GEORGIA

POLICIES EVALUATED

Statutes

UNIFORM CONTROLLED SUBSTANCES ACT
Title 16. Crimes and Offenses; Chapter 13. Controlled Substances

MEDICAL PRACTICE ACT (*No provisions found*)
Title 43. Professions and Businesses; Chapter 34. Physicians, Physicians Assistants, Respiratory Care; Article 2. Physicians

PHARMACY PRACTICE ACT (*No provisions found*)
Title 26. Food and Drugs, Cosmetics; Chapter 4. Pharmacists and Pharmacies

INTRACTABLE PAIN TREATMENT ACT
No policy found

Regulations

CONTROLLED SUBSTANCES REGULATIONS (*No provisions found*)
Title 480. Georgia State Board of Pharmacy (*Part of the Pharmacy regulations*)

MEDICAL BOARD REGULATIONS (*No provisions found*)
Title 360. Composite State Board of Medical Examiners

PHARMACY BOARD REGULATIONS (*No provisions found*)
Title 480. Georgia State Board of Pharmacy

Other Governmental Policies

MEDICAL BOARD GUIDELINE
Georgia Composite State Board of Medical Examiners. "Management of Prescribing with an Emphasis on Addictive or Dependency-Producing Drugs." 1991.

GEORGIA

PROVISIONS THAT MAY ENHANCE PAIN MANAGEMENT

	1	2	3	4	5	6	7	8
Criteria	**Controlled substances are necessary for public health**	**Pain management is part of medical practice**	**Opioids are part of professional practice**	**Encourages pain management**	**Addresses fear of regulatory scrutiny**	**Prescription amount alone does not determine legitimacy**	**Physical dependence or analgesic tolerance are not confused with "addiction"**	**Other provisions that may enhance pain management**
STATUTES								
Controlled Substances Act[1]								
Medical Practice Act[1]								
Pharmacy Practice Act[1]								
Intractable Pain Treatment Act[2]								
REGULATIONS								
Controlled Substances[1]								
Medical Board[1]								
Pharmacy Board[1]								
OTHER GOVERNMENTAL POLICIES								
Medical Board Guideline						●		

Note: A dot indicates that one or more provisions were identified
[1] No provisions were found in this policy
[2] No policy found

GEORGIA

PROVISIONS THAT MAY IMPEDE PAIN MANAGEMENT

	9	10	11	12	13	14	15	16	17
Criteria	**Opioids are a last resort**	**Implies opioids are not part of professional practice**	**Perpetuates belief that opioids hasten death**	**Physical dependence or analgesic tolerance confused with "addiction"**	**Medical decisions are restricted**	**Length of prescription validity is restricted**	**Practitioners are subject to additional prescription requirements**	**Other provisions that may impede pain management**	**Provisions that are ambiguous**
STATUTES									
Controlled Substances Act				●					
Medical Practice Act[1]									
Pharmacy Practice Act[1]									
Intractable Pain Treatment Act[2]									
REGULATIONS									
Controlled Substances[1]									
Medical Board[1]									
Pharmacy Board[1]									
OTHER GOVERNMENTAL POLICIES									
Medical Board Guideline	●			●				●	

Note: A dot indicates that one or more provisions were identified

[1] No provisions were found in this policy

GEORGIA

STATUTES

Controlled Substances Act

O.C.G.A. § 16-13-21

§ 16-13-21. Definitions

As used in this article, the term:

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(8) “Dependent,” “dependency,” “physical dependency,” “psychological dependency,” or “psychic dependency” means and includes the state of dependence by an individual toward or upon a substance, arising from the use of that substance, being characterized by behavioral and other responses which include the loss of self-control with respect to that substance, or a strong compulsion to use that substance on a continuous basis in order to experience some psychic effect resulting from the use of that substance by that individual, or to avoid any discomfort occurring when the individual does not use that substance.

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CRITERION 12: [-]
Physical dependence or analgesic tolerance confused with “addiction”

Other Governmental Policy

Medical Board Guideline

MANAGEMENT OF PRESCRIBING WITH AN EMPHASIS ON ADDICTIVE OR DEPENDENCY-PRODUCING DRUGS

To All Doctors Licensed to Practice Medicine in Georgia:
If you don't have time to read this article now,
we request that you read it later.

The Georgia Board of Medical Examiners is charged by law to protect the citizens of the State from harmful physician management. A significant number of physicians who are asked to appear before the Board are required to do so because of their lack of information about the management and responsibilities involved in prescribing controlled substances. Frequently, the inadvertent offender is a physician with a warm heart and a desire to relieve pain and misery, who is always pressed for time and finds himself prescribing controlled drugs on demand over prolonged periods without adequate documentation. These are often for chronic ailments such as headache, arthritis, old injuries, chronic orthopedic problems, backache and anxiety. (Terminal cancer pain management is not a consideration here.) The purpose of the Board of Medical Examiners in presenting the following information is to help licensed physicians in Georgia consider and reevaluate their prescribing practice of controlled substances. Practicing physicians who become new Board members have often mentioned the abrupt education they received in their own prescribing patterns. Moreover, there have been many requests to the Board from physicians for detailed information on prescribing in certain specific situations.

It's not what you prescribe, but how well you manage the patient's care and document that care in legible form, that's important.

The prescribing matters that come before the Board are almost always related to the prescription of controlled substances. We feel that a majority of instances where physicians have been disciplined by the Board for prescribing practices could have been avoided completely if they followed the steps that are being outlined here.

To prevent any misunderstanding, it's necessary to state what the Board does not have.

It does not have a list of "bad" or "disallowed" drugs. All formulary drugs are good if prescribed and administered when properly indicated. Conversely, all drugs are ineffective, dangerous, or even lethal when used inappropriately.

CRITERION 6: [+]
Prescription amount alone does not determine legitimacy

It does not have some magic formula for determining the dosage and duration of administration for any drug. These are aspects of prescribing that must be determined within the confines of the individual clinical case, and continued under proper monitoring. What's good for one patient may be insufficient or fatal for another.

What the Board does have is the expectation that physicians will create a record that shows:

-Proper indication for the use of drug or other therapy

-Monitoring of the patient where necessary

-The patient's response to therapy on follow-up visits

-All rationale for continuing or modifying the therapy

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OTHER GOVERNMENTAL POLICY

Medical Board Guideline

(CONTINUED)

STEP ONE

First and foremost, before you prescribe anything, start with a diagnosis which is supported by history and physical findings, and by the results of any appropriate tests. Too many times a doctor is asked why he or she prescribed a particular drug, and the response is, "Because the patient has arthritis." Then the doctor is asked, "How did you determine that?", and the answer is "Because that's what the patient complained of." Nothing in the record or in the doctor's recollection supports the diagnosis except the patient's assertion. Do a workup sufficient to support a diagnosis, including all necessary tests.

STEP TWO

Create a treatment plan which includes the use of appropriate non-addictive modalities, and make referrals to appropriate specialists, such as neurologists, orthopedists, psychiatrists, etc. The results of the referral should be included in the patient's chart.

STEP THREE

CRITERION 9: [-]
Opioids are a last resort

Before beginning a regimen of controlled drugs, make a determination through trial or through a documented history that non-addictive modalities aren't appropriate or they don't work. A finding of intolerance or allergy to Non Steroidal Anti Inflammatory Drugs is one thing, but the assertion of the patient that, "Gosh, doc, nothing seems to work like that Percodan stuff!" is quite another. Too many of the doctors the Board has seen have started a treatment program with powerful controlled substances without ever considering other forms of treatment.

STEP FOUR

Make sure you are not dealing with a drug-seeking patient. If you know the patient, review the prescription records in the patient's chart and discuss the patient's chemical history before prescribing a controlled drug. If the patient is new or otherwise unknown to you, at a minimum obtain an oral drug history, and discuss chemical use and family chemical history with the patient.

STEP FIVE

It's a good idea to obtain the informed consent of the patient before using a drug that has the potential to cause dependency problems. Take the time to explain the relative risks and benefits of the drug and record in the chart the fact that this was done. When embarking on what appears to be the long term use of a potentially addictive substance, it may be wise to hold a family conference and explain the relative risks of dependency or addiction and what that may mean to the patient and to the patient's family.

Refusal of the patient to permit a family conference may be significant information.

STEP SIX

CRITERION 16: [-]
Other provisions that may impede pain management

Comment: "Drug holidays" are no longer recognized as appropriate medical practice.

CRITERION 12: [-]
Physical dependence or analgesic tolerance confused with "addiction"

Maintain regular monitoring of the patient, including frequent physical monitoring. If the regimen is for prolonged drug use, it is very important to monitor the patient for the root condition which necessitates the drug, and for the side effects of the drug itself. This is true no matter what type of controlled substance is used or what schedule it belongs to. Also, remember that with certain conditions, drug holidays are appropriate. This allows you to check to see whether the original symptoms recur when the drug is not given - indicating a continuing legitimate need for the drug or whether withdrawal symptoms occur - indicating drug dependence.

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OTHER GOVERNMENTAL POLICY

Medical Board Guideline

(CONTINUED)

STEP SEVEN

Make sure YOU are in control of the supply of the drug. To do this, at a minimum you must keep detailed records of the type, dose, and amount of the drug prescribed. You must also monitor, record and personally control all refills. Do not authorize your office personnel to refill prescriptions without consulting you. One good way to accomplish this is to require the patient to return to obtain refill authorization, at least part of the time. Records of cumulative dosage and average daily dosage are especially valuable. A thumbnail sketch of three cases will illustrate our point here. In the first case, a physician prescribed Tussionex to a patient for approximately five years for a cumulative dosage of nineteen and one half gallons. In the second case, a physician prescribed Tylenol 3's to a patient for slightly more than a year at the average rate of 30 per day! The third case is very similar, except it was Tylenol 4's at the rate of 20 per day. Some quick observations:

-No physician who was aware of that kind of prescribing would have continued with it.

-Few, if any patients could have been consuming that much Tylenol with codeine. In all likelihood, they were selling it.

Another important part of controlling the supply of drugs is to check on whether the patient is obtaining drugs from other physicians. Checking with pharmacies and pharmacy chains may tell whether a patient is obtaining extra drugs or is doctor shopping. It is a felony in Georgia for a patient to fail to disclose to his physician that he has received controlled substances of a similar therapeutic use from another practitioner at the same time. If you are aware of this occurring, contact your local police, the State Drugs and Narcotics Agency or the Board of Medical Examiners.

STEP EIGHT

Maintaining regular contact with the patient's family is a valuable source of information on the patient's response to the therapy regimen, and may be much more accurate and objective than feedback from the patient alone.

The family is a much better source of information on behavioral changes, especially dysfunctional behavior, than is the patient. Dysfunctional changes may be observable when the patient is taking the drug, or when the drug is withdrawn. These changes, at either time, may be symptoms of the dependency or addiction.

The family is also a good source of information on whether the patient is obtaining drugs from other sources, or is self-medicating with other drugs or alcohol.

STEP NINE

To reiterate, one of the most frequent problems faced by a physician when he or she comes before the Board or other outside review bodies is inadequate records. It's entirely possible that the doctor did everything correctly in managing a case, but without records which reflect all the steps that went into the process, the job of demonstrating it to any outside reviewer becomes many times more difficult. Luckily, this is a problem which is solvable.