From Our Member Board Exchanges

ARIZONA

FILING A COMPLAINT JUST GOT EASIER

Filing a complaint against a physician is now as easy as 1-2-3. Consumers can file a complaint with the Arizona Medical Board online at www.azmdboard.org and automatically receive a receipt of the complaint and a tracking number to follow the case progression online. "Arizona is one of the first medical boards in the country to implement a system like this," said Executive Director Barry A. Cassidy, Ph.D., PA-C. "I am extremely proud of the accomplishments board staff continue to make that bring increased services to the public."

The Arizona Medical Board got the idea for the online complaint filing and tracking system while participating in the statewide initiative to bring online payment services to Arizona state agencies. The board is still working on the second piece of the project that will provide online physician licensing and renewal applications and payments. "It seemed logical to build on existing resources to bring this service to realization," said Cassidy.

The system is designed to provide information to consumers in two pieces. After filing a complaint online, consumers are e-mailed a tracking number. That number tracks the complaint through the initial steps of processing the information received, gathering additional information and opening an investigation. "All cases received by the board are opened," said Cassidy, "except for those that fall outside the board's jurisdiction."

After a case has been opened, a case number is assigned. At any time, the complainant or the physician can enter the case number and determine the case status and the date when the case first reached that status. A case can fall within one of four status categories: Case Opened, Case Under Investigation, Case Under Review and Case Closed. Each status category is hyperlinked to definitions of that status.

For those consumers who prefer the traditional approach to complaint filing, complaint forms can be downloaded from the website. Complaint forms may also be requested by calling the board at (480) 551-2700.

Reprinted from the Arizona Medical Board website.

CALIFORNIA

REVISED PAIN MANAGEMENT GUIDELINES

It has been 13 years since the Intractable Pain Treatment Act of 1990 first established laws to assist physicians in the course of treatment for a person diagnosed with intractable pain. In 1994, the board adopted guidelines for *Prescribing Controlled Substances for Intractable Pain.* In the ensuing years, the practice of pain management and the affected patient population have continued to evolve and has received much attention from the medical community and affected patients.

Effective Jan. 1, 2002, Business and Professions Code section 2241.6 (referred to as AB 487) was added requiring the Division of Medical Quality (DMQ) to develop standards to assure the competent review in cases concerning the management, including, but not limited to, the under treatment, under medication and over medication of a patient's pain. When this item was discussed at the May 2002 board meeting, a task force was established to review the 1994 guidelines and to assist the DMQ in the development of the standards. The scope of the guidelines was expanded from intractable pain patients to all patients with pain.

The task force was comprised of representatives from the American Pain Society, the American Academy of Pain Medicine, the California Society of Anesthesiology, the California Chapter of American College of Emergency Physicians, the California Medical Association, Compassion in Dying Federation, the Office of the Attorney General Health Quality Enforcement Section and the board.

The revised guidelines are intended to improve effective pain management of California patients by incorporating a series of annotations which better reflect how these guidelines should be used, and will allow for periodic update, as indicated. It is anticipated that physicians will have a higher level of comfort when using controlled substances, including opioids, in the treatment of pain. And, the revised guidelines will promote improved pain management for patients in pain, while providing better guidance to the board's Enforcement Program, in determining whether or not allegations of inappropriate prescribing are supported by evidence.

At the August 2003 board meeting, the DMQ adopted the recommendations of the task force in the revised *Guidelines for Prescribing Controlled Substances for Pain.*

GUIDELINES FOR PRESCRIBING CONTROLLED SUBSTANCES FOR PAIN

Adopted Unanimously by the Board in 1994 and Recently Revised

"No physician and surgeon shall be subject to disciplinary action by the board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain." — Business and Professions Code section 2241.5(c)

PREAMBLE

In 1994, the Medical Board of California formally adopted a policy statement titled, *Prescribing Controlled Substances for Intractable Pain.* The statement outlined the board's proactive approach to improving appropriate prescribing for effective pain management in California, while preventing drug diversion and abuse. The policy statement was the product of a year of research, hearings and discussions. California physicians and surgeons are encouraged to consult the policy statement and these guidelines, which can be found at www.medbd.ca.gov or obtained from the Medical Board of California.

In May 2002, as a result of AB 487, a task force was established to review the 1994 guidelines and to assist the Division of Medical Quality to "develop standards to assure the competent review in cases concerning the management, including, but not limited to, the under treatment, under medication and over medication of a patient's pain." The task force expanded the scope of the guidelines, from intractable pain patients to all patients with pain.

Inappropriate prescribing of controlled substances, including opioids, can lead to drug abuse or diversion and can also lead to ineffective management of pain, unnecessary suffering of patients and increased health costs. The board recognizes that some physicians do not treat pain appropriately due to a lack of knowledge or concern about pain, and others may fail to treat pain properly due to fear of discipline by the board. These guidelines are intended to improve effective pain management in California, by avoiding under treatment, over treatment or other inappropriate treatment of a patient's pain and by clarifying the principles of professional practice that are endorsed by the board so that physicians have a higher level of comfort in using controlled substances, including opioids, in the treatment of pain. These guidelines are intended to promote improved pain management for all forms of pain and for all patients in pain.

A HIGH PRIORITY

The board strongly urges physicians and surgeons to view effective pain management as a high priority in all patients, including children, the elderly and patients who are terminally ill. Pain should be assessed and treated promptly, effectively and for as long as pain persists. The medical management of pain should be based on up-to-date knowledge about pain, pain assessment and pain treatment. Pain treatment may involve the use of several medications and non-pharmacological treatment modalities, often in combination. For some types of pain, the use of medications is emphasized and should be pursued vigorously; for other types, the use of medications is better de-emphasized in favor of other therapeutic modalities. Physicians and surgeons should have sufficient knowledge or utilize consultations to make such judgments for their patients.

Medications, in particular opioid analgesics, are considered the cornerstone of treatment for pain associated with trauma, surgery, medical procedures or cancer. A number of medical organizations have developed guidelines for acute and chronic pain management. Links to these references may be found on the Medical Board of California's website at www.medbd.ca.gov.

The prescribing of opioid analgesics for patients with pain may also be beneficial, especially when efforts to alleviate the pain with other modalities have been unsuccessful. Intractable pain is defined by law in California as: "a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and surgeon and one or more physicians and surgeons specializing in the treatment of the area, system or organ of the body perceived as the source of the pain." (Section 2241.5(b) of the California Business and Professions Code)

Physicians and surgeons who prescribe opioids either for acute or persistent pain should not fear disciplinary or other action from California law enforcement or regulatory agencies for the mere fact of having prescribed opioids. The appropriate use of opioids in the treatment of intractable pain has long been recognized in California's Intractable Pain Treatment Act, which provides that "No physician and surgeon shall be subject to disciplinary action by the Medical Board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain." (Section 2241.5(c) of the California Business and Professions Code)

The board expects physicians and surgeons to follow the standard of care in managing pain patients.

GUIDELINES

History/Physical Examination

A medical history and physical examination must be accomplished.

This includes an assessment of the pain, physical and psychological function; a substance abuse history; history of prior pain treatment; an assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled substance.

Annotation One: The prescribing of controlled substances for pain may require referral to one or more consulting physicians.

Annotation Two: The complexity of the history and physical examination may vary based on the practice location. In the emergency department, the operating room, at night or on the weekends, the physician and surgeon may not always be able to verify the patient's history and past medical treatment. In continuing care situations for chronic pain management, the physician and surgeon should have a more extensive evaluation of the history, past treatment, diagnostic tests and physical exam.

Treatment Plan, Objectives

The treatment plan should state objectives by which the treatment plan can be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned. The physician and surgeon should tailor pharmacological therapy to the individual medical needs of each patient. Multiple treatment modalities and/or a rehabilitation program may be necessary if the pain is complex or is associated with physical and psychosocial impairment.

Annotation One: Physicians and surgeons may use control of pain, increase in function and improved quality of life as criteria to evaluate the treatment plan.

Annotation Two: When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.

Informed Consent

The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.

Annotation: A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan and the informed consent. Patient, guardian and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain.

Periodic Review

The physician and surgeon should periodically review the course of pain treatment of the patient and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician and surgeon should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

Annotation One: Patients with pain who are managed with controlled substances should be seen monthly, quarterly or semi-annually as required by the standard of care.

Annotation Two: Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment.

Consultation

The physician and surgeon should consider referring the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Complex pain problems may require consultation with a pain medicine specialist. In addition, physicians should give special attention to those pain patients who are at risk for misusing their medications including those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation and consultation with addiction medicine specialists, and may entail the use of agreements between the provider and the patient that specify the rules for medication use and consequences for misuse.

Annotation One: Coordination of care in prescribing chronic analgesics is of paramount importance. Diagnosis of opioid dependence and intractable pain, both of which are being treated with controlled substances, protections apply to physicians and surgeons who prescribe controlled substances for intractable pain provided the physician complies with the requirements of the general standard of care and California Business and Professions Code Section 2241.5.

Records

The physician and surgeon should keep accurate and complete records according to items above, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, ration-

ale for changes in the treatment plan or medications, agreements with the patient and periodic reviews of the treatment plan.

Annotation One: Documentation of the periodic reviews should be done at least annually or more frequently as warranted.

Annotation Two: Pain levels, levels of function and quality of life should be documented. Medical documentation should include both subjective complaints of patient and caregiver, and objective findings by the physician.

Compliance with Controlled Substances Laws and Regulations

To prescribe controlled substances, the physician and surgeon must be appropriately licensed in California, have a valid controlled substances registration and comply with federal and state regulations for issuing controlled substances prescriptions. Physicians and surgeons are referred to the *Physicians Manual of the U.S. Drug Enforcement Administration* and the *Medical Board's Guidebook to Laws Governing the Practice of Medicine by Physicians and Surgeons* for specific rules governing issuance of controlled substances prescriptions.

Annotation One: There is not a minimum or maximum number of medications which can be prescribed to the patient under either federal or California law.

Annotation Two: Physicians and surgeons who supervise Physician Assistants (PAs) or Nurse Practitioners (NPs) should carefully review the respective supervision requirements.

Additional information on PA supervision requirements is available at www.physicianassistant.ca.gov.

PAs are able to obtain their own DEA number to use when writing prescriptions for drug orders for controlled substances. Current law permits physician assistants to write and sign prescription drug orders when authorized to do so by their supervising physician for Schedule II-IV. Further, a PA may only administer, provide or transmit a drug order for Schedule II through Schedule V controlled substances with the advanced approval by a supervising physician for a specific patient.

To ensure that a PA's actions involving the prescribing, administration or dispensing of drugs is in strict accordance with the directions of the physician, every time a PA administers or dispenses a drug or transmits a drug order, the physician supervisor must sign and date the patient's medical record or drug chart within seven days. (Section 1399.545(f) of the California Code of Regulations)

NPs are allowed to furnish Schedule III-V controlled substances under written protocols.

POSTSCRIPT

While it is lawful under both federal and California law to prescribe controlled substances for the treatment of pain, there are limitations on the prescribing of controlled substances to or for patients for the treatment of chemical dependency (see Sections 11215-11222 of the California Health and Safety Code). The California Intractable Pain Treatment Act (CIPTA) does not apply to those persons being treated by the physician and surgeon only for chemical dependency because of use of drugs or controlled substances (Section 2241.5(d)). The CIPTA does not authorize a physician and surgeon to prescribe, dispense or administer controlled substances to a person the practitioner knows to be using the prescribed drugs or controlled substances for non-therapeutic purposes (Section 2241.5(e)).

At the same time, California law permits the prescribing, furnishing or administering of controlled substances to or for a patient who is suffering from disease, ailments, injury or infirmities attendant on old age, other than addiction (Section 11210 of the California Health and Safety Code) and the CIPTA does apply to "a practitioner who is prescribing controlled substances for intractable pain, and as long as that practitioner is not also treating the patient for chemical dependency."

The board emphasizes the above issues, both to ensure physicians and surgeons know that a patient in pain who is also chemically dependent should not be deprived of appropriate pain relief, and to recognize the special issues and difficulties associated with patients who suffer both from drug addiction and pain. The board expects that the acute pain from trauma or surgery will be addressed regardless of the patient's current or prior history of substance abuse. This postscript should not be interpreted as a deterrent for appropriate treatment of pain.

Reprinted from the October 2003 issue of the *Action Report*, published by the Medical Board of California.

KENTUCKY

SELF-PRESCRIBING AND PRESCRIBING TO IMMEDIATE FAMILY MEMBERS

The board continues to receive inquires concerning the legality or propriety of physicians self-prescribing and prescribing to immediate family members. The question becomes even more complicated when treatment involves the prescribing of controlled substances.

While not a per se violation, Kentucky law KRS 311.597 (1) (C) states that self-prescribing and prescribing to immediate family members is contrary to law when the physician "knows or has rea-

son to know that an abuse of controlled substances is occurring, or may result from such a practice."

According to the American Medical Association's Code of Medical Ethics, physicians generally should not treat themselves or their immediate families. Professional objectivity may be compromised when an immediate family member of the physician is the patient; the physician's personal feelings may unduly influence his/her medical judgment, interfering with the care provided. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise. In emergency or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. However, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

The board strongly recommends physicians make every effort to have treatment of themselves or members of their immediate family rendered by another physician who can approach the case objectively. By doing so, the physician will avoid even the appearance of impropriety and thus avoid problems with this board.

Reprinted from the Winter 2004 issue of the *Kentucky Board of Medical Licensure Newsletter*, published by the Kentucky Board of Medical Licensure.

MAINE

NEW EXAM FOCUS – LEGAL AND ETHICS

The board discontinued the practice of conducting oral interviews for new applicants and instead is using a written exam focused on legal and ethical issues. The exam, which contains 36 questions, is considered an "open book" exam and the board provides all examinees with the information needed.

The idea behind the exam is to inform physicians of the unique standards and laws that will govern their practices in Maine. It is the board's hope that by providing this information, possible problems can be avoided and fewer physicians will become involved with the board's disciplinary process. If any currently licensed physician would like a copy of the exam, please contact the board offices at (207) 287-3601.

Reprinted from the Volume 8, Number 1 issue of *Information & Report*, published by the Maine Board of Licensure in Medicine.

NEW MEXICO

THE DISRUPTIVE PHYSICIAN

While there are not many reports to the board regarding disruptive physicians, when these cases are reported, they represent real problems for other health care workers. In the past, the board could only react to the problem by using the provisions of the Impaired Health Care Provider Act. This involved an evaluation by a panel of doctors who would determine whether the physician was unable to practice with reasonable skill and safety because of a "mental illness."

There are, of course, doctors who are not mentally ill, but who can create havoc in the workplace because of their inability to collaborate with other health care providers in a supportive, helpful way. Most physicians have come across these "disruptive" physicians sometime in their career.

The law that governs the board, the Medical Practice Act, was amended this year. One of the grounds for discipline that has been added is Section 61- 6-15(D) 36 — "interaction with physicians, hospital personnel, patients, family members or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient."

The board can now proceed to discipline a physician (or physician assistant or anesthesiologist assistant) based on this disruptive conduct, rather than require a psychiatric evaluation of why they act as they do. While an understanding of the physician's state of mind may determine the form of discipline ordered by the board, an evaluation is no longer the required first step to stopping disruptive conduct.

The message should be clear. If you are involved in disruptive conduct, stop it. If you don't, you could lose your license. If you know of a disruptive physician and believe the board should be notified of the problem, call the board office at (800) 945-5845 for a complaint form.

Reprinted from the Fall 2003 issue of the *Notes From Your Licensing Board,* published by the New Mexico Medical Board.

RHODE ISLAND

POLICY STATEMENT ON OFFICE-BASED AESTHETIC PROCEDURES

It is the position of the board that office-based cosmetic or aesthetic procedures that require the use of medical lasers, high-frequency

radio waves or injection of sclerosing chemicals or biologically active compounds (e.g. Botulinum toxin A, Botox) are medical procedures.

Therefore, prior to undergoing such procedures, patients must receive a medical evaluation for appropriateness by a licensed and qualified physician or other practitioner acting within his/her scope of practice. Although these procedures may be performed by an appropriately trained nonphysician working under the supervision and direction of a physician or other practitioner acting within his/her scope of practice, it is the supervising physician's (or other practitioner acting within his/her scope of practice) responsibility to assure that procedures are conducted appropriately; with appropriate assessment, consent and follow-up; and upon appropriate patients; and that all patient records are maintained according to standards applicable for medical records; and that patient privacy is protected. The supervising physician or other practitioner acting within his/her scope of practice is responsible for any procedures carried out by nonphysicians under his/her direction.

Physicians (or other practitioners acting within his/her scope of practice) who perform and supervise such procedures must be able to demonstrate appropriate training and experience. Such training and experience may include, but is not limited to, residency or fellowship. The physician or other practitioner acting within his/her scope of practice is responsible to assure and document adequate training for individuals under his/her supervision.

Additionally, other cosmetic procedures such as dermabrasion or the application of potentially scarring chemical treatments (e.g. so-called chemical peels) should also meet this same standard.

Reprinted from the Rhode Island Board of Medical Licensure and Discipline website.

LET US HEAR FROM YOU

Would you like information from your board to be considered for publication in the *Journal?* If so, e-mail articles and news releases to Edward Pittman at epittman@fsmb.org or send via fax to (817) 868-4098.