

Should you report a patient who misuses a prescription?



Douglas Mossman, MD
Series Editor

Dear Dr. Mossman:

My patient, Ms. X, returned to see me after she had spent 3 months in jail. When I accessed her medication history in our state's prescription registry, I discovered that, during her incarceration, a local pharmacy continued to fill her prescription for clonazepam. After anxiously explaining that her roommate had filled the prescriptions, Ms. X pleaded with me not to tell anyone. Do I have to report this to legal authorities? If I do, will I be breaching confidentiality?

Submitted by Dr. L

Preserving the confidentiality of patient encounters is an ethical responsibility as old as the Hippocratic Oath,¹ but protecting privacy is not an absolute duty. As psychiatrists familiar with the *Tarasoff* case² know, clinical events sometimes create moral and legal obligations that outweigh our confidentiality obligations.

What Dr. L should do may hinge on specific details of Ms. X's previous and current treatment, but in this article, we'll examine some general issues that affect Dr. L's choices. These include:

- internet monitoring of controlled substance use
- reporting a past crime
- liability risks associated with violating confidentiality.

Monitoring controlled substances

Dr. L's clinical situation probably would not have arisen 10 years ago because until recently, she would have had no easy way to learn that Ms. X's prescription had been

filled. In 2002, Congress responded to increasing concern about "epidemic" abuse of controlled substances—especially opioids—by authorizing state grants for prescription drug monitoring programs (PDMPs).³

PDMPs are internet-based registries that let physicians quickly find out when and where their patients have filled prescriptions for controlled substances (defined in the *Table*).^{4,5} As the rate of opioid-related deaths has risen,⁶ at least 43 states have initiated PDMPs; soon, all U.S. jurisdictions likely will have such programs.⁷ Data about the impact of PDMPs, although limited, suggest that PDMPs reduce "doctor shopping" and prescription drug abuse.⁸

The U.S. Department of Health and Human Services is promoting the development of electronic architecture standards to facilitate information exchange across jurisdictions,⁹ but states currently run their own PDMPs independently and have varying regulations about how physicians should use PDMPs.¹⁰ Excerpts from the rules used in Ohio's prescription reporting system appear in the *Box* (page 20).¹¹

Reporting past crimes

What Ms. X told Dr. L implies that someone—the patient, her roommate, or both—misused a prescription to obtain a controlled substance. Simple improper possession of a scheduled drug is a federal misdemeanor offense,¹² and deception and conspiracy to

Dr. Mossman is Professor and Program Director, University of Cincinnati Forensic Psychiatry Fellowship, Cincinnati, Ohio.

Disclosure

Dr. Mossman reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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Table

Controlled substances: Schedules, definitions, and examples

Classification	Examples
Schedule I: Substances without officially accepted medical uses in the United States and a high potential for abuse	3,4-Methylenedioxyamphetamine (“ecstasy”), heroin
Schedule II: Substances with accepted medical uses but a high potential for abuse and dependence	Hydromorphone, morphine, amphetamine, methylphenidate
Schedule III: Substances with less abuse potential than Schedules II drugs; abuse may lead to physical or psychological dependence	Analgesic plus lower-dose opioid combinations (hydrocodone/acetaminophen, Tylenol with codeine)
Schedule IV: Substances with less abuse potential than Schedule III drugs	Benzodiazepines, such as clonazepam
Schedule V: Substances with low potential for abuse relative to Schedule IV drugs	Preparations containing limited quantities of certain narcotics, such as cough syrups with a low concentration of codeine

Source: References 4,5

obtain a scheduled drug are federal-level felonies.¹³ Such actions also violate state laws. Dr. L therefore knows that a crime has occurred.

Are doctors obligated or legally required to breach confidentiality and tell authorities about a patient’s past criminal acts? Writing several years ago, Appelbaum and Meisel¹⁴ and Goldman and Gutheil¹⁵ said the answer, in general, is “no.”

Psychiatrists might *believe* they are required to do so because of the apparent similarity between reporting a past crime and the public protection obligation associated with the *Tarasoff* decision. *Tarasoff* imposes potential malpractice liability on a therapist who fails to act reasonably to avert a patient’s *future* dangerous actions. By contrast, the law imposes “no similar general requirement as to *completed* criminal conduct, ‘dangerous’ or not.”¹⁴

In recent years, state legislatures have modified criminal codes to encourage people to disclose their knowledge of certain crimes to police. For example, failures to report environmental offenses and financial misdealings have become criminal acts.¹⁶ A minority of states now punish failure to report other kinds of illegal behavior, but these

laws focus mainly on violent crimes (often involving harm to vulnerable persons).¹⁷ Although Ohio has a law that obligates everyone to report knowledge of *any* felony, it makes exceptions when the information is learned during a customarily confidential relationship—including a physician’s treatment of a patient.¹⁸ Unless Dr. L herself has aided or concealed a crime (both illegal acts¹⁹), concerns about possible prosecution should not affect her decision to report what she has learned thus far.¹⁴

Deciding how to proceed

If Dr. L still feels inclined to do something about the misused prescription, what are her options? What clinical, legal, and moral obligations to act should she consider?

Obtain the facts. First, Dr. L should try to learn more about what happened. Jails are reluctant to give inmates benzodiazepines²⁰; did Ms. X receive clonazepam while in jail? When and how did Ms. X learn about her roommate’s actions? Did Ms. X obtain previous prescriptions from Dr. L with the intention of letting her roommate use them? Answers to these questions can help Dr. L

Clinical Point

In Ohio, physicians are not obligated to report crimes learned about during a patient’s treatment



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Clinical Point

A confidentiality obligation might be overridden if reporting a crime prevents imminent harm to others

Box

Excerpts from Ohio Administrative Code § 4731-11-11 concerning the Ohio Automated Rx Reporting System (OARRS)

- If a physician believes or has reason to believe that a patient may be abusing or diverting drugs, the physician shall use sound clinical judgment in determining whether or not the reported drug should be prescribed or personally furnished to the patient under the circumstances.
- The physician shall access OARRS and document receipt and assessment of the information received if the patient exhibits the following signs of drug abuse or diversion: (a) Selling prescription drugs; (b) Forging or altering a prescription; (c) Stealing or borrowing reported drugs; (d) Increasing the dosage of reported drugs in amounts that exceed the prescribed amount; (e) Having a drug screen result that is inconsistent with the treatment plan or refusing to participate in a drug screen; (f) Having been arrested, convicted, or received diversion, or intervention in lieu of conviction for a drug related offense while under the physician's care; (g) Receiving reported drugs from multiple prescribers, without clinical basis; or (h) Having a family member, friend, law enforcement officer, or health care professional express concern related to the patient's use of illegal or reported drugs.
- A physician prescribing or personally furnishing [Schedule II, III, IV, and V drugs] to treat a patient on a protracted basis shall, at a minimum, document receipt and assessment of an OARRS report in the following circumstances: (1) Once the physician has reason to believe that treatment will be required on a protracted basis; and (2) At least once annually, thereafter.
- A physician shall document receipt and assessment of all OARRS reports in the patient record.

Source: Reference 11

determine whether her patient participated in prescription misuse, an important factor in deciding what clinical or legal actions to take.

Think before breaching confidentiality.

Second, Dr. L should recognize that, unless she is reporting a crime that is legally mandated (as is true for child abuse), doing so might create a breach of confidentiality. Psychiatrists can be sued successfully—even if they think they have done the right thing—if their actions needlessly violate their professional obligations to protect patients' privacy.²¹ Protecting society and preventing imminent harm to others are considerations that might override a psychiatrist's confidentiality obligation,¹⁴ but these grave factors don't seem to apply in Ms. X's situation. Dr. L may feel used and offended by what has happened, but hurt feelings don't justify breaching a patient's confidentiality.

Should the patient take the lead? Learning more about the situation might suggest that Ms. X should report what has happened

herself. If, for example, the roommate has coerced Ms. X to engage in illegal conduct, Dr. L might help Ms. X figure out how to tell police what has happened—preferably after Ms. X has obtained legal advice.¹⁴

Consider implications for treatment. Last, what Ms. X reveals might significantly alter her future interactions with Dr. L. This is particularly true if Dr. L concluded that Ms. X would likely divert drugs in the future, or that the patient had established her relationship with Dr. L for purposes of improperly obtaining drugs. Federal regulations require that doctors prescribe drugs only for "legitimate medical purposes," and issuing prescriptions to a patient who is known to be delivering the drugs to others violates this law.²²

The State Medical Board of Ohio recently advised physicians that a patient who uses "deception to obtain narcotics from a physician" and "is engaged in fraudulent and criminal misconduct" does not have a doctor-patient relationship, so "the physi-

cian is required (under Ohio law) to report the matter to law enforcement officials.²³ Such a requirement probably would not apply to physicians who practice elsewhere, because few if any other states have laws that require reporting of all types of felonies. Other state medical boards, however, do *encourage* physicians to consider telling legal authorities about persons who pose as patients to fraudulently obtain controlled substances, noting that such reporting does not violate the Health Insurance Portability and Accountability Act or other patient privacy protections.²⁴

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Related Resources

- Office of National Drug Control Policy. Epidemic: responding to America's prescription drug abuse crisis. www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan.pdf.
- California Department of Alcohol and Drug Misuse. Preventing prescription drug misuse. www.prescriptiondrugmisuse.org.
- U.S. Food and Drug Administration. Combating misuse and abuse of prescription drugs: Q&A with Michael Klein, PhD. www.fda.gov/ForConsumers/ConsumerUpdates/ucm220112.htm.

Drug Brand Names

Clonazepam • Klonopin	Methylphenidate • Ritalin
Hydrocodone/acetaminophen	Hydromorphone • Dilaudid
• Vicodin	

Clinical Point

Some state medical boards encourage reporting of persons who fraudulently pose as patients to obtain controlled substances

Bottom Line

Growing concern about prescription drug misuse has led to nationwide implementation of systems for monitoring patients' access to, and receipt of, controlled substances. Psychiatrists are expected to be more vigilant about patients' use of scheduled drugs and, when they believe that a prescription has been misused, to take appropriate clinical or legal action.