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Guidelines for Prescribing Controlled Substances for Intractable Pain

Adopted unanimously by the Medical Board on July 29, 1994.

"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 2241.5(c)

Preamble

On May 6, 1994, the Medical Board of California formally adopted a policy statement entitled, "Prescribing Controlled Substances for Pain." The statement outlines the Board's proactive approach to improving appropriate prescribing for effective pain management in California, while preventing drug diversion and abuse. The policy statement is the product of a year of research, hearings and discussions. California physicians are encouraged to consult the policy statement and these guidelines.

The Medical Board recognizes that inappropriate prescribing of controlled substances including the opioids can lead to drug abuse and diversion. Inappropriate prescribing can also lead to ineffective management of pain, unnecessary suffering of patients and increased health care costs. The Board recognizes that some physicians do not treat pain properly due to lack of knowledge or concern about pain. Fear of discipline by the Board may also be an impediment to medically appropriate prescribing for pain. This Guideline is intended to encourage effective pain management in California, and help physicians reach a level of comfort about appropriate prescribing by clarifying the principles of professional practice that are endorsed by the Board.

A High Priority

The Board strongly urges physicians to view effective pain management as a high priority in all patients, including children and the elderly. 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 drug and non-drug treatment modalities, often in

combination. For some types of pain, the use of drugs is emphasized and should be pursued vigorously; for other types, the use of drugs is better de-emphasized in favor of other therapeutic modalities. Physicians should have sufficient knowledge or consultation to make such judgments for their patients.

Drugs, in particular the opioid analgesics, are considered the cornerstone of treatment for pain associated with trauma, surgery, medical procedures, and cancer. Physicians are referred to the U.S. Agency for Health Care Policy and Research Clinical Practice Guidelines which have been endorsed by the Board as a sound yet flexible approach to the management of these types of pain.

The prescribing of opioid analgesics for other patients with intractable non-cancer pain may also be beneficial, especially when efforts to remove the cause of pain or to treat it 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 who prescribe opioids for intractable pain should not fear disciplinary action from any enforcement or regulatory agency in California if they follow California law (Section 2241.5(c)), which reads, "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." Also, physicians should use sound clinical judgment, and care for their patients according to the following principles of responsible professional practice:

Guidelines

- **History/Physical Examination**
  A medical history and physical examination must be accomplished. This includes an assessment of the pain, physical and psychological function, substance abuse history, assessment of underlying or coexisting diseases or conditions, and should also include the presence of a recognized medical indication for the use of a controlled substance. Prescribing controlled substances for intractable pain in California, as noted in the definition in the text of the Report, also requires evaluation by one or more specialists.

- **Treatment Plan, Objectives**
  The treatment plan should state objectives by which treatment success 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 should tailor drug therapy to the individual medical needs of each patient. Several treatment modalities or a rehabilitation program may be necessary if the pain has differing etiologies or is associated with physical and psychosocial impairment.

- **Informed Consent**
  The physician should discuss the risks and benefits of the use of controlled substances with the patient or guardian.

- **Periodic Review**
  The physician should periodically review the course of opioid treatment of the patient and any new information about the etiology of the pain. Continuation or modification of opioid therapy depends on the physician's evaluation of progress toward treatment objectives. If the patient has not improved, the physician should assess the appropriateness of continued opioid treatment or trial of other modalities.

- **Consultation**
  The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. 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.

- **Records**
  The physician should keep accurate and complete records according to items 1-5 above, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, agreements with the patient, and periodic reviews.

- **Compliance with Controlled Substances Laws and Regulations**
  To prescribe controlled substances, the physician 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 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.

Postscript

Under federal and state law, it is unlawful for a physician to prescribe controlled substances to a patient for other than a legitimate medical purpose (for example, prescribing solely for the maintenance of opioid addiction), or outside of professional practice (for example, prescribing without a medical examination of the patient).

It is lawful to prescribe opioid analgesics in the course of professional practice for the treatment of intractable pain according to federal regulations and California Business and Professions Code Section 2241.5, the California Intractable Pain Treatment Act (CIPTA). However, the CIPTA does not apply to those persons being treated by the physician and surgeon for chemical dependency because of their use of drugs or controlled substances (Section 2241.5(d)), and does not authorize a physician or surgeon to prescribe or administer controlled substances to a person the practitioner knows to be using drugs or substances for nontherapeutic purposes (Section 2241.5(e)).

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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 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 Medical 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 Medical 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 Medical 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 Web site 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 Medical 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 semiannually 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.

- *Annotation Two:* In situations where there is dual 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, rationale 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 (PA's) or Nurse Practitioners (NP's) should carefully review the respective supervision requirements.

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

PA's 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)

NP's 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 Medical 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 Medical 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.

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Guidelines for Prescribing Controlled Substances for Pain

Adopted Unanimously by the Board in 1994 and revised in 2007

"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 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 this policy statement and the guidelines below.

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.

Under past law, both Business and Professions Code section 2241 and Health and Safety Code section 11156 made it unprofessional conduct for a practitioner to prescribe to an addict. However, the standard of care has evolved over the past several years such that a practitioner may, under certain circumstances, appropriately prescribe

to an addict. AB 2198, which became law on January 1, 2007, sought to align existing law with the current standard of care. Accordingly, a physician is permitted to prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances. The law, Business and Professions Code section 2241, also set forth the conditions under which such prescribing may occur. Further, Business and Professions Code 2241.5 now permits a physician to prescribe for or dispense or administer to a person under his or her treatment of pain or a condition causing pain, including, but not limited to, intractable 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 Medical Board recognized 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 Medical 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.

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.

Business and Professions Code section 2241.5 provides in part: "(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain. (b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section."

However, this section does not affect the power of the board to discipline a physician and surgeon for any act that violates the law, including gross negligence, repeated negligent acts, or incompetence; violation of section 2241 regarding treatment of an addict; violation of section 2242 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs; violation of section 2242.1 regarding prescribing on the Internet; failure to keep complete and accurate records of purchases and disposals of controlled substances; writing false or fictitious prescriptions for controlled substances; or prescribing, administering, or dispensing in violation of the pertinent sections of the Health and Safety Code.

The Medical 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 to 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 semiannually 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.

- *Annotation One:* Coordination of care in prescribing chronic analgesics is of paramount importance.
- *Annotation Two:* In situations where there is dual 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 sections 2241 and 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, rationale 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 (PA's) or Nurse Practitioners (NP's) should carefully review the respective supervision requirements.

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

PA's 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 V controlled substances with the advanced approval by a supervising physician for a specific patient unless a physician assistant completes an approved education course in controlled substances and if delegated by the supervising physician. 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 Title 16, California Code of Regulations)

NP's 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 - including intractable 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). In summary, a physician and surgeon must follow the same standard of care when prescribing and/or administering a narcotic controlled substance to a "known addict" patient as he or she would for any other patient.

The physician and surgeon must:

- perform an appropriate prior medical examination;
- identify a medical indication;
- keep accurate and complete medical records, including treatments, medications, periodic reviews of treatment plans, etc;
- provide ongoing and follow-up medical care as appropriate and necessary.

The Medical 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 Medical 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.

Department of Consumer Affairs

ACTION REPORT

BOARD OF MEDICAL QUALITY ASSURANCE

No. 29—November 1985

FDA Declares Hepatitis B Vaccine Safe for Health Providers and Others at Risk

The Federal Drug Administration (FDA) has recently substantiated the safety of hepatitis B (HB) vaccine. The FDA and the Public Health Service's Advisory Committee on Immunization Practices (ACIP) have clarified recommendations for use in populations at risk.

There had been concern that HB vaccine might transmit acquired immunodeficiency syndrome (AIDS) because the vaccine is manufactured from pooled plasma of asymptomatic individuals with chronic hepatitis B infection, some of whom could be in the high risk groups for AIDS.

FDA reported in the agency's August Drug Bulletin that studies confirmed that HTLV-III, the human retrovirus identified as the etiologic agent for AIDS, is not transmitted by the HB vaccine.

The ACIP recommends that the following populations receive the vaccine:

- Health care workers, especially those frequently exposed to blood, blood products and needlesticks. It is recommended that vaccination be completed during training in schools of medicine, dentistry, nursing, laboratory technology and other allied health professions. Vaccination is also recommended for groups at increased risk in some hospitals, including emergency room staff, nursing personnel and staff physicians. Other health care workers at increased risk include: Dental professionals, laboratory and blood bank technicians, dialysis center staff, emergency medical technicians and morticians.
- Hemodialysis patients.
- Clients and staff of institutions for the mentally retarded.
- Classroom contacts of deinstitutionalized mentally retarded HBV carriers who behave aggressively or have special medical problems that increase the risk of exposure to their blood or serious secretions.
- Homosexually active men.
- Heterosexually active persons with multiple partners and sexually transmitted disease.
- Users of illicit injectable drugs.
- Recipients of clotting factor concentrates.
- Household and sexual contacts of HBV carriers.
- Special high-risk populations. These include Alaskan Eskimos, native Pacific Islanders, and immigrants and refugees from areas with highly endemic disease, depending on specific epidemiologic and public health considerations.
- Inmates of long-term correctional facilities.
- International travelers who plan to reside more than six months in areas with high levels of endemic HB virus and who will have close contact with the local population. Also, short-term travelers who are likely to have contact with blood from or sexual contact with residents of areas with high levels of endemic disease.

ACTION REPORT INDEX

BMQA-Sponsored Licensing Reform Legislation Becomes Law

A BMQA sponsored package of bills constituting a major reform of physician licensing statutes was chaptered into law late in September. Co-authored by Assemblymen Gray Davis and William J. Filante, M.D. and Senator Joseph B. Montoya—the legislation was drafted in response to a growing crisis in BMQA's ability to maintain a quality standard for licensure of physicians and surgeons in California. AB 1859, SB 555 and SB 991 are the products of extensive study and numerous public meetings and hearings over the last two years. The bills address many issues, but of key importance are:

1. Changes in California law to accommodate the new Federation Licensing Examination (FLEX), the Component I/II exam, which recently replaced the three part FLEX used in the past.
2. Requiring foreign medical graduates to pass the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) for certification by the Educational Commission for Foreign Medical Graduates (ECFMG) prior to being admitted to the FLEX. ECFMG certification is currently a licensing requirement in virtually all other states. The test confirms basic medical education and the ability to function effectively in the English language.

(Continued on Page 6)

CONSULTANT'S CORNER

This space reviews interesting and significant cases which have crossed a BMQA Medical Consultant's desk. Names are not used, nor do we identify the physician under discussion.

Please direct all comments to: Antony C. Gualtieri, M.D., Chief Medical Consultant, BMQA, 1430 Howe Avenue, Suite 100, Sacramento, CA 95825. (916) 920-6393.

Every two months the six BMQA medical consultants come together to review the latest malpractice actions of California physicians. These reviews give us the opportunity to observe trends in medical practices, evaluate physicians' deficiencies, and isolate the incompetent.

Our most recent review pointed to a growing trend on the part of physicians to rely too heavily on mammography as the ultimate method for diagnosing female breast cancer.

The widespread spawning of diagnostic screening centers (some even offer mammography to passing shoppers) is to be encouraged. But there is an unsuspected hazard in the comfortable reliance upon a "negative" mammography report.

BMQA consultants, during the past year, have reviewed an increasing number of malpractice cases which have resulted from the missed diagnosis of breast cancer. The examining physician's excuse: "The mammogram was normal."

The patient was a 29 year-old female. In December she noted a small "lump" in her left breast. The doctor believed it to be a benign cyst. He asked the patient to return after her next menstrual period. In January, the "lump" was "unchanged." The doctor had the patient undergo a mammogram that week. The report returned "normal breasts." The doctor reassuringly spoke "not to worry." He did advise the patient to check herself regularly and return "if there is any change."

The patient returned one year later. The doctor found the "lump larger." A surgical biopsy by a consulting surgeon discovered that the "larger lump" had become an "infiltrating lobular carcinoma."

This doctor learned by painful experience that mammography, reputed to be the most accurate method known today for evaluating breasts, has its limitations. One of our consultants, who enjoys astounding us periodically with his knowledge, reported on a survey of recent data from medical literature. "Mammography may have a false negative rate as high as 10% in cases of clinically palpable carcinoma, particularly when the breasts are very dense."

The cumulative centuries of experience of our six wise consultants concurred that breast "lumps" can accurately be diagnosed only after biopsy.

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November, 1985

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DRUG ALERT
Phony Rx Blanks

. . . be careful who gets your DEA number

The following information was given to the BMQA by the State Board of Pharmacy, following some investigations they conducted. Because of the continuing problems with illegal diversion of drugs to "street peddlers" we urge every prescriber to be vigilant about protecting your legitimate prescription blanks. Also be wary of anyone who requests information about your prescribing privileges. If you believe blanks have been stolen, or that phony blanks may have been printed, do not hesitate to contact your nearest BMQA regional office, the Board of Pharmacy at (916) 445-5014, or the Drug Enforcement Administration at 350 South Figueroa Street, Los Angeles, CA 90071, or at 450 Golden Gate Avenue, San Francisco, CA 94102.

A situation has come to our attention in the Los Angeles area. Unsuspecting physicians are being duped into furnishing the means for unlicensed persons to obtain prescription blanks or dangerous drugs and controlled substances. The scam involves advertising in newspapers for physicians to practice in a clinical environment. When a physician answers such an advertisement, he or she usually is asked to complete a questionnaire. They also are asked to provide their license and Drug Enforcement Administration (DEA) registration for photocopying, as proof of licensure.

Regardless of whether the physician is employed by the clinic or not, the clinic then uses the DEA registration copy as authority to purchase controlled substances, and to order prescription blanks. The blanks then are used for forged prescriptions for controlled substances.

The Pharmacy Board reminds drug wholesalers of the importance of positively identifying the purchaser. However, there still have been instances where drugs were illegally acquired. If you are asked to allow your DEA permit to be copied we suggest you write across the copy some statement such as "COPY–Not to be used for purchase of drugs or prescription blanks."

Full Complement of BMQA Appointments

Governor George Deukmejian recently appointed the three members needed to give the Board of Medical Quality Assurance a full membership. The next vacancies will not occur until June 1, 1986, at which time the Board will lose four members.

John Paul Kassabian, M.D., F.A.C.R.

Dr. Kassabian has replaced Barry Warshaw, M.D. on the Division of Medical Quality. Dr. Kassabian received his B.A. degree from the University of Southern California, his M.D. degree from the University of Southern California School of Medicine, and completed his postgraduate training at Los Angeles County General Hospital. He is currently practicing radiology at the Huntington Memorial Hospital in Pasadena, where he is president-elect to the hospital staff.

Dr. Kassabian is a member of the Los Angeles County Medical Association, the California Medical Association, the Los Angeles Radiological Society, the California Radiological Society, the American College of Radiology, the Society of Graduate Radiologist and Faculty, and the Los Angeles County USC Medical Center.

John Charles Lungren, M.D., F.A.C.P., F.A.C.C.

Dr. Lungren has replaced Maire McAuliffe, M.D. on the Division of Licensing. He received his B.S. degree from the University of Notre Dame, his M.D. degree from the University of Pennsylvania School of Medicine, and his postgraduate training was completed at Los Angeles County General Hospital. He has been in private practice since 1946, specializing in internal medicine and cardiology. Dr. Lungren practices in Long Beach, and has served as Chief of Staff at the Memorial Hospital Medical Center of Long Beach.

Among Dr. Lungren's many affiliations, he is a Fellow of the American College of Physicians, the American College of Cardiology, and the Los Angeles Academy of Medicine; a Diplomate of the American Board of Internal Medicine; and a member of the American Medical Association, the California Medical Association, the California Society of Internal Medicine, the Los Angeles County Medical Society, the American Society of Internal Medicine, and the Long Beach Society of Internal Medicine.

Jerome H. Unatin, M.D. F.A.C.S.

Dr. Unatin has replaced Charles Aronberg, M.D. on the Division of Allied Health Professions. Dr. Unatin received his M.D. degree from the University of Miami School of Medicine and has been in the private practice of Orthopedic Surgery in Torrance, California, since 1971. Dr. Unatin is Board-certified in Orthopedic Surgery and is a member of the American Academy of Orthopedic Surgeons and a Fellow of the American College of Surgeons.

Dr. Unatin has served as a member of the Governor's Task Force for Long Term Care for the Elderly and Disabled, a commissioner for Los Angeles County Paramedic Commission and participates in numerous civic and community activities.

Dr. Unatin is past-President of the Los Angeles County Medical Association, Southwest District and has served on many county and California Medical Association committees and offices.

Physician Licensing Activity Fiscal Year 1984

Basis of Licensure:

Reciprocity with another state	418
National Board Examination	2,587
Federation Licensing Examination (FLEX)	1,111
Total	4,116

On June 30, 1984, there were 84,886 physicians licensed in California. Of these, 60,932 had addresses of record in California, and 23,954 listed addresses outside the State.

CPR Required for Podiatrists

It was reported in the last *Action Report* that the Board's Division of Licensing no longer requires physicians and surgeons to be certified in cardiopulmonary resuscitation (CPR) prior to renewing their license. There has been some confusion as to whether this change also applies to podiatrists.

The Podiatry Examining Committee, which has authority over the licensing of doctors of podiatric medicine in California, reviewed the CPR requirement at their February 15, 1985 meeting and determined that possession of a current CPR card *will* continue to be required for the renewal of podiatric licenses.

DISCIPLINARY ACTIONS
March 1, 1985 to July 31, 1985

BALEIRON, Hector, M.D. (C-37263)—Laguna Beach
2234(b)(d) B&P Code
Stipulated Decision. Gross negligence and incompetence in the diagnosis and treatment of three hospitalized patients.
Revoked, stayed, 5 years probation on terms and conditions.
June 24, 1985

BORTMAN, Ronald A., M.D. (C-28370)—Albany
2236, 2234 B&P Code
Stipulated Decision. Conviction for filing false Medi-Cal claims.
Revoked, stayed, 7 years probation on terms and conditions.
March 8, 1985

CHEN, Ching-Tsai, M.D., (A-36094)—Stockbridge, Georgia
Stipulated Decision. Voluntary surrender of license accepted. Accusation dismissed.
May 7, 1985

COX, Richard Henry, M.D. (A-38044)—Northbrook, Illinois
Stipulated Decision. Voluntary surrender of license accepted. Accusation dismissed.
June 6, 1985

DeSOUSA, Byron Nagib, M.D. (C-40851)—Los Angeles
2234(a),(e),(f); 480(a),(2),(3),(c); 2261, 2235 B&P Code
False statements made in application to gain physician's license.
Revoked
April 26, 1985

DeVOUS, Arnold Scott, M.D. (C-40851)—San Francisco
2237 B&P Code
Stipulated Decision. Federal conviction in Wyoming for drug-related offenses.
Revoked, stayed, 5 years probation on terms and conditions.
March 15, 1985

DUNN, Abraham G., M.D. (A-19590)—Fresno
Repeated failure to maintain records of all controlled substances prescribed or furnished, as mandated by probation order of prior discipline.
Revoked.
July 20, 1985

ETTINGER, Marvin Morris, M.D. (C-34877)—APO San Francisco
Stipulated Decision. Voluntary surrender of license while case on judicial review.
Accusation dismissed.
May 30, 1985

GOLEY, Donald, M.D. (C-26984)—Oxnard
725, 2238, 2242, 2261 B&P Code
Stipulated Decision. Excessive prescribing; violation of drug laws; prescribing without prior examination and medical indication; and falsifying documents.
Revoked, stayed, 5 years probation on terms and conditions, including 180 days actual suspension.
June 19, 1985

MANJUNATH, Madhure, M.D. (A-29758)—Long Beach
2234(e), 2242, 2236, 2261 B&P Code
Stipulated Decision. Prescribing without adequate prior examination and medical indication; misdemeanor conviction for presenting false medical claims.
Revoked, stayed, 5 years probation on terms and conditions.
May 22, 1985

MAHAPATRA, Satyabrata, M.D. (A-35604)—Los Angeles
725, 2238, 2242 B&P Code; 11154 H&S Code
Stipulated Decision. Excessive prescribing of controlled drugs; prescribing without prior examination and medical indication; conviction for violating drug statute.
Revoked, stayed, 5 years probation on terms and conditions, including 6 months actual suspension.
July 15, 1985

MILLER, Jon Kimmerle, M.D. (G-17900)—Spokane, Washington
2239 B&P Code
Stipulated Decision. More than one conviction involving the use of alcohol.
Revoked, stayed, 5 years probation on terms and conditions.
March 13, 1985

PEARSON, Keith, M.D. (A-28940)—Cedar Glen
2242, 2237, 2238 B&P Code; 11154 H&S Code
Prescribing controlled substances without prior examination and medical indication; conviction for violating drug statute.
Revoked, stayed, 5 years probation on terms and conditions, including 90 days actual suspension.
July 20, 1985

REYNAUD, Raymond A., M.D. (A-35604)—Los Angeles
2234(e), 2261 B&P Code
Stipulated Decision. Filed false claims with Medi-Cal.
Revoked, stayed, 5 years probation on terms and conditions.
July 5, 1985

SCHRENCONGOST, Raymond A., M.D. (A-27628)—Lodi
2234(b),(d) B&P Code
Gross negligence and incompetence in not recognizing and responding to critical problems of a patient after surgery. Prior discipline for prescribing offenses.
Revoked, stayed, 5 years probation on terms and conditions, including 90 days actual suspension.
July 5, 1985

SHICKMAN, Barry L., M.D. (G-15109)—Houston, Texas
Stipulated Decision. Voluntary surrender of license accepted. Accusation dismissed.
June 6, 1985

SMITH, James J., M.D. (A-29142)—Auberry
2234, 2239 B&P Code
Stipulated Decision. More than one conviction involving the use of alcohol.
Revoked, stayed, 5 years probation on terms and conditions.
June 24, 1985

SPIRTOS, Jack, M.D. (A-29142)—Long Beach
2234(d) B&P Code
Stipulated Decision. No misconduct involved. Physical disability in the form of severe impaired vision requires limitations on practice for public safety.
Revoked, stayed, 10 years probation on terms and conditions.
June 20, 1985

TANENHAUS, Herbert M., M.D. (G-28610)—Eureka
2234 B&P Code
Stipulated Decision. Unprofessional conduct in allowing physician-patient relationship to develop into personal and physically intimate relationships.
Revoked, stayed, 7 years probation on terms and conditions.
June 6, 1985

THOMAS, Charles E., M.D. (C-34687)—Hacienda Heights
490, 2234, 2237, 2238 B&P Code; 11371 H&S Code
Stipulated Decision. Conviction for unlawful prescribing of controlled substances; excessive prescribing; prescribing without prior examination and medical indication.
Revoked, stayed, 5 years probation on terms and conditions, including 6 months actual suspension.
July 31, 1985

WEAVER, John C., Jr., M.D. (G-35959)—Los Angeles
2234(a),(d), 2242, 2238 B&P Code; 11154, 11157, 11173(b) H&S Code
Prescribing without good faith prior examination and medical indication; false prescriptions; violation of drug statutes; dishonesty in conspiring with others to distribute drugs illegally. No appearance by respondent.
Revoked.
July 12, 1985

WILLIAMS, John M., M.D. (G-16613)—Bridgeville, Pennsylvania
Stipulated Decision. Voluntary surrender of license accepted. Accusation dismissed.
March 11, 1985

Physicians in BMQA's Diversion Program
Fiscal Year 1984

	Active Participants		*Successful*
	Number	*Percent*	*Completion*
Diversion For:			
Alcohol Problem.....	52	32.5	5
Other Drug Problem ...	70	43.8	15
Alcohol and Other Drug.	16	10.0	3
Mental Illness	9	5.6	2
Mental Illness with Substance Abuse	13	8.1	2
	160		27

Guidelines for Prescribing Controlled Substances for Chronic Conditions
A Joint Statement by the BMQA and the CMA

The Task Force on Prescription Drug Abuse, with representatives from the California Medical Association, the Board of Medical Quality Assurance, the Board of Pharmacy, the California Pharmaceutical Association, the Bureau of Narcotic Enforcement (State), the Drug Enforcement Agency (Federal), the Department of Health Services, the California Society for the Treatment of Alcohol and Other Drug Dependencies, and Legal Counsel Dennis Warren, Esq., developed the following set of guidelines for the prescribing of controlled substances for chronic conditions.

These guidelines were approved by the CMA Council on June 28, 1985; and by the Division of Medical Quality of the BMQA on September 13, 1985.

The California Medical Association and the Board of Medical Quality Assurance believe that the best medical care occurs within the context of the physician-patient relationship, where the treating physician is familiar with the details of the patient's condition, medical history and life circumstances. That knowledge of the patient's individual circumstances makes the physician the most appropriate person to make clinical interpretations and treatment decisions, including the decision of whether to prescribe medications. Prescribing drugs, particularly controlled substances, requires the thoughtful application of clinical judgment. In the practice of medicine, physicians are often confronted with difficult situations—particularly in the treatment of chronic conditions involving pain, insomnia, anxiety or depression—that require carefully balanced judgment as to whether, when and where prescription of controlled substances is appropriate.

In our view, the best protection for the physician against allegations of inappropriate prescribing lies in the physician's knowledge of and close adherence to the existing standards of appropriate prescribing. Similarly, the best protection for the patient against the development of avoidable drug dependence is adherence to these same standards.

It is important to recognize that the standard for treatment of an acute clinical condition is quite different from the standard for treatment of a chronic condition. These guidelines discuss treatment and on-going care of chronic conditions.

GUIDELINES

When used within the context of a comprehensive treatment plan, the pharmaceuticals now available for pain, insomnia, anxiety and depression are safe and effective therapeutic agents and can safely be used for treatment of a chronic condition when these guidelines are followed.

1) **History and Medical Examination**

A Diagnostic examination must be performed and a medical history taken—appropriate for the clinical circumstances—sufficient to establish diagnosis, allow the formulation of a treatment plan and rule out presence of any contraindications to the use of any medication contemplated.

2) **Diagnosis/Medical Indication**

A working diagnosis should be delineated including the presence of a recognized and accepted medical indication for the continued prescription of controlled substances. The quantity and strength of a controlled substance prescribed must be reasonably necessary and must meet the patient's needs. When the decision is being made whether to use medication, consideration should be given to avoiding, wherever possible, overutilization of controlled substances and minimizing iatrogenic dependence problems.

3) **Written Treatment Plan with Recorded Measurable Objectives**

A written treatment plan should be prepared to include clearly stated measurable objectives, further planned diagnostic evaluation and alternative treatments contemplated. When the decision has been made to use medication, the physician should record the expected dosing schedules and the expected duration of treatment with medications.

4) **Informed Consent**

There should be a discussion with the patient of the risks and benefits of the treatments contemplated. When the treatment includes a controlled substance, there should be discussion of the addiction potential, possible adverse reactions to the drug, likely therapeutic end points, and the risks and benefits of this drug as compared with other drugs and other treatment methods. The discussions should be recorded in the patient record.

5) **Periodic Reviews and Modification as Indicated**

Periodically, the physician should review all aspects of the patient's treatment plan in light of response to treatment and progress toward treatment goals. The physician should consider the effect of any new information which has developed during the course of treatment.

For patients who have not improved despite continuation of controlled substances, the physician should consider (and document) the appropriateness of a new trial of less dangerous treatment.

During these periodic reviews, the physician should

- assess and record the patient's response to treatment, both specific target signs and symptoms;
- assess and record compliance with the medication schedule;
- evaluate the patient for clinical or laboratory evidence of toxicity or adverse reactions to treatment, including the development of tolerance or psychological or physical dependence.

Adequate monitoring includes communication with pharmacists, nurses and other health professionals in an effort to assure that the patient is adhering to the intended treatment plan and that prescribed controlled substances are not being diverted or abused. After such a review, the physician should make any modifications indicated.

6) **Consultation**

In situations where treatment is not producing the desired improvement or where medication is required on an on-going basis, and other modalities are inappropriate or have failed, the physician should obtain appropriate consultation and/or refer the patient to specialists in the clinical problem area.

In geographic areas where specialists are not available, the independent opinion of any other physician with experience with this clinical condition would be helpful in ensuring (and documenting) appropriate care.

Consultation reports should be made a part of the patient's medical record.

7) **Records**

The physician should keep accurate and complete records documenting dates and clinical findings for all evaluations, consultations, treatments, medications, and patient instructions. The failure to maintain entries which fully disclose the type, extent and basis for therapy is one of the major factors in phisician liability. In a situation where a physician decides on an approach which departs from customary practice, documentation justifying such a course of treatment is a critical prerequisite to continuing treatment.

In addition to following a comprehensive treatment plan based on these guidelines, the physician should incorporate two elements into his/her professional practices: 1) being watchful for any indications of manipulation

(Continued on Page 6)

CHRONIC CONDITIONS

(Continued from Page 5)

or illegal conduct by the patient, and 2) staying abreast of current medical information pertinent to the treatment of chronic conditions.

1) **Patient Manipulation**

The physician should be alert to the possibility of manipulation (which can be either consciously or unconsciously motivated) by the drug-seeking patient and ready to withhold potentially harmful treatments from a patient who fails to cooperate with prudent treatment recommendations. Physicians should never accept as a rationale for prescribing controlled substances the argument that, if the physician refuses to prescribe, the patient will buy drugs from the street or obtain them from another physician.

In cases where a manipulative patient refuses to cooperate with the physician's treatment plan, the physician should take the appropriate steps to refuse to continue treatment. (See "Basic Legal Principles: Discontinuing Treatment with the Problem Patient.") At that point referral to a specialty program is generally the most appropriate course of action.

2) **Current Information**

The physician should keep current on new developments, approaches, and recommendations in prescribing. The physician should select continuing medical education activities which address his/her clinical practice. The physician should use the opportunities for informal consultation which are provided by contact with colleagues at hospital medical staff meetings and county medical society and specialty society meetings.

CONCLUSION

This document reiterates the principles of good medical practice which guide physicians in the treatment of all patients. When the treatment is for a chronic condition, these principles take on additional significance for the protection of both the patient and the physician.

BASIC LEGAL PRINCIPLES: DISCONTINUING TREATMENT WITH THE PROBLEM PATIENT

Physicians are not required to continue treatment of a patient who is uncooperative, refuses to follow treatment advice and/or presents difficulties in the doctor-patient relationship. A patient has no legal right to force a physician to continue a particular course of treatment.

Three overriding legal obligations, however, must be meticulously honored when discharging the potential problem patient. These are the obligations to provide for continuity of patient care; to inform and make the patient aware of the consequences of following or *not* following the recommended treatment; and to give reasonable notice of intent to discontinue treatment.

Six areas of physician conduct should be emphasized:

1. **Medical Review.** The physician should review with the patient his medical history and treatment progress leading to his current medical condition. Where a problem patient is involved, emphasis should be placed upon compliance problems and the adverse medical implications of the patient's past lack of cooperation.
2. **Recommend.** A proposed course of treatment should be proposed to the patient explaining how the particular treatment plan presents the most acceptable approach to dealing with the patient's current medical condition.
3. **Warn/Inform.** The patient must be informed and warned about not only the risk of proposed treatment and available alternatives, if any, but the risks of *not* following the treatment plan and/or discontinuing treatment. The physician must make the patient aware of all material risks which may result if a patient refuses or discontinues treatment.
4. **Continuity.** The physician should offer to implement the chosen treatment plan. If the patient refuses, he should be provided with a list of names and addresses of area physicians qualified to deal with the patient's unique needs. An offer to assist the patient by consulting with any new physician should be made. Where the patient has become chemically dependent, needed medications should be prescribed only for a time period reasonably necessary to allow for the establishment of a new doctor-patient relationship.
5. **Confirm With Patient.** Where the medical risks associated with discontinuance of treatment are significant, the physician should confirm all of the above procedural steps by registered mail to the patient. This is an excellent way of documenting the "reasonable notice" requirements imposed by California law.
6. **Documentation.** Thorough documentation of the performance of all relevant procedural steps must appear in the physician's records. This is particularly true where the chemically dependent or high risk patient is involved.

LICENSING LEGISLATION

(Continued from Page 1)

3. Standardizing and simplifying reciprocity provisions. In particular, any reciprocity applicant who has been licensed in another state for more than four years will have to take and pass the clinical competency portion of the written FLEX component examination in order to get a California license. The bills also will eliminate several loopholes that have made it possible for some applicants to be licensed without meeting California standards.
4. Specifying standards for clinical clerkships. In particular, standards are established governing clerkships taken at hospitals which are geographically separated from the applicant's medical school.
5. Allowing the Board to evaluate and license graduates of special accelerated or advanced placement programs in approved U.S. medical schools on an individual basis. Previously the Board was limited to considering only the education formally received in a medical school.
6. Directing the Board to work with the Federation of State Medical Boards to explore the possibility of formally approving foreign medical schools meeting the standards required of U.S. medical schools, in addition to disapproving schools which are clearly unacceptable.

These bills were supported by the California Medical Association, the deans of California medical schools and several prominent foreign medical schools. Most of the bills' provisions become effective January 1.

Another Word on CPR . . .

In our last *Action Report*, #28, we stated "The Joint Commission for Accreditation of Hospitals (JCAH) now requires CPR for physicians to receive hospital staff privileges." Several readers have written or called to point out—correctly—that JCAH no longer has such a requirement.

We have since learned that the California Department of Health Services, which licenses hospitals, does have requirements for certain hospital employees to be trained in CPR. However, they do not require every physician practicing in a hospital to be competent in CPR.

For additional information about specific hospital staff standards, please contact the Licensing Division, Department of Health Services.

We regret any confusion or problems our misstatement may have caused.

BMQA's CONSUMER SERVICES REPRESENTATIVES

The Board has six Consumer Services Representatives who receive complaints from consumers and others about its licensees. Individuals who believe that a BMQA licensee may have violated the law can contact a CSR at any of the following locations. Counties served by each CSR are listed.

COUNTIES	*REPRESENTATIVE*
Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Fresno, Glenn, Inyo, Kern, Kings, Lassen, Madera, Mariposa, Merced, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Joaquin, San Luis Obispo, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Trinity, Yolo, and Yuba.	Nancy Kraemer Sacramento Regional Office (916) 920-6013
Alameda, Contra Costa, Del Norte, Humboldt, Lake, Marin, Mendocino, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma.	Merry Anne Boles San Mateo Regional Office (415) 573-3888
Los Angeles, Santa Barbara, and Ventura.	Joane Kinnard or Alicemary Hoffman Los Angeles Regional Office (213) 412-6363
Imperial, Orange, Riverside, San Bernardino, and San Diego.	Bertha Ruiz Santa Ana Regional Office (714) 558-4452
ALLIED HEALTH PROFESSIONS: Statewide	Tom O'Connor Headquarters Office (916) 920-6341

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE
SACRAMENTO, CA 95825

Executive Office (916) 920-6393

Physicians and Surgeons:
Applications and Examinations (916) 920-6411
Chief Medical Consultant (916) 920-6393
Complaints—Call nearest Regional Office:
Los Angeles (213) 412-6363
Sacramento (916) 920-6013
San Mateo (415) 573-3888
Santa Ana (714) 558-4452
Continuing Education (916) 920-6074
Disciplinary Information (916) 920-6343
License Renewals (916) 920-6943
Fictitious Names (916) 920-6074
Verification of Licenses (916) 920-6343
Allied Health Professions:
Complaints (916) 920-6341
Licensing:
Acupuncture (916) 924-2642
Hearing Aid Dispensers (916) 920-6377
Physical Therapy (916) 920-6373
Physician's Assistant (916) 924-2626
Podiatry (916) 920-6347
Psychology (916) 920-6383
Registered Dispensing Opticians (916) 924-2612
Respiratory Therapy (916) 924-2314
Speech Pathology/Audiology (916) 920-6388

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