

THE RISK OF DISCIPLINARY ACTION BY STATE MEDICAL BOARDS AGAINST PHYSICIANS PRESCRIBING OPIOIDS

Jack Richard, M.D.

Marcus M. Reidenberg, M.D.

Department of Medicine (J.R., M.M.R.) and Departments of Pharmacology and Public Health (M.M.R.),

Joan and Sanford I. Weill Medical College of Cornell University

ABSTRACT

Concern of physicians about being disciplined for prescribing opioids for patients in pain is one cause for undertreatment of pain. This study was done to assess the actual risk of being disciplined by state medical boards. A review of records of actions by the New York State Board for Professional Medical Conduct for three years and of all medical boards in the United States for nine months was done to determine this risk. New York State, with 7.8 percent of U.S. physicians, had 10 physicians disciplined annually related to overprescribing opioids, while the total for the entire United States was 120 physicians annually. Most physicians disciplined had multiple violations in addition to overprescribing controlled substances. In the national sample, 43 percent were prescribing for themselves or for nonpatients, 12 percent prescribed for addicts without addressing the patients' problems of addiction, 42 percent had inadequate records, 19 percent prescribed without indication for opioids, 13 percent were incompetent in additional ways, and eight percent were having sexual activity with patients. Not a single physician, for whom information was available, was disciplined solely for overprescribing opioids. The actual risk of an American physician being disciplined by a state medical board for treating a real patient with opioids for a painful medical condition is virtually nonexistent.

INTRODUCTION

The undertreatment of both acute and chronic pain has been well documented.¹⁻⁵ Multiple barriers to improving the treatment of acute and chronic pain have been identified.^{3,6-8} One of these barriers is the perceived substantial risk of disciplinary action by medical licensing authorities against physicians who prescribe opioids, particularly for patients with chronic nonmalignant pain syndromes. A survey of New York State physicians by the Ad Hoc Committee on Pain Management of the New York State Public Health

Council in 1997 found 58 percent were "moderately concerned" or "very concerned" about the possibility of investigation by a regulatory agency if they wrote prescriptions for opioids for patients with chronic nonmalignant pain. Forty-one percent were just as concerned if they wrote for opioids for acute pain in ambulatory patients.⁹

The Ad Hoc Committee on Pain Management then undertook a study of the process and the results of disciplinary proceedings in New York State related to the prescription of controlled substances during the period from June 9, 1994, to July 31, 1997. Of all the 1,025 disciplinary actions taken, 26 (2.5 percent) were based on improper prescribing of controlled substances. Other charges associated with these actions included misconduct such as issuing prescriptions in fictitious patients' names and failing to take and record pertinent medical histories, or to conduct and record pertinent physical examinations. No physician was disciplined solely because of the amount of controlled substance prescribed.

The President of the American College of Physicians, in testimony to the U.S. Congress, stated:

"Studies have shown that government regulations are one of the barriers to effective pain treatment. According to a 1998 survey done for the New York State Health Commissioner, physicians 'may be concerned that aggressive pain management using controlled substances could be misconstrued as inappropriate prescribing and could lead to [disciplinary] proceedings.' The report went on to say 'the fear of possible disciplinary actions resulting from the use of controlled substances influenced physician practice in a way that impedes patient access to effective treatment.' This concern is not unfounded. A recent report cited cases in Florida and Arkansas where physicians who prescribe large doses of con-

trolled substances for the legitimate purpose of treating pain were disciplined without any evidence that the physicians had prescribed excessive amounts of opioids. Although these cases were eventually overturned by the courts, they create a climate of fear for physicians.”¹⁰

Surveys of Wisconsin physicians,¹¹ oncologists,^{12,13} and primary care physicians¹³ all find fear of disciplinary action a barrier to their prescribing the analgesic regimen they would otherwise prescribe for patients in pain. A review of the disciplinary orders of the Wisconsin Medical Examining Board from mid-1996 to 1998 found 29 actions against physicians for prescribing controlled substances, including but not limited to opioids.¹⁴ The specific violations were not described in the paper.

In recent years, much work has been done to bring the concepts of modern pain management into the decision-making process of the medical licensure authorities.^{15,16} The Federation of State Medical Boards (FSMB) has developed model guidelines for treatment of pain, in part to address physicians’ fears.¹⁷ This effort to bring the current concepts of pain management to state medical boards may have helped make the actual risk of disciplinary action much less than the perceived risk. This study was to determine the actual risk of disciplinary action against a physician by a state medical board for prescribing opioids for patients in pain.

METHODS

Using the Professional Misconduct and Physician Discipline website of the New York State Department of Health, all disciplinary actions taken against physicians by the New York State Board for Professional Medical Conduct were reviewed for the three-year period, from July 1, 1999, to June 30, 2002. Those cases in which the misconduct description contained any reference to overprescribing of controlled substances, inappropriate prescribing, or any similar phrase, were evaluated in more detail. This evaluation consisted of reading the Board Order and Statement of Charges, including the factual allegations, which usually contained a description of the misconduct. Also noted was whether the disciplinary action was the result of a complaint or charge originating in New York State and investigated by the New York State Office of Professional Medical Conduct (OPMC), or whether it was either the result of a disciplinary action taken in another state against a physician who held a New York State license, or the result of a criminal conviction in a matter not necessarily related to the practice of medi-

cine — cases known as “referrals.” Referrals were included in the New York State study to have an adequate sample, but not in the U.S. study to avoid counting an action against a single physician more than once.

Determinations were made of the total number of disciplinary actions and the number of such actions in cases involving overprescribing of controlled substances. Although this study attempted to look at disciplinary actions for the alleged overprescribing of opioids, the factual allegations in the board actions often did not specify “opioids” but referred to “controlled substances.” Inclusion of these cases in the overprescribing totals likely resulted in larger numbers than would have been found if only opioids had been considered. Where specific medications or classes of medications were mentioned, cases involving prescribing only benzodiazepines or barbiturates, but not opioids, were not included. Also tabulated in cases of overprescribing were other forms of misconduct noted in the factual allegations and conclusions of the board such as negligent patient care, inadequate records and drug use by the physician, etc.

After review of the data obtained in the New York State study, the authors applied this review methodology to a national database. The FSMB has as members the medical boards of all of the states in the United States and its possessions, and 13 state boards of osteopathic medicine. The FSMB operates the Federation Physician Data Center, which collects and records information about all disciplinary actions taken against physicians by the state boards. This center maintains paper records, which include the type of disciplinary action, the date of the action, the state medical board or licensing agency that initiated the action, and the reason the action was undertaken. The descriptions of the actions varied from state to state but usually included the charges, a brief summary of the factual allegations, and the conclusions of the board. The FSMB made available files about disciplinary actions involving controlled substances reported to them by member boards for the period between Jan. 1, 2002, to Sept. 30, 2002. These paper records were reviewed by the authors for the same information sought in the New York State study.

The numbers of violations and actions in our study may appear to be different from published data from the boards. Several violations (such as failure to do or document history, prescribing without valid indication = two violations) can be identified in the record of a single hearing about one doctor. Furthermore, to simplify our report, we have

grouped several similar violations reported by the board as if it were a single violation. For example, prescribing for fictitious patients, for non-patients, and for family members without a doctor-patient relationship being established and documented are three different violations but are lumped together since these frequently indicate a physician prescribing for his/her own use. For this reason, the number of violations in our classification is smaller than the total number of violations reported by the boards.

Several actions (such as suspension of license, remedial education and a fine = three actions) can be taken for a single violation. Therefore, the number of physicians receiving disciplinary actions is smaller than the number of disciplinary actions reported.

Tabulations included the identification of the physician, the state in which the action occurred, the date of the action, and the description of the misconduct. Actions by a state board that resulted from the action of another state board were not included in the national figures, as this would have resulted in tabulating the same occurrence more than once.

The violations (and an example of each) were classified as:

1. Physicians known to be addicted and/or self-prescribing or prescribing for fictitious patients, non-patients, and family members. (Four different violations but all are included in this one group.)
Example: Doctor who prescribed meperidine for own use or doctor who prescribed hydrocodone for spouse to maintain spouse's addiction and also wrote fictitious prescriptions to cover this.
2. Sexual relations with patient(s).
Example: Doctor had sex multiple times with woman in office, home and motels. He prescribed drugs, including opioids, for her with no record of prescribing these or any record of a medical need for them.
3. Prescribing without seeing patient.
Example: Patient with recurrent herpes simplex was seen once and prescribed Vicodin for five consecutive months without revisitation.
4. Failure to take history and/or do physical examination.
Example: Doctor prescribed opioids for "lumbar radiculopathy" with no recorded history, physical examination, or laboratory tests or imaging studies. (Billing records but not medical records could be

found. This doctor had other similar patients, one of whom died of an overdose of opioids.)

5. Prescribing for known addicts or people with drug seeking behavior without addressing the problem.
Example: Doctor prescribed for abusers without records documenting "for whom he was prescribing controlled substances" or "a therapeutic purpose for which the drugs were being prescribed." (This doctor also had barbiturates in his own urine.)
6. Prescribing without valid indication.
Example: Prescribed a benzodiazepine and hydrocodone to patient without diagnosis. Patient died of multiple drug intoxication. Prescribed inappropriately to another 20 patients.
7. Failure to maintain adequate records or documentation.
Example: Doctor practicing in hospital had closed office years earlier. He continued to prescribe for 15 patients, phoning in renewals. Records were cards with inadequate histories or physical examination notes. The drugs and dosages were identical from one patient to the next.
8. Prior disciplinary action for similar misconduct, criminal conviction or fraud, or no DEA number.
Example: Prescribed high doses of opioids and benzodiazepines "without medical justification in record" often without history or physical exam in record. Had prior license suspension for same violations and later reinstatement.
9. Other negligence or incompetence.
Example: Prescribed 1,500 doses of hydrocodone with acetaminophen with directions to take enough to ingest 16 g acetaminophen daily.
10. Indeterminate
Example: In one case, there was no description of the violations in the record at the FSMB office.

RESULTS

During the three-year period reviewed in this study (July 1999–June 2002), the New York State Board took 1,050 disciplinary actions against physicians. These actions were the result of more than 18,800 complaints, so that approximately 5.6 percent of complaints, after investigation, resulted in disciplinary actions. Of these actions, 516 resulted from complaints made against physicians practicing in New York State. The remaining 534 disciplinary actions were based upon either criminal convictions unrelated to the practice of medicine or upon the actions of other state boards against physicians who practiced in other states but also held New York State licenses.

Table 1

Physician Behaviors Constituting Misconduct in Addition to the Violation Related to Controlled Substance Prescribing

		National (n=89)		New York (n=32)	
		No.	%	No.	%
1.	Prescribing to self, non-patients, etc.	38	43	12	38
2.	Sex with patient	7	8	2	6
3.	Not seeing patient	8	9	1	3
4.	No history or exam	15	17	10	31
5.	Prescribing for addict without addressing problem	18	20	3	9
6.	No indication	17	19	3	9
7.	Incompetence/negligence	12	13	7	22
8.	Inadequate records	37	42	11	34
9.	Prior disciplinary action or fraud or criminal conviction or no DEA number	7	8	7	22
10.	Indeterminate	1	1	0	0

Since most disciplined physicians had more than one type of misconduct, the totals add up to more than 100%.

No. = number of physicians with this behavior.

% = percent of physicians with this behavior.

Of these 1,050 actions, 32 actions, or approximately three percent, concerned the overprescribing of controlled substances. Four additional actions resulted from criminal possession or illegal dispensing of controlled substances. Only seven of the 32 actions were against physicians practicing in New York State. For the other physicians against whom actions by the New York State Board were taken, the actions were based upon those of other state boards.

In the entire United States, there were 4,169 disciplinary actions by all state medical boards and 395 actions by the New York State Board in 2002. There were 726,984 physicians practicing in the whole United States, of which 56,955 were practicing in New York State.

In every case reviewed, the description of the misconduct, in addition to the controlled substance prescribing, included at least one and, more commonly, several other behaviors which were considered to constitute professional misconduct. This is shown for both the New York State and national data in Table 1 (above). Most common among these were self-prescribing or prescribing for non-patients, the failure to maintain adequate patient records, and the failure to take histories or perform physical examinations. Fifty-six percent of New York State physicians disciplined for charges including controlled substances had more than one additional charge of misconduct, as did 58 percent of all U.S. physicians disciplined for charges including misprescribing controlled substances. No U.S. physician was disciplined by a state board for only the violation of misprescribing opioids. Only seven of the physicians in the national sample with the violation of inadequate records had this as the only violation in addition to the overprescribing of controlled substances.

DISCUSSION

Our detailed initial New York State study found rates of disciplinary action by the state medical board and of violations involving opioids similar to the total U.S. rates. New York State, with 7.8 percent of U.S. physicians, had 9.5 percent of U.S. disciplinary actions. Three percent of physicians disciplined by New York State had actions involving prescribing controlled substances, as did 2.4 percent of physicians in the United States. Thus, the three-year New York State data from July 1, 1999, to June 30, 2002, is very similar to the national data from Jan. 1, 2002, to Sept. 30, 2002.

We recognize physicians are concerned not only with disciplinary actions, but also with the prospect of a complaint resulting in an unpleasant and time-consuming board investigation. Our study, however, could only address the subject of disciplinary actions, as the confidential nature of the investigations prevents reporting of information relating to physicians found to be innocent. Hoffmann and Tarzian did a survey of state medical boards and estimated that there were 3.1 ± 2.8 complaints about overprescribing opioids per 1,000 physicians in the United States in 2001.¹⁸ Since there were about 727,000 physicians practicing in the United States in 2002, if the rates are stable, there are about 2,250 complaints of overprescribing per year. Preliminary fact finding, reviewing pharmacy records and/or sending a letter of inquiry to the doctor found an unknown fraction of these complaints to be without merit. Formal investigations then found approximately 120 doctors per year deserving of disciplinary action by a state board. This represents five percent of the complaints of overprescribing, or one doctor per 6,058 practicing physicians per year receiving an action by a state board for which overprescribing was one of the violations found. In recent years, most medical boards have taken steps to edu-

cate their members and investigators about appropriate pain management. Consequently, we suspect a smaller percentage of complaints of overprescribing are reaching the level of an in-depth investigation or a disciplinary hearing than in the past.

Reviewing the behaviors listed in Table 1 and our results show there was very little, if any, risk for a doctor to receive disciplinary action from a state medical board for prescribing opioids for pain when the medical record showed a doctor-patient relationship actually existed and the doctor was prescribing opioids to treat a painful condition in the patient.

Of those physicians who had actions taken against their licenses, either suspension or revocation, the large majority were found guilty of other serious misconduct such as self use of opioids, sex with patients, and incompetence. In the cases of those physicians whose only additional misconduct was poor documentation or failure to do or to record history and physical examinations, common actions were reprimand, practice monitoring, fine, and mandatory remedial education.

Our review of the records of cases from New York State for three years and all U.S. cases for nine months, experience as a medical board examiner for 10 years (JR), having a major (MMR), and our 42 and 40 years of medical practice, respectively, lead us to make the following suggestions: There should be sufficient information in the record to support the diagnosis of a painful medical condition requiring a treatment regimen including opioids. The record should include documentation of the history and physical findings, a diagnostic impression, a treatment plan, and consultations with other doctors for additional evaluations and treatments when medically indicated. Alternative means of pain control used and the results obtained should be noted. Patients receiving opioids should be seen at regular intervals and the notes of these visits should be written in the medical record. Amounts of opioids prescribed should be included in the record. When treating pain with opioids in a patient with problems of substance abuse, the records should indicate that the prescriber is aware of the substance abuse problem, is addressing it, and has an additional diagnosis of a painful condition that is being treated with the opioids. The record must state the opioids are for treating pain, not addiction. Physicians should not prescribe controlled substances for family members or friends unless there is a doctor-patient relationship clearly documented by a medical record. Obviously, if the prescribing of opioids for a family member

is legally restricted in the area where the doctor practices, these restrictions must be followed.

This review of New York State disciplinary actions for three years and all U.S. actions for most of 2002 indicates the risk of state medical board disciplinary action against a physician for treating a bona fide patient with opioids for a painful medical condition, in the absence of other misconduct, is virtually nonexistent. A similar review of Drug Enforcement Administration actions and state law enforcement actions against physicians for prescribing opioids is needed to complete the evaluation of the risk of disciplinary actions against American physicians for prescribing opioids for patients in pain.

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