Guidelines for the Use of Controlled Substances in the Treatment of Pain
Adopted by the New Hampshire Medical Society, July 1998

Section I: Preamble

The New Hampshire Medical Society believes that principles of quality medical practice dictate that the citizens of the State of New Hampshire have access to appropriate and effective pain relief. The appropriate application of current knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as to reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Medical Society encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment, as well as about statutory requirements for prescribing controlled substances.

Inadequate pain control may result from physicians' lack of knowledge about pain management or from an inadequate understanding of addiction. Fears of investigation or sanction by federal, state, and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Accordingly, these guidelines have been developed to clarify the Medical Society's position on pain control, specifically as related to the use of controlled substances, in order to alleviate physician uncertainty and to encourage better pain management.

These guidelines have been drafted by New Hampshire Medical Society members with expertise in pain management and addiction medicine, using as a basis the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain issued by the Federation of State Medical Boards of the United States, Inc. in May 1998. Use of the Federation's Guidelines as a basis for the Medical Society's Guidelines was elected in order to facilitate compatibility of the Medical Society's vision with that of the New Hampshire Board of Registration in Medicine.

The Medical Society recognizes that controlled substances, including opioid analgesics, are essential in the treatment of acute pain due to trauma, surgery, and chronic pain whether due to cancer and non-cancer origins. Physicians are referred to the US Agency for Health Care and Research Clinical Practice Guidelines for a sound approach to the management of acute and cancer-related pain.

The medical management of pain should be based upon current knowledge and research and includes the use of both pharmaceutical and non-pharmaceutical modalities. Pain should be assessed and treated promptly. The quantity and frequency of medication doses should be adjusted according to the intensity and pattern of pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

The New Hampshire Board of Registration in Medicine is obligated under the laws of the State of New Hampshire to protect the public health and safety. The Medical Society supports the Board in this role and recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may facilitate drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate and non-medical uses.

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 Medical Society considers prescribing, ordering, administering, or dispensing controlled substances for pain to be for a legitimate medical purpose when based on accepted scientific knowledge of the treatment of pain or if based on sound clinical grounds. All such prescribing should be accompanied by clear documentation of unrelieved pain and be in compliance with applicable state or federal law.

The Medical Society believes that the validity of prescribing must be judged based on the physician's assessment and treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goals of pain management should be to treat the patient's pain for its duration while effectively addressing related aspects of the patient's functioning, including physical, psychological, social and work-related factors. The following guidelines are not intended to define complete or best practice, but rather to communicate what the Medical Society considers to be within the boundaries of professional practice.

When concerns regarding physician prescribing for pain arise, each case of prescribing should be evaluated on an individual basis. Disciplinary action against a physician should not be taken for failing to adhere to these guidelines if good cause is shown for such deviation. A physician’s conduct in prescribing controlled substances in a given context should be evaluated based a variety of factors including among others: the individual patient’s needs, the patient’s response to treatment, the overall quality of the physician’s evaluation and management of the patient, and the understanding that

some types of pain cannot be completely relieved.

Section II: Guidelines

The Medical Society supports the following guidelines when evaluating the use of controlled substances for pain control:

1. Evaluation of the Patient

An appropriate medical history and physical examination must be documented in the medical record. The medical record should document the nature and intensity of the pain, relevant coexisting diseases and conditions (including current or past substance use disorder), results of relevant diagnostic evaluations, and the effect of the pain on physical and psychosocial function where indicated. The medical record should also document the presence of one or more recognized medical indications for the use of a controlled substance.

2. Treatment Plan

The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and/or improved physical and/or psychosocial function. The record should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. Informed Consent and Agreement for Treatment

The physician should discuss the risks and benefits of the use of controlled substances with the patient, appropriate significant other(s) and/or guardian. The patient should receive prescriptions from one physician and one pharmacy where possible and should authorize communication between these parties. The physician may elect to use of a written agreement with the patient, especially if the patient has a history of substance abuse or is determined for other reasons to be at high risk for medication abuse . A written agreement may include (1) indication of specific pharmacy and prescribing clinician (2) permission for communication between care providers (3) agreement to have urine/serum medication or drug levels/screen when requested, (4) amount and frequency of medication and prescription refills, (5) expected follow-up and participation in any other pain treatment activities, (6) reasons for which opioid therapy

may be discontinued, and other inclusions as appropriate.

4. Periodic Review

At reasonable intervals based upon the individual circumstance of the patient, the physician should review the course of opioid treatment and any new information about the etiology and impact of the pain. Continuation or modification of opioid therapy should depend on the physician's evaluation of progress toward stated treatment objectives. If reasonable treatment goals are not being achieved, despite medication adjustments, the physician should re-evaluate the appropriateness of continued opioid treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

5. Consultation

The physician should refer the patient for additional evaluation and treatment as necessary and reasonable in order to achieve adequate control of pain and any other treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse, or with a comorbid psychiatric disorder, requires extra care in structuring, monitoring, and documentation. When indicated and available, consultation with, or referral to, an expert in the management of such patients is advised..

6. Medical Records

The physician should keep accurate and complete records to include documentation of (1) medical history and physical examination (2) relevant diagnostic, therapeutic and laboratory results (3) results of evaluations and consultations (4) treatment objectives (5) discussion of risks and benefits (6) treatments and treatment responses (7) medications (including date, type, dosage, and quantity prescribed) (8) instructions and agreements and (9) periodic reviews. Records should remain current and be maintained in an accessible manner and readily available for review.

7. Compliance with Controlled Substances Laws and Regulations.

To prescribe controlled substances, the physician must be licensed in the state, have a valid controlled substances registration and comply with federal and state regulations for issuing controlled substances prescriptions. Physicians are referred federal, state and local regulatory agencies for guidance.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute pain: Acute pain is a normal, expected physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma and acute illness. The experience of pain, in terms of intensity and quality, is always subjective, varies from individual to individual, and is shaped by multiple host factors including physiological, psychological and socio-cultural factors. Acute pain is generally time limited and is responsive to opioid therapy, among other therapies.

Addiction: Addiction in the context of pain treatment with opioids is characterized by a persistent pattern of dysfunctional opioid use that may involve any or all of the following:

-*adverse consequences* associated with the use of opioids
-*loss of control* over the use of opioids
-*preoccupation* with obtaining opioids despite the presence of adequate analgesia.

These phenomena may be accompanied by distortions in thought, chiefly denial, and a tendency to relapse once in recovery. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

Chronic Pain: A pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease or may occur in the absence of demonstrable tissue pathology..

Physical Dependence: Physical dependence is a physiologic state of neuroadaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by re-administration of the opioid. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

Substance Abuse: Substance abuse is the use of any substance(s) for non-therapeutic purposes: or use of medication for purposes other than those for which it is prescribed.

Tolerance: Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.