Review of Disciplinary Actions Regarding Controlled Substances, Rhode Island 2012–2017

Luke Barre, MD, MPH; Justin Gallo; James V. McDonald MD, MPH

ABSTRACT: Inappropriate and excessive prescribing is an important cause of the opioid epidemic. A retrospective review of disciplinary actions related to controlled substances in Rhode Island from 2012–2017 was undertaken from publicly available data. There were 47 physicians with opioid related disciplinary actions. All of them were male and the average age was 63. Providing targeted academic detailing and stratified continuing medical education to physicians who have been in practice longer than others provides state medical boards with a means of primary prevention of inappropriate and excessive prescribing. This approach may provide a more effective use of limited public health resources.

Introduction

To paraphrase George Santayana, if we do not learn from history, we are doomed to repeat it. Rhode Island has not previously had a systematic review of disciplinary actions of physicians, nor has there been an aggregate analysis of common causes or outcomes to develop preventive strategies to reduce further disciplinary actions.

The opioid epidemic facing Rhode Island and the nation is multifactorial, yet one of its driving forces is physician prescribing. In addition to the risks of opioid prescriptions associated with prescription characteristics,[1] physicians whose opioid prescribing requires disciplinary action represent exceptional risks to patients and public health. As the licensing and regulatory body in Rhode Island for physicians, the Rhode Island Board of Medical Licensure and Discipline is responsible for administrative sanctions against physicians for regulatory violations, including opioid prescribing.

Disciplinary actions against physicians are uncommon events, given the number of licensed physicians and interactions that occur without incident. However, risk stratification may be possible, as physician characteristics such as age and lack of board certification have been associated with increased risk of disciplinary actions.[2] We reviewed past disciplinary actions related to controlled substances to determine what primary prevention efforts could be undertaken to prevent disciplinary actions in the future.

Methods

The Rhode Island Board of Medical Licensure and Discipline posts disciplinary actions on a public-facing website that is easily searchable by name.[3] We retrospectively reviewed all disciplinary actions related to controlled substances from the Board's public website from 2012 through 2017 for demographics, such as age, specialty, years in practice and gender. Institutional Review Board (IRB) approval was obtained through the Rhode Island Department of Health IRB.

Disciplinary actions related to controlled substances were grouped into three separate categories based on frequency: inappropriate prescribing (not following rules, regulations or applicable laws); overprescribing (prescribing a day's supply that greatly exceeded calendar days or excess doses); and self- or family-prescribing (prescribing a controlled substance to self or immediate family member).

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We also analyzed the data for trends and characteristics of disciplinary actions that might suggest patterns that could help identify future disciplinary actions. Consideration was given to determine consistency of sanction for a similar set of facts and circumstances.

Results

Review of demographics of disciplinary actions from 2012 to 2017 related to controlled substances revealed the average age of the physician was 63 (+/- 10 years), with an average time in practice of 33 years (+/- 10 years). Review of gender revealed that 100% of physicians with disciplinary

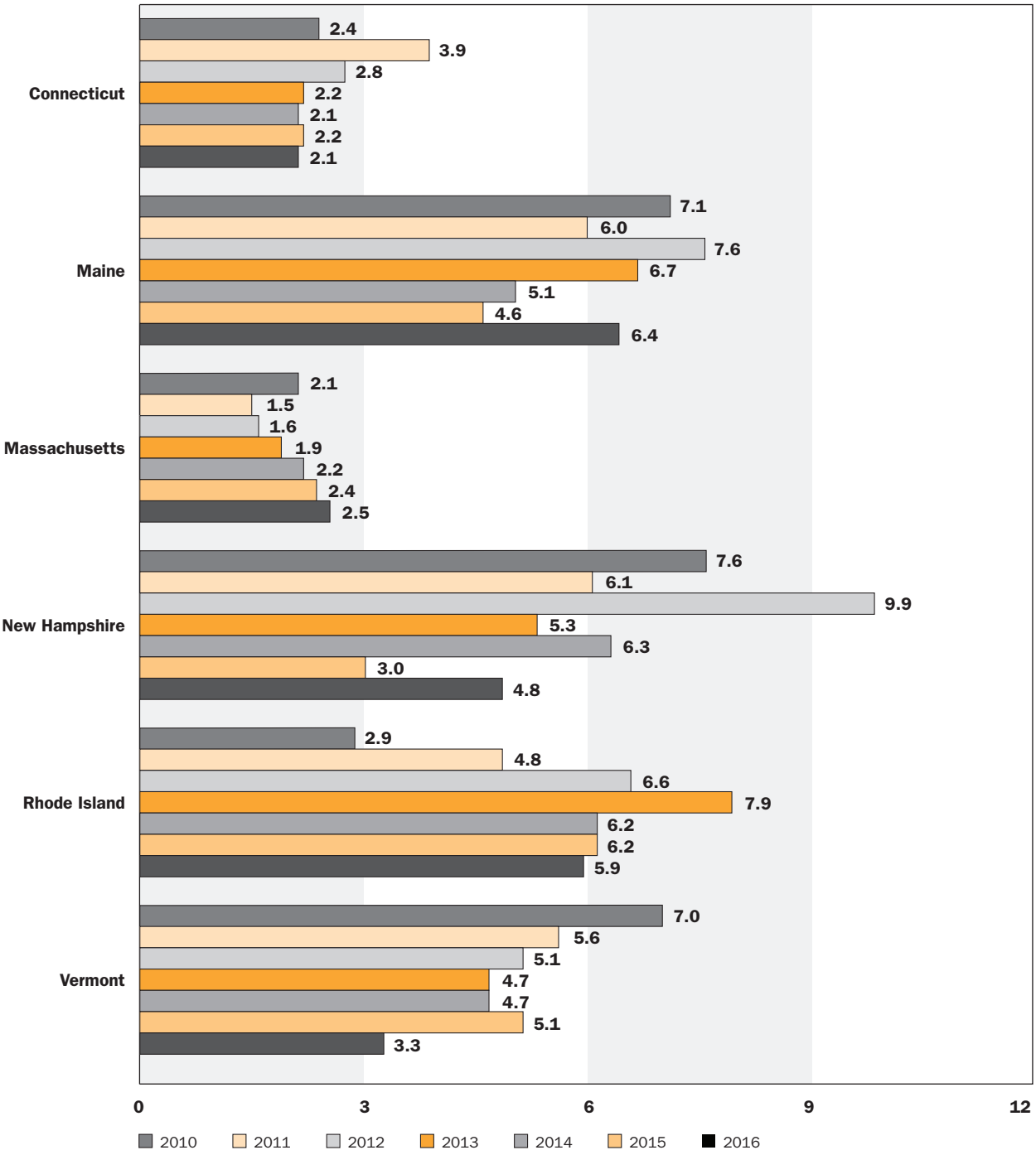
actions regarding controlled-substance related issues were male (n=47).

For comparison, of all disciplinary actions (n=207) during the same period, the average age of the physician was 59 (+/- 10 years) and 91% of physicians with any disciplinary action were male. The difference in gender of 100% and 91% male was found to be statistically significant with a p value of 0.0085.

The current average age of all licensed physicians in Rhode Island is 52 years (+/- 12 years) and 63% are male.

Disciplinary actions were also reviewed from 2010 to 2016 and compared to other New England states. These are illustrated in Figure 1 as number of actions per 1,000 physicians to serve as a general comparison of all disciplinary actions.

Figure 1
Disciplinary Rates per 1,000, New England States 2010–2016



Rhode Island disciplinary actions involving controlled substances were compared to all Rhode Island disciplinary actions during the same time period. Figure 2 separates disciplinary actions by year and indicates how many were disciplinary actions related to controlled substances and how many involved a loss of license.

Figure 3 illustrates in aggregate by these three separate categories how many cases were from each category and provides corresponding disciplinary action.

Figure 4 illustrates the percentage of disciplinary actions in Rhode Island that were related to controlled-substance related actions from 2012 to 2017.

Discussion

The opioid epidemic has put physicians in a challenging position. Physicians are the profession of "first, do no harm," and as healers they have great empathy and compassion for the chronic disease of opioid use disorder. The current nationwide opioid epidemic has several different etiologies and is the product of complex bio-psychosocial factors.

Engaging patients with pain is common, complex and at times confusing for physicians. They have an opportunity to relieve pain, yet there is a risk of causing harm — such as encouraging persistent opioid use, unwittingly contributing to diversion, or, at the worst, being the proximate cause of a fatal overdose.

As state medical boards prioritize their limited resources, it is wise to review more common causes of disciplinary actions and the corresponding public health priority. The opioid epidemic has its roots in the prescribing of prescription opioids, yet it is time for this to change.

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As we reviewed the data from Rhode Island, we found disciplinary actions were more common in

Figure 2
Disciplinary Actions by Year

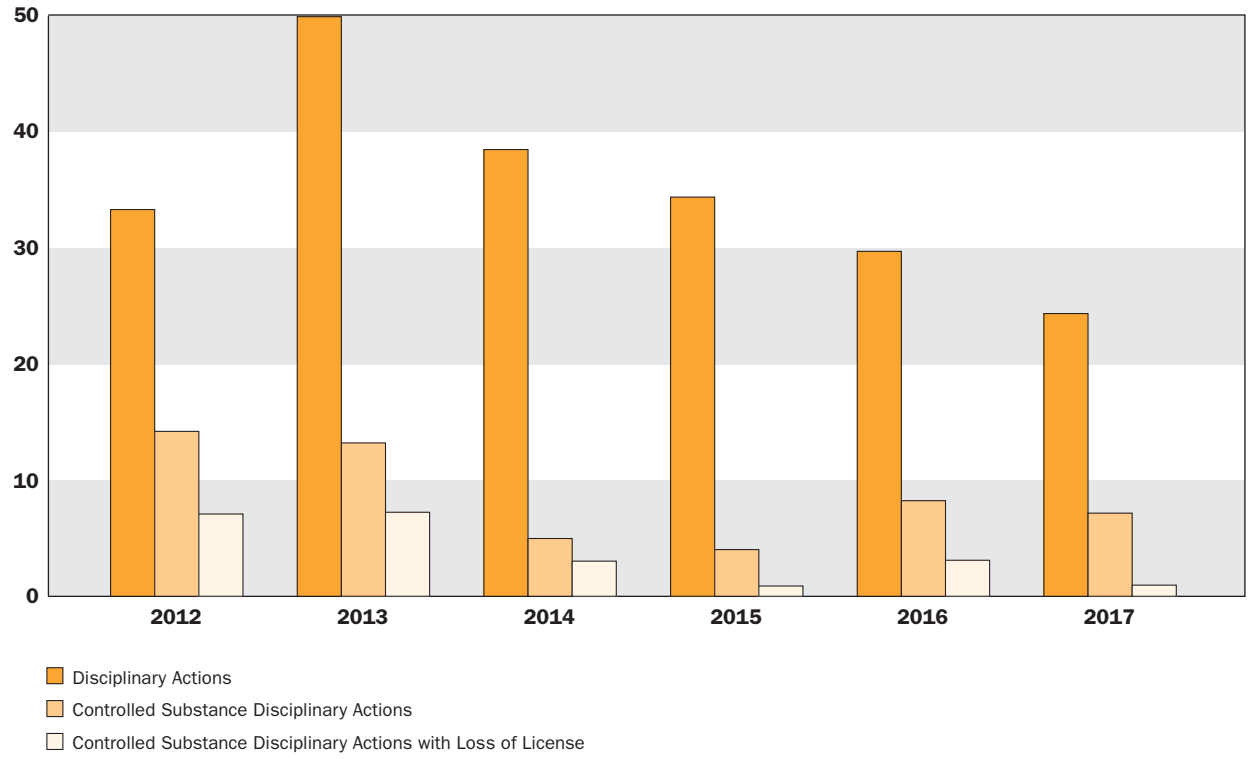


Figure 3
Disciplinary Actions by Category and Outcome

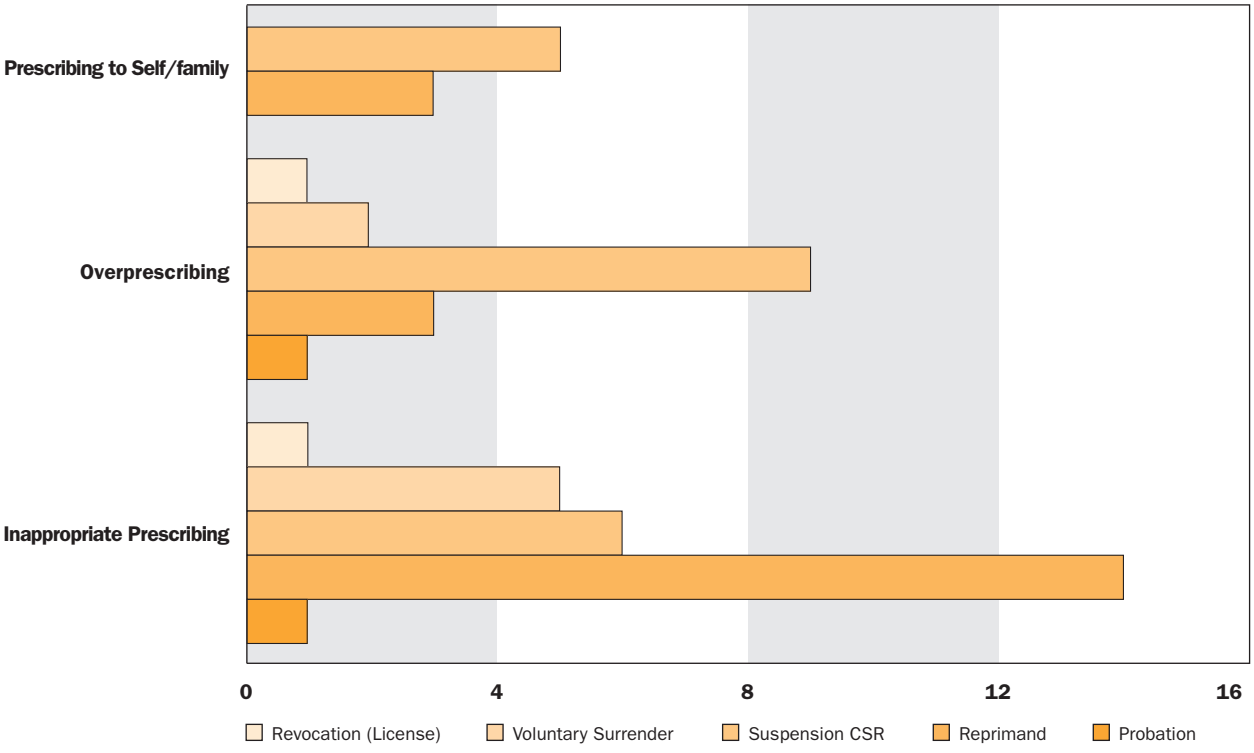
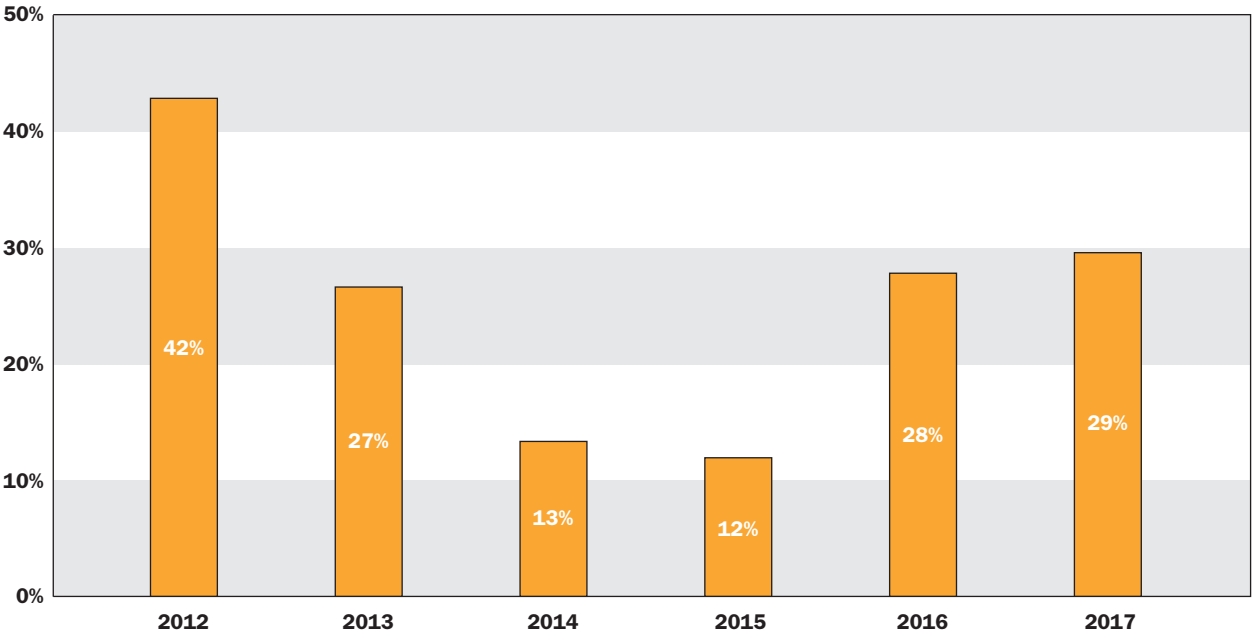


Figure 4
% of Disciplinary Actions per Year Related to Controlled Substance Prescribing Cases



older physicians, as well as in physicians of the male gender. Although it is not immediately clear why this is the case, it does suggest that risk-stratification may be possible. It is difficult to explain the gender difference in controlled-substance related disciplinary actions, and our data is not detailed enough to explain the gender discrepancy noted.

While disciplinary actions are an important mechanism, they function as secondary and tertiary prevention measures to mitigate and prevent further harm. Additionally, disciplinary actions are generated by passive surveillance (complaints received by the board) and are vulnerable to underreporting. By attempting to risk-stratify opioid prescribers, greater resources aimed at older physicians — such as academic detailing and continuing medical education — may be used as primary prevention strategies.

BY ATTEMPTING TO RISK-STRATIFY OPIOID PRESCRIBERS, GREATER RESOURCES AIMED AT OLDER PHYSICIANS — SUCH AS ACADEMIC DETAILING AND CONTINUING MEDICAL EDUCATION — MAY BE USED AS PRIMARY PREVENTION STRATEGIES.

We see disciplinary actions fall into three broad categories: inappropriate prescribing; overprescribing and self- or family-prescribing. As we further understand these issues, strategies emerge that physicians can utilize to reduce the risk of a potential disciplinary action from a state medical board.

Inappropriate Prescribing

Inappropriate prescribing can be avoided by following the relevant prescribing regulations.[4] The Rhode Island regulations titled "216-RICR-20-20-4 Pain Management, Opioid Use and the Registration of Distributor of Controlled Substances in Rhode Island" are comprehensive. The regulations specifically address issues such as minimum standards for patient evaluation, documentation, requirements for acute pain management, patient education, informed consent, utilization of the prescription drug monitoring program (PDMP), written patient treatment agreements, periodic review, consultation with pain management, co-prescribing of naloxone and more. The implementation of these regulations in a physician practice needs to be done in a purposeful and thoughtful manner and it should involve other health care team members, such as nursing staff.

Overprescribing

Overprescribing of opioids, specifically prescribing opioids in a quantity where a prescribed supply exceeds actual calendar days' supply, is problematic. Overprescribing leads to diversion, misuse and overdose. Overprescribing can be most effectively prevented by frequent utilization of the PDMP and effective utilization of the information it provides. Patients who are diverting should be referred to one of the state-recognized Centers of Excellence,[5] as it is common for patients who divert to also have a diagnosis of opioid use disorder. Prescribers should not prescribe to a patient who is diverting, but a Center of Excellence can conduct a comprehensive evaluation and determine the best course of treatment, which may include medication-assisted treatment if clinically indicated.

Self- or Family-Prescribing

Self- or family-prescribing of a controlled substance may be an indicator of a need for an evaluation by a physician-health or impaired-physician program. Regulations[6] enacted in 2016 prohibit prescribing to self and immediate family in Rhode Island ("Physician Self-treatment or Treatment of Immediate Family Members: A physician is not authorized to prescribe a controlled substance to one self or an immediate family member under any circumstances.") Prior to the regulation, the Rhode Island Board of Medical Licensure and Discipline relied on the AMA statement against opioid prescribing.[7] There are times when physicians have self-prescribed as a matter of convenience, yet this represents unethical conduct in the medical profession.

It should be noted that Rhode Island promulgated regulations[8] regarding controlled substance prescribing in 2015. Although the numbers are small, it is interesting that disciplinary actions that involved loss of license (revocation, suspension or surrender) substantially decreased after 2013.

Conclusion and Recommendations

Our data is limited by small numbers, with an N of 47, yet some broad recommendations can be made. Targeting academic detailing to physicians who have been in practice longer may be a more effective use of limited public health resources.

Academic detailing is a form of peer-to-peer educational outreach that is built on the model of traditional pharmaceutical detailing in which evidence-based content from the department of health as well as from academic groups and research centers are used to inform physicians. Knowledgeable, trained clinical educators meet one-on-one with physicians, nurse practitioners, physician assistants and others on the health care team to discuss research on medical topics and to improve the quality of health care delivery.

Rhode Island has used academic detailing as secondary prevention for opioid prescribing since 2015 to address high prescribers of opioids. Clinical educators highlight prescribing activity via the prescriber profile. Prescribers are reminded and empowered to check the PDMP, as well as other regulatory requirements such as patient education, informed consent, safe storage and disposal, need for pain agreements and other regulatory requirements as well as best practices. Resources are given to prescribers to educate patients on safe storage and disposal of their medications. Education and resources are given on the health risks associated with co-use of benzodiazepines and opioids.

Our data also raises questions about the value of stratifying continuing medical education (CME) requirements based on years of practice: Perhaps longer years in practice implies the need for more focused approaches to CME or additional CME. A stratified CME approach offers promise as a means for addressing relevant knowledge gaps in particular physician groups, which could be conditional on type of prescribing of controlled substances.

OUR DATA ALSO RAISES QUESTIONS ABOUT THE VALUE OF STRATIFYING CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS BASED ON YEARS OF PRACTICE: PERHAPS LONGER YEARS IN PRACTICE IMPLIES THE NEED FOR MORE FOCUSED APPROACHES TO CME OR ADDITIONAL CME.

A planned audit of Rhode Island's acute pain regulations may allow further study of compliance with accepted standards for opioid prescribing, and also with opioid CME requirements. ■

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