Pain and Prejudice:
The Use of Chronic Narcotic Therapy In Medical Practice

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"Pain is such an uncomfortable feeling that even a tiny amount of it is enough to ruin every enjoyment."

– Will Rogers

The Board of Medical Licensure and Discipline receives complaints and questions relating to narcotic therapy almost daily. In one common scenario, a patient asserts that a physician has violated the patient's rights by not prescribing narcotics as requested. In another scenario, a physician's office inquires whether it is recommended to discharge a patient because he/she requires chronic narcotic therapy for the treatment of pain. Clearly this is an area of confusion.

Fortunately for both patients and physicians there is guidance from the State legislature, the Board, national organizations such as the **Federation of State Medical Boards** [FSMB], and the literature. Patients should expect that their pain will be assessed and addressed appropriately by their physician. Physicians can expect that their clinical judgment will prevail with regard to prescribing.

CASE

In 2008 the Board received complaints from several pharmacists alleging inappropriate prescription of narcotics by a specific community-based physician for a particular patient. This particular patient's case was noteworthy for his young age, having received rapidly escalating dosages of schedule 2 narcotics, and for frequent early refills.

This young adult man had presented with low back pain 3 years prior that he loosely related to his work as a laborer. He had initially been treated with non-narcotic medications but was shortly thereafter transitioned to narcotics and titrated up to achieve adequate analgesia. At the time of the Board review he was receiving OxyContin 200 mg twice daily.

The well-documented medical record detailed all prescriptions. There was notation of phone calls from family members expressing concern that the patient was abusing his medication, and another during which the patient called to confess that he was "hooked on narcotics and buying significant amounts on the street to prevent withdrawal", and the physician's own suspicion of narcotic abuse.

The medical record was also remarkable for its total lack of any imaging studies, sub-specialty consultation, use of a narcotics contract, or even a specific diagnosis beyond "back pain". The physician had recommended medical imaging on numerous occasions, but the patient had always declined, citing the expense and his lack of insurance coverage. He did, however, pay for his medications out of pocket; The average retail price for #20, 80mg OxyContin tablets was $242 at the time.

The physician voiced his frustration to the Board at having to balance the competing needs to both treat legitimate pain and to not prescribe inappropriately for patients who may be attempting to divert or abuse narcotics. He articulated difficulty assessing a subjective symptom like pain, appropriately weighting collateral information such as phone calls from family, balancing trust and suspicion in the patient-physician relationship, and in meeting the requirements of Rhode Island's pain statute.

Although an extreme example, this case echoes many of the concerns expressed by physicians on numerous prior cases reviewed by the Board. It also provides an opportunity to review Rhode Island's rules and regulations related to pain assessment[1] and the standard of care that the Board applies when investigating an allegation of inappropriate prescription of chronic narcotics.

RULES AND REGULATIONS RELATED TO PAIN ASSESSMENT

In May of 2003 the Department of Health promulgated regulations related to pain assessment. The Rhode Island General Assembly had previously declared "…pain affects quality-of-life, job performance and security; nearly 30% of nursing home resident with daily pain were receiving no pain medication of any form; pain untreated or under-treated adversely impacts the quality-of-life for patients; up to 95% terminally ill patients pain can be relieved with adequate pain management; and too many in Rhode Island are as are suffering and dying in needless pain…"

The regulations, written to apply to both healthcare facilities and healthcare providers, required that all patients be assessed for pain upon initial evaluation, using a combination of patient's self report, a healthcare provider's assessment and/or a pain intensity tool. The care must include ongoing reassessment, to be documented in the clinical record.

Of note, the regulations are mute regarding specific treatment of pain and defer entirely to the judgment of the healthcare provider and community practice standards. Many clinicians and patients have misconstrued these regulations. They are not a mandate to treat pain in a fashion inappropriate to the clinical context.

CHRONIC NARCOTIC THERAPY

The model policy for the use of controlled substances promulgated by the Federation of State Medical Boards underscores that "physicians should not fear disciplinary action... for ordering, prescribing, dispensing or administering controlled substances... for a legitimate medical purpose and in the course of professional practice. The board will consider prescribing…

controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment… ."[2]

Allegations of inappropriate prescribing are evaluated individually in a clinical practice context. When reviewing the medical record of a patient on chronic narcotic therapy, the Board first determines whether there is a legitimate physician-patient relationship. Without a legitimate physician-patient relationship documented by a clinical record, narcotic prescription is always inappropriate. This acknowledges that a genuine physician-patient relationship also exists for physicians participating in a cross coverage or group practice.

Patients receiving chronic narcotic therapy must have an adequate clinical evaluation that should include a history and physical examination, relevant radiographic/imaging and laboratory studies, and subspecialty consultation. Chronic therapy is defined as at least 6 months in duration. There should be a specific diagnosis or at least a considered attempt to make one. There must be a documented treatment plan. Patient follow-up should include assessment and reassessment of pain as well as reevaluation for intercurrent illness and disease progression.

In recent years there has been a movement towards the use of a "narcotics contract" which provides informed consent with review of the possible adverse outcomes including addiction and abuse.[2,3] Such agreements may also require that all narcotics prescriptions be provided by one provider and be filled at a specific pharmacy. The Board advises that such contracts be employed as a general "best practice."

Concerning History

Although trust is central to the physician-patient relationship, the safe and appropriate prescription of narcotics requires a judicious level of suspicion. The prudent clinician should consider whether the subjective complaint of pain is proportionate to the underlying biomedical condition. Concerning factors would include excessive quantities of controlled substances required to control symptoms, frequent or early refills, use of multiple pharmacies, prescriptions from multiple providers, use of street slang in referring to medications e.g. "Percs", "Vics", or "Oxys" and failure to follow-up on recommended tests or consultations.[5]

A positive urine toxicology screen for illicit substances, criminal proceedings such as DUI, or apparent intoxication at the time of evaluation are also of grave concern. Phone calls and letters from family members or anonymous sources should also prompt further investigation or discussion with the patient. Finally, drug utilization reports issued by third party insurers or regulatory agencies to alert providers to poly-pharmacy and doctor shopping must be addressed and should be included in the medical record.

Punishment

The FSMB and the American Academy of Pain Medicine co-sponsored a study of physician discipline relating to narcotics between 1998 and 2006.[6] During this time there were actions against 725 out of the 700,000 US physicians, or a rate of 0.1%. Reasons included drug trafficking, distributing, racketeering, fraud, money laundering, murder/manslaughter, falsification of records, and inappropriate relationships with patients.

The RI experience mirrors the national one. In recent years the Board has issued sanctions for prescribing with inadequate, nonexistent or falsified medical records, prescribing in exchange for sex or money, drug diversion, and drug abuse. There have been no adverse actions simply for prescribing high doses of narcotics where a legitimate medical record documented a genuine need and treatment plan. Finally, as in the case example, the Board tends to emphasize education and mentorship whenever reasonable.

Conclusion

A physician has the paramount ethical obligation to treat pain and to alleviate suffering. RI law mandates pain assessment and continuing reevaluation. At the same time physicians are expected to take reasonable precautions to avoid contributing to abuse and diversion. The Board expects that all narcotics prescribing occur in the context of a bona fide physician-patient relationship, and that patients undergo proper medical evaluation and ongoing reassessment. Subspecialty consultation from pain or addiction specialists can often be helpful.

There is little evidence to substantiate a general concern that physicians are at risk to be sanctioned simply for prescribing high doses of narcotics.

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