering effects (Naegle, 1988b). Some substances used for other purposes can be abused such as glue, certain cleaning fluids, and canned aerosolized products which can be inhaled. Medications that are sold over the counter and do not require prescriptions such as Sudafed, which is a decongestant, and some cough syrups can be abused in large quantities or used to make other illegal substances.

Drug abuse in the United States can be traced back over 150 years to the Opium Wars in the early 19th century (Kandall, 2010). At that time immigrants from China resorted to smoking opium in the United States to alleviate difficult living conditions. This drug use subsequently infiltrated into the general U.S. population. Cocaine and heroin became drugs of abuse at the end of the 19th century. At that time it was legal to distribute opiates such as morphine and opium in medications, including those available without prescriptions, and in food products. The Federal Pure Food and Drug Act was passed in 1906 which required medicines and foods containing opiates to be labeled as such. The Harrison Anti-Narcotic Act was passed in 1914 which criminalized illicit drug use (Kandall, 2010). Drugs classified as illicit drugs are those that have no recognized medical use such as heroin and cocaine. In the 1950s, potentially addictive psychoactive prescription medications grew in favor such as tranquilizers, sedatives and stimulants. Prescription medications with abuse potential were designated as controlled drugs in 1970 by the Controlled Substance Act (National Conference of Commissioners on Uniform State Laws, 2012). Despite laws regulating controlled prescription drugs and use of

illicit drugs which include stiff penalties, substance abuse has continued to be an epidemic in this country with huge financial, societal and personal cost. The U.S. Department of Health and Human Services (2009) estimates the total cost of all substance use disorders, including prescription and illicit use, at \$180 billion per year. This cost includes medical treatment, law enforcement, and all other associated costs.

Historical Perspective of Women and Substance Abuse

Substance abuse has played a pivotal role in the lives of many women. In this section I will summarize a historical perspective of women and substance abuse. From the beginning, women have been no strangers to substance abuse (Worley, 2012a). As early as the mid-to late 19th century, two-thirds to three-quarters of the opium addicts as well as cocaine, chloroform and cannabis abusers in the United States were women (Kandall, 2010). As cited by Ogur (1986), Terry and Pellens reported that in 1924 there were approximately 66,000 women addicted to narcotics in the United States. During that time, many of the medications that legally contained opiates and cocaine were targeted at women for conditions such as menstrual and menopause symptoms, as well as what were described as “nervous disorders” (Kandall, 2010). Many women became addicted to illicit or prescription drugs. Elite women who became addicted to drugs were treated in private clinics as early as 1892. Approximately 15,000 women were admitted to substance abuse programs between 1941 and 1965, which was 18% of all admissions. Women without means were sometimes forced into prostitution and crime to support their habits (Kandall, 2010). Later, methadone clinics sprung up as an alternative to illicit drug use. Methadone is a controlled prescription drug prescribed to heroin and opiate addicts as an alternative to street drugs. Ten thousand women were treated in federally funded methadone

clinics from 1969 to 1973 which was about 25% of all cases. The percentage rose to 35% from 1992 to 2005 (Kandall, 2010).

In the 1950s and 1970s there was an increase in psychoactive prescription drugs targeted at women. These medications, known as “mother’s little helpers,” were recommended for motherhood and singlehood as a means for women to get through the day (Metzi, 2003). Released in 1956, Miltown was the first drug to hit the market targeted at middle class women for anxiety. This drug was heavily marketed to physicians and the public and as cited by Metzi (2003), in 1956 Consumer Reports found that one in twenty Americans was taking Miltown or another tranquilizer in a given month. In 1960, Carter Products, the maker of Miltown and Equinal, which both contained the active ingredient meprobamate, was charged with having monopolized the market in mild tranquilizers (Ranzal, 1960). In 1965 meprobamate was removed from the list of tranquilizers when experts ruled it was a sedative instead. In 1967 it was listed as a controlled substance due to causing physical and psychological dependence (New York Times, 1967). In the 1960s Valium and other benzodiazepines became the drugs of choice prescribed to women for a variety of ailments such as anxiety, stress from motherhood or being a housewife, frigidity, a bride’s uncertainty and a wife’s infidelity (Metzi, 2003).

A study done on data in the 1970’s by Cooperstock (as cited by Hughes, 1989, p. 329) found that substantially greater numbers of women than men used prescription drugs. In a secondary data analysis of a longitudinal study from 1979 ($n = 12,686$) to 1984 ($n = 12,069$), gender differences in prescription drug use were not significant. However, more women than men reported lifetime use of prescription tranquilizers and rates of past month use of tranquilizers for white women were more than twice that reported for white men (Hughes, Day, Marcantonio & Torpy, 1997). In 1993 there were four million women abusing drugs, including

illicit and prescription abuse in the United States (National Institute on Drug Abuse, 1994). According to the Substance Abuse Mental Health Administration (2010), in 2009 the rate of illicit and prescription drugs in females age 12 and up was 6.6%, which is less than the male rate of 10.8% but remains significant, affecting millions of women.

Overview of Theoretical Frameworks Used to Examine Substance Abuse

In order to identify the cause as well as explain and describe the phenomenon of substance abuse, an abundance of theories have been proposed. An overview of theoretical frameworks and models will be discussed in this section. The major categories for theories on substance abuse and addiction are biological, personality, cognitive, behavioral and social theories. In early times, substance abuse was viewed as deviant behavior and addicts were imprisoned, rejected by their families and subjected to punitive medical interventions (Naegle, 1988b). Early theories of drug addiction explained drug use in terms of being weak-willed or morally inferior. These are often defined as moral models of addiction which have lost favor as far as accurately portraying drug abusers (Room, 2005). Other early theories were developed from Freudian views including that substance abuse occurred due to a disorder within psychological structures. Drugs were viewed as a substitute for gratification of oral and genital needs (Vetter, 1985).

Cooperstock (1971) proposed a model to explain sex differences in the use of mood-modifying drugs. According to this model, society at that time permitted a greater expression of feelings among women who also had an increased perception of emotional problems in self. Women then sought care from physicians for emotional problems, and physicians had greater expectations of women than men of that expressiveness. This led to an increase in the physician's expectation of the female patient's need of mood-modifying drugs. It does not

appear that this model has ever been tested or used in research or practice, therefore its relevance in today's society is not clear.

Several biological models of addiction have been proposed. The disease model of addiction came into favor in the early 20th century. According to this theory, addiction fits the definition of a medical disorder which can be diagnosed and treated. Addiction as a disease involves an abnormality of structure or function in the central nervous system (CNS) that results in impairment (West, 2005). Genetic theories postulate that an innate genetic predisposition is related to addiction. Several scientific human studies have supported a substantial genetic vulnerability to substance abuse (Uhl, Elmer, LaBuda, & Pickens, 2000).

Personality theories include those that describe an addictive personality where drug use fulfills a purpose and holds benefits despite negative consequences (Sutker & Allain, 1988). Five factor theory includes the concept that personality traits are biologically influenced and stable (McRae & Costa, 2003). Studies based on this framework have shown that people who abuse opioids have higher levels of the personality trait of neuroticism and lower rates of extroversion (Korner & Nordvik, 2007). Neuroticism has also been identified as a predictor of relapse to substance abuse following treatment (Fisher, Elias, & Ritz, 1998).

Impulse control as a facet of the personality has also been implicated in theories related to substance abuse, such as the inhibition dysregulation theory. In this theory the inhibitory system involved in aspects of response inhibition and selection underlies drug addiction (Lubman, Yucel & Pantelis, 2004). Self-regulation theory has been applied to substance abuse. According to proponents of this theory, addiction results from impaired control or compulsion. This impairment is defined as an inability to self-regulate (West, 2005).

Cognitive models to explain drug abuse include the theory of drug urges, where cravings for drugs involve a feeling of urgent need linked with fear of withdrawal symptoms as well as from the expectation of pleasure from the activity (Tiffany, 1990). Other cognitive models can be classified as rational addiction theories, where addiction is viewed as a choice. In these theories there is a belief that people do things because they expect a benefit despite knowing about and accepting any adverse consequences (West, 2005). These theories debunk the notion that drug addiction is a disease because loss of control is not considered valid. The self-medication model of addiction also involves the choice of individuals who intentionally uses drugs to treat psychological symptoms they suffer from (Gelkop, Levitt, & Bleich, 2002).

Several social theories have been formulated or used to explain substance abuse. Social learning theory states that socially deviant or criminal behavior, including substance abuse, is learned from intimate groups. For this to occur there must be exogenous or social conditions, such as the influence of friends, as well as endogenous conditions, such as physiological or psychological precursors to substance abuse. This theory has been used in studies of drug use with adolescents and college students (Peralta & Steele, 2010). Another social theory used to explain addiction is social disorganization theory. This theory stems from ecological theories and focuses on group adaptations to social processes such as urbanization and shifting patterns of economic growth. The focus is on the community or external influences in the environment rather than on the individual. According to this theory, disorganized communities lead some residents to no longer submit to normative social controls (Rose & Clear, 1998). Another theory that has been used in research on substance abuse which also takes into consideration social influence, is the theory of planned behavior, which assumes that attitudes, subjective norms and perceived behavioral control influence intention and predict behavior (Ajzen, 1991).

Particularly in nursing, the Rogerian model has been used to describe substance abuse as well as to guide research. Martha Rogers (as cited by Compton, 1988, p. 98) was a nurse theorist who conceptualized a human as a unitary, four-dimensional energy field phenomenon. The unitary human and dimensions must be understood in totality and include the concept of developmental diversity with patterns of changes (Naegle, 1988b). Manifestations of substance abuse can be understood through the lens of this theory and are seen as part of a continuous whole. This view shifts assessment from the focus on the explanation of substance abuse to the assessment of patterns (Naegle, 1988b). In light of this theory, drug use can be seen as a means to increase one's awareness of the four dimensional nature of reality. Addiction is seen to arise out of the mutual processes that occur between human and environmental fields (Compton, 1988).

Solomon developed an opponent process theory of motivation which has been used to describe addiction (Solomon & Corbit, 1978). According to this theory, drug addiction occurs when the pleasure of using drugs is opposed by the emotional symptoms of drug withdrawal. When a person first begins to use drugs the pleasure they feel with drug use outweighs the withdrawal symptoms, but over time the withdrawal symptoms increase and the person is then motivated to use drugs to treat the withdrawal symptoms to a greater extent than for the pleasure of doing it.

Flagler, Hughes, and Kovalsky (1997) proposed using Brickman's models of helping and coping where four models are used to describe addiction; the moral model, medical model, enlightenment model, and compensatory models. The moral and medical models have previously been discussed. The enlightenment model shares the perspective of the medical model, but in this model a person needs to accept responsibility for the problem and must

surrender personal control to a higher power to change one's behavior. This perspective or philosophy is espoused by 12-step programs such as Narcotics Anonymous (NA), which are popular support groups for people with substance abuse problems. The compensatory model views addiction similarly to social theories and describes it as occurring as a result of multidimensional factors beyond a person's control, but for which a person can compensate (Flagler et al., 1997). When these models are applied to Brickman's models of helping and coping, they are classified as whether or not the substance abusing person is responsible for the problem as well as if they are responsible for the solution. In the moral model, the person is responsible for the problem and the solution. In the medical model, the person is not responsible for the problem or the solution. In the enlightenment model, the person is responsible for the problem, but not the solution. In the compensatory model, the person is not responsible for the problem, but is responsible for the solution (Flagler et al., 1997).

Conflicting perspectives are noted in the different theories related to substance abuse. Views, values and attitudes of healthcare professionals, researchers, and the public are influenced by a number of factors, including religious background, familial influences, education and training, and personal or professional experience (Hughes, 1989). Theoretical perspectives play a role in influencing research and treatment of substance abuse. Additionally, misapplication of theoretical models held by those in a position to help people who abuse substances may lead to ineffective helping strategies (Hughes, 1989).

Noted Leaders and Researchers in the Field of Substance Abuse

Throughout the years, there has been considerable research in the general phenomenon of substance abuse. In this section, I will provide information about noted nursing and psychology researchers in the field of substance abuse. Although a lack of nurse researchers in the field of

substance abuse theory and research has been noted, there are several nurses who include substance abuse in their area of focus, some of whose works are referenced in this paper.

Florence Nightingale is likely one of the first nurses to focus her attention on the phenomenon of substance abuse in her work with soldiers related to their alcohol use in the 1800s. Nightingale (as cited by Naegle, 1991, p. 124) recognized that the soldiers resorted to alcohol when they lacked emotional supports and activities. In addition she recognized that acute alcohol intoxication was life-threatening and had a negative impact on wellness. In her writings, she discussed measures she implemented to decrease alcohol use including opening reading and recreation rooms. After realizing the men drank away their pay due to dissatisfaction with how their funds were otherwise handled, she intervened and developed a method for which the men could send money home rather than use it to purchase alcohol. Due to her influence British soldiers were no longer characterized as drunken intractable brutes (Woodham-Smith, 1991).

Margaret Compton of UCLA School of Nursing is a researcher and neuroscientist with a research focus on the characterization and pharmacological management of opioid-induced hyperalgesia in opioid addicts and behavioral indicators of addiction in chronic pain patients. She was a postdoctoral fellow at the National Institutes of Drug Addiction Research Center where she studied pain and addiction responses in opioid addicts. She has co-authored several articles including ones on substitution pharmacotherapies for opioid addiction and other topics related to the treatment of opioid addiction and dependence (Ling, Rawson, & Compton, 1994; Ling, Rawson, & Compton, 2003). Another important work of Margaret Compton is her article on the Rogerian view of drug abuse with implications for nursing (Compton, 1988).

Madeline Naegle is a nurse researcher in the field of substance abuse from New York University. She focuses on chemically impaired nurses and nursing education in the prevention and treatment of substance abuse disorders. She has been a champion for increased substance abuse education in nursing. She authored an article about substance abuse issues in women in 1988 (Naegle, 1988a). There has not been another similar work since then. Her article “Theoretical Perspectives on the Etiology of Substance Abuse” (1988b) is unique and notable among early nursing research on substance abuse.

Tonda Hughes of the University of Illinois Chicago School of Nursing has been instrumental in developing the field of knowledge on substance abuse in lesbian women. Her research has included numerous studies on substance and alcohol abuse in lesbian, gay, bisexual and transgender populations (Hughes & Eliason, 2002; Hughes, Johnson, Wilsnack & Szalacha, 2007). She has also done research and published on chemically dependent nurses (Hughes, Howard & Henry, 2002; Hughes, Smith & Howard, 1998). She co-authored an important work, “Toward an Understanding of Addiction” (Flagner et al. 1997) which outlines issues and major perspectives on substance abuse. She authored an early significant paper, “Models and Perspectives of Addiction: Implications for Treatment” (1989). In 1997 she co-authored the results of a large secondary data analysis from survey results in 1984 on gender differences in alcohol and drug use among young adults (Hughes et al., 1997).

Carol Boyd of the University of Michigan School of Nursing is the only nurse researcher identified who focuses on the phenomenon of prescription drug abuse, in which she studies adolescents and college age students. Her work has included studies on prevalence, motives, and diversion of illicit use of prescription stimulants in undergraduate and middle school students (Teter, McCabe, & Boyd, 2003; Teter, McCabe, LaGrange, Cranford, & Boyd, 2006) and opioid

and ecstasy use among college students (Boyd & McCabe, 2003; McCabe, Teter, Boyd, Knight, & Welschler, 2005).

Nurse researcher Mary R. Boyd from the University of South Carolina has a research specialty of alcohol and drug disorders in rural women. Her numerous publications include those on studies predicting substance abuse, psychiatric assessment, and alcohol abuse in rural women (Boyd & Hauenstein, 1997; Boyd, 2000; Boyd & Mackey, 2000).

William Miller is a PhD psychologist and is a professor emeritus in the department of psychology and psychiatry at the University of New Mexico. He has written over 40 books and 400 articles related to addictions and focuses on the development, testing, and dissemination of treatments for addictions (Miller, 2012). He is interested in the psychology of change and his research foci include behavioral self-control training, cross-cultural research, health care and brief intervention, motivational interviewing, relapse research, and spirituality and health. He is credited with introducing new ways of viewing substance abuse treatment. His randomized controlled clinical research on confrontation demonstrated that confrontation leads to resistance and denial (Miller, Benefield, & Tonigan, 1993). He favors motivational interviewing over confrontation as an approach with people who abuse substances.

Another noted psychologist who has done considerable research in the area of substance abuse is Kathleen Carroll from Yale University. She has authored numerous publications on issues related to substance abuse, including evidenced based practice, neural effects of behavior therapy, outcomes in drug dependence treatment, and other randomized clinical trials (Martino, Carroll, Nich & Rounsaville, 2006; Sofuoglu, Sugarman, & Carroll, 2010; Zhiru et al., 2011). She is also known for developing a computer-assisted training in cognitive-behavioral therapy for people who abuse substances (Yale School of Medicine, n.d.)

While this review has revealed the contributions of several noted researchers in the area of substance abuse, there are numerous gaps in knowledge, especially considering the magnitude of the problem. Few research studies have been conducted on the phenomenon of prescription drug abuse, none of which have focused specifically on doctor shopping, which highlights the necessity and importance of the findings from this study. A greater understanding of what constitutes doctor shopping as well as the experiences surrounding it is of paramount importance in order to make strides in reducing its incidence.

New Construct of Doctor Shopping

In order to answer questions about what doctor shopping is and what specifically constitutes doctor shopping, an in-depth discussion and concept analysis of the term doctor shopping is included in this section. The term doctor shopping is a commonly accepted term in the United States denoting patients visiting numerous health care professionals for multiple prescriptions of controlled drugs. Often the term is used in research without providing a definition. Dictionary definitions include the practice of getting prescriptions for a single drug from more than one provider at the same time (Dictionary.com, n.d.) and the practice of going from doctor to doctor to obtain prescriptions for pharmaceuticals (Webster's Online Dictionary, n.d.). USLegal.com (2011) defines doctor shopping as the practice of a patient requesting simultaneous care from multiple provider physicians without efforts to coordinate care or information the physicians of the multiple caregiving. Individual state laws have also been enacted to address doctor shopping. For instance, Connecticut has a statute which states:

“no person who, in the course of treatment, is supplied with controlled substances or a prescriptions thereof by one practitioner shall, knowingly, without disclosing such fact, accept during such treatment controlled substances or a prescription therefore from

another practitioner with intent to obtain a quantity of controlled substances for abuse of such substances” (USLegal.com, n.d.).

Tennessee has a doctor shopping bill that states, “a patient must disclose to a prescriber (physician, nurse practitioner, dentist, podiatrist, or optometrist) that he/she has received the same controlled substance or one with similar therapeutic use from another practitioner within 30 days” (Tennessee Medical Association, 2010). In Texas, it is a felony for patients to receive a prescription for a controlled drug without disclosing they are already receiving controlled substances from another practitioner (Texas Legislature Online, 2011).

The United States National Drug Intelligence Center (2004) defines doctor shopping as occurring when individuals visit numerous doctors in an attempt to obtain multiple prescriptions for drugs, often falsify or exaggerate symptoms in order to receive these prescriptions, and typically have their prescriptions filled at multiple pharmacies in order to prevent detection. According to the Drug Enforcement Administration (DEA), doctor shopping can be defined as visits by an individual – who may or may not have legitimate medical needs – to several doctors, each of whom writes a prescription for controlled substances (U.S. Drug Enforcement Administration, 2006).

Further criteria for doctor shopping include the number of prescribers an individual visits in the course of one year to obtain prescriptions for controlled drugs. This is significant because patients may only be able to secure one or two prescriptions for controlled drug from one prescriber so they move on to other prescribers throughout the year. Legitimate reasons for receiving controlled drugs from more than one prescriber within one year include when prescribers work in large practices patients; may be seen by more than one prescriber if their prescriber is not working that day. Also patients may see different prescribers for different

classes of medications such as seeing a dentist and getting a prescription for a small amount of pain medication after a tooth extraction, seeing a psychiatric prescriber for medication for anxiety, and seeing a primary care provider for pain management for another cause. However, five or more prescribers within one year is likely excessive and would constitute doctor shopping if the prescriptions are obtained for non-medical use.

The United States government as well as other researchers have used the criterion of five or more medical practitioners in one year as criterion for doctor shopping (U.S. Government Accountability Office, 2011; Hall, et. al., 2008). The term “overlapping” prescriptions is used in some studies to define doctor shopping (Cepeda, Fife, Chow, Mastrogiovanni, & Henderson, 2012a; Pradel et al., 2010;). The standard of care when prescribing controlled drugs is to write them for a 30-day supply, therefore overlapping prescriptions are equivalent to prescriptions filled within a 30-day period. Multiple pharmacy use to fill multiple prescriptions for controlled drugs is also a criterion used to define doctor shopping. This is done in order to avoid detection. A large study of 65% of all retail pharmacy sales in the United States found that overlapping prescriptions by more than one prescriber filled at three or more pharmacies per year was indicative of shopping behavior (Cepeda, Fife, Chow, Mastrogiovanni, & Henderson, 2012b).

In the United States, several types of healthcare professionals have legal authority to prescribe medications including APNs, dentists, physicians, physician assistants, ophthalmologists, and podiatrists. The term doctor shopping is well known and routinely used by the media, the government, healthcare professionals, law enforcement and the public. This term is heavily ingrained in the U.S. culture and is known to refer to patients obtaining prescriptions for controlled drugs from any prescriber, not solely physicians.

The term prescriber accurately reflects health care professionals with legal authority to prescribe medications. Other terms such as health care provider or practitioner are problematic because one could be a health care provider, such as a physical therapist, and not be able to prescribe medication. The term prescriber is used in a U.S. Government report on doctor shopping (United States National Prescription Drug Abuse Prevention Strategy, 2009) as well as laws pertaining to doctor shopping. For the purposes of this paper, the term prescriber will be used to describe healthcare professionals who prescribe medication.

A concept analysis of doctor shopping, based on the literature, defines doctor shopping as: a) when a patient visits more than one prescriber in a 30-day period to obtain controlled drugs for non-medical uses, b) patients do not disclose to prescribers previous prescriptions for a same or similar controlled drug, or the prescriber is aware and unscrupulously prescribes the drug anyway, c) patients fill prescriptions for controlled drugs at three or more pharmacies per year, and d) patients obtain prescriptions for controlled drugs from five or more prescribers for illicit use within a one-year period (Worley & Hall, 2012).

Unscrupulous prescribing occurs in doctor shopping when prescribers are aware patients are seeking prescription drugs illicitly yet choose to prescribe them anyway. Illegal prescribing by unscrupulous physicians is a significant source of diverted pharmaceuticals (U.S. National Drug Intelligence Center, 2004). Reasons for this include profiting from numerous patients receiving prescriptions for controlled drugs, in which case they are referred to as “script doctors” (Cicero et al., 2011; Inciardi et al., 2009), as well as under the table payments, exchange for illicit drugs, and sexual favors (Rigg et al., 2012).

Historical Perspective of Prescription Drug Monitoring Programs

Certain measures have been implemented in an effort to reduce the incidence of prescription drug abuse including the advent of PDMPs. In this section I will outline and discuss a historical perspective of PDMPs as well as issues pertaining to their use. Prescription drug monitoring programs are electronic databases started in 2003 to provide a way for healthcare professionals who prescribe medication to look up which prescriptions their patients have had prescribed in order to detect doctor shopping (Worley, 2012b). Prescription drug monitoring programs have been shown to deter doctor shopping (National Alliance for Model State Drug Laws, 2011). Currently 49 states have laws providing for PDMPs, 44 states have active programs and 5 states have programs that are not operational either due to being in the process of implementation or lack of funding (National Alliance of Model State Drug Laws, 2013). Most programs are reactive, meaning that prescribers must log on to the system in order to retrieve information. Currently only seven states have laws mandating prescribers or pharmacists to check the database in certain circumstances (National Alliance of Model State Drug Laws, 2012b). Enforcing prescribers checking PDMPs is problematic and currently there is no nationwide PDMP so patients can cross state lines to prevent detection. Less commonly, some states have more elaborate and expensive reactive programs that notify prescribers of suspected doctor shopping behavior.

Research is lacking on prescribers' use and barriers to use of PDMPs. Two older survey studies done with pharmacists and physicians on older now extinct pilot reactive PDMPs found that barriers to PDMP use included lack of time, lack of knowledge, perceived government oversight, information not viewed as necessary, and lack of Internet access (Barret & Watson, 2005; Ulbrich, Dula-Clark, Green, Porter, & Bennett, 2010).

Review of Empirical Literature

In order to determine the state of the science related to prescription drug abuse, this section details a thorough review of literature related to this phenomenon. Despite the enormity of the prescription drug abuse epidemic, a search of databases CINAHL, PubMed, and PsycINFO revealed there have been relatively few research studies in this area done with women, and even fewer on the phenomenon of doctor shopping. In order to review the literature on women and substance abuse, searches were done using the terms women and drug abuse, women and substance abuse, and women and drug addiction. Studies focusing on illicit as well as prescription drug abuse related to women have been included. All studies located by doing a search for prescription drug abuse, prescription drug diversion, and doctor shopping are included.

In this section I first summarize the findings of illicit drug abuse in studies done with women or those that include gender differences. The focus areas that were identified in these articles are comorbidity of mental illness, physical illness, and history of abuse. In addition, a summary of other significant research findings in this literature is included. Next, articles related to prescription drug abuse in women or those that focus on gender differences is summarized in the areas of comorbidity of mental illness, history of abuse, and polysubstance abuse. Additionally sections are included on reasons for prescription drug abuse, method of obtaining prescription drugs, treatment for prescription drug abuse and other findings in studies on prescription drug abuse. This is followed by a comparison of findings between studies on illicit and prescription drug abuse. A section reviewing the literature on patterns and tactics of prescription drug diversion is then included. Finally, the research articles on doctor shopping is summarized and includes the topics of doctor shopping rates for benzodiazepines, doctor

shopping related deaths, and scope and magnitude of doctor shopping. Identified gaps in the literature are then discussed.

The majority of research in the field of substance abuse has been conducted in the field of psychology. In PsycINFO the first study on women and drug abuse was by Hall (1938) who conducted a study with women ‘drug addicts’ in a reformatory. For the next few decades, studies with women were scarce and focused on alcohol abuse rather than drugs. Studies including women with drug abuse began to appear with more regularity in the 1980s. These predominantly have focused on specific populations of women such as pregnant women, those HIV positive, or those who are incarcerated. Initially studies in the field of substance abuse focused on those abusing illicit drugs, followed by prescription drug abuse and more recently, doctor shopping. Because I am interested in the general phenomenon of doctor shopping, for this review I am including studies done including women with substance abuse in general, and not those in specific populations.

Comorbidity of Mental Illness and Illicit Drug Use

Several studies identified a co-occurring mental health diagnosis in participants with illicit drug abuse. Gender differences in an aging cohort of people with a history of heroin dependence were studied by Grella and Lovinger (2012). In this study the Medical Outcomes Study 36-item Short-Form Health Survey, the Symptom Checklist and Beck Depression Inventory were used with no reliability or validity data provided. Participants in this study were sampled from a methadone clinic in the 1970s and completed follow up interviews between 2005 and 2009. Results of this study include that at a younger age women had more chronic mental health problems than men.

Another gender comparative study was done in India by Pant and Bagrodia (2003) with 15 men and 15 women from a residential drug rehabilitation program in order to identify psychosocial factors related to substance abuse. Data were gathered by using the Personal data sheet which is a semi-structured questionnaire, and the Bell's Adjustment Inventory. Specific information and reliability and validity of these instruments were not provided. A large percentage of the women in the study (60%) reported using drugs to escape from immediate stress and difficulties. The researchers examined home, health, social, and emotional adjustment and found that women had very unsatisfactory home adjustment.

In order to determine the relationship between victimization, psychological distress and high risk behavior among women who abuse substances, Golder and Logan (2011) collected data from 149 sexually active crack-using women who had participated in an AIDS prevention program. In this study trained interviewers asked questions which were adapted from several measures. For psychological distress four measures were operationalized and measured by the Global Severity Index derived from the Brief Symptom Inventory. Analysis of these measures was not provided. The overall level of psychological distress in the women who abused illicit drugs was found to be well above that of female psychiatric patients. Loneliness was measured by the Loneliness Scale described as being reliable based on $\alpha = .90$. In the participants, loneliness was found to be predictive of crack and alcohol use.

Hutchinson (1986) conducted an early qualitative grounded theory study with chemically dependent nurses, and found that the base psychological problem was emotional pain. In this study participants described abusing drugs in order to survive day-to-day life and to feel better during stressful times. The researchers concluded that participants attempted to resolve or obliterate psychological pain through the ingestion of chemicals.

Shinebourne and Smith (2011) used images of addiction and recovery in an interpretive phenomenological analysis. The researchers studied six female participants who were asked to bring artwork made earlier in their recovery to an interview in addition to being asked to draw during their interview. The authors discuss the results from one of those participants and highlight her emotional experience of substance abuse. Analysis was made of both the artwork and the transcript from the interview. Three themes emerged from the artwork and interview with the featured participant; 'I see things through different eyes now', 'I couldn't see anything on the horizon', and 'I'm trying to figure out who and where I am'. In the theme 'I see things through different eyes now', the participant relates to representation of recovery at present which is evident in her drawings of an idyllic landscape, described as an oasis, or in the image of a bird or dolphin associated with freedom. In the drawing of the dolphin and bird there was an absence of ground, which may signify she is adrift or as a reminder of the need to stay vigilant. In the 'I couldn't see anything on the horizon' theme, her drawings reflected wastelands, desolate landscapes, and a punishing sun which may reflect resentment, ambivalence, and isolation. In the 'I'm trying to figure out who and where I am' theme, the participant drew handprints, an addiction eye that does not see, and a black serpent, which allude to struggling to figure things out, renewal, and fear.

Engagement was the focus of a qualitative semi-structured interview study by Godlaski Butler, Heron, Debord, and Cauvin (2009). Twelve rural women in substance abuse treatment were interviewed about their state of mind before entering treatment, what experiences caused them discomfort in treatment, and changes they would recommend in treatment in order to understand factors that might influence comfort and engagement with treatment. Significant

characteristics of the women in the study included that nine of the 12 women stated they were either extremely or considerably troubled by emotional problems.

Twelve women participated in a qualitative semi-structured interview study by Aston (2009), to understand how rural women with addictions are hailed into identities of self-as-addict, through the interpretive lens of interpellation. Facets of hailing as a process were identified in the transcripts of the interviews, including that it took time for the women to come to terms with seeing themselves as addicts. The interviews were also analyzed to provide insight into the readiness of the women to be hailed as addicts. The women reported they had suffered enough and came to a turning point where eventually they became ready and willing to accept themselves as addicts. The participants' responses in relation to their perception of hailing a failed performance were discussed, including that multiple authorities worked unknowingly together to hail them as addicts. The authors concluded that women with addictions are hailed by the addiction services and supports they encounter to accept or reject an identity of self-as-addict. Hailers included friends, health care professionals, police, parents, employers and the media. These hailing encounters had a cumulative negative effect on the women.

To understand the changes that take place in social environments that enable individuals suffering from an addictive disorder to break the cycle and achieve recovery, Watson and Parke (2011) conducted several semi-structured interviews with five heroin addicts which were then analyzed through what is described as an interpretive phenomenological analysis. Three themes emerged from the data: childhood experience, psychological symptoms and perceptions of recovery. In the theme of childhood experience, relationships and rejection was a subtheme and participants' described themselves as 'outsiders' and 'black sheep'. Death and loss was also a subtheme in childhood experiences, and the women recounted experiences and memories of

deaths of family members or friends. Manifestations described in the psychological effects theme included depression, panic attacks, and paranoia. In the perceptions of recovery theme, lost childhood and 'my rock bottom was fear' were the subthemes. Participants described themselves as deviating from normality, and fear was intricately involved in recovery. The authors of this study concluded that fractures in the mother-daughter relationship were evident in all the narratives, which generated feelings of rejection and isolation, and impacted the daughters' identity and ability to build relationships.

A life history study conducted with 26 women in treatment for substance abuse by Woodhouse (1990) included the data collection methods of life line exercises, focus groups, interviews, and written segment exercises in order to understand and highlight women's experiences within the context of their worlds. A common theme among the participants was their experience of motherhood. All the mothers in the study expressed feeling great psychological pain related to the negative effect their substance abuse had on their children.

It is clear from the results of studies done with women who abuse illicit substances that this use is associated with mental health problems. Prior losses and other difficulties were noted in many of their childhoods and their substance abuse also negatively affected other people in their lives, such as their children.

Comorbidity of Physical Illness and Illicit Drug Use

Nurses in the qualitative study previously described by Hutchinson (1986) reported using drugs to self-medicate physical pain in addition to psychological pain. Participants described painful physical conditions associated with drug abuse such as backaches and migraines. In studying the aging heroin users, Grella and Lovinger (2012) measured health conditions based on the respondents' self-report of having any of 16 chronic health conditions. They found that at a

younger age, women had more chronic physical health problems than men, including heart disease, diabetes and liver disease.

In a phenomenological representative case method study done by Furrer (1991) psychological testing, as well as semi-structured interviews, were conducted to study six women who abused either heroin or cocaine. In that study, all of the women reported acute adverse physical reactions to drugs including hospitalization, but none reported lasting effects other than sinus problems or high blood pressure.

These studies highlight a relationship between physical health problems and substance abuse. This is a significant finding as physical health problems have a profound impact on the quality and longevity of an individual and highlight the serious longstanding effects of substance abuse.

Comorbidity of History of Abuse and Illicit Drug Use

A history of physical or sexual abuse is a common finding in research on women who abuse substances. In the study done in India by Pant and Bagrodia, (2003) which used semi-structured questionnaires, 79% of the women addicts began using drugs due to the influence of their husbands including beatings and coercion to use drugs. Data about victimization were obtained in structured interviews and were reported in 94% of the crack-using women in the previously mentioned study by Golder and Logan (2011). Intimate partner violence was noted by 84% of the participants. Interpersonal violence predicted crack use, and childhood victimization and psychological interpersonal violence predicted psychological distress in multivariate models. In the qualitative study by Godlaski et al. (2009), six of the 12 women in substance abuse treatment had a history of physical abuse and six had a history of sexual abuse.

Victimization was also a theme identified in the qualitative study by Watson and Parke (2011) which used semi-structured interviews to examine addiction and recovery in heroin addicts.

In the life history study by Woodhouse (1990) with 26 women, half of them had been raped or sexually abused and described medicating their emotional pain with drugs. In another life history study by Etherington (2006), one woman's story from the United Kingdom was analyzed. Her childhood was chaotic and violent. She lived with an abusive aunt who also abused substances. She had an abortion at age 14 and then lived with an abusive boyfriend starting at age 15. She became pregnant again at that age and was physically abused and took drugs throughout her pregnancy. In the study by Furrer (1991) four of the six women had been sexually abused as children and 50% were physically abused. Four of the six women also reported being battered in relationships as teens or adults.

These studies provide evidence that a history of being physically or sexually abused in childhood is associated with substance abuse in later life. Victimization from interpersonal violence as an adult is also associated with abuse of substances.

Other Research Findings Related to Illicit Drug Use

In the previously mentioned gender comparison study done in India, 79% of the women addicts began using drugs due to the influence of their spouses (Pant & Bagrodia, 2003). Another difference between men and women in this study was the reason for seeking treatment. The women sought treatment because they were unable to care for their families, whereas the men more often sought treatment because they were forced to do so. In the life history study previously mentioned by Woodhouse (1990), the women participants saw themselves as not having an identity without men and as being dependent on men. Additionally, they reported

being introduced to drugs by a man, they shared a commonality of not purchasing the drugs they abused, and they described themselves as being functional in their lives.

The findings from these few studies suggest that men may often or sometimes play a role in initiation into substance abuse for women. Additionally, women who abuse substances may face issues of dependence or reliance on men.

Comorbid Mental Illness and Prescription Drug Abuse

In order to determine psychiatric and pain characteristics of prescription drug abusers, Passik, Hays, Eisner, and Kirsh (2006) collected both quantitative and qualitative data in a study of both males and females entering drug rehabilitation. The Structured Clinical Interview for DSM-IV was used to assess substance use disorders, mood disorders and psychotic disorders. Interrater reliability for this instrument is described as having a weighted kappas of 0.61 for current disorders and 0.68 for lifetime disorders. In this study there was no statistical difference between males and females for mental health diagnosis. Fifteen percent of participants (n = 109) met criteria for an additional mental health diagnosis such as mood disorder.

Gender differences related to risk of opioid misuse among chronic pain patients were studied by Jamison et al. (2010) previously mentioned, who performed a longitudinal predictive study of 275 males and 335 females. The participants completed several questionnaires, including the Prescription Drug Use Questionnaire which includes information on psychiatric history. Reliability and validity information for this measure were not provided. Gender differences were identified in this study in that women identified more emotional issues and affective distress related to their prescription drug use than did men. Women were more likely to admit to a history of psychiatric problems than men. The authors state that their study suggests this puts women at greater risk to misuse prescription opioids. Women with a history of

depression or anxiety also tended to do less well in managing prescription opioids and had a tendency to self-medicate.

Gender differences were also examined by Back et al. (2010) in an analysis of findings from the National Survey on Drug Use and Health. In that study women's, but not men's, prescription opioid abuse was also associated with serious psychological distress. In another study by Back, Lawson, Singleton, and Brady (2011), researchers examined gender differences in a group of 12 men and 12 women, recruited via newspapers and flyers, who were not in treatment. The findings suggested that women were more likely to use prescription opioids in order to cope with interpersonal stress and less likely to use them for physical pain.

Quality of life (QOL) was studied among women in substance abuse treatment by Tracy, et al. (2012). A theoretical framework was not listed as being used in this study. A quality of life measure developed by the World Health Organization was used in this study using instruments stated to have excellent psychometric properties and moderate to high reliability as evidenced by a Cronbach alpha for each domain ranging from .642 to .806. The Trauma Symptom Checklist was also used with a Cronbach alpha .931 for the total scale. The Social Support for Recovery Scale was used along with the Friend's Support for Abstinence Scale both with alphas of .881 and .717 respectively. These instruments were used to assess physical, psychological, social and emotional characteristics of 240 women enrolled in substance abuse treatment at one and six months post treatment intake. Non-African American status was associated with lower psychological quality of life. Additionally, the number of mental disorders was negatively associated with all QOL domains except the environmental domain. Social support was positively correlated with all four QOL domains.

As part of a large ethnographic study on marijuana use funded by the National Institute on Drug Abuse, researchers Bardhi, Sifaneck, Johnson, and Dunlap (2007) identified a small subpopulation of 12 college educated upper middle class White or Asian women who abused prescription drugs. These women participated in a qualitative study using semi-structured interviews developed by the researchers. The questions focused on their past and present history of prescription drug abuse. Initiation into prescription drug use varied among the participants, with three of the women reporting initiation for pain relief, four began using out of boredom, and three for anxiety or depression. Other findings in this study included that there were shifting patterns of prescription drug use among the participants from legal to quasi-legal to recreational users.

Another study was done to study prescription drug misuse in adults, both men and women, who were prescribed anxiolytics and sedatives, which include benzodiazepines. In this cross-sectional study by McLarnon, Monaghan, Stewart, and Barrett (2011) which did not specify a theoretical framework, 67 adults who had a current prescription for anxiolytic or sedative drugs completed a drug list, substance abuse and dependence scale, and substance use risk questionnaires as well as a structured polysubstance interview adapted from an existing measure. Specific reliability and validity measures for the instruments used in this study were not provided other than the authors state the instruments are ‘validated.’ Misuse of prescriptions was reported by 54% of the participants. Misuse included exceeding their drugs recommended dosage (42%), and taking the medication for nontherapeutic purposes (21%). Multiple logistic regression results determined that generalized anxiety disorder and the personality dimensions of hopelessness and impulsivity were predictive of anxiolytic or sedative diversion. Statistical

significance was not found in the relationship between psychiatric conditions and prescription drug misuse. Gender differences were not examined.

Findings from these studies highlight the fact that women who abuse prescription drugs often have a greater incidence of mental health problems than men. However, two studies did not find a statistical difference in psychiatric disorders between men and women.

Comorbidity of History of Abuse and Prescription Drug Abuse

In a gender differences study by Jamison et al. (2010), several instruments were used including the Screener and Opioid Assessment for Pain Patients which is described as having a test-retest reliability of 0.71 with a coefficient alpha of 0.74. Differences between the men and women participant results included that women who abused prescription opioids were more likely to admit to a history of sexual or physical abuse than men. A secondary analysis of data from the National Household Survey on Drug Abuse which used computer assisted telephone interviewing to collect data by McCauley (2009) resulted in findings that non-medical use of prescription drugs was significantly higher in women who had been victims of drug or alcohol facilitated rape. In the quality of life study of women by Tracy et al. (2012) the Trauma Symptom Checklist was used, described as having a Cronbach alpha of .931. Findings from this study included that a history of trauma was associated with lower quality of life in all domains.

Similar to the studies of women who abuse illicit drugs, studies of women who abuse prescription drugs showed a relationship between a history of physical or sexual abuse and substance abuse.

Reasons for Prescription Drug Abuse

Male and female participants in the study by Passik et al. (2006) were studied to examine psychiatric and pain characteristics of prescription drug abusers entering drug rehabilitation.

One of their measures was the Prescription Opioid Abuse Survey which included qualitative data. Specific questions that were asked and reliability or validity of the measure were not provided. Qualitative data gathered in this study included that participants described various reasons for taking drugs such as increasing energy level, achieving a good feeling, and creating euphoria. In a mixed methods study done by Daniulaityte, Falck, and Carlson (2012), 51 men and women were studied including analysis of demographics and prescription drug use variables such as method and frequency of administration. Qualitative data were collected using structured interviews. The participants reported they abused prescription drugs to get high, to self-medicate, or to not abuse other opioids. In the qualitative study of middle class women who abused prescription drugs by Bardhi et al. (2007), respondents reported they took the medication for a perceived medical reason such as to relax or to stay up all night to study as well as to get high.

The results of these studies which examined reasons for prescription drug abuse are particularly helpful and informative in providing insight into the phenomenon of prescription drug abuse because they examine underlying causes of use from the participant perspective in their own words. The varied findings suggest complexity and individual differences in the reasons for prescription drug abuse.

Comorbidity of Polysubstance Abuse

McCabe, Cranford and West (2008) examined prescription drug abuse and co-occurrence with other substance use disorders in men and women by analyzing the findings of two national surveys. The National Longitudinal Alcohol Epidemiological Survey and the National Epidemiological Survey on Alcohol and Related Conditions were used to assess data on alcohol use, non-medical use of prescription drugs and substance use disorders along with demographic

and background characteristics. The findings from this study include that the majority of individuals with a past-year prescription drug abuse disorder for both time frames studied also met criteria for another substance abuse disorder such as alcohol, marijuana, or cocaine. In the study by Passik et al. (2006) with men and women, polysubstance abuse was found in 31% of people who abused prescription drugs. In addition, all the patients met criteria for a diagnosis of opioid abuse or dependence. The Bardhi et al. (2007) qualitative study previously mentioned included excerpts from the participants about their experiences with using prescription drugs along with illicit drugs such as cocaine, indicating polysubstance abuse.

A secondary data analysis was conducted by Green et al. (2009) using the Addiction Severity Index-Multimedia Version. Reliability and validity of this instrument was not provided. This survey was administered to 29,906 people entering substance abuse treatment to determine the characteristics of women as compared to men who abused prescription opioids. Unlike men, women's opioid use was associated with problem drinking. In the study by Back et al. (2010), illicit drug use was associated with prescription opioid abuse and dependence in women but not men. In the previously mentioned study by McCauley (2009), non-medical use of prescription drugs was significantly higher in women with past year illicit drug use or binge drinking. In the study by McLarnon et al. (2011) participants co-administered their anxiolytics with alcohol (37%), cannabis (24%), cocaine (9%) and amphetamine (18%). These studies show polysubstance abuse is common in women who abuse prescription drugs.

Method of Obtaining Prescription Drugs

In the study done with men and women by Passik et al. (2006), 91% had purchased opioids from a street dealer, 36% had stolen someone else's medication, 43% had sold prescription drugs, 43% stole money to buy drugs, and 17% admitted to obtaining their

prescription drugs by doctor shopping. In the gender differences study by Back et al. (2010), differences were found in how men and women obtained their prescription opioids. Women were less likely to obtain prescriptions from family or friends or to purchase them from a drug dealer.

In the qualitative study by Bardhi et al. (2007), all participants demonstrated one of three patterns of prescription drug use and shifts were noted among these patterns. The pattern of legal medical users included women who obtain legitimate prescriptions for controlled drugs but report nothing wrong with diverting them either through giving the pills to friends or selling them to others. The quasi-medical user pattern includes women who do not have prescriptions for the prescription pills they use, but obtain them for free from a friend or family member or by purchasing them from others. Reasons for taking the medication included a perceived medical reason such as to relax or to stay up all night to study. The final pattern is recreational users who obtain their prescription pills from friends or family or purchase them from others to get high or as an adjunct to illegal drugs to counteract the side effects.

How prescription drugs were obtained was a theme found in a case study undertaken to understand the issues of prescription drug abuse in the elderly. One family's experience was examined by Morgan and Brosi (2007) using human ecological theory as a guiding framework. The researchers studied 12 mother-adult dyads and reported findings from one of the cases. The featured caregiving daughter was interviewed about the care system and arrangement and experience of providing care to an elderly parent. The mother was interviewed about the care arrangement to understand the history of care in the family, perceptions of care over time, and beliefs about filial responsibility. The 80-year-old mother in this case was addicted to prescription drugs. The daughter spoke of her experiences taking her mother to prescribers and

how she may have unknowingly contributed to her mother's drug-seeking behavior. Later she fought to educate prescribers about her mother's prescription drug abuse which caused conflict. The mother in the case study did not talk about her daughter's involvement in her drug seeking. Both women talked about how caregiving had changed and strained their relationship. The daughter spoke of the relief she felt when her mother was placed in an assisted living facility and could no longer go to prescribers to try to obtain prescriptions. The authors in this study created a human ecology model applied to the mother and daughter participants and made recommendations such as improved training of healthcare professionals to recognize and treat prescription drug abuse in the elderly.

These studies show that women who abuse prescription drugs do report obtaining prescriptions from numerous prescribers. One of the studies showed that women were less likely than men to obtain their prescriptions from dealers or friends or family. Another study showed that women who abused prescription drugs obtained the drugs for free from family or friends or purchased them from others.

Treatment for Prescription Drug Abuse

In the study of both men and women prescription drug abusers by McCabe et al. (2008), the majority of individuals with past-year prescription drug abuse had not utilized substance abuse treatment in the past 12 months. Fewer women than men had received alcohol or drug abuse treatment in the study by Back et al. (2010). These findings may indicate a lack of treatment options or the presence of barriers to treatment for women.

Other Research Findings Related to Prescription Drug Abuse

Chronic pain was identified as being present in 61% of the men and women who abused prescription drugs in the Passik et al. (2006) study. However, in the gender differences study by

Green et al. (2009), women who abused prescription drugs were less likely to report experiencing pain than men, but more likely to report other medical problems. In the qualitative study by Bardhi et al. (2007) three of the 12 women reported initiating prescription drug abuse due to pain. In the Green et al. (2009) study, women's prescription drug abuse was associated with a history of overdose. The majority of men and women in the study by Back et al. (2011) reported being first introduced to prescription opioids through a prescription from a physician for legitimate pain. In the large survey by Cicero et al. (2011), women over age 45 years with insurance and of higher socioeconomic status were more likely to use doctors' prescriptions as a source of abusing controlled prescription drugs.

Bardhi et al. (2007) reported that most of the women in their study claimed to avoid dependence on their prescription drug use, believed obtaining prescription drugs from others was acceptable, used prescription drugs in conjunction with other drugs, and obtained prescription drugs relatively easily. General practitioners were perceived as being more willing to write prescriptions for controlled drugs than those in psychiatry. McLarnon et al. (2011) reported misuse of their prescriptions for benzodiazepines in 54% of the participants. In addition, 52% reported diverting their medications by either giving it away or selling it to others.

Comparing Findings Between Illicit and Prescription Drug Abuse

In the majority of studies that have examined mental health in women as compared with men with both illicit and prescription drug abuse, women struggle to a greater degree with mental health problems and distress related to both illicit and prescription drug abuse. Women tend to abuse both illicit and prescription drugs to self-medicate and cope with painful emotions. In addition, women who abuse both illicit and prescription drugs had higher rates of being victimized by sexual or physical abuse including rape. This abuse was identified as a precursor

to illicit and prescription drug abuse. In these cases, drugs were abused to medicate the emotionally painful sequelae of past abuse.

Patterns and Tactics of Prescription Drug Diversion

The nature, scope and magnitude of prescription drug diversion was studied by Cicero et al. (2011) through the results of a survey of opioid dependent patients entering treatment (n = 1,983) and focused interviews using standardized instruments with opioid abusers in South Florida (n = 782). Demographic information was collected along with illicit and prescription drug use history and methods to obtain each diverted prescription drug they misused in the last 90 days. Diversion methods included getting prescriptions from doctors who were described as ‘script doctors’ working at pain clinics where narcotic pain medications were readily dispensed, known as ‘pill mills’, doctor shopping, regular doctor, pharmacist, theft, dealer, sharing or trading, family, transport from another country, or internet purchase. In the survey sample, dealers were the primary source of diversion (>50%). A doctor’s prescription, either regular doctor or doctor shopping, accounted for 25% of the means of diversion. Women were significantly less likely to use dealers and significantly more likely to use doctors’ prescriptions. Respondents age 45 years or older were three times more likely to use a medical source for their prescriptions. Respondents of higher socioeconomic class and those abusing hydrocodone or methadone were also more likely to use a doctor’s prescription.

In the South Florida sample the researchers did not examine gender differences. The majority of the participants obtained their prescriptions using dealers (66.6%) followed by sharing or trading with family (54.6%) and only 13.8% reported obtaining through doctor shopping or regular doctor. In both samples, participants with higher income and health

insurance were more likely to obtain prescriptions from doctors. In both samples oxycontin was the most commonly abused drug followed by hydrocodone.

In another study by Inciardi et al. (2009) with an aim to determine patterns of prescription drug diversion, data were collected from a diversion and addiction surveillance system, the National Survey of Drug Use and Health, and other surveys. Additional qualitative data were analyzed from focus groups with prescription drug abusers in the Miami club culture as well as a rapid assessment which included in-depth interviews with three prescription drug dealers, and two prescription pill brokers. Results from six focus groups consisting of patients in residential treatment programs were also included. The authors sought to gain an understanding of what they described as the 'black box', which is the unknown circumstances surrounding diversion. Findings from a nationwide survey of police and regulatory agency personnel, who based their responses on data entered in a diversion system, included that three-quarters of the survey participants considered doctor shopping (39.4%) and prescription theft or forgery (35%) to be the main source of diversion. Results from 346 participants entering substance abuse treatment from a methadone treatment center showed that 75% reported obtaining opioids from drug dealers, 39% from friends or relatives, and 20% from a doctor's prescription.

Also included in the study by Inciardi et al. (2009) was a survey of 1,472 patients referred from substance abuse treatment specialists showed that the majority got their prescriptions from dealers (65%), followed by friends and relatives (64%), doctor's prescriptions (59%), emergency rooms (22%), and forged prescriptions (21%). In the 2007 National Survey of Drug Use and Health, 21,335,000 people reported non-medical use of prescription opioids. The majority of these respondents obtained their prescriptions from friends or relatives for free (57%) followed by prescriptions from one doctor (18%), friend or relative for purchase (9%), friend or relative

stolen (5%), and dealers (4%). Street sex workers were also surveyed and only a small percentage reported prescription drug abuse (12.2%) as opposed to illicit use (80.4%). These participants reported obtaining prescription drugs most often from friends or relatives (68.1%), street buys (30.6%), clients or other sex workers (4.2%), script doctors (4.2%), and theft (1.4%). Doctor shopping was not identified as a means to obtain prescriptions in this population. In a survey of 515 club drug users, all of them reported using prescription drugs for recreational purposes during the past 90 days. The most common drug abused was alprazolam, a benzodiazepine, followed by oxycodone and hydrocodone, both narcotic opioids. These participants obtained their drugs from local drug dealers (75%), sharing or trading with friends (<50%), or from family members (25%). Only 3% of these participants reported engaging in doctor shopping.

Focus groups were done with 27 ethnically diverse men and women connected to the club scene. A common theme in the focus groups was Medicare and Medicaid fraud as mechanisms for obtaining prescription drugs. Situations described included people selling their prescriptions in order to obtain illicit drugs, and young people paying elderly people to obtain prescription drugs which they then sold. Eight drug dealers described methods of obtaining prescriptions which included buying drugs brought in from Mexico, and purchasing from other dealers.

Results from the rapid assessment focus groups included that members of the elderly population in that community were in the business of duping their physicians with complaints of pain in order to obtain prescriptions for pain medication to sell for economic reasons. Some sold their prescriptions themselves or to dealers. Another finding was patients with legitimate pain often sold part of their prescriptions for profit or in exchange for illicit drugs. Pill brokers, dealers and sellers often congregated in open air drug markets such as strip malls and pharmacy

parking lots, and outside methadone clinics to buy, sell, or trade prescriptions. Less commonly, doctor shopping was identified by the focus group participants as a source of diversion (Inciardi et al., 2009).

A qualitative study was conducted in London during 1995 and 1996 by Fountain et al., (1998) with buyers and sellers of prescription drugs to understand the tactics used to obtain prescription drugs which were then resold. In this study, qualitative research techniques, described as observation, conversation, and unstructured interviews surrounding the issue of diversion, were used with an unstated number of participants recruited from over 100 drug users. Diversion techniques included: a) multiple scripting by obtaining more than one prescription from different treatment services, b) overscripting by obtaining a surplus of drugs to sell, c) exaggerating a habit by telling prescribers they were taking more medications than they actually were to get a prescription for a higher quantity of pills, d) bargaining with prescribers by telling prescribers they were having to commit crimes to obtain illicit drugs in order to be prescribed a prescription such as methadone, e) false identities used with different prescribers to obtain prescriptions, f) gaining sympathy by telling prescribers “sob stories” to obtain prescriptions, g) feigning addiction to obtain prescriptions such as methadone or benzodiazepines for withdrawal symptoms, h) becoming a temporary resident by traveling miles to different localities to visit prescribers, i) forgery after having stolen or bought blank prescriptions, j) feigning symptoms such as pain, insomnia or attention deficit disorder (ADHD) in order to obtain prescriptions, k) pretending to be an injector in order to obtain injectable methadone, l) one off tactics by claiming liquid medication was dropped, or pills were lost or stolen, j) and enjoying the game by experiencing enjoyment from outwitting prescribers.

Rigg et al. (2012) conducted semi-structured interviews with 50 prescription drug sellers in South Florida to understand patterns of prescription medication diversion among drug dealers. The ethnically diverse sample included 36 men and 14 women ranging in age from 20 to 53 years old (mean = 33 years). Six themes were identified in the interview transcripts: a) the omnipresence of opioids, b) pain clinic shopping, c) sponsorship, d) buying scripts, e) using a 'connect', and f) healthcare fraud. Sellers in this study obtained the majority of their prescription drugs from pain management clinics. Opioids and benzodiazepines were obtained by presenting a magnetic resonance imaging (MRI) report and complaints of pain to a pain doctor. In some cases special arrangements were made with pain doctors including recruiting additional patients, sexual favors, exchanging illicit drugs or under the table cash payments. Doctor shopping was described as the 'norm' among dealers who reported visiting pain clinics for prescriptions, at times 10 or more pain clinics a month, to obtain prescriptions for large quantities, up to 240 pills or more for one drug.

Sponsorship was also reported among the sellers which involved subsidizing someone else's trip to pain clinics, the cost of the visit, the cost of the prescription, transportation costs, and the cost of a MRI. In return, the dealer required 50-75% of the medication obtained, often from 16 to 50 people per month. Dealers who bought prescriptions from others typically did so from veterans, Medicare and Medicaid recipients, crack or heroin addicts, or HIV/AIDS patients. Connects are described as people with connections or access to prescription drugs such as those who work at healthcare facilities including pharmacies, medical offices or hospitals, in addition to those with access to blank prescription pads. Healthcare fraud was committed with fake MRIs, fake prescriptions and billing Medicare or Medicaid for costs of prescriptions that were sold for profit.

Using mixed methods, Green et al. (2013) studied 195 participants were studied to assess collaboration and coercion in partnering to divert prescription opioids as part of a rapid assessment and response process in Connecticut and Rhode Island. Key informant interviews were conducted with 143 participants as well as 52 anonymous brief intercept surveys. The interviews were recorded and the transcriptions analyzed using a coding scheme for themes, one of which was partnership as a pattern of prescription opioid diversion. In some cases this was collaborative, involving situations where both partners benefited from the diversion such as by sharing rides in exchange for pills. Exploitive partnering was also noted in some instances where one member took advantage of the other to get access to prescription opioids such as when elderly or disabled persons were coerced into going to doctors to obtain prescriptions.

These studies show a wide variety of diversion tactics including doctor shopping are used as methods of obtaining prescription drugs for abuse. Working together or purchasing pills from other addicts was also noted in these studies.

Doctor Shopping for Benzodiazepines

Pradel et al. (2010) studied the abuse potential of benzodiazepines, a class of controlled drugs used to treat anxiety, using doctor shopping as an indicator through a secondary data analysis of health insurance claims from a region of France. All prescriptions for benzodiazepines reimbursed for a one-year period were assessed. Benzodiazepines were classified for their abuse potential from very high to low. The researchers calculated a doctor shopping indicator, defined as the overlap between prescriptions from different prescribers. During the study period, 12% of the population received at least one prescription for a benzodiazepine. Doctor shopping indicators were calculated for 14 benzodiazepine medications. The range of doctor shopping indicators was 0.3% to 42.8%. Through statistical analysis the

authors concluded that the expected doctor shopping indicator for all benzodiazepines combined was 2.6% but the observed doctor shopping indicator found was 3.6%, which was 38% greater than expected, accounting for 361,428 daily doses.

Hospitalizations for Poisoning by Prescription Drugs

Nationwide data of unintentional poisoning by prescription opioids, sedatives, and tranquilizers examined by Coben et al. (2010) found that the rate of hospitalizations for these poisonings increased by 65% from 1999 to 2006. The largest increase in poisonings was involved benzodiazepines. When compared to other hospitalizations for poisoning, women over the age of 34 were more likely hospitalized for poisoning by opioids, sedatives and tranquilizers and presented at rural or urban nonteaching hospitals.

Prescription Drug Related Deaths

A secondary data analysis of a forensic drug database was conducted to examine characteristics of all alprazolam-related deaths in West Virginia between 2005 and 2007 including demographics, toxicology and comorbidity information. Shah et al. (2012) found that alprazolam, a benzodiazepine, contributed to 17% of all the drug-related deaths during that time frame and at least one other drug, predominantly an opioid, was identified in 97.5% of the alprazolam cases. An alprazolam prescription existed in 52.5% of the alprazolam deaths and a prescription for all drugs identified existed in 77.6% of the cases. In several cases, two benzodiazepines were detected on autopsy and in 63% of those cases, prescriptions for both were noted. Since concomitant use of two benzodiazepines such as alprazolam and diazepam is not recommended, the researchers determined that inappropriate prescribing, doctor shopping, and inconsistent use of PDMPs occurred. The number of prescribers was not evaluated in this study.

The results of the study included that alprazolam was a contributing cause of death in a substantial and increasing number of drug-related deaths.

Doctor Shopping Related Deaths

A secondary data analysis using a case-control design was conducted using controlled substance prescription data from the West Virginia Controlled Substance Monitoring Program. Drug-related death data from the Forensic Drug Database over a two-year period was analyzed by Peirce et al. (2012) to identify factors related to the odds of drug-related death and for the incidence of doctor and pharmacy shopping. The researchers compared subjects who were dispensed a controlled substance who were living (control) with those who were in the drug-related death group (case). Approximately one quarter of the deceased group were doctor shoppers compared with 3.6% of the living group. Pharmacy shopping was noted in 17.5% of the deceased group compared to 1.3% of the living group. In addition, a significantly greater proportion of doctor shoppers were also pharmacy shoppers when compared to non-doctor shoppers (20.23% vs. 0.60%). Using logistic regression, it was determined that subjects who were older had less odds, and subjects with the greatest number of prescriptions dispensed had greater odds of drug-related death. Doctor shoppers had twice the odds of drug-related death. Subjects who filled a prescription for an opioid or a benzodiazepine had significantly greater odds of drug-related death. A relationship between doctor and pharmacy shopping was found although one was noted to occur without the other. In this study 80% of doctor shoppers were not pharmacy shoppers and 44% of pharmacy shoppers were not doctor shoppers. The authors conclude that both shopping behaviors impact medication safety among patients.

Scope and Magnitude of Doctor Shopping

Cepeda et al. (2012b) conducted a large secondary data analysis was done on opioid shopping behavior using 65% of all retail pharmacy prescription records in the United States. The authors do not use the term ‘doctor shopping’ but instead define opioid shopping as at least one day of overlapping dispensing of opioids written by two or more different prescribers. They also studied filling prescriptions at multiple pharmacies. Rates of opioid shopping were compared to overlapping prescriptions for benzodiazepines and diuretics. Diuretics are not known to have abuse potential. Findings from this study include that 13.1% of all prescriptions during 18 months of follow-up involved an overlapping prescription for opioids by at least two prescribers, 9.8% occurring in prescriptions benzodiazepines, and 13.8 for diuretics. With the additional criteria of filling prescriptions at three or more pharmacies, opioid shopping occurred in 0.18% of cases, 0.10% of benzodiazepines and only .03% of diuretics. The authors conclude that having overlapping prescriptions by two or more prescribers filled at three or more pharmacies clearly distinguished opioids and benzodiazepines from diuretics and is predictive of shopping behavior.

Gaps in the Literature

There is a paucity of research on the phenomenon of doctor shopping. Predominantly, the available studies have been done with specific populations such as drug dealers, street sex workers, and those from the club scene in South Florida. These studies reveal a heavy reliance on obtaining prescription opioid from pain clinics or pill mills. At that time, Florida was widely known for having a problem with an abundance of pill mills, but since that time Florida has implemented a PDMP, as well as strict laws regulating pain clinics in an effort to combat and

shut down pill mills. More studies are needed on doctor shopping in general populations because findings may be different from specific populations.

Qualitative studies done on prescription drug diversion have been done using structured or semi-structured interviews or focus groups. Additional qualitative studies are needed using other qualitative methods in the area of prescription drug diversion and doctor shopping with many populations, including women to increase understanding which would provide additional information to develop instruments and interventions. At present there is a complete lack of research on prescribers' experiences or decision making when prescribing controlled drugs. Studies are also needed on prescriber use of PDMPs and perceived barriers to their use. There is a lack of quantitative studies to measure doctor shopping because instruments have not been developed. Interventional studies to reduce the incidence of doctor shopping are also lacking.

This qualitative study on the experience of female doctor shoppers will be a significant contribution to the literature in that it provides an avenue toward a better understanding of the phenomenon of doctor shopping related to prescription drug abuse. Since people who engage in doctor shopping have not previously been interviewed by researchers using the method of existential phenomenology, themes identified in the research findings may suggest new directions for scholarly investigation and clinical intervention.

Chapter III

Methodology

The purpose of this study is to examine the experiences of female doctor shoppers. In this chapter I explain the method I used in this qualitative study on the experiences of women who engage in doctor shopping. In this section I further elaborate on the existential phenomenology of Merleau-Ponty. I describe the method used in purposive sampling, and collecting data. I describe the University of Tennessee Knoxville (UTK) method of phenomenology (Thomas & Pollio, 2002) which was used in this study. Finally, study rigor and threats to rigor is addressed.

Qualitative Research Design

A qualitative approach was appropriate for this study due to the paucity of research available on the phenomenon of doctor shopping. The qualitative study method was useful to aid in the discovery of insight and meaning (Sandelowski, 2008). Findings of qualitative studies can contribute to concept and theory development as well as interventions, changes in health care policies, and in the development of quantitative instruments (Kearney, 2001; Morse, 2012; Sandelowski, 2008). I chose to explore the experience of women who engage in doctor shopping using a phenomenological approach. This approach was appropriate when studying the experience and perception of the person within the environment. This understanding is important and involves a relationship between the patient and their environment, which includes the prescriber, with subtleties and complexities that can be captured through a phenomenology study (King, 2006).

Historical Perspective of Existential Phenomenology

Existentialism can be described as the search and journey for true self and true personal meaning in life. Key assumptions in existentialism include that humans have a special existence that points beyond itself which cannot be assimilated to the mode of existence of nonhuman things and that it is possible to overcome the error of conceiving of ourselves as estranged from the world by revealing the dependence of a significant world upon human meaning-bestowing practices (Shand, 2010).

Soren Kierkegaard was a Danish Christian philosopher (1813 – 1855) who is considered the first existentialist. Kierkegaard was born into a wealthy Danish family and his life was influenced by a broken engagement. He studied theology, philosophy and religion at the University of Copenhagen. He was a prolific writer of several essays and kept journals that were often published under pseudonyms. He studied how one lives as a single individual giving priority to concrete human reality over abstract thinking highlighted by the importance of personal choice. He explored emotions and feelings related to choices. He believed life is experienced in distinct stages: a) aesthetic, concerned with experience and materialism which leads to boredom, which gives way to b) ethics, and then to c) religion (Stanford Encyclopedia of Philosophy, 1996).

German born Edmund Husserl (1858 – 1938) became known as the founder of phenomenology. Husserl received his PhD in mathematics and became interested in and studied philosophy. His first publication was on the philosophical foundations of mathematics in 1887. He later became a professor at the University of Germany. He was greatly affected by the serious injuries and eventual death of one of his sons who fought in World War I, as well as by the Nazi movement. His philosophy focused on how objective knowledge arises in and for a

person through experience (Drummond, 2008). He sought to focus on a phenomenon without any presuppositions, focusing on what is known, not how it is known (Tameri Guide for Writers, 2010).

Martin Heidegger (1879 – 1976) studied under Husserl and is readily associated with existentialism and phenomenology. Although he rejected Husserl's views focusing on consciousness, he eventually took over a teaching position vacated by Husserl. He published an acclaimed philosophical book titled *Being and Time* in 1927. Heidegger was controversial because he joined the Nazi party, but his work is significant in regards to existential phenomenology because of his focus on the meaning and experience of being (Stanford Encyclopedia of Philosophy, 2011). Jean Paul Sartre (1905 – 1980), another well-known French novelist is famous for his defense of atheistic existential philosophy which focused on the human experience of being. He believed in two kinds of being: being in itself, having no reason for its being, it just "is" and being for itself; both of which corresponds to human consciousness. He also characterized human existence by "nothingness" (Stanford Encyclopedia of Philosophy, 2004).

Phenomenology of Merleau-Ponty

The French philosopher Merleau-Ponty (1908-1961) was influenced by the works of Husserl, Sartre, and Heidegger (Thomas, 2005). His early life was touched by tragedy when he lost his father in a battle in World War I. He studied philosophy in Paris and later taught in various universities (Thomas, 2005). Merleau-Ponty further developed Husserl's and Heidegger's phenomenological thinking about 'being' and suggested that phenomenology is the rigorous science of the search for essences. He authored books on the structure of behavior and the phenomenology of behavior which focused on the lived experience of being in the world

which supersedes the notion of consciousness (Sadala & Adorno, 2003). I have chosen to use Merleau-Ponty's existential philosophy as my guiding philosophy because it is a holistic, positive, all-encompassing approach to the study of experience, incorporating both Husserl's focus on consciousness as well as Heidegger's emphasis on the state of being.

Merleau-Ponty describes a sense experience as vital communication with the world making it present as a familiar setting in a person's life (Merleau-Ponty, 1945/2005). From the existential phenomenology view, perceived things have figures or forms against background. Figures and ground co-create each other in human experience (Thomas, 2005). Rather than a literal approach to science and a view of the world, meaning is derived through perception of a persons' experiences, in relation to existential grounds. According to Merleau-Ponty (1945/2005) "we must therefore rediscover, after the natural world, the social world, not as an object or sum of objects, but as a permanent field or dimension of existence" (p. 1269). In this sense there is a more fluid illuminating interaction between a person, their world, time, their body, and others. The experience and response to others, body, time and the world is an individual and unique experience. These unique experiences however, can share common threads and themes. These themes and their structure can help increase understanding of a phenomenon and can be used to describe the meaning of it. Other tenets of the existential phenomenology method which relate to its applicability in nursing research are intentionality or relatedness to the world, embodiment wherein the body is a fundamental category of human existence, and connectedness with others, which is seen by Merleau-Ponty in a positive beneficial light (Thomas, 2005). These existential grounds of world, body, time and others, are avenues toward which perception of experience occurs and from which meaning is derived.

Nurses along with other disciplines have increasingly used existential phenomenology to conduct research. Early researchers in nursing used the phenomenological method in the 1970's and 1980's (Oiler, 1982; Parse, 1981; Paterson & Zderad, 1976). This approach allows an in-depth examination of human experiences which provides a greater opportunity to gain new perspectives and knowledge insights. When researchers investigate a phenomenon from the perspective of the experience of the participant, the essence of that experience can be realized (Sadala & Adorno, 2002). This view differs from traditional research methods which predominate in the medical as well as other health professional fields where subjects under study are viewed scientifically as malfunctioning or with complaints or problems that need treatment. Phenomenological research is useful for my study because I want to listen to the participants and understand their experience in regard to their perception. Commonalities in their individual experiences will provide insight and understanding of the meaning of the phenomenon of doctor shopping.

Ethical Considerations

Institutional Review Board (IRB) approval was obtained from the University of Tennessee (UT). Participants were informed of the study, both in writing, in the consent form, and verbally, by the researcher (Appendix A). Participation was voluntary, with no consequences to subjects who declined to participate or withdrew from the study. A digital recorder was used to record the interviews which were then sent electronically as a file through an encrypted password protected program to the transcriptionist who then returned the typed transcription of the interview through the same program to the researcher. The digital recordings were destroyed at the completion of the study. The transcriptionist and members of the interdisciplinary interpretive group signed a confidentiality agreement (Appendix B). Following

the interview participants were asked to complete demographic questions about age, race, marital status, education level and occupation (Appendix C). Consideration was taken that describing events surrounding the experience of doctor shopping could be distressing to participants, therefore a referral for counseling, or other treatment was offered as stated in the consent form. However no follow up needs were identified or requested. To protect the rights and minimize risks to the participants of the study, confidentiality of all interviews and transcripts was maintained. Pseudonyms were used for any identifying information in the transcripts and no identifying information was kept with the interviews, recordings or transcripts. All transcripts, and informed consent forms were kept in a locked file at the office of the researcher during the study and the consents were then placed in the office of the dissertation chair for a period of three years.

Bracketing Interview

Initially a bracketing interview was conducted with the researcher using the same interview questions asked of the participants to highlight the researcher's pre-understanding. This was done to increase the researcher's awareness of prejudgments and biases to facilitate an open nonjudgmental attitude. The bracketing interview was recorded and transcribed and a portion of the results were read by the interpretive interdisciplinary phenomenology group at the University of Tennessee. This facilitated bracketing because the bracketing interview results were available for reference by the group throughout the data analysis process, as needed, in the event that issues arose related to interpreting the participants' transcripts. Insights gleaned from the bracketing interview included that the researcher would be a need to refrain from taking a therapeutic approach with the participants during the interviews and that she should avoid focusing on whether information the participants provided would be factual or not.

Participant Recruitment

Participants were recruited through a flyer placed in the foyer of a location where substance abuse support groups are held as well as on a Narcotics Anonymous (NA) bulletin board in one of the rooms where that group met in the building. A snowballing approach was used where people who saw or heard of the study were encouraged to refer women who met study criteria to participate. Flyers included a phone number to schedule an appointment. Additionally, I attended approximately 15 NA meetings, each time introducing the study, staying for the meetings and then staying after to talk. This was the method through which most of the participants were recruited. The study was explained to participants in person or during a telephone call initiated by the potential participant. An explanation of the inclusion criteria was provided. Inclusion criteria included age 21 or older, English speaking and self-identifying as having engaged in doctor shopping. A definition was provided to them based on the concept analysis previously discussed. Exclusion criteria included being a current or former patient of the researcher and no current or former patients of the researcher volunteered for the study. Additionally it was decided that participants who presented for their interview appearing to be acutely intoxicated would be excluded from the study, but this did not occur. Participants were invited to set up an appointment for an interview at their convenience. Participants were permitted to reschedule their appointments if necessary. Participants were given a \$25 gift card following their interview.

Participant Interviews

Informed consent was obtained from each participant prior to the interview. The questions that were asked were, “Tell me what your experience has been doctor shopping” and “Is there anything that stands out for you about your experience doctor shopping?” These

questions were followed by further open-ended questions with an aim to facilitate the participant's elaboration of their experience. An effort was maintained to avoid any leading questions or statements. There was no set time frame for the interviews. The average length of the interviews was 45 minutes. Field notes were recorded following each interview to provide impressions of the interviews which were transcribed and referred to as needed during the data analysis process. Field notes included information on the setting of the interviews, as well as any observations and insights about the participants.

Participant Characteristics

The study sample consisted of 14 women who were English speaking ranging in age from 27 to 51, who identified themselves as having engaged in doctor shopping. All names used in this report are pseudonyms chosen by the participants. Twelve of the women were Caucasian and two were African-American which is representative of the geographic area in which the study was conducted in the Southeast United States. The majority of participants were not currently employed: four were disabled, three unemployed and one described her occupation as a homemaker. Six participants listed their occupations which included working as a hairdresser, cosmetologist, construction worker, medical assistant, nursing assistant, and factory worker. Eleven of the participants listed some college as their level of education, two graduated high school and one listed having obtained a GED. An equal number of participants were married, single or divorced (4) and two participants listed their marital status as single. The sample size $n = 14$ was determined by saturation of the data through ongoing analysis of the transcripts, including input from the multidisciplinary interpretive phenomenology group at the University of Tennessee Knoxville (UTK). The sample size was congruent with the estimated sample size to

reach saturation in qualitative research as approximately six to twelve participants (Guest, Bunce, & Johnson, 2006).

Table 1: Participant Demographic Characteristics

Name	Age	Marital Status	Education Level	Occupation
Sue	29	Separated	Some College	Disabled
Summer	30	Single	Some College	Nursing Assistant
Tammi	27	Divorced	Some College	Cosmetologist
Jane	33	Divorced	Some College	Hair Dresser
Melissa	29	Divorced	Some College	Unemployed
Flo	28	Married	High School	Homemaker
Becky	29	Single	Some College	Construction
Victorious	31	Divorced	Some College	Disabled
Mya	34	Married	Some College	Medical Assistant
Londie	39	Single	Some College	Disabled
Desiree	51	Married	Some College	Unemployed
Rebecca	48	Separated	GED	Disabled
Susan	36	Married	High School	Unemployed
Samantha	30	Single	Some College	Factory

Six interviews took place at a private office, two took place at a secluded location outside at a picnic table near the building where the substance abuse support groups met, and six took place at the participant's place of residence, which included the participant's apartment and a half-way house for women.

Data Analysis

Following the interviews, the transcripts were professionally transcribed. The transcripts were read at least twice. Meaning units were identified as short phrases, ideas, or key concepts

that emerged. Code labels were assigned to identify categories which were then analyzed for the presence of themes and interrelationships. Initially themes were identified as patterns of descriptions and then as experiential patterns in diverse situations. Global themes were then developed across interviews followed by the development of a thematic structure which included the themes and their relationships. The Thomas & Pollio (2002) rule for determining a global theme was used which specifies that a global theme is present in every interview or at least not contradicted in any interview. Portions of the transcripts were taken to the interdisciplinary group and read and analyzed. The group offered thoughtful comments, challenges, and alternative interpretation of the data. Themes were named with terms closely aligned to participants' own words and identified themes were supported with verbatim quotes from participants (Thomas & Pollio, 2002). Finally, textural and structural descriptions were incorporated into a composite description in order to summarize the essence of the women who engage in doctor shopping.

Study Rigor

The bracketing interview as previously described, was used in this study to add rigor of the findings by clarifying and reducing researcher bias (Brink & Wood, 1998). According to Lincoln and Guba (as cited by Polit and Beck, 2009, p. 492) trustworthiness of qualitative studies can be developed using four criteria: credibility, dependability, confirmability and transferability. The findings of the study were validated as the results contain convincing evidence and plausible, illuminating findings (Thomas & Pollio, 2002). Confirmability is achieved when there is agreement from more than one person about the meaning of the data which is free of researcher bias. In order to provide a realistic assessment of the phenomenon of interest, peer review and debriefing was conducted among the researchers (Creswell, 2012). In this study,

members of the interdisciplinary phenomenology group were consulted during data analysis and provided valuable input regarding data interpretation including determination of meaning units, themes, the final thematic structure and data saturation. Dependability of the data is achieved as the themes are replicated across the interviews despite variability in each participant's experience. Transferability or generalization of the findings to other groups is considered plausible since the themes were overwhelmingly present in the participant's experience. The results from this study are generalizable as evidenced by repeated variation in the findings which adequately describe the structure of the experience, and additionally by readers of the findings (Thomas & Pollio, 2002). Therefore, credibility was established in this study as it was carried out in a way that meets the highest standards for qualitative research through the aforementioned methods.

Threats to Study Rigor

When beginning this research, I had no personal knowledge of the experience of doctor shopping. I do, however, have extensive experience dealing with patients engaging in doctor shopping. Any threat this posed to the study rigor was reduced through bracketing, peer review, and the interpretive group.

Summary

This phenomenology study based on the existential philosophy of Merleau-Ponty was an appropriate method to study the experience of doctor shopping in women. An exhaustive literature review revealed that there is a paucity of research on the phenomenon of doctor shopping. In addition previous research showed that women have unique characteristics related to prescription drug abuse. Therefore, findings of the present study contribute new knowledge about the phenomenon of doctor shopping. These findings are presented in the next chapter.

Chapter 4

Findings

It's dark out as I drive up to the building and park in the back parking lot. Several older cars are already parked there and a few people stand outside smoking near the heavy metal door that leads to the basement room I am about to enter. I walk into the basement room which has no windows and is lit by fluorescent lighting. The room is stark. There is a long rectangular table in the center of the cramped room surrounded by chairs. Against the walls around the table are chairs, an old couch and a few ratty loveseats. Several people of all ages, mostly men, are seated around the room, mostly alone but some are conversing quietly. There is an old coffee maker on a metal stand against the wall in the center of the room and several people get cups of coffee to drink. Several plastic coated sheets of paper lay in the middle of the table which are either passed out by the leader or different people take one to read. At precisely 7 pm the leader, the man who sits at the head of the table, starts the meeting announcing that for all the addicts out there who are still suffering there will be a few minutes of silence. Then the Serenity Prayer is said out loud in unison. The leader then reads a list of rules, including that people talk for no more than five minutes and that cross talk or talking between attendees is not allowed. He asks if there are any announcements. A basket is passed around for donations to help pay for the use of the space and coffee. Visitors are asked not to donate. He looks at me and asks me to introduce myself and tell why I am there. I explain my research study and say I will be around after the meeting if anyone wants to talk about it.

Then the people with the papers read them one by one. The first is "who is an addict" which is written in first tense using the words "we are addicts." The next reading is "why are we here" followed by "how it works." Next the 12 traditions of NA are read followed by the daily

reading from the NA daily meditation book. This takes 15 minutes. After attending several meetings I already know them by heart. It seems they are read out loud each time to drill it into the minds of the reader and those listening. Spoken words have power. During the reading, the listeners seem uninterested and look either away or down. Some people talk softly to each other during the reading and a few stragglers enter the room. After all the sheets and the daily meditation are read the leader says the meeting is open for anyone to talk. Silence sets in. I glance around and see that as usual no one is looking up or at each other. Finally someone starts to talk.

When someone talks, a variety of things are said, such as trouble they are going through, how they are able to stay clean, conflicts with family, loved ones who don't understand, legal problems, and relapsing. More than once someone cries when they talk. All the while no one responds or looks up. Eye contact is rare. When someone finishes talking they say, "that's all I got." After the monologue several in the room respond by saying "glad you're here" or "keep coming back." Silence again. Sometimes the silence lasts several minutes and seems to lurk on awkwardly forever. No one looks up, everyone's expression is blank. Then someone else will talk, again in monologue fashion, sometimes dramatically pontificating, sometimes bragging, sometimes broken and distraught, followed by saying "that's' all I got." Afterwards the response again is "glad you're here" and "keep coming back."

Close to ten minutes before the hour the leader asks for the final reading which is "just for today." At that time someone takes charge of a bunch of different colored key tags and reads off what length of sobriety each color represents starting with two years and working down to 30 days. After each color and length of time sober is stated, attendees are asked to come forward and claim a tag if they have achieved that length of sobriety. After each one is read the attendees

say in unison “keep coming back.” The last key tag is for someone rededicating their life or starting at day one. Afterwards the entire group stands and forms a large circle and puts their arms on each other’s shoulders. Looking down, everyone says “God, take my will and my life, guide me in my recovery and show me how to live clean. Keep coming back, it works if you work it!”

Immediately following the meeting I sit back down in a chair and wait to see if anyone will approach me about the study. Usually there are only a few women present at the meetings. If no one approaches me I go outside and stand around and mingle with the attendees while they smoke. Often people want to know more about me and why I am doing the study and express concerns about confidentiality because they don’t want to get in trouble. Sometimes if someone is interested I schedule the interview then; this way, they don’t have to call since they are reluctant for me to know their phone number.

This experience of attending the meetings in order to recruit participants led to a greater understanding of the lives of people suffering from substance abuse. Often they would talk in the meeting about “doctor day” and the temptation they felt when it was a day they would normally go to the doctor to get medication to abuse. Several times attendees talked about how they had been misdiagnosed and treated for a variety of mental health illnesses which were in reality all caused by their substance abuse. Several attendees talked of losing their children and being estranged from their families. Many times it was mentioned with a great amount of pain that loved ones had given up on them and written them off. A few times someone came to a meeting admitting to using drugs that day or recently prior to that day. Relapses were frequently discussed as well as the number of days of sobriety. I was struck by the lack of eye contact and verbal interchange amongst the people who attended the group. The lack of interaction felt

isolating, disconnecting and unsupportive. I wondered if this one reason why so few women attended.

Nonetheless a sense of community among the people who attended was noted before and after the meetings. They all seemed to know each other and stayed around afterwards to talk. Occasionally it was announced that the group would be holding a social gathering such as meeting for dinner at a restaurant. There were also “speaker nights” which were held to celebrate someone achieving a significant time frame for being sober which was referred to as their birthday, such as one year or five years. It was often standing room only for speaker nights. Frequently prior to the meetings starting attendees would talk about these birthdays and how they would be celebrated. Reports of frequent relapses in sobriety seemed common. I attended numerous meetings and only rarely did someone come forward for a sobriety tag but the few who did were only for the 30 day and one day tag. This corresponds to the evidence that relapse rates for drug addiction are estimated to be between 40 and 60% (National Institute on Drug Abuse, 2008). Periods of sobriety often related to inpatient detox programs or longer rehabilitation stays followed by relapses back into drug abuse reflects a common repetitive pattern or cycle in those who abuse drugs. Addiction was the focus of the meetings and a relationship with other addicts was noted, both of which emerged as being significant in the encompassing thematic structure of the meaning of doctor shopping in this study.

Existential Grounds

When analyzing the data, a particular emphasis was taken to consider the existential grounds of world, time, body and others of the participant’s experience of doctor shopping. According to Merleau-Ponty, meaning is understood through our experiences of these grounds (1945/2005), “But if we rediscover time beneath the subject, and if we relate to the paradox of

time those of the body, the world, the thing, and others, we shall understand that beyond these there is nothing to understand” (p. 1280). Thomas and Pollio (2002) also described existential grounds as playing a vital role in experience. For the participants, the world is the setting in which the experience of doctor shopping takes place in regards to a physical location or environment. The existential ground of time encompasses themes of change and continuity, limits and choices, capturing time, and tempo (Thomas & Pollio, 2002). The existential ground of body human involves the human experience of body including a physical and interpersonal meaning. The existential ground of others includes those who are present or notably missing in the experience. The experience of others involves relationship, comparison, and benefit.

The world of visiting prescribers and pharmacies is the contextual ground within the experience of doctor shopping takes place. This often involves traveling to distant locations and requires careful planning to elude detection. The participants’ world consists of going to new places when constantly seeking new sources for prescription drugs. This is a complicated process, often involving a calendar to keep track of their appointments and is perceived as stressful and hard work. Because the entire focus of the participants is visiting prescribers and pharmacies, the participants’ world in the experience of doctor shopping is a limited and restricted one. No mention is made of interaction with nature or recreational settings or other locations as would be found in most people’s descriptions of their world. Additionally the entire focus described by the participants involved the acquisition of drugs with little mention of the use of the drugs. This could be explained by Solomon’s opponent process theory of motivation. The withdrawal symptoms seemed to outweigh the pleasurable effects of the drugs and therefore served as the primary motivation to use.

The existential ground of time for the participants is driven by their need for drugs, which prompts them to use most of their waking hours to engage in doctor shopping. This engulfment leaves little extra time for other activities in life. The participant's energy and time are entirely focused around fulfilling their addiction which limits time to expend in other areas of their life. The participants choose to focus their time on doctor shopping as a result of their addiction which is overpowering them. If they choose not to seek and use drugs they will become physically ill. This causes an urgency to doctor shop in a short time period, to prevent drug withdrawals. The time devoted to doctor shopping is often great, involving traveling far distances to different locations. Additionally the participants described tediously long periods spent sitting in waiting rooms waiting see prescribers or waiting to have prescriptions filled. Time spent in addiction seems to pass at a rapid pace and for prolonged periods for the participants. The participants described many years living in addiction involving time spent in jail or hospitals or rehab.

The participants engage in this world of doctor shopping in the healthcare arena which is very time consuming because of their experience of their body as being associated with addiction. They experience cravings for the substances they abuse as well as severe withdrawal symptoms when they do not have them. This abuse results in the experience of the need for feeding the addiction. The participants' experience of engaging in doctor shopping when traveling to numerous prescribers and pharmacies was described as stressful and hard work. Additionally they report physical symptoms of boredom when sitting in waiting room and fear of being detected. Other adverse effects of addiction on their body include seizures and overdoses. Some participants stated they had almost died due to their drug use, yet they continued in their addiction. They ignored their bodily risk signifying that the risk was not significant to them.

Conversely, when the participants successfully manipulated prescribers they experienced joy. The discussion of the adverse effect on their body was mentioned in a detached manner. The participants describe their body as a tool, or mechanism by which to feed their addiction, with little regard to the damage being done to it. The interpersonal meaning of the body in the participants' experience of doctor shopping centered on its existence as a vessel to doctor shop and an empty vessel that needs to be filled with drugs.

Interaction with fellow addicts and with prescribers is grounded in the experience of others. The participants report a tightly knit 'network' or 'circle' of addicts who work together to share information which enables them to doctor shop. Additionally the participants report networking with addicts by helping each other in the actual act of doctor shopping including sharing transportation and paying for visits and medication for others in exchange for pills. A central component to the relationship between the addicts is that it involves benefit to the participants. Other addicts are merely seen as a mechanism to obtain drugs with little regard to their well-being or value as human beings. Comments about other addicts getting caught or dying from overdoses are referred to in a matter of fact manner, without emotion or regard.

Prescribers are viewed as easy targets by participants. Interaction with prescribers involves conning and manipulating them for prescriptions which involves complacency and collaboration of prescribers in the act of doctor shopping. The relationship participants had with prescribers was based on falsehoods and deception. Success at manipulating prescribers is perceived as being easy, thrilling, and satisfying. The prescribers were viewed as a means to obtaining drugs. When relationships with prescribers were terminated when doctor shopping was suspected or detected, the participants seemed unaffected and merely moved on to another target. When the relationship between the participant and prescriber involved collaboration, this

entailed mutual benefit. Prescribers were compared and categorized as being either ‘writers’ who were sometimes referred to as ‘pill doctors’ or those who were ‘not writers.’ The sole value of the prescriber as a person was centered on whether or not they would write prescriptions for controlled drugs. Expressions of caring and concern are not a part of the participants’ experience of others in regards to other addicts or prescribers.

Notably missing from the experience of the participants related to the existential ground of others in this study were significant others who would normally be a part of a person’s world. Relationships in the experience of doctor shopping primarily focused on other addicts and prescribers. The relationships that took place between addicts were tenuous and dependent on the pursuit and use of drugs. The participants stated that relationships ended when they were no longer using or in possession of drugs. Very little mention was made about significant others who would normally be part of the world of others such as spouses, partners, children, or friends. On the rare occasions when participants mentioned their children, it was to state that they had been removed from their custody due to drugs and this was spoken about in a way that reflected little emotion.

Figural Themes

The meaning of doctor shopping was comprised of four themes for the participants in this study: (1) “feeding the addiction”; (2) “networking with addicts”; (3) “playing the system” and (4) “baiting the doctors.” The participants were driven to engage in doctor shopping because of their ongoing need for feeding their addiction. They networked with addicts to obtain information and in the act of doctor shopping, which involved work and was at times scary. Playing the system enabled them to be successful in obtaining prescription drugs which they accomplished through baiting the doctors. Conning and manipulating prescribers was easy and

sometimes thrilling and often involved complacency or collaboration on the part of the prescriber.

Theme One: “Feeding the addiction”

A central theme of this study arising from the existential ground of the body is feeding the addiction. The participants perceive their addiction as the driving force to engage in doctor shopping. They experienced physical cravings for drugs as well as painful physical withdrawal symptoms when they did not have drugs. Addiction is sometimes reported almost as if it were an external being which directs the participants’ actions. This addiction is a controlling force which they perceived as though they were powerless to go against. Addiction was all encompassing for the participants leaving the rest of their world empty and vacant. Their experience is that their bodies are hollow empty shells or vessels which need constant feeding with drugs.

The driver of the behavior of engaging in doctor shopping for all the participants is addiction. The participants were either addicted to the medications they got prescriptions for through doctor shopping, or they sold the controlled drugs they obtained from doctor shopping to buy other drugs to abuse. The severity of the addiction was noted in that all but two of the participants reported using drugs intravenously. The process of addiction led to doctor shopping, which fueled the addiction, which in turn led to more doctor shopping. This process is described as a cycle. The cycle of doctor shopping in the participants’ lives is perceived as all encompassing, leaving little time or energy for any other normal activity or relationships in life. Little emotion was expressed concerning the ravaging effects of addiction in the participants’ lives or on others in their lives. The participants expressed being overcome or controlled by the force and control of their addiction which they were powerless to stop.

Tammi, who was the youngest participant at age 27, is divorced, with some college education, and employed as a cosmetologist. She stated the first time she used IV drugs was when she was age 14. She ran a sophisticated sponsoring operation while doctor shopping. She reported her addiction to prescription drugs had resulted in many losses and problems in her life. Her IV drug use affected her health adversely in the past resulting in a hospitalization for a life threatening blood infection. At the time of the interview she was trying to detox herself from IV opiates. She was trying to get off drugs because she regretted at times taken her children with her to doctor shop. She stated that recently she had become destitute and after having sold all her furniture, she found herself alone in her apartment in the dark because her utilities had been shut off for nonpayment, sitting on the floor shooting up morphine.

My whole life with everything that was going on I was powerless. I felt like I couldn't do anything to stop. I was in a cycle. (Tammi).

Even when participants suffered great significant consequences due to their addiction to drugs, they continued on that path. When describing the effects of addiction as miserable or bad, they showed little emotion. Consequences such as health problems, legal problems or losing custody of their children were perceived by the participants in a matter of fact way as if they were just a normal aspect of life they had to go through. They experienced themselves as being powerless to break the magnetic pull of their addiction and rather than fight it or take steps to stop it, they willingly gave in to it. Even when they recognized retrospectively the adverse effects of their addiction on their lives, this was expressed in a nonchalant detached manner.

Londie, age 39, is single, listed some college education, and is on disability for physical problems. She had legitimate health problems but falsified her pain in order to obtain prescriptions for pain medications which she snorted. She stated she had a history of IV heroin abuse and although she abused pain pills, she described her drugs of choice as alcohol and crack, which she smoked. She also sold her prescription pain pills in order to get money to buy crack. She had been in rehab more than once, had legal problems and had lost custody of her children more than once due to her drug use. She also described her experience of doctor shopping as a cycle.

Yeah, I would have to go buy some from this dealer I knew and he would supply to me. He'll give me a discount because I normally sold to him. Yep, it's a vicious cycle. You know, it was bad and my family was pleading with me to get help and I knew I needed help but I just couldn't bring myself to get that help. Know it was hard on them. It was hard on me because I was miserable. I couldn't think clear. Just couldn't think straight at all. It was a nightmare I couldn't wake up from. (Londie).

Participants referred to themselves as 'full blown addicts' with a need to feed their addiction. The addiction dictated the behavior of doctor shopping wherein the participants were pulled to feed their addiction, despite fear and dire consequences. This need for drugs was described as the driving force behind doctor shopping. In a detached manner they described what they went through including lying to and manipulating prescribers which was acknowledged as being illegal, and involving risk. Going from one prescriber to another to

obtain prescriptions was part of their normal every day experience because of their continued need to feed their addiction.

Melissa, age 29, is divorced with two years of college education, and was unemployed at the time of the interview. She was in a court ordered outpatient substance abuse treatment program and was a user of IV opiates. She had a legitimate health problem but falsified symptoms related to that condition to obtain prescription pain medications from more than one prescriber, including a relative. Often she was not able to obtain prescriptions for morphine, which was her drug of choice, so she would trade the hydrocodone pills she got for morphine with other addicts. She also described her addiction as something that needed to be fed.

I would have a prescription and go to another one, another doctor, knowing I already had it, wanting to get more, just to feed my addiction (Melissa)

The participants perceived their experience of having to feed their addiction in a detached manner and without normal emotions that one would expect when discussing a force in one's life that is all consuming and that involved such great risk. Rather than experiencing distress, guilt, sorrow, anger or fear about the hold the addiction had on them, the participants perceived feeding the addiction as merely something they did as part of their everyday life with seemingly little thought or emotion connected to it.

Mya, age 34, is married with some college and employed as a medical assistant. She had a sophisticated understanding of ways to obtain medications from prescribers, including using different names and filling the prescriptions in rapid succession of one another so that there would not be enough time for them to show on the PDMP. She also forged urine drug tests for

other addicts while she was employed at a physician's office. She described several overdoses. She smoked methamphetamine in addition to taking several prescription pain pills, alprazolam, and the muscle relaxer carisoprodol, which is a controlled drug, throughout the day. She stated she had used IV drugs in the past but this was not her primary method of administration. Her addiction had resulted in legal problems as well as losing custody of her children. She went to great lengths to obtain prescription drugs to abuse.

I don't know, it's not fun, it's not enjoyable, but you do what you do to feed that addiction (Mya).

At times addiction was referenced as if it was an entity outside of or separate from the participant themselves. The addiction held a level of control over them and influenced their actions. The participants were driven to satisfy the addiction despite their stated desire not to do so.

Samantha age 30, is single, had two years of college, and was employed in a factory. After obtaining prescriptions from doctor shopping she used opioid pain meds intravenously and snorted or took alprazolam orally. Her drug use resulted in going to jail which caused her to lose her apartment and her belongings. Additionally she described several episodes of becoming physically sick when she did not have drugs. She often drove for more than an hour out of town to visit prescribers in numerous locations and described her experience as 'the insanity of addiction.' Her addiction was also described as a separate entity that spoke to her.

That's what my addiction was telling me, that I had to have them. I wasn't

thinking about anything besides getting more. (Samantha).

Reports of painful withdrawal symptoms which are described as being experienced when drugs could not be obtained were also reported. These withdrawal symptoms caused severe body aches, nausea, vomiting and diarrhea and resulted in an urgency to obtain more drugs to stop the sickness. The physical pain of drug withdrawals also reinforced their need for pain medication wherein the pain was not organic in nature but due to withdrawing from the substance. The withdrawal symptoms are described by participants as being ‘pill sick,’ meaning that they were sick from not taking pills. Again, the response to the physical bodily consequences is met without resistance. Rather, it was met with the participants further succumbing to the addiction by continuing to pursue and use drugs.

Becky, age 29, is single with some college and listed her occupation as working in construction. She, along with other participants, described herself as a “pill head” who used IV opiates and sponsored others to doctor shop. She stated she had been using drugs since age 17 and described several methods to get around pill counts and urine drug tests. She described how painful her withdrawal symptoms were when she was unable to get drugs. Becky described being so desperate for drugs that she would crush and snort her Xanax at a red light after leaving a pharmacy or pull her car over on the side of the road after leaving a pharmacy to shoot up her opioids.

Cause you were like going to get sick or whatever if you didn’t. Being pill sick is not fun. It’s no fun at all. (Becky).

Becoming physically sick when the participants did not have drugs is perceived as a normal part of their everyday life and they accept it. They sought pain medications under false pretenses from prescribers to abuse, which then in turn ended up resulting in their experiencing severe pain when they went without it. This pain reinforced to them their need for pain medication, therefore they continued doctor shopping to avoid the pain of withdrawal.

Jane, age 33 is divorced, listed some college as her level of education and was currently employed as a hair dresser. She described a long history of IV drug use resulting in her children being removed from her custody. She reported overdosing several times and having had DUIs related to drug use. She had several unnecessary surgeries for the sole purpose of obtaining prescription pain medication and often visited emergency rooms to obtain opioids which she used intravenously. She described severe physical pain when she was not taking drugs during her addiction.

I was in pain from the pain medicine like when I wasn't taking it. I thought I was doomed for the rest of my life. I thought I had to take that stuff but it was really weird how the pain medicine caused pain you know. (Jane).

Despite the variety of methods of administration of the drugs obtained through doctor shopping, all the participants experienced adverse physical effects on their bodies. Some participants related blood infections stemming from intravenous drug use. Others who snorted pills did damage to their nasal passages resulting in congestion or bleeding. While only a few participants did not use drugs intravenously, their health consequences were equally as great, often involving overdoses. The physical effects of drug use on their bodies were perceived in a

detached manner and seemingly inconsequential. The addiction drove them despite disfiguration including needle track marks, skin lesions, or weight loss.

Susan, age 36, is married with a high school education and unemployed. She stated members of her family, including her adult children, also used drugs. She described going to numerous prescribers to obtain pain medication for pain she did not have as well as often working with others to obtain prescription drugs from prescribers. She described periods of lapses in her memory, self-induced comas, weight loss and almost dying due to her drug use. She denied intravenously drug use and stated she snorted her pills which also caused adverse physical symptoms.

My nose would start bleeding and you know stay stopped up or it would run. When I didn't have anything my nose would run. (Susan)

She described becoming comatose after abusing prescription drugs as well as having severe withdrawal symptoms.

Honey, you are deathly sick if you don't have 'em. Deathly sick. You will not get out of the bathroom for days, trust me. Yeah, it makes you very sick. (Susan).

Londie also described terrible physical symptoms she developed as a result of her drug abuse.

I started blacking out and, you know, my pill addiction became heavier. I was snorting

three and four pills at a time and just, you know, I had burnt off my fingertips. I still have scars on my fingertips now from a month now where I burnt off the tips of my fingers smoking crack just, you know, it was bad. I had blisters on my lips. My nose, uh, the inside of my nose has scabs from sniffing pills. (Londie)

Theme Two: “Networking with Addicts”

Throughout the interviews all the participants described ways in which they worked with other addicts when doctor shopping. The relationship between the addicts was referred to as a ‘network’ or ‘circle.’ The participants engaged in networking with addicts to secure drugs when doctor shopping. The extent to which the participants described relying on other addicts to obtain information about doctor shopping was significant. A sense of camaraderie with other addicts which served as a source of support was noted amongst the participants’ expression of their experience. The participants networked in two distinct ways which reflect two subthemes within this overall theme: (1) getting information and (2) acting together.

While the addicts worked closely to network, these relationships lacked the emotional connections that are commonly experienced with others. Other addicts were perceived by the participants as tools or instruments to meet their needs or for their benefit to secure drugs to abuse. When another addict was arrested and jailed or suffered a consequence of their addiction such as illness or death, the participants expressed little regard or concern. Rather this was mentioned in their characteristic unemotional, nonchalant manner. The relationships between addicts were transient and tenuous, existing for the sole purpose of networking and thereby feeding their addiction. When the need for information or drugs ended, so did the relationships, endings which did not seem to have an effect on the participants one way or another.

The participants did not perceive any culpability in networking with addicts to engage in activities that were both illegal and life threatening. When they helped one another to doctor shop, it did not matter if this resulted in someone going to jail, losing their children, or losing their life. The addiction seemed to override any emotional response such as empathy or guilt. The drive and focus on securing the drugs was foremost in their minds with little thought of anything else. The use of drugs seemed to dull their emotions and regard for their own well-being as well as the well-being of others. A detached approach was taken when sharing information or engaging in activities when doctor shopping, despite the risk of serious harm to themselves or others.

The relationship that formed between the participants and other addicts and prescribers was so all encompassing that it precluded the importance or existence of other relationships that would normally be important such as those between loved ones in a family. Significant relationships of value and importance to participants in their experience of doctor shopping were primarily those with other addicts and with prescribers. Only infrequently and often with a lack of emotion were others mentioned. People were compared and classified for the participants as being either ‘addicts’ or ‘pill heads’ or not. Prescribers were compared and classified as being either ‘writers’ or ‘pill doctors’ or not. This black and white categorization left no room for others to be part of the experience of others in the lives of the participants.

Getting information

Others were used to benefit the participants as part of their experience of doctor shopping. All the participants described how they listened to each other and found out information about where to go to doctor shop and how to do it. Information was also shared about which pharmacies were more likely to fill prescriptions they obtained through doctor

shopping. Information about prescribers who were apt to prescribe controlled drugs was shared along with prescribers who were not. Additionally information about what to say to prescribers, sometimes specifically to one prescriber or another was also shared.

Sue is a 29 year old separated female with some college who is on disability for a variety of physical illnesses including seizures she developed from drug withdrawals. She described conflicted relationships with her family, many of whom were addicts. She experienced numerous traumatic events in her life involving the loss of loved ones, and unlike the other participants she talked about her daughter, and stated she was her main reason for living. She stated she had abused prescription drugs intravenously for many years and at the time of her interview was being prescribed suboxone, an opiate prescribed as maintenance therapy for opioid addiction. Sue described sharing information with other addicts as part of her experience of doctor shopping.

They spread it around, you know, “hey I know you can go to this doctor and get this.”

You just talk to people and they’ll say, you know, “I went to this doctor and he wouldn’t give me nothing.” Addicts listen to each other, other addicts, that’s how they find out their information and then that’s how you find out where you can doctor shop. Addicts spread it around. (Sue).

Just as the participants used prescribers to manipulate to write them prescriptions for controlled drugs to abuse, the participants used other addicts to obtain information. The perception was that other addicts had something they needed and they took steps to get that information from them. The relationships between addicts arose not necessarily out of friendship

or companionship, but instead often for the sole purpose of obtaining information. The participants perceived a need to manipulate other addicts to divulge information which could then be used to secure drugs to abuse for themselves.

Summer is 30 years old and single. She reported some college education and her occupation as a nursing assistant. She stated she gained friends from doctor shopping and also dated a doctor who was prescribing her controlled drugs which she used intravenously. Additionally she said she had an addiction to doctor shopping and described it as her drug of choice. She related going to jail, going to rehab, having seizures, and overdosing several times due to prescription drug abuse. In addition to making friends through doctor shopping she described how other addicts helped her gain information.

I got some people talking about where they were going and I made appointments there.

I would get tips on what to say. I listened to people that were doctor shopping.

(Summer).

Sharing information between addicts was described as part of the norm in the ‘network’ or ‘circle.’ They counted on and depended on information from other addicts. This sharing of information was perceived by the participants as a camaraderie and necessity related to doctor shopping. For the participants, the social support they received from others was not focused on enjoying or having an affinity for another person or sharing in each other’s company, but rather for the sole purpose of furthering their addiction. Characteristics or qualities of people in the network seemed inconsequential; all that mattered was what benefits could be gained from them.

Rebecca, is age 48, separated, has a GED and is on disability. She primarily doctor shopped for benzodiazepines and the sleeping medication zolpidem (Ambien), which she took so

that she could sleep long periods, often days at a time in an attempt to deal with depression. In addition to taking more than the prescribed amount of benzodiazepines to cope with stress, she also hoarded prescription drugs to use in suicide attempts by overdose. She did not use IV drugs and stated her primary addiction was to alcohol. She often used information from other addicts when doctor shopping.

I knew somebody that was doing it and he was giving me the name of another doctor in another town that I could go to and they would give drugs out freely. I mean, because this is passed around to all of us. We pass it around who gives drugs out, you know, and who doesn't. (Rebecca).

Susan also used information she got from other addicts to determine where to doctor shop and what to say when she did it.

I mean, people told me how to do it to get them. I told the doctor which pain clinic I wanted him to refer me to because I knew people who went there. You know somebody and they're going to know somebody else. (Susan).

Samantha, as well, talked about part of her experience doctor shopping including networking with other addicts to obtain information.

People would be like "oh, uh, this is a good doctor. He'll write" or "she'll write" you know. I went to a doctor's office because I had heard he'd write and he did. Yeah,

that's always a common thing you know, when anybody is just trying to go get whatever they can, whether to do or sell, whatever. They'd be like "hey man, where's a good doctor?" Everybody asks for what you know and they say, "hey I heard," you know, or something. (Samantha).

Acting together

Not only did the participants in the study discuss networking with other addicts to obtain information, acting together was also integral to the participants' perception of doctor shopping. Relationships with other addicts were used to benefit the participants in their efforts to secure drugs. This was done in a variety of ways such as sharing rides, paying for others' appointments, borrowing pills for pill counts, providing urine for urine drug screens, and borrowing MRIs.

Many of the participants sponsored others to doctor shop or were sponsored by others. Sponsoring involves one person paying for another person to doctor shop, including money for gas or providing transportation, paying for the visit, the MRI, and/or the medication, and then the medication is shared.. The participants who were sponsored by others did so when they lacked funds to obtain the medication. Some of the participants sponsored others to doctor shop, which proved to be quite lucrative when excess medication could be sold for a profit.

The participants did not perceive regard for the well-being of another person as part of their experience when acting together. When participants talked about recruiting others to sponsor to doctor shop there was never a mention of any adverse effects this might have on them such as getting arrested or furthering an addiction that could lead to death. The relationship formed to act together when networking with addicts was based solely on need. It did not seem to matter if that person shared any common characteristics or if they were congenial, all that

mattered was that they were addicts and they shared the need for drugs. Unlike most social relationships, the camaraderie when acting together was based solely on being together to doctor shop. If the person they acted with to doctor shop experienced harm such as being arrested or any form of suffering, this was not mentioned as being significant in the participant's perception of acting together.

Sue described a situation where someone else paid for her to have a tooth pulled and then they shared the pain medication that was prescribed.

We both needed something for pain. This person was like, "well if you go in and get it pulled, I'll pay for it and I'll pay for you to get 'em filled and you know, I was like 'we'll split 'em down the middle.'" (Sue).

Sometimes the problems of other addicts were perceived as an inconvenience for those who sponsored others to doctor shop. This was a complication which was not welcomed and rather than responding with empathy or concern, it was dealt with in a matter of fact fashion, as just another step that had to be taken in stride. Putting others at risk or danger to doctor shop through sponsorship was also financially beneficial and participants perceived other addicts as a means to make money. Tammi ran a sophisticated sponsoring operation. At times she described having to be the caretaker of her sponsors who would sometimes call her when they were sick from withdrawals when they ran out of their pills. She also had to make sure they had enough pills for pill counts if they were requested, as well as making sure they could pass their drug tests.

I sponsored people to go to the pain clinic. I paid for other people to go so I could get half their pain medicine. I was sponsoring people to go to the pain clinic and they were getting the same prescriptions I was so it's kind of like a package deal. You meet people who do 'em when you're buying 'em or selling 'em and offer to pay for them to go to the doctor. I would pay for their visit and then I would get half of their prescription. I would drive 'em and take 'em to the pharmacy. I had to make sure the people I sponsored had what they needed in their system for drug tests. I'd make quite a bit of money off 'em and that paid for my habit. If someone got called for a pill count I have to call somebody and try to borrow pills for a pill count. (Tammi).

Desiree, age 51, was the oldest participant in the study. She is married, has some college education, worked as a medical receptionist in the past, but was unemployed at the time of her interview. She described many years of doctor shopping which she described as being thrilling and glamorous often in exchange for sexual favors. She reported going to numerous prescribers in several states. She admitted to using drugs IV in the past but stated her primary method of administration was snorting pills and taking them orally. Her drug use had resulted in her going to jail and caused problems in her relationships with her family. Additionally she sponsored others to doctor shop which she described as being part of her experience of doctor shopping.

I would get other people doctor shopping and I recruited as well. 'You go see Dr. so and so and I'll pay for your visit, I'll pay for your prescription and I'll give you half and gas money.' It became a lucrative business after a while as well as me using, so the cycle just snowballed and became larger than I even imagined.

(Desiree).

The only relationships that the participants described as being part of their experience of doctor shopping were ones that involved getting information or acting together with other addicts. They went through whatever steps were necessary, often working in unison to secure the drugs to abuse. Often it did not matter what drugs they got or how they used them, the focus was on feeding the addiction, one way or another. This acting together often involved a significant amount of planning to outwit prescribers. Using drugs together with other addicts was also part of acting together. If the participants physically went together to secure drugs, they would often use the drugs together. The central focus of being in each other's presence was the need to abuse drugs due to addiction

Flo, age 28, is married with 12 years education and listed her occupation as a homemaker. She was enrolled in a court ordered outpatient substance abuse program at the time of her interview due to a drug related legal charge from which she had lost her vehicle. She doctor shopped from prescribers in primary care, dentists and emergency rooms. She would often sell the pills she got from doctor shopping in order to buy morphine which she used intravenously, although sometimes she snorted the pills she got. She stated her mother also had a substance abuse problem. She and her husband used drugs together as well as with other addicts. Flo and her husband and a group of friends would take turns going to emergency rooms to obtain drugs so that the emergency room staff would not become suspicious.

I used to go to the hospital, me and my friends would go and we would pick one of the friends to go there and then we would switch out so we could get more medicine. We'd

share the pills together. We would drive ‘em to the hospital you know, and they would give us so much pills to do and we would just do ‘em together you know, like snort ‘em or whatever. Whatever they did you know, if they snorted ‘em, we would snort ‘em, but if they IV’d then we IV’d. (Flo).

Victorious is age 31, divorced, with some college, who is on disability. She had several health problems for which she reported falsifying symptoms to obtain prescriptions for controlled drugs which she used by snorting them or taking them orally. Her drug use had resulted in several overdoses. She frequently went to emergency rooms in other towns and then was referred to other doctors for follow up, from whom she got prescriptions. She described trading things like milk or gas money for pills as well as going with other addicts to appointments to doctor shop.

After so long without insurance it became so expensive so I would use pills with the doctor shoppers. I can think of numerous people I have rode with to sit in the doctor’s office waiting for them. I would go with ‘em and wait till that got filled and then we’d get high. I would go with them every time and find them more doctors. (Victorious).

Theme Three: “Playing the System.”

The worldly setting which the participants interacted with to feed their addiction is the healthcare system, including doctors’ offices, pain clinics, hospitals, emergency rooms, and pharmacies. The participants became skilled at playing the system to secure prescription drugs

to abuse. The participants often used the term ‘doctor’ when describing prescribers; however, as previously discussed, these professionals represent a variety of prescribers including physicians, physician assistants, dentists, and nurse practitioners. Participants perceived healthcare professionals as merely being people they needed to manipulate, fool, or con so that they could secure drugs with little regard of their actual profession or credentials. The only regard voiced for others in the system was whether or not they could be played. Playing the system had to be done for the benefit of the participants despite any consequence to themselves or the people they interacted with in the process.

The healthcare system is set up to thwart abuse through measures such as checking patient’s identification and insurance companies not covering or pharmacies not filling duplicate prescriptions. However, the participants reported sophisticated means and measures they would take to play the system in order to elude detection. Safeguards employed by prescribers, such as having patients bring in their medication bottles for pill counts to be sure they were not overtaking them, as well as urine drug screens, were easily thwarted by participants. Other objective testing used to verify the need for pain medication such as MRIs were shared or borrowed, allowing the participants to deceive prescribers about the nature of their illness.

It really took me no time at all to figure out how to play the system. I really learned to play that system too, to get lots of things. (Mya).

Although the participants perceived playing the system as being fairly easy to figure out, the act of playing the system was at times described as being hard, exhausting, time consuming,

and stressful, like a 'full time job.' There were several steps in the process to secure prescriptions which involved planning and effort.

It's a lot of work, doctors in different cities and pharmacies in different cities and pretty consuming. It takes up a lot of time. You have to sell some just to pay for your other visits and to be able to afford to go back for the gas money and the places are far away. You don't go in the same town that you live in and then most of the time they drug test you so you've got to have the exact pain medicine in your system that you're supposed to have and that's exhausting because you usually don't, and trying to remember what you get at where and it's pretty ridiculous. That was all I did. That was my full time job. (Tammi).

It was my job almost. I would travel as far as I needed to go. I had an appointment book and I had the doctor's names, you know, like he'll be here this day and he'll be here that day. I was putting some thought into this. It was very stressful, hectic and expensive. (Jane).

It became like a job. Its insanity, total insanity. I had 20, 25 or more doctors in one specific area. (Desiree).

It's hard work. You have to keep up with which doctor you have that week. Sometimes I had two in one week, you know, so you had to keep a calendar. It's so much work to do all that. (Susan).

Networking with addicts was a common strategy employed to play the system. Some aspect of playing the system could not be done without the help of others. Becky described borrowing pills for pill counts, borrowing MRIs, and paying cash rather than using her insurance to play the system, or as she put it ‘fly under the radar.’

If they want a pill count, get on the phone with everybody you know to get the pills and try to come up with them. You call everybody you know (laughs) and try to get some together. You use other people’s MRI’s, “you let me use your MRI, I’ll give you 10 of ‘em.” If you’re doctor shopping, you pay for the doctor and you let your insurance fill your prescription or you can just pay for all of it and fly under the radar. (Becky).

Several participants, including Becky, talked about fooling urine drug screens requested by prescribers to either be sure the prescribed drugs were being taken or to be sure other controlled drugs were not being taken along with what was being prescribed. Some of the women would sneak other people’s urine in to use and others would put a small amount of the actual medication in the urine itself.

You can cheat to pass a drug test, you can also cheat to fail one. If you need to, you know, you can fix pee. I mean, I take somebody that doesn’t have anything in their system and you can pull it up like you’re going to pull up a shot of the Roxy and squirt it in the pee and it will show up perfect on a drug test, you just do like a half of one and like a half Xanax and put it in the pee and it shows up perfect.

You can take a pill bottle put clean pee in it and put aluminum foil over the top of it and wrap black electric tape around it and put it up in you (motioning to vaginal area). When you sit down to pee, you poke it open. The nurse has to officially be in the room but they're not watching you that close. (Becky).

Another way that several participants described playing the system was by monitoring which prescribers were on duty in offices or emergency rooms and purposely waiting for certain prescribers to visit who they felt were easier targets to prescribe them controlled drugs.

I can think of a couple times that I have went to a certain ER at a certain time, you know, because you knew that that doctor is there. (Victorious).

I traveled out of town an hour or two, four hours away from where I was living to go to an emergency room. I made sure I got to know what doctors were on call. It took work. It took ingenuity to do this. (Desiree).

The participants described other ways to prevent their doctor shopping from being detected including going to more than one pharmacy, not using their insurance, paying cash and using different names.

When I was going to both places to get the Xanax's I would go to different pharmacies. One was 45 minutes from the other one. I went there so I could pay for 'em. I told

‘em I didn’t have insurance. (Samantha),

I never went in my hometown and get ‘em filled because everybody knew me there. The high dosage ones I always got filled way, way, away from home and I used my insurance for them instead of cash. (Susan).

I had four pharmacies. You can get around the PDMP by using your maiden name. I would use another ID, it doesn’t matter which photo ID. Instead of my whole first name I would do a portion of my first name or I would use my middle name or a different address. There were just tricks like that, go to two doctors on the same day and the prescriptions don’t show up until I actually filled ‘em. (Mya).

Despite being successful at doctor shopping, many of the participants admitted experiencing fear when playing the system. Disproportionately, they identified getting caught as more of a cause for fear than other serious adverse consequences such as physical illness, death, or losing their children.

I was just scared of going to jail more than anything. I remember being scared. I was afraid, very afraid. (Sue)

I was really scared. It scared me. I was always afraid of being caught or being embarrassed or um, going to jail. I’m like terrified of all that. Yeah, it scared me. I was always afraid of getting caught. I didn’t want to go to jail. I have kids and

that was always a big fear, but the benefit outweighed the risk. It scared me but nothing ever stopped me from doing it though. I mean, I was never too stressed or scared or anything. I mean, there's a lot of crap that went along with it, but I really felt obligated, like I had to do this. (Tammi).

I would go to one doctor and pay cash because if you use cash it don't show up on your insurance and stuff and the next one that I went to, I'd use my insurance so I was getting 'em all the time. I went to, I don't know how many pharmacies I went to, because I was afraid they'd get to noticing. (Susan).

When talking about being afraid when doctor shopping during their interviews, they exhibited little emotion. Instead, they often laughed and seemed proud of themselves when talking about their success at playing the system. Even though many times they did talk about being afraid as part of their experience, this stated fear was never mentioned as a reason to dissuade them from doctor shopping.

Theme Four: "Baiting the Doctors."

Another central theme noted among the participant's experiences was the act of conning or manipulating prescribers to write prescriptions for controlled drugs which they abused or sold. Baiting the doctors was accomplished by falsifying symptoms and denying or hiding the fact that prescriptions had been obtained from previous prescribers. The focus of the participants is self-focused on meeting their needs through conning others. At times the participants played the role of an actress by dramatically feigning symptoms of pain or anxiety. Other times they simply

requested certain medications and the prescribers complied. Going through painful medical procedures was another strategy used to manipulate prescribers into writing them prescriptions for controlled drugs. Other times participants became loud and demanding. Overall the participants described baiting the doctors to be easy, fun, and thrilling.

The primary method the participants perceived themselves as being successful at conning prescribers was by eliciting sympathy through complaints of physical pain or distress. They became 'good actresses' to make these complaints believable. Often dramatic scenes were created full of moaning and groaning in pain and shedding real tears. The participants perceived the discomfort of the prescribers when they expressed extreme distress and used this to their advantage. They saw that the prescribers would rather write a prescription than listen to or witness their extreme displays of emotion, so this became a common method employed.

Just hearing my sob self-pity story, they just fell into that and gave me all kinds of narcotics due to that. They just fell into this sob story and I used that to bait them doctors. (Summer).

I learned all the tricks. All the hard luck stories. Everybody's got one, especially addicts, we've got the best ones because we're the best liars you know, that's just how it is. Once I was crying because I was hurting so bad from withdrawals but they don't know that. They just know that I'm in pain and this is what they gave me before and that's what got me to stop crying. They just want me to stop crying (laughing), 'just please stop crying in this office.' (Mya).

The manipulation is the key that anybody can turn (laughs). I was faking that you know, faking the tears and how on an instant you know, I could cry or yell out in pain and not really be hurting. I would milk it, milk it to the fullest extent. (Melissa).

Some participants even went through painful experiences such as having teeth pulled or surgeries in order get pain medication. Experiencing physical pain or disfigurement to their bodies was taken in stride as part of what they considered necessary to get prescription drugs to abuse.

I got so desperate I even would let them do surgery on me. I was so convincing that I would convince the doctors. I've had so many surgeries for that. I guess that's part of being a con artist, part of being a manipulator. I can't think of a time that I had surgery that I really needed it in my life. I invented every one that I've ever had. (Jane).

I would make up stuff. It didn't matter. I would make up whatever. I could, like, have a headache. I hurt my arm or my back, or whatever, and I called the dentist, some of the dentists, and see what they would give, you know, if they would give Percocet's, hydros and say, 'what do you give for pain?' (Flo).

A skill that the participants described as having, which enabled them to bait the doctors, was the ability to 'read the doctors' so that they would know what to say or do to get them to

write prescriptions. They were savvy at picking up on verbal and nonverbal cues that they used in their manipulation.

I'd go to a doctor and you know, complain about aches I didn't have. You got to be a good actress. You got to have a poker face. You got to know exactly what to say and how to say it. You've got to learn how to read that doctor and what you need to be for that doctor so the doctor will give you what you want. You got to fake it, you got to fake whatever that injury is or whatever that health problem is. Addicts go around and they test the doctor, they know the weak ones. (Sue).

You learn to lie, manipulate, connive and convince. You learn to read the doctors. I about pretty much found what worked. I'd be nervous if he's going to buy my story even though the last 15 doctors have. You can call before you go and say, "do they write narcotic pain meds?" They love to hand out drugs. (Mya).

Some participants were demanding to prescribers and launched false accusations if they were not prescribed pain medication. Just as prescribers were noted to become uncomfortable when participants cried or elaborated on their distress, the participants learned that prescribers could be berated into prescribing them medications. They learned that prescribers would often give in and prescribe them controlled drugs rather than deal with the participants' vocal demands or objections when prescribers attempted to refuse them.

All the manipulation and especially how bratty and ugly I would be. I would treat

the doctors and nurses like I was above them and I was going to tell them how they were going to do it. They were going to treat me. I treated the doctors and nurses absolutely horrible. I was going to get what I wanted and I would cause as much trouble as I could until it went my way and it always went my way. If not I'd file a grievance. I was going to get what I wanted and it was easier just to give it to me and get me out of there because I was going to throw a fit. They did it just to shut me up I think. It gave me a challenge. (Jane).

Often the participants expressed a sense of pride and accomplishment when they were able to secure prescriptions under false pretenses. In addition to feeling contentment about getting drugs to abuse, the participants perceived the success of manipulating prescribers as being particularly meaningful. Since many of them had not had many previous successes in their lives, this sense of pride they felt over being successful at doctor shopping was especially gratifying to them. The act of conning prescribers was seen as a challenge and was described as being thrilling and exciting. This fun and positive experience was the only one that the participants described. Using the drugs was something they had to do and was not described as particularly enjoyable, whereas manipulating the prescribers was described as pleasurable.

You feel great when you're doing it. You have all these pills and lots of money and there's a thrill in that. There's a big thrill in that. You feel good. Always look forward to doctor day. (Tammi).

Overwhelmingly the participants expressed that doctor shopping was ‘easy’ as part of their experience when it came to convincing prescribers to write them prescriptions for controlled drugs. They were very successful with the manipulation and falsification of symptoms. In comparison to playing the system, which involved a lot of work, baiting the doctors was easy to accomplish. This was the only time during the interviews when the participants expressed emotion. Their perception of baiting the doctors as being easy and fun was reflected in the way they smiled and laughed when describing it.

Yeah, it really is easy to just get what you want if you know what you’re doing.

It works that simple. It’s very easy. I could talk ‘em into it, it’s so easy. (Jane).

It’s easily faked. That’s pretty much it, you know, it’s really not hard. It was easy to get it. (Mya).

It wasn’t hard work. It was not a problem. I couldn’t believe how easy I thought it was. It was like slicing cake, a piece of cake handed on a platter. (Desiree).

It’s not hard to get ‘em. They just gave ‘em to me. (Susan).

It’s not hard to do. (Becky).

It was pretty easy and I felt like I had that, you know, and it was pretty easy to pull that off. (Tammi).

A few participants described doctor shopping as something they loved and thrived on even to the point of feeling addicted to it. The fear and danger were exhilarating. They seemed to experience a physical high from their ability to bait the doctors. They would go into the health care arena with fear and trepidation, but once they were successful at securing their prescriptions, they became elated. This is likely an arousal seeking behavior where dopamine levels are elevated causing a physically pleasing response.

It became like a big hobby for me to see who I could and couldn't manipulate. It just got really out of control and I would crave to doctor shop. Absolutely loved it. I thrived off that. I paid all my bills that way, bought all my nice things that way, kept myself high that way and had a lot of friends that way. It's exciting and it's kind of like a person that is in a high speed chase that gets off on that, being chased, 'I wonder if they're going to catch me.' It's just being on the edge. I thought at that point in time that doctor shopping was going to be there for me always and take care of me and I really depended on that and thought it was my friend. I miss the rush of doing it and the abusing part of it of course. My drug of choice was doctor shopping. (Summer).

You do it once or twice and that right there is an addiction alone. I got addicted to the excitement and danger of it. It was dangerous. It was on the edge and the closer to the edge I could get the more I did it. It was fun and exciting. The excitement was there but it was also a challenge. It was like, 'let me see if I can break this new doctor. Let me see if I could, how many times I can get this doctor to write.' (Desiree).

An aspect of the success the participants experienced when ‘baiting the doctors’ was that many of the prescribers were either complacent with the act of doctor shopping, or in some cases they were collaborative with the participants. Many times the participants described how they were not checked for the accuracy of the information they provided, pill counts were not done, nor were drug screens or examinations for needle marks. Even when needle marks were found, some prescribers continued to prescribe the medication that was being abused. Participants reported that seldom were PDMP reports checked. The participants perceived the complacency of prescribers as common and something they expected and took for granted. The prescribers were perceived as being uninterested, unconcerned, and as not being diligent in thwarting their efforts. The participants were unconcerned with the fact that this could indicate that the prescribers did not care, or were not considering the participants’ best interest. The fact that no one tried to question them, or stop them, or offer them help, was inconsequential and not perceived as significant by the participants.

I don’t know how I didn’t get caught. I think it’s because my doctor didn’t run that narcotic check where they see what you have gotten since the last time you were there. I think what it was is, I had a trust built with him that he felt maybe he didn’t need to do that and my other doctor never did either. (Jane),

When I was sponsoring people and you can make a lot of money that way. I bought a car (laughs). I sponsored people who were doctor shopping a lot. Whenever you sponsor people we don’t really get called in that often for pill

counts or nothing. They'll pretty much just send you out of there with whatever you want, a lot of 'em. (Becky).

The doctors would basically ask me, 'what do you need?' and I tell them. They kept me well supplied. It's like once you establish with them, you know, you get something from them. It was so easy because it seemed like once they know you they don't really check anything. If they drug tested me, I would carry other people's pee with me. (Londie).

You go in and they'll ask you what you want. Then they said, 'do you need any more?' They increased it and kept increasing it and increasing it. They'd say, 'OK what do you need?' 'What do you want?' 'How many do you need?' and you just tell 'em. You go in and tell 'em what's wrong and they'd write 'em that day without even going over your records or anything. I've sat there waiting four hours before even going back to see the doctor. Once you got back there, you wasn't in there two minutes, two or three minutes. You know, they just write out what you tell 'em. They're there to give you medicine whether you need it or not, you know, because they want their money, especially if you're paying cash. Some do pill counts and some don't. If they drug tested me I don't know how I passed. I think they just let me slide. (Susan).

In some cases participants developed relationships with prescribers, staff at prescribers' offices or pharmacists in order to secure special favors or to prevent detection. This relationship served to benefit both parties. In the case of sexual favors, the participants did not seem to

recognize that they were being used similar to prostitution in securing their prescriptions. The fact that the participants' bodies were being used and disrespected by prescribers, who were supposed to be protecting and helping them was not relevant to the participants' experience. Rather, the participants perceived the sexual favors as part of their manipulation of the prescriber, which gave them power. They portrayed the prescriber as the one who was being used.

I started doctor shopping for multiple reasons, to support a drug abuse habit, to get them to sell, and um, eventually it became um, an intimate thing with the doctors. I developed sexual relationships with them. If I flirted just right, I could get whatever I wanted. I would make promises to the doctors and always got anything I wanted. That doctor would introduce me to another shady doctor. I would befriend some of the pharmacists to get refills in advance. The doctor would tell me what pharmacists to go to fill them and I got a discount. (Desiree).

I dated a doctor and he would write anything I wanted. He would send me to one of his friends that also prescribed to me. I became friends with a few other doctors I could make house calls to. I got them right where I wanted them. (Summer).

In some cases the prescribers were described as also being addicts. The prescriber was then perceived by the participant as an equal with whom to exchange favors for their mutual benefit.

The doctor that was writing them was trying to cover his ass as much as I was trying to cover mine. He was using as well. He was trying to cover his tracks. He would write me a prescription but it was going to his wife. (Melissa).

Summary

Weaving together the four themes found in this study in the experience of doctor shopping as conceptualized by the existential grounds of world, time, body, and others, the findings of this study are summarized in the following paragraphs.

The world in which the participants in this study interacted was limited. The only locations they talked about frequenting were doctors' offices, hospitals and pharmacies. Some of the participants had jobs and they also attended NA meetings but the focus of their experience of doctor shopping took place in healthcare environments. Their addiction to drugs was an all-consuming force and priority. This created a perceived need for feeding their addiction as a result of cravings for the drugs as well as to prevent or treat severe withdrawal symptoms. When discussing their addiction in their interviews, it was described as an entity outside themselves which exerted dominance and control in their lives. In addition to the severe physical withdrawal symptoms they experienced, they also experienced serious physical effects from their drug use including infections, overdoses, seizures, and becoming comatose. The participants apparently did not perceive the risks of abusing drugs to be significant enough to stop them from doing it, although they had attended NA meetings either voluntarily or by court order.

The participants lived solo lives with a self-centered focus. Rarely were significant others mentioned, and when the participants mentioned disturbing facts like their children being removed from their custody, they did so with little emotion or expression of remorse which is

evidence of emotional numbing. The primary people the addicts talked about having relationships with were other addicts for the sole purpose of networking to obtain drugs. Networking with addicts was done to obtain information as well as collaboration in the actual act of doctor shopping. An addict 'network' or 'circle' was described as something the participants relied on. Many of the participants also sponsored others or were sponsored by others to obtain medications. This was often done when the participants either lacked money to doctor shop or sponsorship of others was done as a method to make money which was used to support a drug habit. Although the addicts networked with other addicts, this relationship appeared to lack the care and concern that would normally be involved in interpersonal relationships. The participants perceived the other addicts as a tool or instrument to be used to their benefit to secure drugs.

Playing the system was part of the experience for the participants as they interacted in the healthcare environment with prescribers, medical practices, hospitals and pharmacies. In some cases when safeguards were implemented by prescribers, such as pill counts or urine drug screens, the participants found ingenious ways to thwart these efforts. Using false names, fake IDs and paying cash rather than using insurance were other ways that the participants were able to play the system in order to remain undetected. The process of eluding detection involved a lot of effort and work by participants and provoked fear in some of the participants, but fear did not stop them from engaging in doctor shopping.

Baiting prescribers through conning and manipulating was essential to the act of obtaining prescriptions when doctor shopping. Most often this involved falsifying or exaggerating physical complaints such as pain or anxiety. The participants would read the prescribers and figure out what to say or do to get prescriptions. They learned that causing a

scene by crying or demanding medication made prescribers uncomfortable and more likely to write them prescriptions for controlled drugs. Prescribers were complacent when they did not check out patient's histories, past records, PDMP reports, or ask for pill counts or drug tests. Often participants waited long periods in waiting rooms to see prescribers but the amount of time prescribers spent with the participants was very short. Several participants expressed their belief that the prescribers did not care, looked the other way, and continued to prescribe them controlled drugs to make money. In a few instances prescribers collaborated with participants in doctor shopping in exchange for sex, profit, or to share the medication.

Conclusion

The thematic structure of the meaning of doctor shopping, which encompasses the four figural themes can be synthesized as if it were told by a hypothetical participant: I am an addict. I am a pill head and if I don't take drugs I will get pill sick. My addiction rules my life. My primary focus in life is feeding my addiction. I don't care if my addiction causes me to get sick, overdose, lose my kids, go to jail or die. One way I feed my addiction is through doctor shopping. The only places I go are to the doctor to get prescriptions and to the pharmacy to get them filled. The only people I have room for in my life are other addicts. Networking with addicts helps me get information about where to go to doctor shop and we also help each other to doctor shop and do it together. I play the system by going to numerous prescribers and pharmacies to avoid detection which takes a lot of work. Sometimes I pay cash and sometimes I use my insurance. I foil pill counts and drug screens. It's easy to bait the doctors into prescribing me drugs through conning and manipulating them. Most of the time they just go along with it, whether they know what I'm doing, or not.

Chapter 5

Discussion

The purpose of this study was to describe the meaning of the experience of doctor shopping. Guided by existential phenomenological philosophy based on the works of Merleau-Ponty, I conducted 14 interviews with women who self-identified as having doctor shopped. All the participants were asked to describe their experiences related to doctor shopping. The audio recordings of the interviews were transcribed verbatim and analyzed using the UTK method of phenomenology. Each interview was examined within the context of the entire set of interviews to identify both the preliminary themes within each individual interview and then global themes throughout the interviews. Finally a thematic structure was developed.

Thematic Structure

The themes of ‘feeding the addiction,’ ‘networking with addicts,’ ‘playing the system,’ and ‘baiting the doctors,’ form the thematic structure of the experience of doctor shopping. For each theme there is a multidirectional association with the other. ‘Feeding the addiction’ caused the participants to ‘network with other addicts’ to enable them to ‘play the system’ and ‘bait the doctors.’ This in turn, fueled their need to ‘feed their addiction.’ Success at ‘playing the system,’ despite it being hard and scary, enabled them to ‘bait the doctors,’ which was easy, and provided positive feedback. Success served as encouragement for them to continue doctor shopping, as well as the impetus for them to share their experience with others when ‘networking with other addicts.’ Success at doctor shopping also enabled them to secure more and more prescriptions which they used to abuse or to sell to obtain other drugs to ‘feed their addiction.’

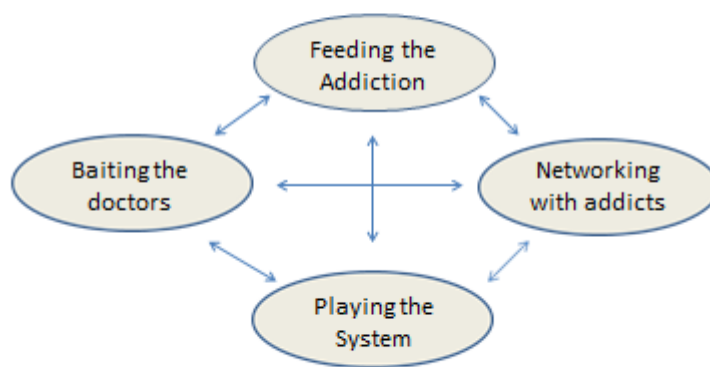


Figure 1: Thematic structure of the meaning of doctor shopping

For all the participants ‘feeding the addiction’ drove the phenomenon of doctor shopping. In many cases the medications were sold but this was done to support a drug habit. The second component in the experience of the meaning of doctor shopping is ‘networking with addicts.’ Just as in the meetings I attended where a sense of community was noted, the women heavily relied on other addicts for information about which prescribers to target for doctor shopping. Additionally, they networked together in the act of doctor shopping, by doing things such as providing transportation to medical appointments, paying for another addicts’ appointments and prescriptions in exchange for some of their medication as well as borrowing pills for pill counts or urine for drug tests. After obtaining information from other addicts about where to go to doctor shop, the participants ‘played the system’ of the health care arena, to foil detection. This involved strategic timing of visits to prescribers, alternating using insurance or paying cash, and traveling long distances to see prescribers or to have prescriptions filled.

Other ways they ‘played the system’ included carrying urine from other people or putting drugs into urine, using false MRI’s and borrowing pills for pill counts. ‘Playing the system’ involved much hard work and effort by participants and often involved fear of being detected. Finally, prescribers conned and manipulated prescribers by falsifying symptoms and acting like they were in severe pain or in need of other controlled drugs when they were not. Dramatic displays of distress were enacted as well as demands for prescriptions. This process of ‘baiting the doctors’ was described as being easy and a piece of cake. Obtaining prescriptions often involved prescriber complacency when prescribers either failed to take measures to decrease the incidence of doctor shopping or looked the other way even when doctor shopping or prescription drug abuse became evident. In some cases prescribers collaborated with the participants, such as through an exchange for sexual favors, or profited from the doctor shopping scheme when other

addicts were referred to them. To some extent pharmacies also played a role in complacency and collaboration.

The world of the participants in their experience of doctor shopping was limited, excluding other activities and people aside from those focused on doctor shopping. There was little time for the participants for anything but doctor shopping and using drugs. The way the participants described their bodies seemed as though they were empty vessels which needed filling with drugs. They experienced bodily cravings and withdrawal symptoms when they didn't have drugs. Other people in their world consisted of other addicts for whom they had little regard, and prescribers who they conned and manipulated to secure drugs.

Findings Related to Previous Literature

This phenomenological study has revealed many new findings about the meaning of the experience of doctor shopping for women. The phenomenon previously has not been studied. The phenomenon can now be better understood based on the findings from this study that the participants experienced their world, time, and others as being limited and restricted primarily to doctor shopping. Furthermore, the study adds to the literature an understanding that addiction and its bodily effects, such as drug cravings and withdrawal symptoms, plays an integral role in the engagement in doctor shopping. While networking with other addicts has been briefly noted in existing literature, the extent to which people who engage in doctor shopping rely on each other to obtain information and to work together while doctor shopping, along with the extent to which specific tactics are employed, has not been previously understood or described. The results of this study add to existing literature a further understanding of the act of conning and manipulating prescribers, including a sense of it being easy and involving excitement. The

extent to which prescribers are complacent or collaborative with the act of doctor shopping is also better understood based on the findings from this study.

All the participants described a pattern or cycle of doctor shopping which resulted from and perpetuated their addiction to drugs. They described the painful withdrawal symptoms they experienced when they did not have the drugs. All but two of the women were IV drug users. The drive to feed their addiction was overpowering despite great personal and financial costs. Some women had lost custody of their children and others were estranged from their children or other family members. Many had arrests related to substance abuse which resulted in time in jail. Some women were homeless and were living with friends or in a half-way house. Almost all the women reported serious physical consequences resulting from their addiction including numerous overdoses, seizures and other hospitalizations.

Findings about serious health-related effects resulting from prescription drug abuse in this study were consistent with previous literature, such as the study by Coben et al. (2010) which found that poisoning by opioids, sedatives, and tranquilizers has increased, often involving benzodiazepines. The majority of participants in this study mentioned abusing benzodiazepines, specifically alprazolam, which Shah et al. (2012) showed to contribute to the cause of overdose deaths. Coben et al. (2010) found that women over the age of 34 were more likely hospitalized for poisoning by opioids, sedative and tranquilizers which is consistent with this study, as the average age of participants was 34 years. However, since the majority of the participants in this study were under age 34, it appears overdosing from poisoning of drugs occurred at younger ages in this study. Doctor shopping clearly poses a serious health risk for women who engage in doctor shopping due to prescription drug addiction. This is tantamount to

a potentially deadly game being played by the women, as the study by Peirce et al. (2012) has found that doctor shoppers have twice the odds of drug-related death.

While specific questions were not asked during the interviews, some information about the participants was revealed about their characteristics, which can be used to compare to findings from previous studies. Consistent with the findings of Hutchinson (1986), Grella and Lovinger (2012) and Furrer (1991), co-morbidity of physical illness was noted in this study. Nine of the fourteen women in the study reported having a physical health problem that at times was the reason that prescription pain medication was initially prescribed, which they later began abusing. Three participants had been declared disabled due to a physical illness.

Consistent with previous studies (Aston, 2009; Back et al., 2010; Bardhi et al., 2007; Godlaski et al., 2009; Golder & Logan, 2011; Grella and Lovinger, 2012; Jamison et al., 2010; McLarnon et al., 2011; Pant & Bagrodia, 2012; Passik et al., 2006; Shinebourne & Smith, 2011; Tracy et al., 2012; Watson & Parke, 2011; Woodhouse, 1992), five of the women in this study described mental illnesses, which was referred to as the reason for prescriptions for benzodiazepines, which were then abused. One participant specifically stated the reason for her disability was due to mental illness.

Contrary to previous studies, (Etherton, 2006; Furrer, 1991; Godlaski et al., 2009; Golder & Logan, 2011; Jamison et al., 2010; McCauley, 2009; Pant & Bagrodia, 2003; Tracy et al., 2012; Watson & Parke, 2001) history of abuse was not mentioned by the participants in this study as being part of their experience of substance abuse. Similar to previous literature (Back et al., 2010; Bardhi, et al., 2007; Green et al., 2009; McCabe et al. 2008; McCauley, 2009; McLarnon, et al, 2011; and Passik et al., 2006) all participants in this study described polysubstance abuse often including any controlled drug they were able to obtain, as well as

alcohol. Six participants stated they had been in either outpatient or inpatient drug rehabilitation for their addiction. Since all participants were recruited from NA meetings, they were all in some way striving to recover from addiction, either voluntarily or under a court order.

Similar to the findings of Bardhi et al. (2007), the participants in this study believed that obtaining prescription drugs from others was acceptable, they used prescription drugs with other drugs, and obtained prescription drugs relatively easily. However, contrary to the findings of Bardhi et al. (2007) the women in this study did not claim to avoid dependence on their prescription drug use. Rather, abuse and addiction drove their doctor shopping and they frequently referred to themselves as addicts or 'pill heads.' The participants in the study by Bardhi et al. (2007) reported that general practitioners were more willing to write prescriptions for controlled drugs than those in psychiatry. In the current study, the majority of prescribers the participants mentioned who prescribed them controlled drugs were general practitioners, although a few participants did also visit psychiatrists for controlled drugs. One participant specifically mentioned that nurse practitioners and physician assistants were not as likely to prescribe controlled drugs as physicians.

Similar to the findings of Inciardi et al. (2009), three participants in this study mentioned patterns of drug diversion they engaged in aside from doctor shopping including forgery of prescriptions. Also similar to Inciardi et al. in addition to doctor shopping, often participants purchased prescriptions from friends, relatives or dealers. As in the study by Fountain et al. (1997), the women in this study described diversion techniques of multiple scripting, overscripting, false identities, gaining sympathy, forgery, one off tactics, feigning symptoms, and enjoying the game, by experiencing enjoyment from outwitting prescribers.

Other similar patterns of prescription drug diversion were noted in this study compared to the study by Rigg et al. (2012) in that special arrangements were sometimes made with prescribers including recruiting additional patients, sexual favors, and exchanging prescription drugs. Sponsorship was reported in this study similar to the Rigg et al. (2012) study involving subsidizing another person's trip to a pain clinic, cost of the visit, and transportation costs in exchange for a percentage of the medication. Targeting vulnerable persons such as veterans and the elderly to sponsor to doctor shop was not noted by the participants in this study. Health care fraud was committed with fake IDs, fake MRIs, and billing insurance for the cost of prescriptions that were either abused or sold by women in this study, which was similar to the Rigg et al. (2012) study.

Consistent with the findings of Green et al. (2013), participants in this study networked together. Their collaboration involved sharing rides, pills, MRIs and information. However, contrary to the findings from the study by Green (2013), coercion was not noted as being part of the experience of women in this study. The participants did not mention coercing others to engage in doctor shopping. Additionally, the women in this study did not report being coerced or influenced by others in doctor shopping which is contrary to the findings by Pant and Bagrodia (2003) and Woodhouse (1990).

Many findings from this study of female doctor shoppers are consistent with previous studies done related to prescription drug abuse, diversion and doctor shopping. These similarities and differences along with many new findings, helps shed light on a phenomenon that is only recently being examined. In the following section I will discuss the implications of the findings from this study related to the identified themes.

Implications of the Study

Responsible Prescribing

Despite many years of education and training, and evidence of the severity of prescription drug abuse, prescribers, for a variety of reasons, continue to write prescription for controlled drugs to patients who abuse them. In general, health care providers are trained to help patients and relieve their suffering. When patients present with dramatic complaints of pain or anxiety, a natural instinct of the prescriber is to take them at their word, in an honest effort to provide them help. A need exists to shift the focus of care to prevention and treatment of addiction, because if prescribers write prescriptions for controlled drugs to people who are abusing them, prescribers are actually contributing to a serious and potentially deadly disease.

Treating pain, anxiety, or other conditions with controlled drugs should be done on as short term a basis as possible for the majority of cases. Current recommendations include that greater clinical judiciousness is warranted when prescribing opioids due to a lack of evidence of safety or effectiveness in long term use of opioids for chronic back pain and other nonmalignant pain (Alexander, Kruszewski, & Webster, 2012). Long term use of benzodiazepines has also come into question as some studies link it to a risk of increased falls, impaired memory, impaired cognition, and a higher incidence of dementia (Galacher et al. 2012; Ilomaki, Johns, Shakib & Bell, 2013; Uzan, Kozumplik, Jakovljevic, & Sedik, 2010).

Another problem prescribers face when trying to prescribe responsibly is that screening patients for abuse based on their appearance, what they say, their actions, or even how they complete screening instruments, is fraught with error because addicts are so good at deception and manipulation. In practice, prescribers rely on their judgment and intuition when making decisions about what treatments to endorse, and in the case of doctor shoppers, this is often

ineffective. In most cases, people do not present to prescribers telling lies in an effort to deceive, therefore this is an unexpected and often unrecognized occurrence. For some prescribers, it can be perceived as being unsympathetic, negative, or unkind, to be suspicious of patients.

Prescribers often erroneously believe that they can a patient who is lying. This is contrary to a meta-analysis of 206 studies done on deception judgments. The authors of that meta-analysis determined a lie-truth discrimination rate of 54% which is only slightly better than could be achieved by flipping a coin (Bond & DePaulo, 2006).

An article published by Gerhardt (2004) *Identifying the Drug Seeker: The Advanced Practice Nurse's Role in Managing Prescription Drug Abuse* outlines several red flags when making a determination to prescribe a controlled drug: Evidence of escalated use is a warning sign. This evidence includes patients reporting they have run out of their medication before scheduled appointments and claiming their medications were lost or stolen, which were tactics some of the participants in this study reported having told their prescribers. Prescribers should be suspicious of patients who claim they have no regular provider, state they are from out of town, request care after hours, or at emergency rooms. Other methods of scamming include patients being overly complimentary, demanding, or threatening a lawsuit for failure to treat when prescriptions are denied. Requesting specific controlled medications and refusing others, stating they are allergic or they are ineffective, is another tactic that may signal addiction or intent to divert medication. Other suspicious tactics include avoiding physical examination or stating their previous prescriber has gone out of business (Gerhardt, 2004).

PDMP

The implementation of the PDMP is the most significant screening mechanism currently in place to detect doctor shopping. Problems with the PDMP include that it is not a real time

system and there is usually a few day delay in data being available to prescribers which varies from state to state. Each PDMP is run independently and there are varying rules and regulations about which drugs are entered. Only some states share information with each other, so doctor shoppers can avoid detection by traveling to other states. A significant barrier to the effectiveness of PDMPs to detect doctor shopping is the fact that they are not widely used. Only eight states have statutes that require prescriber training of the PDMP (National Alliance of Model States Drug Laws, 2012b). While few studies have examined prescriber use of PDMPs, in one study of 23 hospices, 90% of respondents reported never using the PDMP (Blackhall, Alfson, & Barclay, 2013).

Some states have imposed regulations requiring prescribers to check PDMPs when prescribing controlled drugs, but these regulations have met resistance from some physicians groups. Currently five states have some form of a law requiring prescribers to check the PDMP at varying intervals (Dolan, 2012). The Tennessee Medical Association was successful at loosening the requirements of their law requiring prescribers to check the PDMP. Initially the law called for a check of the database every time a controlled substance is prescribed and every six months after that. This was changed to require a check initially and then only annually (Dolan, 2012). In response to a law passed in New York requiring prescribers to check the PDMP, the New York Medical Association objected and released a statement that legislators are placing too much of the blame on physicians for the prescription drug abuse problem (Dolan, 2012).

A sentiment of some physicians is that they should not have to police patients by checking their prescription histories and they also resent government oversight (Schreiner, 2012). The American Medical Association published an article *Prescription Abuse Laws Can*

Create a No-Win Situation for Doctors (Stack, 2012). The author argues that requiring physicians to check PDMP data goes against a duty to treat pain. Furthermore an objection is raised about requiring patients to provide a photo ID, and a recommendation to not routinely administer or prescribe controlled drugs in emergency rooms. The author complains that if he prescribes Percocet to an addicted patient, with a legitimate medical need, he could be liable if that patient overdoses a month later. He also states that it is a widely held falsehood that patients seen in emergency rooms are recklessly irresponsible or have criminal intent (Stack, 2012).

In an article on the legal response to America's prescription drug epidemic, Schreiner (2012), a medical attorney, advocates that courts should "impose a legal duty upon doctors to check prescription databases prior to issuing prescriptions in order to strengthen potential tort claims against those who fail to do so" (p. 536). His view is that requiring prescribers to check PDMP databases will "provide clear direction to doctors on the professional standard of care of an electronic monitoring program" (p. 536). Additionally, he states that prescribers may be liable for damages that result from their failure to check a patient's drug history prior to prescribing "dangerous and addicting" (p. 536) drugs.

As evidence of physician resistance to being held liable for checking PDMP data, 17 states have laws in place that grant immunity to prescribers for failing to access PDMP data (Schreiner, 2012). According to Schreiner, "granting civil immunity to physicians who fail to check PDMP data can be seen as nothing more than an unacceptable example of legislatures throwing a powerful lobby group a bone" (p. 537). Furthermore he states that "immunity provisions are counterproductive and undermine the policy objectives of establishing a PDMP" (p. 537).

Checking the PDMP reports of patients prescription histories should be a standard policy and protocol when controlled drugs are prescribed. This should be done at every visit in order to detect doctor shopping. Mandating PDMP checks every six months or annually will allow the possibility for patients to visit numerous prescribers within that time period.

Drug Testing

Once a decision has been made to prescribe a controlled drug, drug testing should be done prior to writing the first prescription and then periodically while the patient is being maintained on a controlled medication. Drug tests should be ordered to determine if a patient is taking any illicit drug or a controlled drug other than what is prescribed. Secondly, drug testing is done to determine that the patient is actually taking the controlled drug prescribed to them, rather than selling it or taking it all at once, and then going without it. In that case, a negative drug test, or one that did not have the prescription drug prescribed found in it, would indicate aberrant use of the prescription. A common practice engaged in by doctor shoppers is fooling drug tests when they were ordered. A national standard and requirement to screen patients for drugs with the most accurate method available when controlled drugs are prescribed is needed. Contrary to normal practice, drug screens need to be done prior to prescribing a controlled drug as well as after, which would detect drug use which is either illicit or prescribed by another prescriber.

Several professional organizations recommend periodic drug testing including the American College of Preventive Medicine (2011), and the American College of Physicians (n.d.). The most common form of drug testing is a urine drug screen (UDS). Recommendations for frequency of urine drug screens were determined by Owen, Burton, Schade, and Passik (2012) after pain experts reviewed best practices and the literature, as well as survey results from

physician pain society members. They concluded that for patients receiving prescriptions for controlled pain medication should be evaluated for risk, including behaviors, and through risk assessment instruments, such as the ones previously mentioned. Other risk factors they identified were co-occurrence of a mental health disorder, pain after a motor vehicle accident, and pain involving three or more regions of the body. Their recommendation is that patients who are prescribed controlled drugs who are at low risk should have a UDS done one to two times a year. Patients at moderate risk should have them done three or four times a year, and patients at high risk should have them done either four times a year, every month, every office visit, or every drug refill (Owen et al., 2012).

There are two types of UDSs, dipstick enzyme immunoassays (EIS) and gas chromatography mass spectroscopy (GC/MS). The most common way UDSs are done is with dipstick EIS which is convenient and inexpensive, but not very accurate (Owen, et al. 2012). This type of testing fails to distinguish drugs from the same class; therefore, patients could pass a drug test for an opioid they are prescribed even if they are abusing an opioid which has not been prescribed. Metabolites or levels are also not measured, which is why participants in this study were able to put a small amount of the actual drug they were supposed to be taking as prescribed into someone else's clean urine to pass a UDS. Gas chromatography mass spectroscopy is a more extensive, accurate, and expensive test for drugs in urine and is the gold standard for urine drug testing (Owen et al. 2012). GC/MS testing can detect more drugs, distinguish one drug in the same class from another, tests for metabolites, which only shows if the drug has been ingested, and give drug levels, making it more difficult to fool. Nicotine is also tested which can be useful to detect deception if the person being tested smokes and uses urine from someone who does not or vice versa. Numerous products are on the market designed to help people fool urine

drug screens which are likely ineffective. These include pills to take orally or put into urine, and even fake penises with compartments to hold urine for men.

Other measures are needed to prevent adulterated urine from being used by patients to avoid prescription drug abuse detection. Recommended measures include having the patient observed while giving the specimen, having patients remove any unnecessary outer clothing or personal belongings prior to entering the room to give the sample, placing a bluing agent in the commode and turning off the water supply in the testing area so that water cannot be used to dilute the specimen. Additionally, checking the temperature, pH, specific gravity, nitrates and creatinine concentration of urine can also be done to detect adulterated urine (Standridge, Adams, & Zotos, 2010). Mandating regular urine drug screening with GS/MS and other measures to detect adulterated urine provided for drug screens would reduce the ability of patients to fool drug testing. Audits of documentation that these measures are being taken would help ensure that there is compliance. Additionally, measures should be taken to make GS/MS testing more available and affordable.

Other methods of drug testing include saliva testing, hair follicle testing, and serum blood testing, are all more difficult to fool but more expensive. There may be some variability to the findings from oral fluid tests as well as collection issues if there is a difficulty producing enough saliva for the test (Drummer, 2006). Hair follicle tests reveal drug use in the last 90 days which can be helpful and accurate (Huang, Liu, Huang & Chien, 2009). Both of these tests are expensive and not widely done for regular screening. Commercial adulterants such as oral tablets and techniques such as dying or using harsh chemicals in the hair are often used to try to fool these tests, but their success rate is thought to be relatively low (Drummer, 2006; Hill, Cairns & Shaffer, 2008). Serum drug screens can be done but each drug must be ordered

individually, and a large amount of drug testing is hard to do on the small amount of blood normally collected in blood testing. Additionally, there is a separate charge for each drug which is expensive. Serum blood tests detect actual drugs in the blood rather than metabolites, so there would need to be recent use for detection. One benefit of doing serum blood screens would be that the patient's arms would be examined when preparing for venipuncture, which could detect needle marks indicating intravenous drug use.

Treatment Contracts

According to Bruckenthal (2007) key aspect of safe prescribing for pain management include patient assessment and a treatment agreement or contract. A patient assessment should include a thorough physical exam as well as a psychosocial assessment, which will help identify patients who would be appropriate for opioid therapy. A treatment agreement should be signed by the patient and include policies on refills, frequency of office visits, monitoring, including pill counts and drug screens, and verification that medications are stored securely. Additionally, contracts require a single prescriber policy, where patients are not permitted to seek pain medication from another prescriber and only one pharmacy is permitted as well. This type of contract should also be implemented when patients are prescribed benzodiazepines or other controlled drugs.

Physical Examination

Other recommendations include ongoing physical assessment of patients for signs of drug abuse such as appearing sedated, intoxicated, impaired or physically unkempt. Unlike other objective examinations which can be fooled, the presence of needle marks, also called tracks, in people who use drugs intravenously cannot be hidden. While the exact number of people who engage in doctor shopping and abuse prescription drugs intravenously is not known, it is likely

that the number is significant. Some participants in this study did report that they were checked for IV needle marks. Patients who are prescribed controlled drugs should be checked for needle marks which would involve disrobing and putting on an examination gown so that their legs as well as their arms could be examined. While this may be inconvenient, it should be part of routine screening of patients who are prescribed controlled drugs. Other physical examination techniques to screen for prescription drug abuse are nasal examination for redness or bleeding from snorting drugs, examining fingers for burns or lesions from smoking drugs, and an eye examination for pin point pupils which indicates acute intoxication.

Screening Instruments

To aid in screening for substance abuse, instruments to assess inappropriate drug use should be utilized, including those that patients complete as well as those for prescribers to complete. The Addiction Behavior Checklist (ABC) completed by the prescriber to document and assess for drug seeking behavior provides a valuable tool to help prescribers assess their patients behaviors which could indicate abuse. Patient response instruments such as the Patient Version Prescription Drug use Questionnaire (PDUQp) and the Revised Screener and Opioid Assessment for Patients with Pain (SOAPP-R) should be used to attempt to detect addiction, despite the fact that patients can lie when completing these instruments, because studies have shown them to be effective in many cases.

The PDUQp is a 31-item questionnaire which patients complete, which was developed to help clinicians identify opioid abuse or dependence in patients with chronic pain (Compton, Wu, Schieffer, Pham, & Naliboff, 2008). Questions included in this instrument are: ‘have you used the pain medication to help other symptoms such as problems sleeping, anxiety or depression?’ and ‘have you ever borrowed pain medication from a friend or family member?’ The PDUQp

showed statistically significant validity based on t-test results ($p < 0.001$). The instrument was able to distinguish between patients whose medications were stopped due to problematic use compared to those who continued on them or who discontinued for other reasons. Additionally, logistic regression results were used to determine that the PDUQp score was a significant predictor of medication agreement violation–related discontinuation.

The SOAPP-R is a self-report questionnaire designed to predict aberrant medication behaviors among chronic pain patients (Butler, Fernandez, Benoit, Budman, & Jamison, 2008). This 24-item questionnaire includes questions about behavior that have occurred in the last 30 days, including: ‘how often have you run out of pain medication early,’ ‘how often have you counted pain pills to see how many are remaining,’ and ‘how often have you attended an AA or NA meeting?’ Stability and internal consistency of this scale was statistically significant ($p < .001$). Testing of this screening tool found an 80% success rate at identifying people at high risk for aberrant medication behaviors.

The ABC is a 20-item instrument developed to assess behaviors characteristic of addiction related to prescription opioid medications in patients with chronic pain using items focused on observable behaviors of the prescriber during and in between clinic visits (Wu et al., 2006). The scale also includes questions for patients prescribed sedative analgesics along with their narcotic pain medication. Items assessing addiction behaviors observed by the prescriber since last visit include: ‘patient has hoarded meds,’ ‘patient ran out of meds early’ ‘patient received narcotics from more than one provider’ and ‘patient bought meds on the street.’ Items assessing addiction behaviors within the current visit include: ‘patient appears sedated or confused,’ ‘patient misrepresented analgesic prescription or use,’ ‘patient indicated she or he ‘needs’ or ‘must have’ analgesic meds,’ and ‘patient expressed a strong preference for a specific

type of analgesic or a specific route of administration.’ Interrater reliability for this instrument was statistically significant $p < 0.01$. Concurrent validity of the instrument was also significant ($p < 0.001$) when compared to the global judgment of the clinician ($p < 0.01$) and when compared to the PDUQ. A cut-off score of three or more on the ABC showed a good general estimate of appropriate versus inappropriate opioid use, which therefore warrants more careful monitoring of patients.

Documentation Flow Sheet

The implementation of a flow sheet when controlled prescription drugs are prescribed to document responsible and necessary measures that must be taken should become the standard of care which may need to involve mandatory use by statute. This flow sheet would allow a prescriber to document when steps such as physical exam, UDS, pill counts, checking PDMP, checking for needle marks, checking pupils, nasal exams, documenting patient’s meds are stored securely, and completion of screening instruments. Prescribers could be audited to produce this flow sheet to ensure that responsible measures of prescribing are being taken. The extra effort and time which would be required to responsibly monitor patients who are prescribed controlled drugs should be reflected in a higher reimbursement rate for services.

Prescriber Education

In order for responsible prescribing to occur, adequate training must take precedence. Mandatory training on the use of controlled drugs and issues related to addiction would ensure that all prescribers who write prescriptions for controlled drugs are provided with the information and tools they need to make responsible decisions about patient care. Use of the PDMP, identifying drug seekers, principles of medication safety and risks, signs of addiction and addiction treatment need to be included. Training on how to counsel patients about non-

pharmacological treatment for conditions that are treated with controlled drugs should also be provided.

Another important area where prescribers need training is how to handle the situation when doctor shopping or abuse is detected. In some cases prescribers may avoid implementing measures to detect abuse because they feel uncomfortable confronting patients. In a study of palliative medicine fellows *“I Feel Uncomfortable ‘Calling a Patient Out’: Educational Needs of Palliative Medicine Fellows in Managing Opioid Misuse* (Childers & Arnold, 2012), 77% of the 57 participants in that study had seen at least one patient with substance abuse and 47% had concerns about a patient having a substance abuse disorder. Despite this, only half felt they had a working knowledge of addiction, 41% felt that their training prepared them to manage opioid misuse, and 36% felt they knew how to differentiate pain from addiction. Only 21% were satisfied with how they treat symptoms in patients who misuse opioids. Detecting and treating addiction or drug misuse needs to be included as part of the training of prescribers.

Addiction Treatment

The United States government continues in its efforts to address the problem of substance abuse, however, it devotes comparatively little resources to treat addiction as compared to other health conditions. The results of a five-year study from the National Center on Addiction and Substance Abuse at Columbia (2012) include that 40 million Americans age 12 and older have some form of addiction involving drugs, alcohol or nicotine. Additionally, in 2010 only \$28 billion was spent to treat addiction affecting that large segment of the American population, as compared to \$44 billion to treat diabetes, which affects 26 million people, or \$107 billion to treat heart disease, which affects 27 million people. In 2012, the Substance Abuse Prevention and Treatment block grant received an increase of \$20.9 million; however, the Substance Abuse and

Mental Health Services Administration (SAMSA) has requested cuts to substance abuse prevention for the second year in a row (Budget, prescription drug abuse, workforce, parity main concerns, 2013). With budget shortfalls in all areas of government, battles over expenditures continue.

Parity

Another area of controversy relates to coverage of addiction treatment in this country. In 2008, the Mental Health Parity and Addiction Equity Act was signed. This is a federal law that requires group health insurance plans with more than 50 employees that offers coverage for substance use disorders, to provide those benefits in no more of a restrictive way than coverage for all other medical and surgical procedures (Substance Abuse and Mental Health Services Administration, 2013). Unfortunately, after four years, final rule for the law has not been determined on issues such as non-quantitative treatment limits, and whether residential treatment is included (Budget, prescription drug abuse, workforce, parity main concerns, 2013). How the Affordable Care Act (ACA) will affect the parity law is not certain.

Substance Abuse Treatment Workforce

Workforce issues need to be addressed concerning the professionals in this county who treat substance abuse. Currently there is no consensus on whether addiction treatment counselors should be required to hold a Master's degree, and the educational requirement is presumed to be a matter that will be resolved on a state-by-state basis. This issue is relevant, as a report from the Addiction Technology Transfer Center network recommends that the substance abuse treatment workforce needs to be more diverse and better trained. Furthermore, they predict that more professionals will be needed in 2014 when the ACA takes effect and more Americans are insured (Budget, prescription drug abuse, workforce, parity main concerns, 2013).

Nurses often work with patients with addictions in a variety of settings including inpatient and outpatient treatment. Addictions nursing is a subspecialty of nursing with certification offered in this specialty through the International Nurses Society on Addictions. Psychiatric mental health nurse practitioners (PMHNPs) are advanced practice nurses who treat mental illness, including substance abuse disorders. According to the American Psychiatric Nurses Association (n.d.), there is a shortage of nurses working in mental health, including PMHNPs. Salaries for PMHNPs in 2011 were over \$90,000, representing the seventh highest paid specialty for nurse practitioners, but for unknown reasons, the salary rate dropped by 8% from the previous year (Perron-Pronsati, 2012).

While the exact nationwide numbers of the psychiatric nurse practitioner workforce is unknown, a shortage is particularly meaningful given the shortage of psychiatrists in this country. According to a *U.S. World & News Report* ("Fewer U.S. medical students choose psychiatry," 2012) there are about 50,000 psychiatrists in the United States, described as being too few to serve all the patients who need help. Additionally, there has been a downward trend over the past six years of medical students choosing psychiatry as a specialty. Although the exact reason for the decline is not known, it may have to do with the relatively low salary of psychiatrists who have the fifth lowest salary of all physician specialties (Physician Compensation Report 2012, 2013). Efforts to increase the overall workforce of professionals providing care for people suffering from drug addiction should be employed such as increasing the availability of scholarships and grants for education and training, tuition reimbursement, ensuring adequate compensation, and increasing recruitment and public awareness of needed professionals in this field.

Detox and Rehab

Treatment options for people with addiction focus on detoxification and rehabilitation. These treatments are often compartmentalized and not offered at the same location. Detox units are often found within traditional inpatient psychiatric units and involve a fairly short four to five day stay. During this time, patients are administered medications to safely wean them off drugs of abuse, and to treat the withdrawal symptoms. Most insurance plans cover detox unit stays which average a cost of \$1,700 per day (Choose Help, 2011). When discharged, patients are generally set up with treatment options such as outpatient drug treatment programs which last an average of 10 weeks at a cost of \$7,000 (Choose Help, 2011). Rarely are patients willing to go, or do they have insurance coverage or the ability to privately pay for inpatient rehab programs which typically involve a 28-day stay at a residential facility with an average cost of \$19,000 (Choose Help, 2011). Insurance plans that do cover these services often have limits on the number of substance abuse treatments which is problematic, considering the incidence of numerous relapses and repeated treatment needs for most addicts. Most patients are discharged from detox back to the same environments from which they came, often resulting in relapse within days. There is a need to compel insurance companies to cover rehabilitation as well as for addicts to participate in them.

It may be that addicts would be more inclined to enter a rehabilitation program if it is directly located within a detox unit facility. Court orders for rehabilitation participation are common when a person has been charged with a drug-related crime. Since prescription drug abuse is a crime, a feasible recommendation would be to court order patients who undergo detox to comply with rehab. Judges routinely hold sessions on psychiatric units for involuntary admissions, so they would be readily accessible to order rehabilitation. This measure, however,

may lead to fewer addicts voluntarily agreeing to admission for detox if they knew they will then be court ordered to rehab. Additionally the rights of the individuals are limited when involuntarily admission to rehab is ordered, which poses an ethical dilemma. Another problem with short term detox is that many addicts will voluntarily enter a detox unit if they run out of drugs or money since they know they will be given controlled drugs to wean them off drugs as well as being provided a safe place to stay which includes meals. Often they leave detox only to immediately resume abusing drugs. Currently there are no mandates for detox or rehab units to check PDMPs or notify prescribers of the patient's prescription drug abuse status. Because of this, many patients leave treatment units and go immediately back to a prescriber or pharmacy to obtain prescription drugs to abuse. Offering an incentive, such as a monetary one, may be effective to encourage people who abuse prescription drugs to participate in rehab. Considering the skyrocketing costs of prescription drug abuse, it would likely be cost effective to offer addicts a small sum such as a \$250 gift card to successfully complete rehab. The savings from the successful treatment of those who are able to remain off drugs would offset the additional cost of rehab.

Treatment Issues for Women

As was described by the participants in this study, relapse from recovery to abuse in addiction is common, and is estimated to be at a rate of 60% (National Institute on Drug Abuse, 2008). Due to this high failure rate of treatment, innovative approaches should be considered. Gender differences are evident in the phenomenon of substance abuse, therefore treatment and recovery needs specific to women must be addressed. Gender specific substance abuse services were recommended following a meta-synthesis of 30 qualitative studies on substance abuse treatment views and recommendations of substance abusing women (Hines, 2011). The findings

from this study also indicate that gender specific aftercare for women is needed due to dissatisfaction with current programs as well as reports of unmet needs.

After Care

Often when patients leave detox units or rehab they do not have a safe drug free environment to return to. Half-way houses, sometimes called recovery houses, or sober living houses, can provide a safe structured environment for people suffering from addiction during the initial phase of their recovery. These houses typically charge rent of approximately \$100 per week. Most states require these houses to be licensed by the Department of Health. Often there is a shortage of halfway houses for a variety of reasons. Many times if there are zoning laws, communities or neighborhoods will oppose a halfway house from opening within their parameters. Running a halfway house can be difficult and it is often hard to maintain adequate staffing.

The Center for Behavioral Health Statistics and Quality at SAMHSA gathers data on treatment facilities, and reports that in the United States there are a total of 1,290 halfway houses affiliated with a treatment facility, and 200 non-treatment halfway houses (C. Alderks, personal communication, February 19, 2013). Gender information is not gathered on non-treatment halfway houses. For the 1,290 treatment facilities that also have a halfway house, 897 indicated that they accept adult women; however, it is not known if they house men and women together or women alone. In the geographical location where the study participants were recruited, there was only one halfway house for women within a 60 mile radius. For the entire state where the study took place, there are only four independent halfway houses, gender served is unknown. There are 36 treatment facilities in that state that have a halfway house, 30 of which accept women (C. Alderks, personal communication, February 19, 2013).

Support Groups

It is generally recommended that people suffering from addiction attend support groups to aid in their recovery. According to the Substance Abuse Mental Health Service Administration (SAMHSA) (2008), the most widely available mutual support groups are 12-step groups. According to a report by SAMHSA, research has shown that active participation in support groups significantly increases the likelihood of abstinence from drugs and alcohol. Attending the groups provides a forum to talk about recovery with other people sharing the same journey. Another aspect of 12-step groups is the concept of sponsorship, where a person with greater time in sobriety will sponsor another addict with less time and be available to them for support. This concept of support is seen as important because rather than using drugs when a person experiences cravings, they are urged to call their sponsor instead.

A few times at meetings I attended, when a person voiced that they were struggling, a pad of paper was passed around for people of the same gender to write their name and phone number as an option to call if needed. A principle in NA is that only women sponsor women, and men sponsor men, to avoid any relationships which could take the emphasis off of recovery. Since sponsorship is common in doctor shopping, a term referring to addicts working together to obtain prescription drugs to abuse, it is interesting that this same term is used to help another person maintain abstinence in recovery. Before recovery sponsorship leads to further addiction. During recovery, sponsorship is a tactic to eradicate addiction. In both cases it involves a relationship and clearly relationship plays an important role not only in addiction, but also in recovery.

Narcotics Anonymous was founded in 1953 and sprang out of the Alcoholics Anonymous program of the 1940s. The organization is a community-based organization that offers recovery from addiction through working the 12 steps and attending group meetings. There are more than

58,000 weekly meetings in 131 countries (Narcotics Anonymous, 2012). Each group runs itself based on the principles of NA, with no formal organization association or oversight; therefore statistics about demographics are not certain.

The effectiveness of 12-step support groups such as NA has come into question. The Cochrane Library published a review on the results of a meta-analysis which indicated that available experimental studies did not show the effectiveness of Alcoholics Anonymous or other 12-step approaches in reducing alcohol use or achieving abstinence (Ferri, Amato, Davoli, 2009). A similar review on the evidence for the effectiveness of psychosocial interventions for people with opioid dependence revealed that experimental studies are lacking and therefore there is insufficient evidence at this time to draw any conclusions (Mayet, Farrell, Amato, & Davoli, 2010).

A survey was taken of the attendees at the annual world convention which was held in San Diego California, in 2011. Of those in attendance, which is likely not entirely representative, 47% of respondents were female, 53% male. Additional demographics include that 74% of respondents were Caucasian and the average age was 43 (Narcotics Anonymous 2011 membership survey, 2012).

Another study, which probably more accurately represents NA demographics, was done by Galanter, Dermatis, Post and Santucci (2013) who surveyed 396 members of 10 NA meetings in three states. The purpose of their study was to determine abstinence from drugs of abuse in community-based members of NA. The participants had been abstinent an average of 5.7 years. The percentage of males in this study was 71.5% and the mean age was 38. The percentage of Caucasian respondents in that study was 68.2%. The gender differences with a much higher percentage of men being present are more approximate to what I witnessed and was told by

participants during my study. The age of participants and percentage of Caucasians in this study is similar to the survey done at the NA convention.

The fact that women are a minority may be a significant reason why women do not feel as comfortable attending. The format of the meetings where cross talk between attendees is discouraged may also leave women feeling disconnected and unsupported. Additionally, the older age of the average participants of 43, as compared to the younger age of participants in the present study, and the growing incidence of prescription substance abuse in people at younger ages, may indicate that a greater variety of support groups geared toward younger women could have a positive effect on the lives of women in their recovery. Since Caucasians are overwhelmingly overrepresented in NA, a need exists to identify the needs of people with substance abuse from a variety of racial backgrounds to increase their participation in support groups.

During the field work spent attending NA meetings to recruit participants for this study, I noted a scarcity of women attending the groups. In one meeting this was discussed and several people pointed out that NA meetings have always been better attended by men than women. Noted in the experience of doctor shopping by the women in the present study, a sense of community and camaraderie with other addicts was important. Some women pointed out that the friendships they made while using drugs ended once they stopped using drugs. Providing the option of a network of support for women in recovery where they could experience camaraderie to promote abstinence may be beneficial.

There are a few mutual support groups geared at women such as Women for Sobriety (WFS), but this organization is primarily centered on alcohol abuse. Formed in 1976, the program is based on a 13 statement 'New Life' program. These statements include, 'I have a

life-threatening problem that once had me,’ ‘negative thoughts destroy only myself,’ ‘happiness is a habit I will develop,’ ‘problems bother me only to the degree I permit them to,’ ‘I am what I think,’ ‘love can change the course of my world,’ and ‘the fundamental object of life is emotional and spiritual growth’ (Women for Sobriety, 2011). The program is based on positive thinking, metaphysics, meditation, group dynamics, and pursuit of health through nutrition. There are nearly 300 WFS groups held weekly worldwide (Substance Abuse Mental Health Service Administration, 2008). This type of group for women suffering from drug abuse would likely be an asset to the repertoire of options available. Other groups, which are also less plentiful, include SMART Recovery, Save Ourselves (SOS), which has an online E-Support group for women, and LifeRing Secular Recovery, with worldwide meetings estimated at 100 to 500 a week (Substance Abuse Mental Health Service Administration, 2008).

Interventions to improve access to and availability of support groups for women in recovery are needed. Grants to expand the availability of these groups might include assessments of those in the community to identify their needs, start-up money for group development, and paid positions for group leaders. Support groups are generally run by people who have experienced addiction, but in some cases it may be appropriate for healthcare professionals to start and run these groups if needed. Studies of the appropriateness and effectiveness of health care professionals starting and running support groups are needed.

Addiction Prevention

Since addiction is the central key factor that drives doctor shopping related to prescription drug abuse, steps to improve prevention and treatment are warranted. Determining successful strategies to prevent and treat the complex, multifaceted problem of substance abuse has been elusive for centuries. Because substance abuse is so resistant to treatment, efforts

aimed at prevention should be a primary focus. Education based at prevention is warranted targeted at children to prevent prescription drug abuse. The White House Office of National Drug Control Policy (2011) emphasizes education on the hazards of prescription drug abuse including a recommendation for parents to talk to their kids about this problem. They recommend the Time to Talk Toolkit published by the Partnership for a Drug Free America (2013) and offer a link to download this free from their website. This toolkit offers tips for parents on how to talk to their preschool through teenage children about drug abuse prevention, including prescription drugs.

Further recommendations include proper storage and disposal of prescription drugs. According to a report on prescription drug abuse in adolescents by the National Center for Mental Health Promotion and Youth Violence (2013) children often access prescription drugs to abuse in their own homes from medicine cabinets. This behavior is sometimes referred to as “pharming.” This report highlights the fact that easy access combined with the common misconception that prescription drugs are a “safe high,” calls for the increased attention of educators, parents, law enforcement officials, policy makers, health professionals, and prevention specialists. To deal with easy accessibility which also leads to controlled prescription drugs being taken by others outside the home from medicine cabinets to abuse or sell, proper safe storage is also recommended. Several types of medication safes or lock boxes are on the market at a nominal cost of approximately \$25. Use of such devices should be included as a general recommendation as part of child proofing one’s home for all parents as well as a general safety recommendation for every household for any controlled drug prescriptions. Public service announcements about the need to keep controlled drugs in locked boxes could impact access to prescription drugs within homes which often leads to prescription drug abuse which could lead to

doctor shopping. Prescribers and pharmacists should routinely advise patients with prescriptions for controlled drugs to keep them in locked boxes.

System Change and Safeguard Recommendations

Doctor shoppers succeed in securing prescription drugs through playing the system. Safeguards to close loopholes in the system are needed to decrease the incidence of prescription drug abuse. People who doctor shop are ingenious and creative; they are finding numerous clever ways of outwitting measures to prevent abuse. It is unlikely that all loopholes can ever be closed, but all possible measures should be taken to decrease the incidence of prescription drug abuse and its devastating consequences.

Terminology

A variety of terms are currently used to describe the phenomenon of prescription drug abuse. A need exists for agreed upon terminology related to prescription drug abuse both for professionals and the public. According to the American College of Preventive Medicine (2011) consensus on terminology is needed because currently terms such as abuse, misuse, addiction, and nonmedical use are used interchangeably. The terms misuse and nonmedical are often used to describe aberrant or unintended use or abuse of medications that have been prescribed to a person, but these terms are also used when referring to people accessing drugs from others such as friends, family members or dealers. Making a distinction between people who abuse medications that are prescribed to them, versus those who abuse medications they obtain from others is important in regards to tailoring interventions for prevention, detection, and treatment.

Identification

Accurately verifying a patient's identity (ID) is necessary to prevent doctor shopping. Since fake IDs or using alternate names is a strategy used when doctor shopping, the policy of

verifying identification solely through an ID is not adequate. More than one document to verify ID is needed, similar to measures taken when applying for a driver's license, such as requiring utility bills or other mail verifying identity through their address or passports or social security cards. People who require long term use of controlled drugs could also be required to have a special tamper resistant photo identification card to show when presenting for medical visits or at pharmacies. This controlled drug recipient card could be issued at a health department. Information which has been thoroughly verified and contained on this card could be included in the patients PDMP profile.

Geographical location of prescribers

People who engage in doctor shopping often travel great distances to visit prescribers and pharmacies to obtain controlled drugs to abuse. A regulation could be instituted where patients are required to obtain and fill prescriptions within a specified geographical location in which they reside such as within a 30-mile radius. This could be verified through their controlled drug recipient card. In the vast majority of cases there would be an available prescriber or pharmacy within 30 miles. Exceptions could be made for persons residing in remote locations. Additionally, exceptions would need to be made to see prescribers, if specialists were not available in the geographic location of the patient. Patients could be required to have a waiver for this requirement, but only one per specialist, prohibiting them from traveling far distances to visit more than one pain clinic, for example. Information regarding a patient's geographical radius restriction and exceptions could be available on their PDMP profile.

Method of payment

Another way that doctor shoppers avoid detection is by paying cash rather than using their insurance, or they alternate between using their insurance and paying cash. With the onset

of the ACA in 2014, there will be a requirement for Americans to have health insurance or pay a tax. This should decrease the potential for abuse through cash payments, but a certain percentage of patients will remain without insurance in place at the time of their visit. This would be due to a variety of reasons, such as a delay in it getting instated, not being willing or able to pay for it, or being in between coverage. Some states, such as Tennessee, have enacted statutes that disallow cash payments for visits at pain clinics other than insurance co-pays, in an attempt to decrease abuse, and to ensure that a paper trail of payments can be tracked (Tennessee State Capital, 2012). This would not preclude patients from paying cash at other locations, and the only way a paper trail would prevent abuse is if someone had reason to track it. Surveillance of prescribers in clinics, hospitals, and office settings, as well as at pharmacies is seldom done. Occasionally the top prescribers of controlled drugs in individual states will be identified and contacted by government regulators, such as officials at the DEA. Often, only if crimes are suspected involving prescribers or pharmacists is an investigation done. A nationwide regulation prohibiting cash payments for medical visits when controlled drugs are prescribed or to pay for controlled drugs would be another measure to take. Audits of prescribers and pharmacies could be done to verify method of payment.

The use of a controlled drug recipient debit card could also be required for patients to pay for visits to prescribers or prescriptions for controlled drugs. This card could be issued at a health department and could be coded to match the ID card. Kiosks where patients could upload cash or other forms of payment to the controlled drug debit card could be placed in convenient locations such as pharmacies, hospitals and health departments. Prescribers and pharmacists would swipe this card when patients pay for services or medications and this data could also be included in a patient's PDMP profile in real time similar to electronic banking transactions.

When payment is not necessary, such as when insurance is covering the entire cost, a code could be entered prior to swiping the card indicating that there was not an exchange of money but rather insurance was used, including the amount.

Standardized fees for services

Some participants in this study reported they were required to pay inflated charges to prescribers or pharmacies to secure controlled prescription drugs. Paying \$500 for a visit at a pain clinic or having to pay double the normal cost for prescriptions was reported. This practice, which clearly serves as monetary incentive for prescribers to write prescriptions for controlled drugs, and for pharmacists to fill them, should be outlawed, to prevent a conflict of interest. This would serve as a measure to prevent unscrupulous prescribers and pharmacists from profiting from writing or filling prescriptions for controlled drugs.

Insurance status

Some method for determining which patients have insurance and then requiring them to use that insurance rather than cash, would help close the loophole where patients use cash, or claim to not have insurance, in order to prevent detection. Currently insurance status can be verified by contacting individual insurance companies such as Medicare and Blue Cross and Blue Shield through an automated system. This information could be available through a national database with a call center for prescribers. This information could also be included in the patients PDMP report.

Visit Monitoring

Another loophole in the system is that the current use of PDMPs involves collecting and recording data on prescriptions filled at pharmacies. However, this does not preclude doctor shoppers from visiting more than one prescriber in a short time frame without filling the

prescriptions they obtain that day. Because in most states, pharmacists are only required to enter the prescriptions but not monitor them, those prescriptions can be filled at a later time. One possible recommendation to track and dissuade patients from visiting numerous prescribers would be to include these visits in the PDMP data. Prescribers could be required to enter in date of service whenever a controlled drug was prescribed within an established time frame such as 60 minutes. Prescribers could log on to the PDMP when considering prescribing a controlled drug to a patient and see if they had recently visited another prescriber for a prescription for controlled drugs regardless of whether it had been filled or not.

Monitoring Arrests and Substance Abuse Treatment

Currently patients may be arrested on a drug-related charge or hospitalized or treated for substance abuse, and their prescriber who is prescribing them controlled drugs may not be aware. Drug-related arrests and substance abuse treatments could be entered into the patients' PDMP profiles. Law enforcement or treatment facilities should be mandated to report to prescribers drug related arrests or treatment. This may or may not affect treatment practice but it provides the prescriber information that should be considered when making decisions about prescribing.

Prescription Pill Identification

Pill counts to determine that prescribed medications are being taken as directed should become part of standard measures in place when controlled drugs are prescribed. These should be done at random, when patients are contacted randomly and asked to bring their medications in to be counted within a short period of time. For patients who are taking more of their medication than prescribed or who are selling their medication, they will not have enough pills in their bottle when they are counted. It was learned in this study that addicts will often call around and borrow pills from other addicts to use for pill counts the rare times they were requested. Some

method of marking the medications to match that specific patient's medication bottle could be developed to verify that the pills are the correct ones that the patient was dispensed from the pharmacy. This would also help track prescription medications that are confiscated in arrests to determine how they were diverted.

Abuse deterrent prescription formulations

One strategy that is currently being employed and studied, is the development and production of abuse deterrent formulations of controlled drugs. The FDA has identified the development of abuse-deterrent formulations as a public health priority and is encouraging their development (U.S. Food and Drug Administration, 2013). These preparations include hard gelatin capsules which cannot be extracted with a needle; tablets that contain niacin, designed to produce flushing and other unpleasant side effects if taken in excessive quantities, or other formulations which are compromised if chewed or crushed (Raffa & Pergolizzi, 2010). Currently these products are not widely available and addicts are known to be ingenious at thwarting efforts to prevent them from abusing prescription drugs, therefore the success rate of these abuse deterrent formulations is not known.

Controlled Drug Recipient Office

A problematic feature of implementing effective system safeguards is that they largely rely on prescribers and pharmacists for their implementation. In a certain amount of instances, these healthcare professionals are either complacent with doctor shopping or collaborate with patients when prescribing them controlled drugs. Relying on the very people who have been party to the phenomenon of doctor shopping to date, to safeguard the system, will likely involve a certain amount of failure. The development of an established office staffed with objective adequately trained personnel, who could play a role in assessing and monitoring patients, and

assisting with their care related to controlled prescription use, would be an asset to the current system.

As previously stated, debit cards to pay for services to obtain or to fill prescriptions for controlled drugs, as well as an ID verifying the identity of patients in need of ongoing controlled drugs, could be made available at a local health department. An office which could be called a controlled drug recipient office (CDRO) could be set up within these departments to provide these services, as well as screening and ongoing assessment of patients who are prescribed controlled prescription drugs. Patients in need of acute pain management, such as for an unexpected injury or surgery; or controlled anxiety medication, such as following a severe trauma, could initially receive a three day supply of controlled medication from a prescriber. A similar strategy is already being implemented in New York City public hospital emergency rooms, where a policy was instated which prohibits more than a three day supply of prescription painkillers, in an effort to crack down on prescription drug abuse (Hartocollis, 2013). In most cases, a three day supply would be adequate treatment with a controlled drug as recommendations are for short term use when possible to prevent tolerance or dependence. Patients would be told that they should follow up with their primary care provider or specialist if they need ongoing treatment with controlled drugs and that in order for this to occur, they would need to be seen at a proposed CDRO.

Patients could be seen at a CDRO by a professional such as a counselor, social worker, or nurse, with special training in addictions, pain management and mental health. A thorough assessment would be done including a psychosocial assessment, UDS, screening instruments, a PDMP check, physical assessment for needle marks and other signs of abuse. Patients would receive regular counseling on non-pharmacological management of pain and anxiety symptoms.

Patients would be required to be seen at a CDRO on a periodic basis as long as they are being prescribed controlled drugs, such as every two to three months. If at any time abuse or addiction is suspected, the CDRO would be in charge of recommending treatment and assisting patients to obtain treatment or other services such as referrals to half way houses, counselors, or support groups. A certificate verifying they are being seen at the CDRO, would need to accompany patients to prescribers as well as pharmacies in order to be prescribed controlled drugs or have them filled. The CDRO staff could also be involved in periodic audits of prescribers to verify that practices related to responsible prescribing are being utilized. This safeguard of an outside agent to monitor, assist, and intervene in a system that has so far been fraught with problems and failure, would be beneficial to the safety and well-being of patients. The implementation of a CDRO office could also prevent prescribers from unwittingly prescribing controlled drugs to patients who abuse them. Given the resistance of some prescribers to checking the PDMP and the existence of statutes granting immunity to prescribers when they do not check it, outside partnership to combat this problem is warranted. The costs of the CDRO office would be offset by savings from less fraud and abuse of the system.

Implications for Nursing

Advanced practice nurses, being a significant proportion of prescribers, need to implement measures to ensure responsible prescribing, as well as advocate for systematic changes to decrease the incidence of doctor shopping. Nurses in a variety of specialties and settings can use these findings to increase their understanding of women who engage in doctor shopping related to prescription drug abuse. Nurses are often in key positions to detect abuse and to intervene when addiction is suspected. Additionally, Nurses are well suited to design treatment interventions and recovery support options for women that would be more appealing

than traditional programs. Gender specific program interventions both in inpatient hospital units and residential programs are needed. Psychiatric nurses are already employed in these settings and therefore would be in an optimal position to recommend, design, and implement changes.

Support group options for women are particularly needed that would meet the needs of women, unlike NA groups, which usually follow a male model and attract mainly men. Nurses could play a role in the development, implementation and facilitation of support groups for women who abuse substances. Since support groups are associated with a higher incidence of abstinence, the addition of gender specific groups for women could result in a lowered incidence of doctor shopping. Community assessments could be performed by nurses to identify the needs of women in their community in order to develop appropriate programs and groups.

The fact that there is a lack of safe and recovery focused housing for women in this country is a problem that could also be addressed by nurses. Through grants, and other sources of funding, such as private and business collaboration, nurses could establish and staff halfway houses in their communities so that women leaving treatment programs could have somewhere to stay during recovery. The availability of gender specific programs and treatments available at these houses for women would further meet the needs of women in recovery and thus help curb the cycle of addiction.

Strengths and Limitations of the Study

Strengths of this study include that it was conducted in accordance with ethical standards and using several methods to achieve rigor and validity. The UTK method of phenomenology requires the input and feedback of an interdisciplinary phenomenology group, which is a major strength of this study. Another strength is that data saturation was achieved in 14 informative interviews, which were done with women who self-identified as doctor shoppers. The findings

are significant and illuminating including four themes which have been used to increase awareness and understanding of the meaning of doctor shopping as well as to determine implications and recommendations for change in this phenomenon. Another strength of this study is that no previous qualitative studies have been done with women who engage in doctor shopping, so the results of this study are groundbreaking and original. The use of the method of phenomenology is also a strength because it highlights the experience of the participants including an emphasis on various aspects of their world, body, time, and others, which reveals illuminating findings about the meaning of the phenomenon of doctor shopping. Because I attended numerous NA meetings which involved lengthy interactions with many individuals suffering from drug addiction, I was able to further glean insight into their world and experience.

Limitations of this study include that it was conducted in a specific geographical region and the findings may not be reflected in other regions. The majority of the women on the study were Caucasian, which is typical of the region but the findings may not be representative of women from other racial groups. A possible limitation is that my being a prescriber in the same geographical area as the participants, this could have affected the participants responses. However, I only addressed myself as a PhD student and as far as I know, none of the participants or people at the NA groups I attended were aware that I am a prescriber. The present study was done with women participants; therefore the results may not be generalizable to men. Additionally, the participants for this study were recruited from NA meetings, therefore, their experience may not reflect women who engage in doctor shopping who are not participating in an addiction support group.

Unintended Consequences

Unintended consequences of this study would be that if the recommendations proposed are implemented and the incidence of prescription drug abuse is reduced, addicts may resort to abusing illicit drugs such as heroin, which would also be a significant problem. To combat this, resources currently directed at combatting prescription drug abuse could be focused on illicit drug abuse. Savings to the healthcare and legal system from a decrease in prescription drug abuse could be used to help pay for costs related to illicit drug abuse.

Another possible unintended consequence of this study would be that if the recommendations set forth in this study are implemented, they in some cases, could be perceived as barriers for people in legitimate need of controlled drugs to obtain them. It is not the intention of this study to prevent patients who need pain medication or other controlled drugs from being treated. Rather, the measures recommended should lead to an improvement in the ability of patients to be treated with controlled drugs when indicated, because prescribers should be less hesitant to prescribe them when causes for suspicion are eliminated. Some of the measures proposed in this study would incur a hardship on patients in need of controlled drugs for instance if they would have to undergo more in depth screening. Some screening, such as examinations and producing urine drug screens may be embarrassing or inconvenient for patients. Some of the recommendations would result in an increased cost to the health care system, such as a CDRO office or an increase in laboratory screening. These costs would be offset by the savings to the system from a decrease in doctor shopping.

Future Research

Since there has been so little research done in the area of prescription drug abuse and specifically doctor shopping, a plethora of research is still needed in this area. The present study

was done with women. Since no similar study has been conducted with men, research is needed to understand the experience of men who engage in doctor shopping. The experience of prescribers in their role in prescribing controlled drugs or with doctor shopping is another area in need of study. This study should include a variety of professionals who prescribe controlled drugs such as both physicians and APNs so that differences and similarities could be examined. A grounded theory study to formulate a theory of doctor shopping is needed.

Quantitative studies are needed to measure doctor shopping and prescribing practices. Instruments need to be developed in order for these studies to be done. Interventions to prevent or reduce the incidence of doctor shopping are needed such as testing the effectiveness of training programs for prescribers and the use of more stringent screening. A flow sheet to document responsible prescribing practices needs to be developed and tested.

Currently there are screening instruments for patients once they have been started on opioids but similar instruments need to be developed for other controlled drugs such as benzodiazepines, stimulants, and hypnotics. Instruments to assess risk of abuse or addiction prior to starting a controlled drug which could be used by prescribers in their decision making process when considering controlled drugs are also needed.

Studies of women who engage in doctor shopping to assess their personality traits, self-esteem, emotional intelligence and other characteristics would be helpful to identify risk factors, and develop effective interventions for them. Similar studies of prescribers could help identify those prescribers who are risk of inappropriate prescribing. Additionally, development and testing of effectiveness of new and innovative treatment programs including support groups are needed for women. Research is also needed to develop more accurate and fool proof drug testing methods and tamper proof prescription pill formulations. Another area for future research

is the role of pharmacists in doctor shopping. Studies are needed on the experiences of pharmacists who dispense controlled drugs to patients and their experience when they encounter doctor shopping. Interventions aimed at prescription drug abuse prevention are also needed.

Conclusion

Prescription drug abuse is a serious problem in the United States which adversely affects people and society involving huge financial cost. Prescription drug abuse often involves doctor shopping where individuals visit numerous prescribers and pharmacies to secure controlled drugs to abuse. Women are more likely to engage in doctor shopping than men, and are more likely to have physical and mental health co-morbidities related to addiction. This is the first study of its kind to examine in depth the experience of people who engage in doctor shopping. This qualitative phenomenology study revealed four themes evident in the meaning of the experience of women who doctor shop; (1) feeding the addiction, (2), networking with addicts, (3), playing the system, and (4) baiting the doctors. Other findings include an analysis of the meaning of the doctor shopping experience related to existential grounds. Findings from this study have been used to propose several innovative recommendations for practice. Changes in policy, procedures, practice, and future research need to be implemented to reduce the incidence of doctor shopping related to prescription drug abuse and its devastating effects.

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APPENDIX

INFORMED CONSENT STATEMENT

Consent Form

You are invited to participate in a research study about the experiences related to doctor shopping. The study is being conducted by Julie Worley, a PhD student at the University of Tennessee, College of Nursing. The study involves answering questions in an interview that will take about one to two hours in which you will be asked general questions about your experiences related to doctor shopping, that is obtaining controlled prescription drugs from numerous prescribers and filling them at more than one pharmacy for non-medical use such as for abuse, recreational use or to sell. Interviews will be recorded and then typed out by a professional transcriptionist who will sign an agreement to keep all information in the interview confidential. You are asked not to name any names of yourself or others during the interview. Approximately 6 to 12 participants are estimated to be included in this study.

A risk of this study is that there is a chance that you will experience stress when sharing your story in this study. If need be the interview will be paused or discontinued. If you experience distress that may warrant treatment you will be given a referral to a licensed counselor and/or referred to contact the Plateau Mental Health Center crisis line. Injury is not expected during this study but if it occurs you will be referred to your primary care provider or the emergency room. The University of Tennessee does not "automatically" reimburse subjects for medical claims or other compensation. If injury is suffered in the course of research, or for more information, please notify the investigator in charge (Julie Worley, 931-260-2738). Participation may also involve risks to participants that are unforeseeable. Participants who appear acutely intoxicated may be

terminated from the study without regard to the participants consent. Significant new findings developed during the course of the research that may related to your willingness to continue participation will be provided to you. The interview will last approximately 60 to 90 minutes. After the interview you will be asked to write answer some questions about some general information about yourself such as age, race, education level and type of employment. Participation is optional and voluntary and you are free to leave the study at any time. If you leave the study before completing the interview, your incomplete interview recording will be destroyed. Discontinuing participation in the study at any time is without penalty or loss of benefits or services you are otherwise entitled or receiving.

One benefit of participation in the study is that the results from this study will help others to understand the experience of women who engage in doctor shopping. All information collected about you will be kept confidential. The information will not be shared with anyone who is not directly related to the research study other than the fact that some of the data, without names, may be used for future research studies. No one will have access to the materials of this study or any future studies using these data except Julie Worley (the principal investigator), and Dr. Thomas (Advisor). The Institutional Review Board of the University of Tennessee may also request access to the study data if indicated. The transcripts, consent forms, and question answers will be stored securely in the office of the advisor, Dr. Thomas, for three years. No reference will be made in oral or written reports which could link you to the study. The tape recordings of the interviews will be destroyed after the study is completed. No information will be kept on computer files

If you have questions at any time about the study or the procedures, you may contact the researcher, Julie Worley at 2370 Quinland Lake Rd. Cookeville, TN 38506 and 931-260-2738. If you have questions about your rights as a participant, contact the Office of Research Compliance Officer at (865) 974-3466.

I have read the above information. I have received a copy of this form. I agree to participate in this study.

Participant's name (Print) _____

Participant's signature _____ Date _____

Investigators signature _____ Date _____

DEMOGRAPHIC QUESTIONS FOR PARTICIPANTS

Participant Name (Pseudonym) _____

1. Age _____
2. Race _____
3. Marital Status _____
4. Education Level _____
5. Occupation _____

CONFIDENTIALITY PLEDGE OF TRANSCRIPTIONIST

I understand that the material I am transcribing from interviews must be held in complete confidence. This means that no words, phrases, or other segments of the material can be discussed with anyone. All names of places, such as schools or hospitals, will be replaced in the typed text by blanks or pseudonyms. All names of persons will also be replaced with pseudonyms.

_____ (Signature)

_____ (Date)

CONFIDENTIALITY PLEDGE OF PHENOMENOLOGY GROUP

I understand that the information from the transcripts from interviews presented and discussed must be held in complete confidence. This means that no words, phrases, or other segments of the material can be discussed with anyone.

_____ (Signature)

_____ (Date)

VITA

Julie A. Worley was born and raised in Barrington, Illinois and after high school attended Ravenswood Hospital School of Nursing in Chicago where she earned a registered nurse diploma in 1984. She worked as a nurse in a variety of settings in Chicago and went on to complete a bachelor of nursing degree from Northern Illinois University in 1992. She then completed a master's degree in nursing with specialization as a family nurse practitioner from University of Illinois Chicago in 1994. She moved to Tennessee and worked as a family nurse practitioner in a variety of settings and then completed a post master's certificate in a psychiatric mental health nurse practitioner program from the University of South Alabama in 2004. She has worked at a mental health clinic and in private practice as a psychiatric mental health nurse practitioner and has been on the medical staff of two inpatient psychiatric units. She has also taught nursing at the bachelors and doctorate level. She has published two articles on psychotropic medication adherence, one review of literature on prescription drug monitoring programs, and one concept analysis on doctor shopping. She belongs to a variety of professional organizations and is a member of the nursing honor society Sigma Theta Tau and the Phi Kappa Phi honor society for all disciplines. She completed her doctorate of philosophy at the University of Tennessee College of Nursing in May, 2013.