The Opioid Epidemic and the Minnesota Board of Medical Practice

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America is suffering from an epidemic of opioid misuse that has been attributed to the narcotic prescribing practices of physicians. This article focuses on the State of Minnesota and the role that its Board of Medical Practice (BMP) played in this crisis. It presents a review of guidelines issued by the BMP over the last 30 years, showing that it followed national trends in emphasizing increased prescribing of narcotics for pain up until last year, when a much more cautious and nuanced approach to opioid prescribing was advised.

Those of us who applied for our medical license 25 years ago remember having to trudge over to the offices of the Minnesota Board of Medical Practice (BMP) for an in-person interview to confirm that we were indeed the person who appeared on our application. We also may recall being required to watch a 15-minute video encouraging us to be more aggressive in treating patients who complained of pain. Fast forward to today: Prescription opioid abuse is front-page news, and the president of the United States has announced broad initiatives aimed at combating it and the related heroin epidemic. More prescriptions are written for narcotics than there are patients in the United States. Americans, constituting only 4.6% of the world’s population, consume 80% of the global supply of opioid pain medications. Each year, there are more than 16,200 deaths from opioid use in the United States.

In Minnesota, the problem is less severe. Minnesotans are less likely than people in other states to be prescribed narcotics. On a per capita basis, we rank 44th overall in prescription morphine equivalents consumed. We receive only a quarter of the narcotics on a per-person basis than residents of Nevada, the highest ranking state, and about 60% less than the mean for all the other states. Still, deaths from opioid use are on the rise. Data collected by the Minnesota Department of Health and reported in the Minneapolis Star Tribune show that 317 deaths in the state in 2014 were linked to prescription opioids, up from 23 in 2000.

The contrast between today and a quarter century ago is sharp. Many are trying to understand how we got to where we are and who is to blame. Some point to physicians, saying they have been too quick to prescribe opioids. Although the ultimate responsibility for inappropriate prescribing does indeed fall on individual providers, it must be pointed out that physicians have taken their cues on opioid prescribing from their medical societies and boards.

This article looks at the role the BMP appears to have played in bringing on the opioid epidemic in Minnesota and how it is now beginning to respond to this crisis.

A Delicate Balance

Most historians who have examined the origins of the current epidemic look back to November 11, 1996, the day James Campbell, MD, president of the American Pain Society, introduced the phrase “pain as the 5th vital sign.” During his presidential address, he contended that if physicians assessed pain “with the same zeal” as they addressed other vital signs, they would be more likely to treat it properly. “We need to train doctors and nurses to treat pain as a vital sign,” he said. “Quality care means that pain is measured and treated.” In Minnesota, the push to prescribe more narcotics for pain actually began years before Dr. Campbell’s presentation. Even then, the practice was controversial.

In the Fall 1988 edition of the BMP’s newsletter, Update, an article titled “A Delicate Balance” addressed the somewhat conflicting issues surrounding narcotics for treatment of pain. The report stated: “Despite the unequivocal efficacy of these drugs in treating pain, there is great controversy surrounding their usage. Some argue that physicians tend to overprescribe opioids for chronic pain, while others argue that for acute pain, physicians underprescribe these potentially useful drugs. Both arguments are correct.”
hospitalized patients into addicts upon discharge, fear of respiratory depression and the sentiment that having some pain “strengthens moral character.” (The term “opiophobia” was not coined by the BMP. Earlier articles, including one written in 1985, encouraged physicians not to succumb to the fear.)

A 1990 Minnesota Board of Medical Examiners report presented a more nuanced argument. It concluded that under-prescribing was a concern in the treatment of acute pain and cancer pain, and that aggressive treatment with a controlled substance may be necessary for these types of pain but that “the use of narcotics for chronic benign pain is usually not indicated.”

That same year, the BMP, along with the Minnesota Medical Association, held a number of continuing education seminars on this topic. Recommendations were based on national guidelines and included a detailed nine-step program: 1) make an accurate diagnosis, 2) create a treatment plan including the use of nonaddictive modalities and referrals to appropriate specialists, 3) document the failure of nonaddictive treatments, 4) confirm that the patient was not drug-seeking, 5) obtain consent from the patient prior to prescribing medications that have addictive potential, 6) monitor the patient at regular intervals, 7) keep records of the quantity of medications prescribed, 8) have ongoing contact with the patient’s family and 9) confirm that steps 1–8 were followed. Underlined in these recommendations was the following: “What’s important is how well you manage a patient’s care, and create a record of that care, not what you prescribe.”

Continued Push
The issue of pain control continued to be a major concern for the BMP, so much so that the 1988 “Delicate Balance” article was reprinted and distributed to all Minnesota doctors in the fall of 1993. Four years later, in 1997, just as the fifth vital sign revolution was beginning. Update published a long article on the assessment and management of acute pain. This report, which coincided with the introduction and marketing of Oxycontin, appeared to contradict the 1990 recommendation that “the use of narcotics for chronic benign pain is usually not indicated.” In contrast, the 1997 report concluded that “in carefully selected chronic pain patients, opioids may provide substantial benefit and can be maintained for years with acceptable side effects, including a low risk of iatrogenic addiction and a manageable amount of tolerance…. in the right patient, opioid maintenance can work, allowing the patient to restore function and hope.”

The liberalization of recommendations for the treatment of chronic pain was consistent with the widely accepted sample guidelines published by the Federation of State Medical Boards (FSMB) a year later. The FSMB’s model guideline, adopted by many medical boards including Minnesota’s, stated that “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 sample guidelines went on to address the issue of opiophobia: “Physicians should not fear disciplinary action from the Board or other state regulatory or enforcement agency 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 not take disciplinary action against a physician for failing to adhere strictly to the provisions of these guidelines.” The guideline also stated that “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 momentum to push Minnesota physicians to prescribe more narcotics continued unabated resulting in the 2007 publication of a Minnesota BMP Work Group’s report “Appropriate Prescribing of Controlled Substances for the Management of Pain.” The language in this report was extreme in concluding that “undertreated or untreated pain when controlled substances are indicated is a public harm, a serious departure from the prevailing standard of care, and a violation of the Medical Practice Act.” What was a physician to do? What provider in the state has not had a drug-seeking patient claim that they remain uncomfortable and unable to function normally after no discernible source could be found for the severity of their symptoms? Such statements by the BMP were, it appears, designed to pressure physicians to prescribe narcotics for their patients or face the threat of corrective or disciplinary action.

This same report appeared to actively discourage primary care physicians from referring patients to pain management specialists. A finding of a shift or migration to pain specialists for these patients “indicated that primary care practitioners were abdicating their responsibility to manage pain patients within their practices out of fear of having their prescriptions monitored by the data base, and hence a deviation from acceptable standards.” Furthermore, the report discouraged “interventional techniques to manage pain as a substitute” to pharmaceutical management because they carried a far higher dollar cost and a “significantly higher risk of complications.” The report went on to say that such a shift from the use of pharmaceuticals to interventional techniques constituted a deviation from the standard of care and would subject Minnesota physicians to corrective action.

Thus, as recently as 10 years ago, primary care physicians were being given little choice but to care for these patients themselves and encouraged to prescribe for them relatively inexpensive narcotics. These reports and guidelines did not suggest that the emphasis should have been
on finding and eliminating the source of the chronic pain.

In 2009, a Joint Statement on Pain Management by the Minnesota boards of Medical Practice, Nursing and Pharmacy reaffirmed the earlier report imploring providers in our state to “effectively address the dimensions of pain and to provide maximum pain relief with minimal side effects.” The statement noted that “the effects of unmanaged pain are serious and wide-ranging and yet, pain is widely under-treated.” The boards recognized that experts were “more concerned about patients receiving sufficient pain relief” than the potential abuse of these narcotics.14,15

A Change of Course

Over the past seven years, the pendulum has swung back. The emphasis of the most recent joint statement from the boards of Medical Practice, Nursing and Pharmacy is dramatically different from that of the one published in 2009. Instead of stressing the undertreatment of pain, the 2015 statement centers on the growing concerns of prescription drug misuse and overdose. Nowhere to be seen are suggestions to prescribe more “cost-effective” narcotics or recommendations to curb referrals to pain-management specialists. Instead, the boards recommend using a multi-disciplinary approach to identify all treatment options including pharmacologic and non-pharmacologic modalities. “Consider the integration of nonmedication and multimodality therapeutic approaches and set functional goals.”16

It is important to remember that practicing physicians have many layers of oversight: their employers, the hospitals in which they admit patients, malpractice insurers and third-party payers. Still, none of these has the ability to completely shut down a doctor’s practice. Only the Minnesota Board of Medical Practice has the authority to determine whether a physician is practicing within the “minimal standard of care” and has the right to see patients. Thus, it can be argued that their recommendations carry more weight than any other supervisory entity. It appears that when it came to making recommendations about treating pain, the Board followed national initiatives and was trying to “do the right thing” at the time. The emphasis on “better” treatment of pain by prescribing more narcotics appeared consistent with the general trends in our country.

The finding that Minnesota providers were much less likely to prescribe narcotics than their peers in other states suggests that the BMP either failed in its previous efforts to encourage physicians to prescribe narcotics for pain or that physicians in our state were ahead of the curve and more prudent in the judicious use of these potentially abused drugs than those elsewhere. It is also fair to note that the BMP does not establish the standards of care but encourages Minnesota physicians to practice within the norms of their communities. Yet, given the dangers of overprescribing opioids, it makes sense that the BMP should now pursue efforts to curb opioid use with same vigor it had when it encouraged their use in the past. Minnesota physicians need to take the lead with our governing and regulatory bodies to better address this crisis. MM

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