

Appropriate Prescribing of Opiates as Professional Conduct

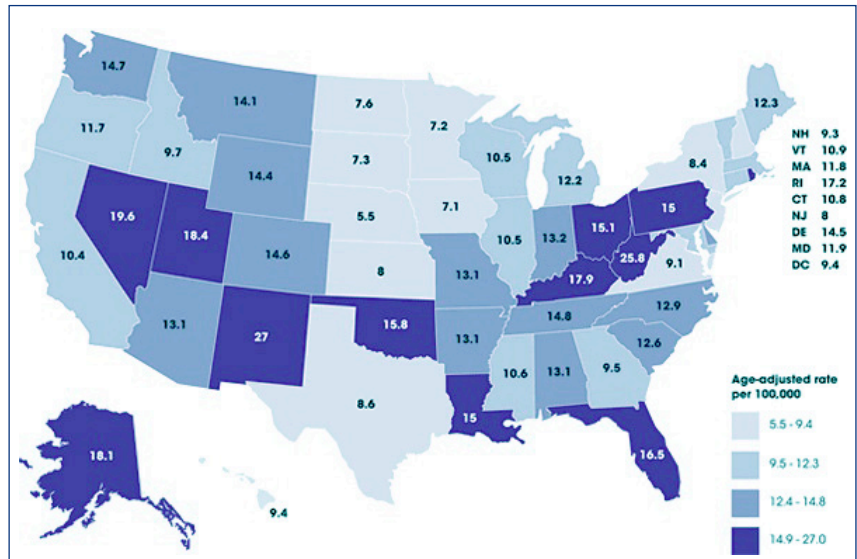
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ABSTRACT

Prescription drug abuse/misuse in Rhode Island and the US is an epidemic. Chronic pain is often treated with prescription opiates which offer some relief, yet present risks to the patient of dependence, addiction and overdose. Physicians find themselves at times at odds with their patients regarding the management of pain and may feel bullied or pressured regarding prescribing. The Rhode Island Board of Medical Licensure and Discipline recognizes the value of established parameters for responsible and safe prescribing.

KEYWORDS: Prescription drug abuse, responsible prescribing, www.health.ri.gov/saferx

Drug Overdose Rates by State, 2008



A PROBLEM OF PAIN

Relieving pain, healing the sick, caring for people, lending an ear and helping others are perhaps some of the reasons we chose to go to medical school in the first place. No one desires to have an adversarial relationship with a patient, yet the issue of long-term opiate use can create conflict in the exam room. Patients are in a difficult position as is the prescriber. All too often the problem of treating pain can lead to an unintended vicious cycle of pain, opiate use, addiction and all that comes with the disease of addiction.

Most physicians did not see the prescription drug abuse epidemic coming. A common teaching years ago was to “treat pain” and that patients will not become addicted. It is clear addiction to pain medication does occur, that addiction is a disease¹ and chronic pain is challenging to manage. Physicians can find themselves between the proverbial “rock and hard place” as they try to manage pain, yet protect their patients from a remedy known to be addictive and currently responsible for 4 deaths weekly in Rhode Island.²

In 2008, Rhode Island ranked 7th among states regarding deaths from overdose of prescription drug abuse.³ Prescription drug abuse has been declared an epidemic by the CDC,⁴ perhaps the most vexing epidemic of our generation. The purpose of this article is to highlight expected practices and standards when it comes to responsible opioid prescribing.

STATUTORY AUTHORITY

The Board of Medical Licensure and Discipline derives its statutory authority from § RI 5-37⁵ and is charged with its mission: “To protect the public through enforcement of standards for medical licensure and ongoing clinical competence.”⁶ The Board has long advocated that pain be treated appropriately and responsibly.⁷ There is no prohibition from using opiates; rather the expectation is that opioid medications be prescribed responsibly⁸ and thoughtfully. It is the expectation that prescribers will meet minimum expectations regarding standards of care and understand that treatment goals are tailored to the patient. Elimination of pain may not be possible without undue risk to the patient and control of pain maybe the best achievable goal.

EXPECTED PRACTICES AND STANDARDS

Minimum standards when prescribing opiates are appropriate to establish boundaries and clearly communicate expectations of the physician community.

Medical Records

It is expected that the physician will maintain appropriate medical records⁹ and more specifically, the medical record should contain the following elements:

1. appropriate medical history and physical examination
2. diagnostic, therapeutic and laboratory results
3. consultations
4. treatment objectives
5. coexisting disorders, alcohol, substance use history
6. informed consent
7. controlled substance log
8. medications (including date, type, dosage and quantity prescribed)
9. narcotic/pain management agreements
10. problem summary list

Medical records should be current, immediately available for review, and stored securely for at least 5 years.

Physician Patient Relationship

An appropriate physician patient relationship should exist. Evidence of this should be readily apparent in the medical record. Prescribing opiates without physically seeing a patient is inappropriate unless for a brief (less than 5-day period) for an emergency.

Prescribing to Self and Family

In accordance with the policy set forth by the AMA,¹⁰ it is inappropriate to treat immediate family members or oneself with controlled substances of any type.

Informed Consent

Informed consent is an interactive process and involves at a minimum a meaningful exchange of information regarding the proposed treatment or non-treatment. This is important before prescribing opiates, particularly if for longer than 5 days. Attention should be directed to indication for treatment, side effects, risk of addiction and the patient's responsibility in preventing diversion. Patients should be specifically directed that this medication has potential for dependence and is intended only for the patient and never to be shared with a family member. Sharing prescription drugs is a violation of state¹¹ and federal law.¹² Non-opiate options including no treatment for pain should be part of the dialogue. Documentation of this consent is expected in the medical record and should be periodically updated if opiates are used long-term.

Pain Agreement

The use of a pain contract, pain agreement, provider patient agreements, controlled substance agreement or a similar agreement is expected when prescribing opiates for long term use.¹³ These tools are available from multiple sources and often can be tailored to your practice.¹⁴

Pain specialists should consider a trilateral opioid contract¹⁵ which includes the patient, pain specialist and primary care provider. This promotes transparency, reduces the risk of diversion and can effectively bridge the pain clinic and primary care provider.

Establishing clear boundaries help frame outcomes, expectations, as well as allow treatment to be started in a non-judgmental and objective manner. The agreement should be reviewed periodically and updated to reflect changes. Some may consider the practice of *Universal Precautions*,¹⁶ having an agreement with every patient who is prescribed a controlled substance.

When to Refer

Periodically patients will exceed the scope of your practice and appropriately need to be referred. Understanding your strengths and limitations is wise and should consider the patients' best interests. Some have advocated strong consideration of referral to pain medicine, addiction medicine or other appropriate entity when morphine equivalent dose is 120mg/day.¹⁷ Referral can certainly occur before that dose and perhaps should occur sooner than later. Strong consideration should be considered to a multidisciplinary¹⁸ approach to the treatment of chronic pain and refer to appropriate disciplines as clinical judgment dictates.

Treatment Plan

The treatment plan should state objectives by which treatment can be evaluated. Performing a functional assessment prior to treatment and as treatment progresses tailors therapy to the individual needs of the patients. Additionally, addressing the functional impact of pain and translating it to objective relevant goals which are verifiable encourages prescribing decisions connected to outcomes demonstrated by the patient.¹⁹ Complete analgesia may not be possible nor in the patient's best interest, yet efforts should be directed at optimizing functional outcomes.

DIVERSION

Diversion occurs when a prescribed medication for one person is given to another person. Diversion is common; it occurs in many patients who may be diverting opiates to support their own addiction, for financial gain or for other reasons. Physicians need to be cognizant that opiates are frequently diverted, often by friends or family of the patient.²⁰ Periodically monitoring the patient with urine toxicology screens is expected as well as using existing tools to monitor patient's utilization. Patients who frequently refill medications early, lose medications, or have negative urine screens should raise suspicions.

Prescription Monitoring Program

Rhode Island is one of 42 states that currently has an active prescription drug monitoring program (PDMP).²¹ The PDMP allows prescribers to currently see what schedule II and III drugs their patients are taking. There are limitations to this tool – it does not show schedule IV and V medications routinely and the data may be up to 30 days old. Currently, prescribers can only see patient's activity in one state. There is

presently not a national PDMP. The PDMP has been shown to positively impact prescribers' habits and reduce in some states opioid misuse.²² A best practice is to review the PDMP before prescribing any controlled substance to a patient. It is expected that every prescriber of controlled substances will use the PDMP often and incorporate it into daily practice.

ADDICTION

Addiction is a disease, often chronic, relapsing and challenging to diagnose and treat. Physicians should periodically review their treatment and differentiate if they are treating chronic pain, dependence, addiction or a combination. Honest discussions are appropriate for the exam room and making a diagnosis of addiction may not be well received by a patient, yet that does not make it less true. Patients often need to hear this message multiple times from multiple sources before they seek help.

CONCLUSIONS

The prescription drug abuse epidemic is perhaps our greatest public health challenge. Regulatory agencies such as the RI BMLD can establish guidelines, enforce law and continue to educate the professional community. No physician has ever been disciplined by the BMLD for responsible opioid prescribing. Physicians are highly encouraged to treat pain appropriately, yet to do it responsibly and transparently.

The vast majority of Rhode Island physicians are conscientious, caring and compassionate and trying to manage this issue as best they are able. There are consequences, however, for those who do not prescribe opiates responsibly. The BMLD takes very seriously those who prescribe irresponsibly or are complacent with this serious issue. Physicians are well advised to keep up to date on current practices regarding prescribing opiates and exhaust all other reasonable options before initiating therapy.

Physicians must practice responsible opioid prescribing, collaborate and refer as needed while using existing tools and resources. Perhaps most important is to remember the exam room represents a sacred space where trust, honesty and healing are the most valuable currency we have with our patients. The exam room should be a "safe place" for the patient and physician. Although physicians are under enormous pressure from external entities, respecting the patient and determining what is best for the individual in front of you should hearken back to why you entered this profession in the first place.

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