Prescribing of Controlled Substances for Non-Patients in the Educational Setting: Review of the Ethical, Legal, and Moral Dilemma for Residents

Ari Halldorsson, M.D.
Department of Surgery
Texas Tech University Health Sciences Center
Lubbock, Texas, USA

Abstract: Prescription drug abuse is an enormous problem in modern society. Studies have shown that it results in more injuries and deaths to Americans than all illegal drugs combined. In this review, the author discusses the prescribing of controlled substances by residents as it relates to intercollegial and other non-patient workplace encounters. Physician drug abuse, medical/legal issues regarding controlled substance prescriptions, and ethical conflicts will be discussed. These issues will be specifically addressed as they relate to the academic institutions where residents can potentially be placed in a moral, ethical and legal dilemma by supervisors and co-workers. Finally, a recommendation for an institutional policy will be suggested to help residents and other physicians recognize and deal with drug seeking behavior by coworkers. Also, a recommendation regarding strict institutional regulation of resident prescription practices regarding controlled substances will be presented.

Keywords: ethics, prescribing, controlled substances, residents

Substance Abuse among Health Care Workers

Several studies have looked at the prevalence of alcoholic and drug abuse among physicians, residents, and medical students. It is currently felt that the incidence is at least the same as the general population, if not higher. Most studies estimate between 10-15% risk over a lifetime. Some studies have suggested that prescription drug abuse, specifically benzodiazepines and opiates, is higher in this group than in the general population. The epidemiology data have shown that all subspecialties are afflicted, although the highest incidents seem to be among Anesthesiologists, Family Practitioners and Psychiatrists. The male to female ratio is about 4 to 1, and it is estimated that about 100 deaths among physicians are directly attributable to chemical dependency every year. The etiology of addiction among physicians has been found to be very similar to the ones seen in other sub-groups, including family history of addictive disorders, other psychiatric illnesses, problematic childhoods, lack of religious affiliation, and low self-esteem. Some studies have suggested that heavy demands during medical school, postgraduate training, and work contribute to this disease, but strong relationships have not been found. Talbott et al. pointed out that the trends toward addiction start very early in many physicians, although not diagnosed until later on, and have more to do with poor coping skills regarding stress, and poor social and interpersonal relationships dating back to childhood. When the abusive behavior manifests itself in midlife or later, etiologic factors such as lack of education about impairment, absence of effective prevention strategies, availability of drugs, sleep deprivation, and work demands play a bigger role. It is commonly accepted that the earlier the substance abuse becomes uncontrollable, the worse the prognosis in this group of addicts as in others. Several studies have pointed out that the detection of addictive behavior among physicians is more difficult than the general population. The hallmark of chemical dependency is denial. It seems to be even more heightened among physicians. They become very good at concealing their problems; it has been stated by several studies that physicians’ job performance and employment issues are affected very late in their disease process and their possible addiction is therefore often overlooked by themselves, friends, and colleagues. The other issue often associated with abuse by physicians is the reluctance of others to recognize and confront the addictive behavior. This unwillingness to confront the problems of peers is multifactorial and includes the need to protect professional image, our own unwillingness to consider substance abuse and the stigma that goes with it for colleagues we respect, and the uneasy feeling that “next it could be me”. On the other hand, several studies have documented that with treatment, long term abstinence among physicians is much higher than the general population and often quoted to be approximately 75-85%. Some studies have shown up to 96% long term abstinence in those who enter monitored programs. These numbers verify that if an impaired physician seeks the appropriate help and enters a monitored program, his/her professional and personal life will be back on track. Physicians, therefore, have to
understand that in the current era of addiction management, early identification, intervention, and non-threatening access to treatment will help their colleagues and most likely save them from a fatal disease.

Substance abuse within the hospital workplace does not affect physicians alone and seems to be a growing problem. Several recent articles have emphasized that the problem seems to be escalating. Many hospitals have increased their education, awareness, and in-house employment assistance programs. Physicians play a key role in identifying and confronting employees with possible addictive problems. Physicians have to be specifically aware of those issues as they relate to controlled substance prescriptions. Ossi pointed out some of the methods used by hospital employees to obtain controlled substances which include rerouting patient medication, forging a physician prescription, establishing a superficial physician/patient relationship with several physicians (even feigning illnesses) and using personal contacts within the workplace. Clark et al. investigated this prescription-writing pattern among house officers at a major university medical center. They found that house officers’ prescription patterns accounted for a sizable source of psychoactive medication in the clinical environment.

This raises the question of how residents and other trainees are taught about substance disorders and how to identify the signs and symptoms, including a drug seeking behavior. Fleming et al., in a recent article entitled “Who Teaches Residents about the Prevention and Treatment of Substance Use Disorders? - A National Survey”, found that physicians in general were poorly prepared to identify and treat drug use disorders. They concluded that the teachers themselves were inadequately trained in this subject matter and that numerous faculty development programs needed to be created to increase the awareness and understanding of this disease in the general public. As it specifically relates to drug abuse and drug seeking behavior within the medical community, education is lacking, and the residents’ understanding of the disease process, including what to look for and how to react to colleagues with potential addictive disorders, is minimal. The concept of drug-seeking behavior, although widely used by addicts, is poorly defined and rarely, if ever, taught in medical school or during post graduate training. Longo et al. discussed the dilemma of physicians confronted with a drug seeking patient. They discuss in detail the characteristics of those patients and how to deal with them. This article should be required reading for all who prescribe controlled medications.

Laws Regarding Controlled Substance Prescription

Physicians who prescribe controlled substances have to know and understand multiple laws, regulatory policies, professional attitudes, and ethics about those prescription practices. Because of their prevalence and common clinical indications associated with high abuse potential, two classes of drugs, opioids and benzodiazepines, have gotten special attention. Several articles and oversight agencies have tried to address the delicate balance between the need to use these drugs versus the potential abuse. In 2003, the American Medical Association launched a pain management education program to provide primary physicians with up to date information on assessment and management of pain including the possibility of substance abuse. The American Medical Association also reinforces in its policy statement on prescribing controlled substances that educating the prescribers on the proper use of these medications is the best way to insure their proper use and decrease prescription drug abuse. Gilson et al, in a recent article, addressed the problem of using opiate pain medication in patients with addictive disorders, specifically emphasizing that using those medications under these circumstances is a last resort and should only be done after extensive consultation with an addiction medicine specialist. Although federal and state laws are complex regarding prescription of controlled substances and vary between states, they boil down to the following paragraph: “a prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.” This paragraph is then further clarified by statute, both federal and individual state. Individual prescribers, therefore, have to accept the responsibility of using controlled medications appropriately when needed, knowing and understanding the law regarding their prescription, understanding the high potential for abuse, and knowing how to recognize abusive and drug seeking behavior.

The above mandate is easily understandable and accepted by most physicians after years of training before going into the practice of medicine. It is not as straightforward and clear cut when physicians are approached by colleagues and other coworkers with issues regarding the writing of prescriptions for controlled substances. “Hallway consultations” are common among colleagues and co-workers, and might include a request for the prescribing of controlled substances. Residents and other physicians must be made fully aware that prescribing controlled substances or other medications without entering into a formal doctor/patient relationship (including documentation) is both illegal and unprofessional. The issue of informal prescriptions of controlled substances
to colleagues becomes magnified and even more complicated when residents are approached by a person in a supervisory position causing a possible ethical dilemma for the trainee.

**Teacher/Learner Relationship in Medical Education**

The teacher/learner relationship in medical education in the last few decades has been increasingly examined, researched, and re-evaluated. The earlier models of medical education emphasizing the mentor/apprentice relationship were unstructured, unregulated and the almost-total power of the teacher taken for granted. The American Medical Association has, in its policies, set forth a very strong recommendation on the teacher/learner relationship. They strongly recommend that each medical institution have a widely disseminated policy that 1) sets forth the expected standards of behavior of the teacher and learner, 2) delineates procedures for dealing with breaches of the standards and 3) outlines a mechanism for prevention of conflict in education. It also urges all medical education programs to regulate a code of behavior including that the teacher/learner relationship should be based on mutual trust, respect and responsibility. Several research papers have recently dealt with issues regarding ethical conflicts between residents and attending physicians and how those conflicts are resolved. They concluded that the five major categories of ethical conflicts were concerns over telling the truth, respecting patient’s wishes, preventing harm, managing the limits of one’s competency, and addressing the performance of others. They also stated that many of the conflicts were exacerbated by the hierarchical structure in the residency training. The authors of these articles, although they disagree somewhat on the prevalence of this problem and exactly which issues constitute an unethical or moral dilemma for the resident, agree that a great deal of frustration on the residents’ part stems from the fact that they either didn’t know of a formal process or the institution did not have a formal process to resolve the ethical disagreement between teachers and learners.

Very little literature is available on the specific ethical conflict a house officer might encounter regarding prescription of controlled substances and possible drug seeking behavior of coworkers. Reuben and Noble looked indirectly at this issue in an article entitled “House Officer Responses to Impaired Physicians”. They examined the response from a house officer when confronted with an impaired physician, either fellow residents, medical students, or attendings. The most interesting finding in that study was that the house officer’s response was significantly different when the impaired person was an attending physician versus a fellow house officer. In that study, the house officers felt almost uniformly that they were unaware of how to approach these issues and that very few of them had any education in how to recognize drug seeking behavior, the treatment available, and outcome to the affected individual. They were, for instance, much more likely to confront and try to help those who suffered from depression and other psychiatric illnesses than chemical dependency. In a similar study by Mott dealing with impaired supervisors, the author concluded that whenever a trainee knows and understands the disease process, the availability of support systems and the prospect of good successful rehabilitation, they were much more likely to confront the issue to help the affected individuals. The subjects of this study also echoed the frustration seen by others that even when a formal process was in place at their institution, they were not educated on how to use it. A recent study by Roberts et al. found that medical students had the same dilemma and biases regarding impaired colleagues as did residents.

**Proposed Solution**

Based on the available literature, specifically concentrating on addictive disorders among physicians, law and regulations guiding the prescription of controlled substances, and ethical and moral dilemmas associated with learner/teacher relationships, the following are reasonable recommendations.

**Increased education**

1. Learners and faculty need to be educated about addictive disorders among physicians and other health care workers, including prevalence, signs, symptoms, treatment, and outcome.

2. Education on drug seeking behavior and management thereof, including both patients and coworkers, need to be reinforced.

3. Residents need to be taught very early about the pertinent laws and regulations regarding prescribing controlled substances, including record keeping. They need to understand their moral responsibility in prescribing these drugs appropriately and the legal ramifications of not adhering to the state and federal laws.

4. Residents and other learners need to be educated very early about the institutional policies regarding conflict with supervisors, including their own rights and responsibilities, and understanding that punitive reaction to their complaints will never be tolerated.
Institutional Policies

1. Most medical education institutions have a House Staff Policy and Procedures manual that includes sections on dealing with fellow physicians that are possibly impaired or incompetent and the proper procedure for resolution of disagreements and ethical dilemmas with teaching staff. These policies need to be taught to incoming trainees, specifically pointing out their role in protecting patients, helping their fellow physicians and understanding that this process is there for their benefit.

2. House officers should be strongly discouraged, or even banned, from writing any subscriptions outside a formal treatment relationship. This policy should be widely published within the institution, thereby making it easier for the house officers to refuse a request for a prescription by a non-patient.

Conclusion

Substance abuse among physicians and other hospital staff is a problem that cannot be ignored. The issues associated with this disease in the workplace, including drug seeking behavior, are bound to affect the residents. Education on addiction in medical schools and residencies is inadequate. Residents and learners in general are unfamiliar with societal and institutional rules and regulations regarding prescription of uncontrolled substances. Moral and ethical conflicts with attendings are a significant source of stress and concern for residents. Many do not understand current institutional policies and regulations at their disposal when grievances arise. Institutes of medical education need to increase their education about addictive disorders specifically in the medical workplace, how to recognize drug seeking behavior and impairment, the importance of early intervention, treatment and outcome, and the protection provided to the learners who feel they are placed in a compromising position. Medical institutions need to place strict rules on informal prescription policies by residents and others, specifically to avoid placing any physician in a compromising position.

Addendum

The following are excellent internet resources regarding the ethical issues discussed in this paper.

1. Project Professionalism from the American Board of Internal Medicine (http://www.webcitation.org/5NJkc15xQ)
2. American Medical Association Code of Ethics (http://www.webcitation.org/5NJkhGqR2)

References

1. Weiss KJ, Greenfield DP. Prescription drug abuse. Psychiatr Clin North Am. 1986;9:475-90.
2. Dhai A, Szabo CP, McQuoid-Mason DJ. The impaired practitioner – scope of the problem and ethical challenges. S Afr Med J. 2006 Oct;96:1069-72.
3. Hughes PH, Brandenburg N, Baldwin DC Jr, Storr CL, Williams KM, Anthony JC, et al. Prevalence of substance use among us physicians. JAMA. 1992;267:2333-9.
4. Flaherty JA, Richman JA. Substance use and addiction among medical students, residents, and physicians. Psychiatr Clin North Am. 1993;16:189-97.
5. Wilkerson M. Effective components of treatment for the chemically dependent physician. J Okla State Med Assoc. 2006;99:547-8.
6. Blondell RD. Impaired physicians. Primary Care. 1993;20:209-19.
7. Taub S, Morin K, Goldrich MS, Ray P, Benjamin R, Council on Ethical and Judicial Affairs of the American Medical Association. Physician health and wellness. Occup Med (Lond). 2006;56:77-82.
8. Lloyd G. One Hundred Alcoholic Doctors: A 21-year follow-up. Alcohol Alcohol. 2002;37:370-4.
9. Hyde GL, Wolf J. Alcohol and drug use by surgery residents. J Am Coll Surg. 1995;181:1-5.
10. Talbott GD, Benson ED. Impaired physicians: the dilemma of identification. Postgrad Med.
11. Centrella M. Physician addiction and impairment – current thinking: a review. J Addict Dis. 1994;13:91-105.

12. Farber NJ, Gilibert SG, Aboff BM, Collier VU, Weiner J, Boyer EG. Physicians’ willingness to report impaired colleagues. Soc Sci Med. 2005;61:1772-5.

13. Roberts LW, Warner TD, Rogers M, Horwitz R, Redgrave G; Collaborative Research Group on Medical Student Health Care. Medical student illness and impairment: a vignette-based survey study involving 955 students at 9 medical schools. Compr Psychiatry. 2005;46:229-37.

14. Knight JR. A 35-year-old physician with opioid dependence. JAMA. 2004;292:1351-7.

15. Ossi J. Substance abuse and dependence in the hospital workplace: detection and handling. Per spect Healthc Risk Manage. 1991;11:21-6.

16. Deming RA. Hospitals face substance abuse problems. Tex Hosp. 1987;43:14-6.

17. Arshem EE. Dealing with substance abuse in the medical workplace. Med Group Manage J. 1993;40:46-51.

18. Clark AW, Kay J, Clark DC. Patterns of Psychoactive Drug Prescriptions By House Officers for Nonpatients. J Med Educ. 1988;63:44-50.

19. Fleming MF, Manwell LB, Kraus M, Isaacson JH, Kahn R, Stauffacher EA. Who teaches residents about the prevention and treatment of substance use disorders? A national survey. J Fam Pract. 1999;48:725-9.

20. Longo LP, Parran T Jr, Johnson B, Kinsey W. Addiction: Part II. Identification and management of the drug-seeking patient. Am Fam Physician. 2000;61:2401-8.

21. Clark HW. Policy and medical-legal issues in the prescribing of controlled substances. J Psychoactive Drugs. 1991;23:321-8.

22. Gilson AM, Joranson DE. U.S. policies relevant to the prescribing of opioid analgesics for the treatment of pain in patients with addictive disease. Clin J Pain. 2002;18(4 Suppl):S91-8.

23. Gibbs LS, Haddox JD. Lawful prescribing and the prevention of diversion. J Pain Palliat Care Pharmacother. 2003;17:5-14.

24. Hill CS Jr. Pain management in a drug-oriented society. Cancer. 1989;63(11 Suppl):2383-6.

25. American Medical Association [homepage on the Internet]. H 292.972 Education regarding prescribing controlled substances. Chicago: The Association; c1995-2007 [cited 2007 Mar 12] [about 1 screen]. Available http://www.webcitation.org/5NI14RKeA.

26. American Medical Association [homepage on the Internet]. H295.955 Teacher-learner relationship in medical education. Chicago: The Association; c1995-2007 [cited 2007 Mar 12] [about 2 screens]. Available from http://www.webcitation.org/5NI11o4tD.

27. Rosenbaum JR, Bradley EH, Holmboe ES, Farrell MH, Krumholz HM. Sources of ethical conflict in medical housestaff training: a qualitative study. Am J Med. 2004;116:402-7.

28. Egan EA. Organizational ethics in residency training: moral conflict with supervising physicians. Camb Q Healthc Ethics. 2003;12:119-23.

29. Shreves JG, Moss AH. Residents’ ethical disagreements with attending physicians: an unrecognized problem. Acad Med. 1996;71:1103-5.

30. Levi BH. Ethical conflicts between residents and attending physicians. Clin Pediatr. 2002;41:659-67.

31. Jones JW, McCullough LB, Richman BW. Clinical disagreements between residents and faculty surgeons. J Vasc Surg. 2004;39:270-2.

32. Reuben DB, Noble S. House officer responses to impaired physicians. JAMA. 1990;263:958-60.

33. Mott JS. Dealing with the impaired supervisor. Physician Assist. 1990;14:93-4,99-101.

34. Baldwin DC Jr, Daugherty SR, Rowley BD. Unethical and unprofessional conduct observed by residents during their first year of training. Acad Med. 1998;73:1195-200.
Correspondence:

Ari Halldorsson, MD
Residency Program Director
Professor and Chief
Division of Cardiothoracic Surgery
Department of Surgery
Texas Tech University Health Sciences Center
3601 4th Street MS 8312
Lubbock, TX 79430

Telephone: (806) 743-2370
Fax: (806) 743-1475
Email: ari.halldorsson@ttuhsc.edu