



Testimony on House Bill 2649
To The
House Health and Human Services Committee
By Charles L. (Chip) Wheelen
February 1, 2006

Thank you for the opportunity to express some concerns about the provisions of HB 2649. We generally support the intent of the bill; including the statement of public purpose contained in new section two. We assume that new section two is not intended to create a new cause of action and result in civil lawsuits against physicians. We are concerned, however, about language in sections three and four of the bill.

Item (3) under subsection (a) of new section three does not seem to make sense. Perhaps the word "or" in line 36 of page one should instead say "of other." This would mean that if the patient's physician is for some reason reluctant to prescribe a narcotic drug, the physician would have a duty to refer the patient to another physician who would prescribe narcotics. Unfortunately, there are not many physicians who sub-specialize in pain management, and in many communities there just aren't very many physicians at all. Item (3) could create an impractical requirement that simply cannot be met.

We respectfully request that all the language in new section three be deleted and the following be inserted in lieu thereof.

New Sec. 3. K.S.A. 65-2838 is hereby amended to read as follows: 65-2838.

(a) The board shall have jurisdiction of proceedings to take disciplinary action authorized by K.S.A. 65-2836 and amendments thereto against any licensee practicing under this act. Any such action shall be taken in accordance with the provisions of the Kansas administrative procedure act.

(b) Either before or after formal charges have been filed, the board and the licensee may enter into a stipulation which shall be binding upon the board and the licensee entering into such stipulation, and the board may enter its findings of fact and enforcement order based upon such stipulation without the necessity of filing any formal charges or holding hearings in the case. An enforcement order based upon a stipulation may order any disciplinary action authorized by K.S.A. 65-2836 and amendments thereto against the licensee entering into such stipulation.

(c) The board may temporarily suspend or temporarily limit the license of any licensee in accordance with the emergency adjudicative proceedings under the Kansas administrative procedure act if the board determines that there is cause to believe that grounds exist under K.S.A. 65-2836 and amendments thereto for disciplinary action authorized by K.S.A. 65-2836 and amendments thereto against the licensee and that the licensee's continuation in practice would constitute an imminent danger to the public health and safety.

(d) The Board shall not take disciplinary action against any licensee for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board shall consider prescribing, ordering,

administering or dispensing controlled substances for pain to be for a legitimate medical purpose if based on sound clinical grounds. The Board shall adopt guidelines for the use of controlled substances for the treatment of pain. In the event a licensee's use of controlled substances has been questioned by another regulatory or enforcement agency and such licensee has prescribed, dispensed or administered controlled substances, including opioid analgesics, in accordance with guidelines adopted by the Board, the Board shall support the licensee in response to the other regulatory or enforcement agency.

New section four of the bill attempts to reiterate public policies that are already a matter of law, but in doing that, it creates inconsistencies. For example, item (1) under subsection (c) restates a definition of unprofessional conduct contained in the Healing Arts Act, but the language differs. If you compare this item (1) with item (25) under subsection (b) of section 6 in line 37 of page 4, which is current law, the language is not the same. Similarly, item (2) under subsection (c) of new section four should be consistent with current law at item (23) under subsection (b) of section six in line 28 of page 4, but it is not. In other words, new section four of HB2649 is probably unnecessary and could be problematic because of inconsistent legal standards for physicians.

We respectfully request that all the language in new section four be deleted and the following be inserted in lieu thereof.

New Sec. 4. Nothing in this act shall be construed to prohibit disciplinary action by the state board of healing arts or interfere with the investigative authority of any law enforcement agency.

This language would be concise and straightforward, and would compliment and clarify our requested amendment in section three.

We endorse the amendments to current law contained in sections five and six. These changes would improve clarity of meaning and expression of legislative intent.

Assuming adoption of the above amendments to sections three and four, HB 2649 would be consistent with the existing guidelines for use of controlled substances (narcotics) adopted by the Kansas Board of Healing Arts in 1998. A copy of that document follows. We consider these guidelines to be the standard of care for all physicians licensed to practice in Kansas.

Thank you for your consideration of our concerns. We respectfully request adoption of our proposed amendments prior to your Committee action on HB2649.

Guidelines for the Use of Controlled Substances for the Treatment of Pain

Approved by the Kansas State Board of Healing Arts October 17, 1998.

Section I: Preamble

The Kansas State Board of Healing Arts recognizes that principles of quality medical practice dictate that the people of the State of Kansas have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment.

Inadequate pain control may result from physicians' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Accordingly, these guidelines have been developed to clarify the Board's position on pain control, specifically as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

The Board recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The medical management of pain should be based on current knowledge and research and include the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

The Kansas State Board of Healing Arts is obligated under the laws of the State of Kansas to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.

Physicians should not fear disciplinary action from the Board for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board will consider prescribing, ordering, administering or dispensing controlled substances for pain to be for a legitimate medical purpose if based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with these guidelines. If such prescribing meets these criteria, the Board will support physicians whose use of controlled substances has been questioned by another regulatory or enforcement agency.

Allegations of improper prescribing of controlled substances for pain will be evaluated on a case- by-case basis. The board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these guidelines, if good cause is shown for such deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's individual needs including any improvement in functioning and recognizing that some types of pain cannot be completely relieved.

The Board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors. The following guidelines are not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of professional practice.

Section II: Guidelines

The Board has adopted the following guidelines when evaluating the use of controlled substances for pain control:

1. Evaluation of the Patient

The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

2. Treatment Plan

The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. Informed Consent and Agreement for Treatment

The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities, including

- urine/serum medication levels screening when requested;
- number and frequency of all prescription refills; and
- reasons for which drug therapy may be discontinued (i.e., violation of agreement).

4. Periodic Review

At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician's evaluation of progress toward stated treatment objectives, such as improvement in patient's pain intensity and improved physical and/or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living and quality of social life. If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

5. **Consultation**

The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

6. **Medical Records**

The physician should comply with and meet the requirements of K.A.R. 100-24-1 in the maintenance of an adequate record for each patient.

7. **Compliance With Controlled Substances Laws and Regulations**

To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

"Acute pain" is the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

"Addiction" is a neuro-behavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

"Analgesic tolerance" is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

"Chronic pain" is a pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

"Pain" is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

"Physical dependence" on a controlled substance is a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

"Pseudoaddiction" is a pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

"Substance abuse" is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

"Tolerance" is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.