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Physician’s Narcotic Prescribing Practice Patterns of Putnam County, Tennessee

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ABSTRACT
Medical tradition dictates that variation in the treatment of a disorder from those methods that are common, customary, and usual within a medical community (the standard of care) constitutes a violation of medical practice, that is, malpractice.

With a survey of 76 physicians within the medical community of Putnam County Tennessee, this paper attempts to define the usual and customary practice of describing opioids and to determine the standard of care.

Since opioid addiction is now epidemic, and over-prescribing of narcotics facilitates addiction, this survey attempted to determine the practice pattern and level of knowledge of the disease of addiction.

The objective of this survey is to permit the average physician to evaluate his/her practice in comparison to his/her colleagues. However, the results show that a significant minority of practicing physicians are not prescribing consistent with evidence-based opioid guidelines. Thus, the standard of care in this community includes deviations from evidence-based guidelines

INTRODUCTION
Tennessee is at the very epicenter of the overprescribing of opioids earthquake. The evidence for this is not just the number of pills prescribed, but also the number of deaths from prescription narcotics which exactly parallels prescribing rates\(^2,3\).

Tennessee's prescription narcotic overprescribing problem is significant, especially in the 13 counties of the Upper Cumberland region centered around the city of Cookeville. Death from prescription narcotic overdose is twice the state average, as this is similarly reflected in the Upper Cumberland having the 4\(^{th}\) highest regional incidence of neonatal abstinence syndrome (NAS) in Tennessee\(^4\).

The authors want to define narcotic overprescribing in this community: What is over-prescribing, and who are the over prescribers?

Since an unintended consequence of prescription narcotic use may be addiction, the authors wanted to define the level of awareness of the diagnosis and treatment of this disease.

STANDARD OF CARE
This coin has two sides. We have evidence based guidelines for common conditions, including guidelines for prescribing opioids for chronic pain\(^5\). This is the professional side of the coin and what physicians should do scientifically.

The other side of the coin is the legal side. "Standard of care" is a term in tort law.
"... In legal terms, the level at which an ordinary, prudent professional with the same training and experience in good standing in a same or similar community would practice under the same or similar circumstances. An "average" standard would not apply because at least half of any group of practitioners would not qualify. The medical malpractice plaintiff must establish the appropriate standard of care and demonstrate that the standard of care has been breached, with expert testimony."

Thus the standard of care can be thought of as a minimally acceptable level of care that a reasonably significant minority of physicians would endorse for a given scenario. Violation of the standard of care may be questioned in the courtroom or at the level of the Board of Medical Examiners.

Over treating of any condition may be a breach of the “standard of care” for that community by a healthcare professional. Although standard of care may ultimately be determined in a court of law, we think that publication of a survey on the norms of local physician practice could help define the local standard of care.

METHODS
Over a period of 14 months, 76 physicians in Putnam County, Tennessee completed a survey of 19 questions about opioid prescribing (Figure 1). Nearly all of these surveys were personally presented by one of the authors (STB) to the interviewed physician. Of the dozen surveys that were mailed out, only about half were returned. Four additional physicians either refused to see the interviewer or to participate in the survey. Physicians practicing at “pain clinics” were not surveyed, and nurse practitioners and physician assistants with DEA licensure to prescribe controlled substances were not surveyed.

ANALYSIS GROUPS
The survey data have been analyzed with the software package “SPSS” by the Decision Sciences Department of the College of Business Administration at Tennessee Technological University through one of the authors (TG). The first general analysis is of the respondents as a whole without a subsetting. Then three comparison subsets were analyzed. The first subset comparison were older physicians who graduated more than 20 years ago (that is 1993 or before) compared with a younger physicians set. The second comparison set were primary care physicians versus referral physicians. The third subset analysis contained the responses of the physicians who treat chronic pain patients with narcotics.

FIGURE 1. Survey for Putnam County Providers by Power of Putnam.

1. What year did you finish your training? ________
2. My practice is… Primary Care / mostly referral.
3. Do you prescribe opioids for treatment of chronic pain? Y N
4. If yes:
   a. What percent of your practice are chronic pain patients on controlled medications? ___________
   b. Do you refer chronic pain patients to:
      1) Specialists in the area involved (viz., arthritis to a rheumatologist)       Y       N
      2) Pain clinics       Y       N
   c. How many chronic pain patients do you see daily on average? _____________________
   d. What percent of your chronic pain patients are discharged from your practice for non-compliance? ______________
   e. Do you combine benzodiazepine prescriptions with opioid prescriptions? Y       N
5. Your opinion...How long should a practitioner maintain chronic pain patients on opioids?
   1) 3 months or less         2) 6 months or less       3) indefinitely
6. What percent of a (non-pain clinic) practice should ethically be chronic pain patients? ___
   (more than 50%=pain clinic)
7. What is the most common diagnosis of chronic pain that you see? __________________________
8. Do you think fibromyalgia is a valid diagnosis? Y       N
9. If there were a chronic pain support group locally, would you refer patients to it? Y       N
10. Are you aware that the Tennessee Prescription Safety Act of 2012 requires searching the TNCSMD database on new patients receiving narcotics? Y       N
11. Have you (or your office) used the database? Y       N
12. Do you prescribe Methadone? Y       N
13. Do you prescribe Suboxone (Buprenorphine)? Y       N
14. Would you confront a colleague for overprescribing? Y       N
15. Have you had any training in addiction diagnosis and treatment? Y       N
16. Do you supervise/monitor/employ para-medicals who prescribe controlled medications? Y       N
   If so, how many? _______________
17. Do you monitor their data-base? Y       N if so, how frequently? ______________
18. Were you aware that prescription drug overdose deaths equal driving accident/deaths in Tennessee? Y       N
19. Do you accept pain as a “vital sign”?
RESULTS

Questions 1, 2, and 3 served to divide the study into the three subsets (Figure 2). Question 1 found there were 44 older physicians who finished medical training before 1994, and 32 younger physicians. Question 2 revealed that the study contained 35 primary care physicians and 41 referral physicians. Question 3 determined that 24% of the 76 physicians treated chronic pain patients with opioids. Most of these opioid treating physicians were older (11 of 18) and had primary care practices (15 of 18).

FIGURE 2. Table of Results: (LBP = Low Back Pain)

<table>
<thead>
<tr>
<th>Question</th>
<th>All MDs n= 76</th>
<th>Trained &gt; 20 years ago, n=44</th>
<th>Trained 20 or less years ago, n=32</th>
<th>Primary care MDs, n=35</th>
<th>Referral MDs, n=41</th>
<th>MDs who treat chronic pain with opioids, n=18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you treat chronic pain with opioids</td>
<td>25% yes</td>
<td>22% yes</td>
<td>43% yes</td>
<td>5% yes</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>How long should chronic pain patients be on opioids</td>
<td>48% &lt; 3 months, 24% abstained</td>
<td>60% &lt; 3 months</td>
<td>29% &lt; 3 months</td>
<td>46% &lt; 3 months 26% did not answer</td>
<td>50% &lt; 3 months</td>
<td>31% &lt; 3 months, 56% indefinitely</td>
</tr>
<tr>
<td>What is the most common chronic pain diagnosis</td>
<td>LBP 68%, arthritis 12%, fibromyalgia 7%</td>
<td>LBP</td>
<td>LBP</td>
<td>LBP</td>
<td>LBP</td>
<td></td>
</tr>
<tr>
<td>Is fibromyalgia a “valid” diagnosis</td>
<td>54% yes</td>
<td>55% yes</td>
<td>48% yes</td>
<td>59% yes</td>
<td>44% yes</td>
<td>56% yes</td>
</tr>
<tr>
<td>Would you refer to a local chronic pain support group</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Do you prescribe methadone/suboxone</td>
<td>3%/3%</td>
<td>5%/5%</td>
<td>0%/0%</td>
<td>6%/6%</td>
<td>0%/0%</td>
<td>11%/6%</td>
</tr>
<tr>
<td>Would you confront a colleague for overprescribing</td>
<td>66% yes</td>
<td>60% yes</td>
<td>60% yes</td>
<td>71% yes</td>
<td>62% yes</td>
<td>65% yes</td>
</tr>
<tr>
<td>Have you been trained in addiction diagnosis and treatment</td>
<td>25% yes</td>
<td>25% yes</td>
<td>31% yes</td>
<td>25% yes</td>
<td>30% yes</td>
<td>40% yes</td>
</tr>
<tr>
<td>Do you employ NPs or PAs who prescribe opioids – if “yes” do you monitor their TNCsM report</td>
<td>46% yes 40% of those employing MDs monitor the database</td>
<td>47% yes &lt; 50% monitor</td>
<td>43% yes &lt; 50% monitor</td>
<td>60% yes, 53% monitor the database</td>
<td>34% yes, 29% monitor the database</td>
<td>50% yes, 67% monitor the database</td>
</tr>
</tbody>
</table>
Are you aware prescription drug overdose deaths equal motor vehicle collision deaths in TN

<table>
<thead>
<tr>
<th></th>
<th>database</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you aware prescription drug overdose deaths equal motor vehicle collision deaths in TN</td>
<td>43% yes</td>
</tr>
<tr>
<td>Do you accept pain as a “vital sign”</td>
<td>20% yes</td>
</tr>
</tbody>
</table>

Responses of Doctors who Prescribe Opioids for Chronic Pain

| What % of practice is chronic pain patients | 10% |
| Do you refer chronic pain patients to local specialists | 100% yes |
| Do you refer chronic pain patients to pain clinics | 77% yes |
| How many chronic pain patients do you see daily | 82% said 3-4 pain patients/day |
| What % of chronic pain patients do you discharge for non-compliance | 7% |
| Do you combine opioids and benzodiazepine prescriptions in chronic pain patients | 41% yes |

In terms of standard of care definition:

- Only a minority felt opioids were only appropriate for less than 3 months, meaning a majority felt opioids could rationally be prescribed chronically (> 3 months is generally acknowledged as chronic use).
- Few physicians were prescribing methadone or suboxone.
- Few physicians were monitoring the opioid prescribing patterns of nurse practitioner and physician assistants they were supposed to be supervising.
- Forty-one percent of those physicians prescribing opioids for chronic pain were combining opioids and benzodiazepines, which evidence based guidelines do not generally recommend and which increases the rate of opioid overdose death by a factor of 3.  

**DISCUSSION**

The most glaring finding of the entire survey is that a low percentage of physicians who prescribe narcotics for chronic pain and who supervise mid-level practitioners have been trained in the diagnosis and treatment of addiction. Addiction is the most important and most lethal side effect of prescription opioids.

Obviously, if the profession of medicine is to remain true to its goals of prevention as well as treatment, and the oath to “do no harm,” there should be an emphatic and urgent requirement for education of physicians regarding the disease of addiction.

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Many local physicians have expressed their concern about how to prescribe for chronic pain patients. Unfortunately, this survey revealed that the Upper Cumberland region of Tennessee has a community standard of care that is not consistent with current evidence based opioid guidelines, as a significant minority of prescribing physicians are not adequately supervising their mid-level providers, and are frequently combining opioids and benzodiazepines.

The subset “older vs. newer trained” physicians was selected for analysis to try to determine if the specious and quasi-political introduction of “pain” as a vital sign (in 1999 by the Veterans Administration and in 2000 by the Joint Commission for Accreditation of Healthcare Organizations) would show a difference in the practice profiles. It did not. The question, do you accept pain as a vital sign, was added late in the survey and was therefore a small data set; however, the overwhelming majority reported “no”. We think this a legitimate expression of physician integrity.

The subset, primary vs. referral practice physicians, was selected to contrast their profiles. As expected, referral physicians were more conservative in the number of chronic pain patients that they see and also treat with narcotics (very few), and the length of time that they opine pain patients should be treated with narcotics. The burden of chronic care of patients with chronic pain falls on primary care physicians, and increasingly on “pain clinics”. Referral physicians have fewer expanders that write narcotic prescriptions. However, the referral physician is less apt than the primary care physician to check the Tennessee Controlled Substance Database of the expanders for which they are responsible.

The “ethical” percentage of chronic pain patients in a practice was a question. Interestingly, no physician in the survey objected to the term “ethical”. The large numbers of chronic pain patients seeking relief of their pain and how to treat them is clearly perceived as both an ethical problem as well as a scientific problem.

LIMITATIONS
This was a survey of practicing physicians in one small Tennessee medical community. Not all physicians participated, and pain clinic physicians were not included in the survey. There are currently 8 chronic pain clinics in Cookeville (population about 30,000).

RECOMMENDATIONS

1. Physicians need to be educated in the diagnosis and treatment of chronic pain, and especially in the diagnosis and treatment of addiction.
2. Physicians need to know the current evidence-based guidelines for chronic pain treatment with opioids, as the standard of care, as defined by current practice patterns, appears to be inconsistent with current guidelines.

References:

3. MMWR 2011; 60 (43): 1487-92