MARYLAND

Maryland Board of Physician Quality Assurance
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PRESCRIBING CONTROLLED DRUGS

In a recent AMA survey of physicians, the majority of physicians responding reported that their prescribing of controlled drugs was negatively influenced by a fear of licensing board sanctions. The issue of prescribing adequate pain medication for the terminally ill, generally patients with cancer, has received extensive attention. But what about patients with chronic noncancer pain? Little has been done to alleviate physician anxiety that regularly prescribing controlled drugs to such patients will result in the physician being accused of diverting drugs illegally or supporting addictive patients in their habits. How can a physician both meet their patients' needs and avoid coming to the attention of the licensing authorities?

BPQA, by statute, has a minimum of eleven Board members who are actively practicing physicians. We see these patients in our offices, too, and we recognize that there are many painful conditions which cannot be cured and that diagnoses may be totally based on subjective symptoms. As physicians, our role is to relieve suffering; we may have no hard evidence that "proves" the patient is in pain, yet we believe our patients and we try to help them. All the members of BPQA wish to reassure Maryland physicians that they need not under-prescribe needed medications for fear of Board action. Under-prescribing results in unnecessary suffering.

But what about all those Board actions you've read about in which the doctors are sanctioned for "inappropriate" controlled dangerous substance prescribing practices? Were these physicians just trying to alleviate suffering with the end result that the Board sanctioned them? Hardly. Most of the physicians charged under this provision of the Medical Practice Act were clearly acting in other than the best interest of their patients. Usually, obvious addicts were buying prescriptions from the physicians and the transactions were disguised as office visits. Occasionally, truly naive physicians, once they have been targeted as "easy writes," attract every addict in town. All of us in practice occasionally have been duped by a patient in this way. But some physicians simply don't recognize addiction. Usually, in addition to inappropriate prescribing, we find that the physician's practice is substandard in multiple other areas. It is rare that an otherwise well-trained and competent physician is identified as a naive prescriber.

Because the Board is concerned that fear of disciplinary action may lead to inappropriately restrictive prescribing of controlled drugs, the following guidelines are offered by Dr. Charles Hobelmann Jr., who has served on the Board since 1991. Although the primary focus of his remarks is analgesic prescribing, these guidelines can be applied to every prescribing and treatment situation. It's just good medical practice spelled out, and it's how the Board evaluates the delivery of all medical care, not just controlled drug prescribing. His comments follow.

In order to help the physicians whose patients may require long-term analgesic medications, a common sense approach coupled with experience and medical knowledge is essential. It is important to realize that habituation and tolerance to drugs are not the same as addiction. These are expected consequences of long-term analgesic therapy and do not have the characteristics of sociopathy and psychologic dependence associated with addiction. Whereas it is inappropriate to prescribe analgesics to maintain addiction, it is good medical care to provide relief from chronic pain even in the face of habituation and tolerance. Some general guidelines may be helpful both in the management of these patients and in protecting one's self from legal or Board action in prescribing for them. The following comments have been adapted from published material of the Medical Board of California and provide a useful guide in this area.

History and Physical Generally speaking, it is improper to prescribe any medication for any patient without first taking the steps essential to evaluation. This is particularly true of the chronic pain patients because other treatment modalities may be beneficial and because it is important to recognize the addict who may complain of pain as a means to maintain a habit. Prescribing narcotics without a documented evaluation always represents substandard care.

Treatment Plan Just as treatment for diabetes or hypertension has a specific objective, so should treatment for chronic pain. Frequently, the pain cannot be completely relieved but the use of analgesic drugs may lead to an improved sense of well-being, better sleep or even a return to work. The goal of analgesic therapy should be documented and the patient's progress measured against this goal.

Informed Consent Since long-term narcotic use will usually result in habituation and tolerance, these risks should be discussed with the patient. Alternatives should be offered if they exist and the clinical record should refer to the discussion.

Periodic Review The course of treatment and the meeting of therapeutic goals should be periodically reviewed as is the case with any patient suffering from chronic disease. Modification of treatment or its discontinuation should be considered depending upon how well goals are being met. New information about the etiology of the pain or its treatment should be evaluated.

Consultation The complexity of chronic pain frequently requires evaluation by consultants who may suggest alternatives or additions to therapy. This may be particularly true in the patient who is at risk for drug misuse. The patient with a history of substance abuse requires special care in documentation, evaluation and consultation before long-term opiate treatment can be safely prescribed. Some pain management specialists recommend a written agreement with these and other patients before such therapy.

Records Adequate documentation is the key to management of these difficult patients and is the key to protecting the physician from legal or Board action. Documentation of the steps noted above should be recorded in a fashion that would allow another practitioner to understand and follow through with treatment.

Finally, the physician who uses scheduled drugs should be familiar with federal and local laws regulating their use. The U.S. Drug Enforcement Administration publishes a physicians' manual and Maryland laws are available through the Board. The Board hopes that physicians will use these guidelines to help them manage patients with chronic pain without fear of regulatory scrutiny. At the same time, the Board maintains its commitment to prevent the diversion and abuse of controlled substances.

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