

# Best Practice for Safe and Effective Prescribing

## Legal and Liability Considerations

### ND Opioid Symposium

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# Recent CDC Guidelines

- **Voluntary**
- **Primary Care focus**
- **Chronic Pain** (pain lasting past 3 months, or past the time of normal tissue healing.)

# Recommendations:

- 1) Non-pharmacologic/non-opioid treatment preferred
- 2) Goals
- 3) Risks/Benefits/Alternatives(R/B/A)
- 4) Immediate-release form first
- 5) For acute pain, 3 days Rx usually sufficient, 7 days rare
- 6) Lowest effective dosage. IF ongoing need, carefully assess when going up to  $\geq 50$  MME/day; avoid  $\geq 90$  MME/day

\*MME= morphine milligram equivalents

Drug	Oral Equianalgesic Dose (mg)
Morphine	30
Buprenorphine	0.4 (SL)
Codeine	200
Fentanyl	15mcg/hr (TD)**
Hydrocodone	30
Hydromorphone	7.5
Meperidine	300
Methadone	10**
Oxycodone	20
Oxymorphone	10
Tramadol	120

# Recommendations, cont...

- 7) If using for chronic pain, evaluate R/B/A within 1-4 wks (dose start or adjustment)
- 8) Mitigate risks (concomitant)
- 9) PDMP (prescription drug monitoring program)
- 10) U/A prior, and periodic
- 11) Avoid concurrent benzodiazepines if possible
- 12) MAT (medication-assisted treatment) for those with opioid use disorder.

# Issues

## Individual

- Level of Comfort
- Training, Licensing, Certification, and Competence

## System

- Time constraints (panel, EHR, etc...)
- Mission
- Pay for Performance
- Isolation
- Review

# Legal and Liability Considerations

- Disclaimer:

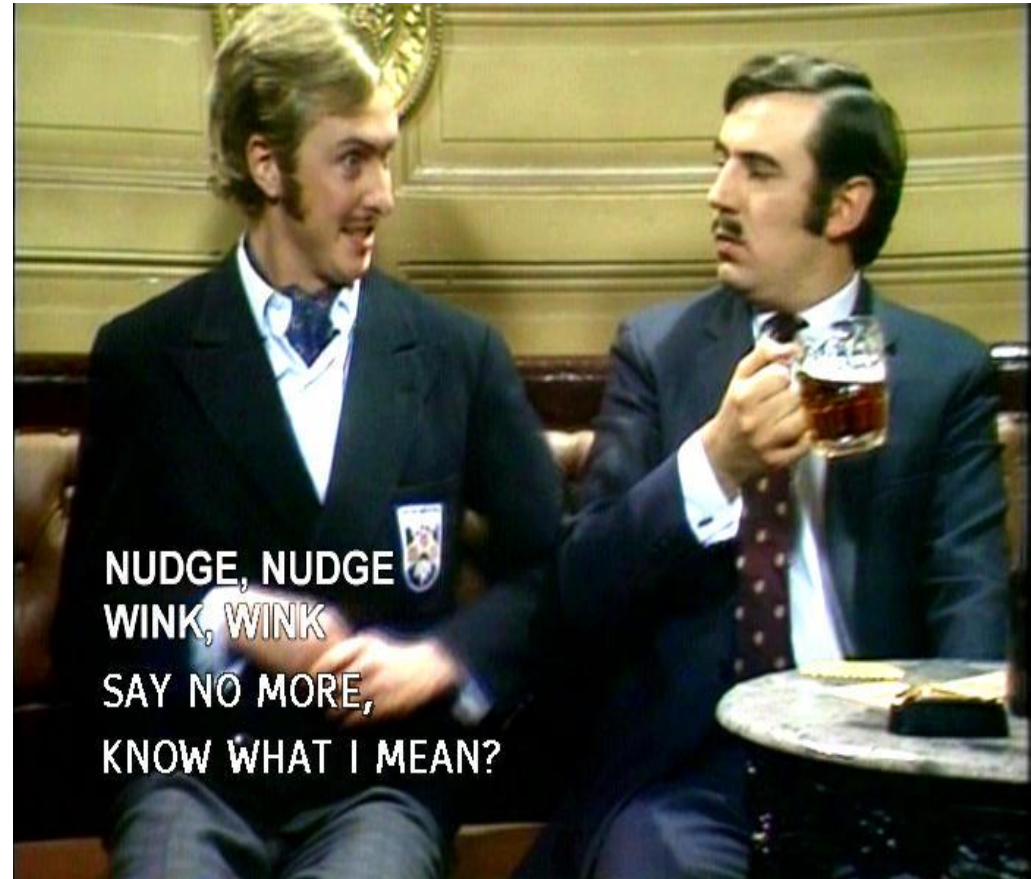
I am not an attorney, nor do I play one on TV.

I do teach “Law and Medicine.”



# Prescribing of methadone and buprenorphine

- Physicians, APRNs, PAs can prescribe these medications for treatment of pain.
- Physicians who have a Drug Addiction Treatment Act of 2000 waiver (DATA 2000 waiver) can prescribe buprenorphine for opioid addiction



# Elements of Informed Consent

- Informed consent should include:
  - Nature of the treatment (procedure/meds/other)
  - Purpose of the treatment
  - Benefits
  - Risks
  - Alternative treatments (including no treatment at all)
  - Implies discussion, not just “sign here...”



# Legal/Liability-Medical Malpractice

- Civil claim for negligent care or failure to obtain informed consent
- Parties to the suit – plaintiff (patient) and defendant (prescriber / staff / medical institution)
- Standard is preponderance of evidence



# 4 Elements re: negligent care

- **Duty:**

Provider has a duty to provide competent care to the patient

**Breach:**

Did the conduct, whether by act or omission, fall below the applicable standard of care

- **Cause:**

“but for....”

“foreseeable”

**Damages:**

# Elements

- Omission of Fact

(Did you not review  
the record, the PDMP,  
access NDHIN, etc...)

- Omission of Judgment

Where did you land?

# Confidentiality/Health Information Exchange

## HIPAA (45 CFR)

- Releases of information re: PHI are not required for treatment issues pertaining to coordination of care between covered entities...

## Federal Statute behind 42 CFR part 2

- Patient Consent required for all releases of identifiable patient information for treatment **except in a medical emergency**
- Prohibits use of patient information for criminal charges or investigation unless there is a substantial risk of death or bodily harm

# “Controlled Substance Agreements” (i.e, “Pain Contracts...”)

- Need to be reasonable
- If a provider decides to “dismiss” a patient:
  - How is this communicated with the patient?
  - Are there dangers of withdrawal, and what has been the recommendation/instruction for dealing with this?
  - Further recommendations for other treatment? Assistance re: continuity of care?
  - Cannot abandon

# Internal and External Reviews

## Internal

- Hospital/Clinic Boards
- Peer Review

## External

- Joint Commission
- State Licensing Boards
- DEA
- CMS
- OIG
- Other

# 4 Cs of Risk Management

- Compassion

- Communication (both patients/colleagues)

WHEN YOU ARE STUCK, EXPAND THE FIELD!

- Competence

- Charting

Questions? Comments?

