From the Desk of the Medical Director

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Updated Stance on Pain Management, Opiate Prescribing

Anyone prescribing opiates for more than acute pain is likely to be (should be) familiar with the CDC Guidance updated November 2022. Expectations have shifted to patient-specific management with shared decision-making with less emphasis on frequent UDSs and MRNs. The absence of MME numerical targets is particularly notable.

The document is comprehensive (lengthy) and will not be broken down further here. Nor is it reiterated in the revised OMB Statement of Philosophy on Pain Management (SOP), which essentially refers OMB licensees to the CDC guidance (see page 5 to read the SOP in full). The Board is well aware some number of clinicians have shied away from long-term pain management in part or in whole for fear of Board sanctions. We wish it weren't so, and the Board is hopeful the realignment in prescribing guidance will provide reassurance to those licensees caring for patients with long-term pain.

That said, patient safety cannot fall away. The standard now can be summarized as working in collaboration with chronic pain patients to safely maximize their functionality. What does this standard look like in practice?

- ⊗ *Gone is the requirement to rapidly taper or discontinue opioids for patients on high doses, but that does not mean continued escalation should be practiced.*
- ⊗ *Gone is the mandate to taper stable patients, but that doesn't mean a patient's MME of 720 is optimal.*
- ⊗ *Gone is the expectation that concomitant opioids and benzodiazepines are forbidden, but that does not mean it's a good idea.*
- ✓ *Still mandated is careful, patient-centered consideration and documentation of true benefits vs. risks.*
- ✓ *Still required is an appropriate PARQ, reiterated at appropriate intervals.*
- ✓ *Still expected is appropriate monitoring to verify adherence to the treatment plan, including checks of the PDMP and use of UDSs when appropriate.*

Several times we have seen a prescriber vacate practice, leaving behind patients on dangerous dosages or combinations of pain meds and other CNS depressants. Subsequent providers have been reluctant or even refused to accept them for fear of Board action. However, the Board wishes to reassure and encourage licensees to assume the prescribing responsibilities for such patients, regardless of MME level, at least temporarily, in order to avoid patients going into withdrawal or turning to illicit sources.

The mission of the OMB is to protect the health, safety, and wellbeing of Oregonians. The Board cannot achieve this mission without responsible clinicians willing to step in and provide safe, effective treatment in our communities.

These Just In:

Readers of this space will recognize my never-ending, quixotic mission to inform licensees of ways to avoid OMB investigations. (We'd rather not talk to you. Don't take it personally.)

1. As you know, there are things the law requires you to report. I'll be in those weeds soon, but for now let's discuss "group awareness" of a doctor impaired in the workplace. This requires a report to the Board within ten days. All OMB licensees with firsthand knowledge are required to report. While it might seem logical one report would do, someone else's report does not discharge your individual responsibility. The Board was once obligated to investigate eleven licensees over a single incident. (Good news: no disciplinary sanctions were necessary.) In order for a single report to suffice for a group of providers, the report must be made on behalf of specifically named licensees and must describe how each licensee came to be aware of the reported conduct. If the report is timely and includes all licensees with firsthand knowledge, there will be no need for investigations regarding failure to file a mandatory report.
2. Attention telemedicine licensees: Your standard of practice is no different from anyone else's. No, you cannot delegate your medical decisionmaking to an online chat bot that generates a prescription for Ozempic. Yes, you should verify a patient's BMI and do all the other necessaries required by Oregon law before prescribing phentermine. No, you should not prescribe self-injection of an anti-psychotic every two days with zero local involvement. Yes, regardless of your prescribing, you must arrange appropriate follow-up and make available urgent consultation (i.e. call coverage). In brief, do not become overly reliant on technology or compromise your standard of care.
3. I've spoken before of the inadvisability of intimacy with patients. Inherent power differentials in the provider-patient relationship make romantic and sexual relationships with patients unethical. The Board most frequently learns about sexual misconduct when the patient is jilted; when the patient confides in another person; when a spouse or significant other finds out; or when the blackmail money runs out. It should be noted that the genesis of the report is irrelevant to adjudication. We don't like being the tool of revenge, but we do follow the law. Text messages are forever, including photographs. Please call these to mind before making or accepting that invitation to coffee. Careers have died. ✚

Oregon Medical Board
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Statement of Philosophy

Pain Management

Decades ago, pain became the fifth vital sign. Clinicians prescribed opiates liberally, aiming to alleviate all pain. But an unintended consequence occurred. Some patients developed dependence and addiction, and people died of overdoses and sedative symbiosis.

As a result, prescribing controlled substances became tightly constrained. As an unintended consequence of this shift away from liberal prescribing, some patients have been indiscriminately terminated from well-tolerated medical treatments.

On November 3, 2022, the Centers for Disease Control and Prevention (CDC) revised its guidelines for pain management. See: **CDC Clinical Practice Guideline for Prescribing Opioids for Pain** and **Factsheet: CDC Guideline for Prescribing Opioids for Chronic Pain**.

Oregon Medical Board licensees are advised to read the guidelines and familiarize themselves with the standard of care, specifically the expectation for individualized, shared decision making. Prescribers should conduct a patient-centered evaluation when determining appropriate Morphine Equivalent Dose (MED) limitations for each unique patient. Prescription Drug Monitoring Program (PDMP) checks and detailed counseling conversations with patients – and documentation of these – are still critically important. The risks versus benefits of opioid treatment for chronic pain and frequency of drug screens are to be considered on a case-specific basis. The new guidance makes clear the ongoing assessment and documentation of the benefits of opiates and all controlled substances versus the risks and side effects is still of paramount importance.

Finally, additional resources are available to assist licensees in providing the best patient care available, particularly as it relates to prescribing for chronic pain. Experts in the field are readily willing to support and advise other Oregon physicians and physician associates in working to meet the needs of patients in our communities.

- Adopted January 1993
- Amended April 1999; July 2004; April 2011; January 2013; April 2016; July 2021; January 2024