Hijacking Prescriptions

by Abigail Zuger

The patient said he was transferring his care from an HIV clinic in Brooklyn to ours, which was closer to his home. The paperwork he brought us consisted of a ragged piece of paper extracted from his back pocket that listed his medications. He said he needed to see a doctor right away.

When our administrator asked why, he said, "so I can get my meds." "Your other doctors weren't giving them to you?" she asked. "Look," he said. "I just want my meds."

He was a vigorous man in his late 30s. He lived with a girlfriend and worked odd jobs unloading boxes for local stores. Medicaid covered his medical care. He had been using intravenous heroin every two or three days since he was a teenager. He didn't consider his drug use a problem, and had never been interested in methadone or any other means of curtailing it.

The unfathomably random gods who parcel out HIV infections had been kind to this man. Infected for ten years or more, he had never had health problems from HIV, and his immune system was still in reasonably good shape. He had a very modest level of HIV detectable in his blood, suggesting that he was at low risk of developing HIV-related health problems any time soon. He had no other medical problems.

But you wouldn't know this from the list of medications in his back pocket. He did not take antiretroviral drugs—his immune system was fine without them—but his list contained just about every other drug prescribed for the person ailing from AIDS. It included appetite stimulants and anti-nausea medications, powerful narcotics for pain, sedatives and anti-anxiety drugs, anabolic steroids for energy, skin emollients, even the antibiotics prescribed to keep opportunistic infections at bay. And, of course, Viagra.

"You need all of these?" I asked—for the unfathomably random clinic administrator who parcels out new patients had assigned him to me.

"Sure," he said. "My docs told me I had to take them all or I would get sick."

"You actually take all of these?" I asked.

"Sure," he said. And sure enough, the shopping bag he was carrying contained empty vials for all of them, prescribed by a doctor in Brooklyn.

I had been down this road before. There was probably a chance this man was taking every single one of these medications. There was a considerably higher chance that he was taking very few of them, and selling the rest on the street to finance his habit.

Thousands of words have been written about ethical issues raised in the care of HIV-infected patients. Most date from the days when the illness was uniformly fatal and illuminate issues of death and dying, withholding and withdrawing treatment, and the care of contagious patients. With the development of effective antiretrovirals, discussions of research ethics and access to medical care have become paramount.

But one issue has gone largely unmentioned for the duration of the epidemic: the shotgun marriage this virus has forced between the medical community and the world of illegal drug use. Perhaps this issue appears relatively minor next to the larger ones. Still, the epidemic grinds on, and those of us in the trenches are as troubled by it as ever.

Nationwide, drug use has fueled about 25 percent of the AIDS epidemic. In some places, such as New York City, the figure is closer to 50 percent, and in some neighborhoods in New York, the figure approaches 100 percent. No disease is more common in the drug-using community. And while many of those who acquired HIV through drug use abandoned the habit long before their HIV diagnosis, and others immediately upon diagnosis, still others continue active use. This percentage varies from study to study but is generally reasonably high—high enough to support the frequent finding that needle exchange programs limit HIV transmission.

Drug use is an expensive habit, and AIDS is an expensive disease. The always-obliging street-corner marketplace linked the two early on. AIDS patients are treated with dozens of prescription drugs with high street value—not only the notoriously expensive antiretrovirals, but other medications intended to keep them vigorous, pain free, and emotionally intact. Anyone doubting the extent of the black market in prescription drugs need only consider the 2002 National Household Survey on Drug Abuse, in which an estimated 14.7 million Americans reported illicit use of pain relievers or psychoactive drugs in the course of a year, in contrast to the 6.3 million who reported using heroin or cocaine.

These pills do not fall off the back of a truck. Most were presumably prescribed by a physician and were at some point thereafter diverted into the illicit marketplace.

What is a doctor to do?

In twenty years of caring for HIV-infected drug users, I have had my prescriptions altered to change the number of pills prescribed from fifty to 250, or to mandate the dispensing of brand name medication (far easier to sell than generics). I have had prescriptions expertly forged de novo on home computers. I have seen desperately ill patients furtively exchanging the amber vial of

medication I had just prescribed for a wad of bills.

All sources assure me that none of these situations is likely to involve me in actual legal jeopardy; I write my prescriptions in innocence and good faith. What it does do, however, is change the dynamics of the doctor-patient relationship in unexplored ways.

Medical training aims to foster a sense of identity between doctor and patient. Emotionally, students are gently moved along the spectrum of goodwill from sympathy to empathy as they adapt to an ethos in which the patient's well-being, both physical and mental, is so important it becomes equivalent to their own.

When a patient alters a prescription or sells the prescribed drugs, what happens to this carefully fostered relationship of collegiality and trust? Is it automatically destroyed? Or is it possible to create some kind of a theoretical construct that allows both parties to carry on the mutual project of health care?

I certainly have no such construct to offer for review. But I do have questions I hope brains wiser than mine will someday address.

First, how does the inevitable dishonesty of the inevitable confrontation affect any analysis of the issue? This is how it goes: "Are you selling your meds?" "No." "What happened to your prescription?" "This guy I know took it, then he gave it back." There is really no such thing as full disclosure in this arena; it just doesn't happen. Which means, among other things, that there is always some doubt as to what has actually taken place, and whether the violation occurred as perceived. And suppose the violation has not yet taken place, as with the patient in my office. Does one forestall it, or wait for the script to play itself out?

Second, should the prescription be given its full symbolic value in these events, or is it just a piece of paper? Invariably, the first emotion a doctor feels on seeing a forged prescription is utter betrayal. Our prescriptions symbolize an array of intangibles, including our professional competence, our good intentions, our belief in the tenets of orthodox medicine, our good standing in the community, our roles as custodians of public funds budgeted for drugs. A defaced prescription can feel like an actual personal attack. But, in fact, once the prescription is signed and handed over, it and the drugs it procures belong to the patient, who is seldom aware of these overtones. Patients are selling their own drugs, not the doctor's. No spiritual violation is intended; it is a simple business decision. How are these disparate views of a commodity to be reconciled? Suppose a patient sells his medications to buy not drugs, but food for his children. Does anything change?

Third, what about the nature of AIDS itself? Controlling the disease mandates that a patient establish and maintain a close connection with the health care system. Banishing an HIV-infected patient from a health-care setting has weightier implications than it does for an uninfected patient. Drug users are a disenfranchised population whose suspicions of orthodox medicine and its strictures are difficult to overcome. One picks one's battles carefully in their care, trying to bend enough rules to maintain a relationship that will eventually spawn some trust. In this arena, how are limits to be set?

What about the personal ethos of the physician? Should doctors' own views of the current drug laws affect their response to the patient who defies them? Should doctors who work together adhere to a consistent policy, or may each follow his or her conscience? What about doctors who live in the same city, or who treat the same illness? How much professional consistency is possible, or even optimal? Do I have any obligation to write the same prescriptions as some unknown (and, I suspected, not very swift) doctor in Brooklyn? Probably not. But does a patient have a right to expect some consistency from medical providers working three miles apart? In this age of disease management guidelines, that is a trickier question.

Over the years I have seen doctors react in every possible way to the hijacking of their prescriptions, from ignoring the events completely to banishing the patient immediately from the site of care. No solution ever seems to be entirely right.

The patient in my office was jiggling his leg, impatient to be done. I looked at his list of meds and wrote him prescriptions for half a dozen of the simplest and least expensive that seemed least likely to harm him or others. I told him I could not fill the rest. He accepted his prescriptions and left, broke his next appointment, and I haven't seen him since.