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Issues&Answers

Brave New World Redux

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Sandy Sanbar, MD, JD, PhD, recently wrote a two-part article in the OSMA Journal (and those who haven't read it, should) on the use and non-use of addicting medications in the treatment of chronic pain. A very brief summary was that these drugs tend to be underused, primarily because of practitioner's fear of legal problems from regulating entities (e.g., DEA, OBN, OSBMLS).

While that conclusion may be debatable, it raises the realization that in 23 years of attending local, state and national meetings where the use of opiates and other analgesics was discussed, I never heard just what the optimal outcome of treating pain really is. Just what is the ultimate aim of pain management?

Several levels of achievement spring to mind. Should the prescriber be satisfied, and the user accepting, if a full night's sleep results but with daytime uncomfortableness? Is the target the ability to adequately perform activities of daily living including job requirements but with personal malaise? Or is it complete freedom from any and all undesirable sensations?

Indeed, is there an adverse relationship between creation and comfort? Would there be the great books, musical works or visual arts without Winston Churchill-type "blood, sweat, and tears"?

Many years ago, Aldous Huxley wrote of a world where sheep-like inhabitants each morning took a pill (amazingly he even named it "Soma"), which made them docile and controllable. Is Nirvana to be desired where we all float on an innerspring mattress beneath down comforter, never again to experience reality?

Let me know if you think there should be down to know up, cold to enjoy hot, pain to feel relief, or not.

this issue

PRESCRIPTION DRUG ABUSE: WHAT PHYSICIANS NEED TO KNOW

Photo by Rob Ferguson

Prescription drug abuse has reached epic proportions in the United States at the same time that physicians are encouraged to use everything at their disposal to treat their patients' illnesses and relieve their pain and suffering while sophisticated computer technology allows local, state and federal agencies to monitor precisely patients' prescription drug histories and physicians' prescribing habits.

"A 2005 study...found that more new drug users began by abusing pain relievers than marijuana or cocaine."

Over ten million Americans abuse prescription medications, more than those who abuse cocaine, heroin, hallucinogens and inhalants combined. A 2005 study by the Substance Abuse and Mental Health Services Administration found that more new drug users began by abusing pain relievers than marijuana or cocaine. The Centers for Disease Control and Prevention reports that prescription opioids are responsible for more overdose deaths than cocaine and heroin combined.

The Medical Board's policy on prescribing states that "Physicians should not fear disciplinary action from the Board for ordering, prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the course of professional practice… if based on sound clinical judgment." Yet at every meeting of the Board, several physicians are summoned to appear to explain lax or aberrant prescribing practices.

What's a physician to do? Physicians must exercise extreme diligence every time they write a prescription. The following is a review of some prescribing basics.

Legend Drugs

Legend drugs, now more commonly referred to as prescription drugs, are any drugs or medications that require a prescription for their use written by a physician or other authorized health professional and dispensed by a pharmacist (or dispensing practitioner) because they are considered potentially harmful if not used under the supervision of a licensed health care professional.

A Legal Prescription

Federal law states, at minimum, that a prescription for a controlled substance is legal only if the prescription is written for a legitimate medical purpose by a licensed practitioner registered with the Drug Enforcement Agency (DEA) acting within the scope of professional practice. To meet this requirement, three criteria must be met: the patient must desire treatment for a legitimate illness or medical condition; the practitioner must establish a legitimate need for the prescription through patient assessment and pertinent diagnostic procedures; and a reasonable correlation must exist between the patient's medical problem and the drug prescribed.

Controlled Substances

Because of their susceptibility to abuse, certain prescription drugs are subject to special requirements under the Federal Controlled Substances Act (CSA, 1979). These Controlled Dangerous Substances (CDS) are grouped in five (5) Schedules. Factors used to determine if a drug should be controlled and into which Schedule it should be placed are: the drug's actual or potential for abuse; scientific evidence of the drug's pharmacologic effects; current scientific knowledge of the drug; the drug's history and current abuse pattern; scope, duration and significance of abuse; degree of risk the drug poses to public health; the drug's psychic or physiological dependence liability; and whether the drug is an immediate precursor of a substance already controlled.

Five Drug Schedules

Schedule I: Drugs with a high potential for abuse and no currently accepted medical use, e.g., heroin, lysergic acid diethylamide (LSD). Schedule I drugs are not available for medical practice.

Schedule II: Drugs with a high potential for abuse and addiction but with a currently accepted, legitimate medical use, e.g., opium, morphine, cocaine and their derivatives, and stimulants such as amphetamines, methylphenidate and some short-acting barbiturates.

Schedule III: Drugs with less potential for abuse and addiction than those in Schedule I or Schedule II with a currently accepted, legitimate medical use e.g., some stimulants and depressant drugs not in other schedules and preparations containing limited amounts of codeine.

Schedule IV: Drugs with less potential for abuse and addiction than those in other Schedules but with currently accepted, legitimate medical use e.g., certain sedative-hypnotics and anti-anxiety agents, analgesics and stimulants not in other Schedules like diazepam, Phenobarbital, benzodiazepines, pentazocine, propoxyphene, and phentermine.

Schedule V: Drugs (including some over-the-counter preparations) with a low potential for abuse compared to the other scheduled drugs with a current accepted, legitimate medical use, e.g., antitussive, antidiarrheal and other mixtures containing limited amounts of opioids with nonopioid drugs.

Physician Responsibility

Physicians are responsible and liable for all prescriptions which bear their names, regardless of the mode of transmission to the pharmacist, whether hand written by the doctor, faxed, e-mailed, scanned, or called in by the practitioner or his/her staff. Physicians should never write a prescription without at least a cursory (but preferably thorough) examination of the patient with documentation for the prescription placed in the patient's medical record.

Computer technology and current Oklahoma law allow physicians (and law enforcement officials) to monitor exactly their own (and their office's) prescribing habits and their patients' prescription histories.

Oklahoma's Prescription Monitoring Program

Since 2010, the Oklahoma Anti-Drug Diversion Act requires pharmacists to report all prescriptions for Schedule II, III, IV and V drugs to a central data base operated by the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD). In addition to specifics of the prescription itself, the report includes the identity of the prescribing physician and patient. Currently pharmacists and dispensing physicians have twenty-four hours to file reports with the Prescription Monitoring Program (PMP). By January 1, 2012, however, pharmacists and dispensing physicians must report prescriptions to PMP within five minutes of being delivered to the patient or patient's designee.

Nearly seventy per cent of Oklahoma physicians have registered with OBNDD to gain almost "real time" access to prescription data regarding them and their patients.

To learn more about PMP or to register and secure the Personal Identification Number (PIN) required to retrieve PMP data, call the PMP Help Desk, 1-877-627-2674, or online at pmpadmin@obn.state.ok.us.

FSMB PROPOSES REENTRY TO PRACTICE GUIDELINES

A special committee of the Federation of State Medical Boards (FSMB) recently published a draft report outlining guidelines for physicians and physician assistants planning to return to practice after lengthy absences from their clinical activities.

While not mandatory, the guidelines are designed to assist State Medical Boards (SMB) in their mandate to protect public health and patient safety by ensuring the clinical competency of physicians (and physician assistants) and provide a standardized process for physicians who have taken extended leaves from medicine to demonstrate their competence prior to reentering clinical practice.

An increasing number of physicians are taking extended leaves from the active practice of medicine. Reasons range from lifestyle and/or family choices; research or administrative opportunities; personal health needs; humanitarian activities; and profession interests not involving clinical medicine; to career frustration and dissatisfaction. Anecdotal evidence seems to indicate that female physicians may be more affected by practice reentry issues than their male counterparts due to childbirth and the responsibilities of childcare and caring for ill or elderly family members many will undertake.

There is also concern that SMB Maintenance of Licensure (MOL) requirements and Maintenance of Certification (MOC) requirements of the American Board of Medical Specialties may identify many physicians not in active clinical practice.

While recognizing the need for more data and flexibility, the FSMB report states “more than two years away from practice is commonly accepted as the timeframe for when physicians should go through the reentry process.”

The draft report encourages SMBs to develop a reentry process based on FSMB’s MOL components of reflective self assessment by the practitioner; assessment of the physician’s knowledge and skills; and the physician’s performance in practice.

A key to both the MOL and reentry processes is the compilation of accurate data on the number of licensed physicians and physician assistants no longer in clinical practice.

Medical Board Subscriber Services Assist in Application/Credentialing Process

Oklahoma physicians know all too well that the process of applying for hospital and/or clinic privileges, membership on insurance panels and managed care entities etc., can be cumbersome, duplicative, time consuming and expensive. The Board possesses the most complete and comprehensive data base of medical doctors in the state. All education, training, and licensing information is certified through original source verification.

Oklahoma physicians may streamline the application and/or credentialing process if the entity they wish to join is affiliated with OSBMLS Subscriber Services. Currently over sixty (60) hospitals, clinics, insurers, pharmaceutical companies, government agencies and others pay a nominal fee of $60.00 a month to access, with physician approval, the Board’s Subscriber Services data base. Some organizations use OSBMLS Subscriber Services as a primary credentialing source, others to supplement existing programs.

To learn more about the Board’s Subscriber Services, call Board Deputy Executive Director Reji T. Varghese, 405-962-1400 Extension 118.

FSMB MAINTENANCE OF LICENSURE INITIATIVE

The Federation of State Medical Boards (FSMB) House of Delegates recently endorsed a concept currently known as Maintenance of Licensure (MOL), an initiative to ensure the ongoing competence of physicians seeking license renewal.

According to FSMB, MOL will be a "system of continuous development that requires all licensed physicians to demonstrate, as a condition of license renewal, their involvement in lifelong learning that is objective, relevant to practice and improves performance over time."

While FSMB cannot mandate individual state medical board (SMB) policy, the FSMB MOL Implementation Group recommends the MOL program be implemented "as expeditiously as possible with SMBs moving forward together. For practical purposes, some SMBs may institute MOL in a phased in implementation. Regardless of implementation approach, all SMBs should complete the implementation process within a 10-year period."

Currently, Oklahoma State Board of Medical Licensure and Supervision (Board) has no timetable or schedule for FSMB MOL implementation.

FSMB representatives made a MOL presentation to the Oklahoma Board at its meeting in September, 2011. The essence of the FSMB MOL program has three components: Reflective Self-assessment; Assessment of Knowledge and Skills; and Performance in Practice.

Reflective Self-assessment

Physicians should complete certified and /or accredited Continuing Medical Education (CME), a majority of which is practice-relevant and supports performance improvement. This should be accomplished annually.

Assessment of Knowledge & Skill

Physicians should undertake objective knowledge and skills assessments to identify learning opportunities and guide improvement activities. The FSMB MOL Implementation Group report notes "… Many types of external assessment are structured, valid and practice-relevant…SMBs may want to concentrate their efforts on requesting physicians to document use of tools from objective third parties with demonstrated expertise in these activities to assess their own knowledge and skills." This should be completed every five-six years.

Performance in Practice

Physicians should use comparative data and, when available, evolving performance expectations to assess the quality of care they provide and then apply best evidence or consensus recommendations to improve and subsequently reassess their care. The FSMB MOL Implementation Group acknowledges that this component "will evolve with time. Increasingly robust use of health information technology will enable physicians to more easily and comprehensively understand the impact of their efforts on patient outcomes and to learn how their personal outcomes compare to those of fellow physicians." This should be documented every five-six years.

The FSMB MOL Implementation Group report states that: "SMBs should consider physicians who provide evidence of successful ongoing participation in American Board of Medical Specialties' (ABMS) Maintenance of Certification (MOC) to have fulfilled all three components of MOL."

Currently, some seventy-five per cent (75%) of Oklahoma medical doctors in active practice are ABMS certified.

The FSMB MOL Implementation Group has identified several particularly challenging areas for MOL implementation: physicians practicing in medical and surgical areas not well described by traditional specialty designations and descriptions; and physicians not involved in direct patient contact. Additional study is needed in these areas. FSMB encourages SMBs to regularly collect data from physicians about the nature of their daily work and involvement in direct patient care.

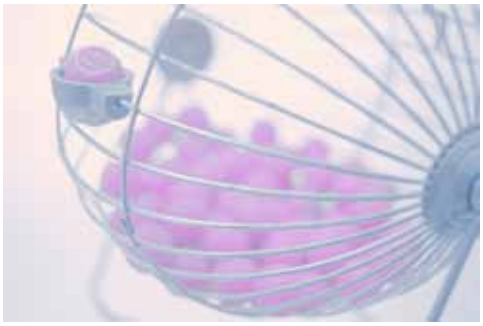
Medical Board Website a Marketing Tool

The vast majority of those visiting the Board's website are members of the public, most looking to find a physician. Physician information available to the public consists of a physician's name, specialty, office address, telephone and FAX numbers, office hours, insurances accepted, and if the practice is accepting new patients.

The public can search the public physician data base by name, specialty, hospital(s) affiliation, county, insurance participation, accepting new patients or any combination of these.

The "Find a Doctor" website feature is an excellent way to market a practice. This is another reason to update your physician profile whenever it changes. When a physician updates his or her private profile, the Find a Doctor page incorporates the appropriate changes immediately as well.

Visit the Board's webpage. You'll like what you see.



Wages of Sin

by Gerald C. Zumwalt, MD, Board Secretary/Medical Advisor

Currently, the State Legislature is studying whether the lottery should be privatized and/or the mandated 35% allotment of its income to the state schools be reduced. It brings to mind what has occurred during my lifetime in use/abuse of morality/immorality to finance public education.

Oklahoma has always been glad to accept taxes on the disease and death producing use of tobacco. In the late '50s, we abandoned prohibition on legal alcohol sales and allowed opening of state licensed bottle stores (never mind the hypocrisy of always having allowed beer sales as a legal "non-intoxicating beverage"). When this didn't fill the unfillable pocket of government, liquor by drink was to be the solution.

When schools still cried poverty, media depictions of beautiful children helped bring about the adoption of the aforementioned lottery.

Since we have swallowed our religious pride and opened our arms and purses to tobacco, whiskey and gambling and still not achieved the goal of academic halls paved with gold and populated by intelligent, multi-degreed teachers, is it not time to look toward "wild women" and follow Nevada's approval of state licensed brothels?

It is certainly apparent that prostitution openly exists in Sooner-land. Here at the Board we have had cases of doctors being disciplined for solicitation of prostitutes (or police personnel posing as prostitutes). It is also pertinent that prostitution as it presently exists degrades people and street corners and neighborhoods, but also serves as a conduit to sexually transmitted diseases. Go to any county health department and view the multiple diagnostic/treatment encounters due to gonorrhea, chlamydia and HPV. Would not the existence of state licensed, financed and managed cathouses not lead to frequent random testing of their employees?

If we can wink at the psychological, social and medical damage done by our present government-approved/-taxed societal ills, why would one more not be just as embraced by our callous consciences.

November 2011 Medical Board Meeting

At its regularly scheduled November 2011 meeting, the Board considered licensure and discipline issues.

- Two full medical licenses were issued after personal appearances by the physicians
- One medical license was reinstated allowing for participation in a one year fellowship program under standard terms for substance abuse including attendance at five 12-step programs per week and no prescribing of CDS.
- One medical license application was denied because of multiple, prior incidents of sexual misconduct.

Two physicians were disciplined and another license was surrendered:

- One was placed on three years' probation under standard terms for unauthorized use of opiates and lying to investigators.
- The other physician, who relapsed following treatment, received a three-month license suspension followed by indefinite probation with the stipulation of attendance at four 12-step meetings per week and a work limit of 40 hours per week.
- The third physician's license was surrendered after an insanity ruling by a district court.

The Board disciplined two Physician Assistants:

- One was suspended for three months, denied prescriptive authority for CDS and required to complete a prescribing course within one year for prescribing CDS to family and friends without medical records, examination or authorization.
- The other was suspended for six months and placed on probation for five years due to substance abuse and prescribing violations with the requirement of attendance at four 12-step programs per week, counseling and a 40 hour work week limitation in an approved environment.

The Board reinstated two Respiratory Care licenses both under five years' probation and standard terms for alcohol abuse including counseling and multiple 12-step meetings.

September 2011 Medical Board Meeting

The September Board meeting resulted in numerous licensing and disciplinary actions.

- One medical license was issued after a personal appearance
- One medical license was granted under an agreement that contained standard terms for alcohol abuse including four 12-step meetings per week.
- One application for reinstatement of medical license after revocation for sexual misconduct and harassment was denied.

Two physicians were officially reprimanded and fined $1,500.00:

- One of these physicians also was denied CDS prescribing privileges for three months and required to complete a CDS prescribing course for furnishing pre-signed, blank prescriptions for unlicensed staff to use.
- The other physician was disciplined for prescribing CDS to a family member and conviction of financial exploitation of an elderly person by a caretaker.

One physician license was suspended for six months for prescribing CDS to minors without medical need or parental consent. The physician must complete a CDS prescribing course before any consideration of reinstatement.

One physician license was surrendered after conviction of prescribing CDSs without medical necessity and sharing in the use of the opioid.

Two physicians were placed on probation:

- One received five years probation under standard terms for alcohol abuse including five 12-step meetings a week and continued treatment for depression.
- The other physician was issued two years probation for failure to report a DUI and conviction of domestic assault and battery on the medical license renewal form. The physician must participate in psychotherapy, complete a medical ethics course and attend one 12-step meeting a week.

One Respiratory Therapy license was granted under standard terms for alcohol abuse including outpatient treatment and three 12-step meetings a week.

Professional Development

Medical & Legal Aspects of Pain Management

February 3, 2012

Oklahoma City

www.okmedicalboard.org

7 hours AMA Category 1/ AOA Category 1-A CME

Upcoming Events

Pain Management CME Program

The Medical Board will offer "Medical & Legal Aspects of Pain Management" on Friday, February 3, 2012, at Francis Tuttle Technology Center, 7301 West Reno, Oklahoma City. The program, which begins at 7:45 a.m., is approved for **seven hours of Category I credit by both the American Medical Association and the American Academy of Family Practice and ten hours of PLICO's Risk Management premium credit**.

Other sponsors and presenters are the University of Oklahoma College of Medicine, American Board of Legal Medicine, Oklahoma State Medical Association, Oklahoma Osteopathic Board, Oklahoma Osteopathic Association, Oklahoma Bureau of Narcotics and Dangerous Drugs, and Office of the Oklahoma State Attorney General.

Register online at www.okmedicalboard.org.

MD CME Requirements for Licensure

60 Category 1 hours within the previous three years

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