The diversion dilemma

identifying and preventing prescription drug diversion

Objectives

At the conclusion of this educational activity, the physician should be able to:

1. discuss statistics relevant to prescription drug abuse;

2. identify state and federal requirements for controlled substance prescriptions;

3. describe common drug diversion methods; and

4. list steps that can be taken to help prevent drug diversion.

Course author

Laura Brockway, ELS is the communications and advertising manager at TMLT.

Disclosure

Laura Brockway has no commercial affiliations/interests to disclose related to this activity.

Target audience

This one-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for malpractice liability.

CME credit statement

Texas Medical Liability Trust is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. TMLT designates this educational activity for a maximum of *1 AMA PRA Category 1 Credits* ™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Ethics statement

This course has been designated by TMLT for 1 hour of education in medical ethics and/or professional responsibility.

Directions

Please read the entire article and answer the CME test questions. To receive credit, submit the completed test and evaluation form to TMLT. All test questions must be completed. Please print your name and address clearly. Please allow four to six weeks from receipt of test and evaluation form for delivery of certificate.

Estimated time to complete activity

It should take approximately 1 hour to read this article and complete the questions.

Release/review date

This activity is released on October 1, 2008 and expires on October 1, 2010. Please note this CME activity does not meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

Prescription drug diversion

An article in the July-August 2008 issue of *the Reporter* discussed the challenges many physicians face when treating patients with chronic pain. This article will address the related issue of prescription drug diversion. "We have two public health crises going on at the same time: one is undertreating pain and the other is prescription drug abuse . . . As we treat one of those problems and get doctors to treat more aggressively for pain, we're simultaneously seeing numbers go up related to prescription drug abuse—and no one knows with any certainty if one is driving the other." [1]

Because many drug diverters have obtained their controlled substances by "doctor shopping" or by feigning symptoms and manipulating physicians, it is important for physicians to learn how to guard against abuse. This article will review statistics on prescription drug abuse, briefly summarize federal and state laws related to prescribing controlled substances, examine common diversion methods, and discuss risk management techniques that can reduce the likelihood that diversion will occur.

Definition

Prescription drug diversion is the channeling of controlled substances or other pharmaceuticals for illegal purposes and abuse. [2] Typical means of diversion include the illegal sale of prescriptions by physicians and pharmacists; "doctor shopping"; theft, forgery, and alteration of prescriptions by patients or health care workers; robberies or thefts from manufacturers, distributors, pharmacies, hospitals, or clinics; residential burglaries; undercounting, pilferage, and recycling by pharmacy personnel; theft of prescription medication by cleaning and repair personnel in homes or hotel rooms; Medicare, Medicaid, and other insurance fraud by patients, pharmacists, and "street dealers"; and by the purchase of prescription drugs over the Internet. [2]

"Moreover, it would appear that pill-abusing middle- and high-school students are obtaining their drugs through medicine cabinet thefts, medication trading at school, and thefts and robberies of medications from other students." [2]

An article published in the *Journal of Pain Symptom Management* highlights the problem of diversion through loss or theft from Drug Enforcement Agency (DEA) registrants. In reviewing DEA theft/loss reports from 22 eastern states, researchers found that in 2003, 2 million doses of six Schedule II opioid analgesics—fentanyl, hydromorphone, meperidine, methadone, morphine, and oxycodone—were reported stolen. About 4 million doses of hydrocodone with acetaminophen, the most frequently diverted controlled substance, were reportedly stolen that year. The thefts occurred mostly from retail pharmacies. [3]

"Against the backdrop of a nation conditioned to medicate every ill, the abuse of controlled prescription drugs has gone unattended. Education, prevention, treatment, and enforcement efforts have focused primarily on illicit drugs. Thanks to the Food and Drug Administration (FDA), the medical use of prescription drugs is considered relatively safe. Unfortunately and incorrectly, for too many, this perception extends to their abuse as well. " [4]

Statistics on prescription drug abuse

According to a report published by the National Center on Addiction and Substance Abuse at Columbia University, the most commonly abused prescription drugs include opioids such as oxycodone or hydrocodone with acetaminophen; central nervous system depressants such as diazepam or alprazolam; central nervous system stimulants such as methylphenidate, amphetamine, or dextroamphetamine; and anabolic-androgenic steroids such as oxymetholone. [4]

Other facts about prescription drug abuse include the following.

- From 1992 to 2002, the U.S. population increased by 13%. During this time, the number of prescriptions for non-controlled substances increased by 56.6% while the number of prescriptions for controlled substances increased by 154.3%. [4]
- Hydrocodone with acetaminophen has been the most prescribed medication in the U.S. for the last five years, according to an article in the *Journal of the American Medical Association.* In 2005, more than 100 million prescriptions were written for hydrocodone with acetaminophen, compared with the second and third most prescribed medications—atorvastatin at 63 million prescriptions and amoxicillin at 52 million prescriptions. [1]
- "The number of people who admit abusing controlled prescription drugs increased from 7.8 million in 1992 to 15.1 million in 2003. . . this is 23 percent more than the combined number who admit abusing cocaine (5.9 million), hallucinogens (4.0 million), inhalants (2.1 million), and heroin (328,000)." [4]
- 73.8% of prescription drug abusers are poly-substance abusers. They either drink alcohol excessively and/or use illicit drugs in addition to prescription drugs. [4]
- "Abuse of controlled prescription drugs is implicated in at least 23% of drug-related emergency department (ED) admissions and 20.4% of all single drug-related ED deaths." [4]
- In 2002, opioid analgesic poisoning was listed in 5,528 deaths, more than either heroin or cocaine. [5] A report in a recent issue of *Morbidity and Mortality Weekly* stated that in 2004, poisoning was second only to motor-vehicle crashes as a cause of death from unintentional injury in the United States. "Nearly all poisoning deaths in the United States are attributed to drugs, and most drug poisonings result from the abuse of prescription and illegal drugs." [6]
- According to an analysis of U.S. death certificates, deaths from medication errors at home have risen dramatically over the last 20 years. In an article published in the *Archives of Internal Medicine*, the authors examined all death certificates from January 1, 1983 to December 31, 2004. Of the approximately 50 million deaths, 224,000 involved fatal medication errors, including overdoses and mixing prescription drugs with alcohol or street drugs. From 1983 to 2004 the overall death rate from fatal medication errors increased by 360.5%. The death rate for at-home fatal medication errors that did not involve alcohol or street drugs increased by 564%, while the death rate for at-home medication errors that did involve alcohol or street drugs increased by 3196%. "This increase far exceeds the increase in death rates from adverse effects of medications (33.2%) or from alcohol and/or street drugs (40.9%)." [7]
- Between 1992 and 2003, the number of teens ages 12 to 17 who admit abusing prescription drugs increased by 212%. In 2003, 2.3 million teenagers reported abusing a controlled prescription drug in the past year. [4] Teenagers often "use prescription drugs for 'practical' effects: hypnotic drugs for sleep, stimulants to enhance their school performance, and tranquilizers such as benzodiazepines to decrease stress. They often characterized their use of prescription drugs as 'responsible,' 'controlled,' or 'safe.'" [8]

Controlling the controlled substances

"Both Texas and the federal government have a complex system of laws governing the availability and dispensing of dangerous drugs and controlled substances. The Drug Enforcement Agency (DEA) is the federal agency and the Department of Public Safety (DPS) is the Texas agency that regulates controlled substances." [9]

The term "dangerous drugs" includes any drug that requires a prescription and bears the legend "Caution: federal law prohibits dispensing without a prescription" or "Prescription Only." A controlled substance is a drug with a potential for abuse that may lead to physical or psychological dependence. [10]

The federal Controlled Substances Act (CSA) of 1970 created a system of classifying controlled substances according to their medical value and potential for abuse. These substances, which include both illicit and prescription drugs, are listed in schedules. "Although there are separate provisions under state and federal law describing the drugs that fall within each of the schedules, the definitions are substantially similar." [9] "Dangerous drugs" require a prescription, but are not included in the list of scheduled drugs. [10]

Drug schedules in the CSA

Schedule I

These drugs have no currently acceptable medical use and high potential for abuse, addiction, or physical dependence. Examples include marijuana and heroin.

Schedule II

These drugs have accepted medical use and high potential for abuse, addiction, or physical dependence. Examples include morphine, oxycodone, methadone, and hydromorphone.

Schedule III

These drugs have accepted medical use and potential for abuse, addiction, or physical dependence less than drugs in Schedules I and II. Examples include methylphenidate, hydrocodone with acetaminophen, and anabolic steroids.

Schedule IV

These drugs have accepted medical use and potential for abuse, addiction, or physical dependence less than drugs in Schedules I to III. Examples include benzodiazepines and chloral hydrate.

Schedule V

These drugs have accepted medical use and potential for abuse, addiction, or physical dependence less than drugs in Schedules I to IV. Examples include codeine-containing analgesics and codeine-containing cough and cold preparations. [4]

Please note that this list is not all inclusive. For a complete list of substances within each schedule, please visit http://www.deadiversion.usdoj.gov/schedules/index.html. To view the Texas schedules, please visit http://www.dshs.state.tx.us/dmd/control_subst_sched.shtm.

Requirements for controlled substance prescriptions

Texas and federal laws require that physicians who prescribe, administer, or dispense controlled substances be registered with the DEA and the DPS. "State and federal controlled substance registrations are interdependent. If the state registration is suspended or revoked, the federal registration may be suspended or revoked, and vice versa." [9] (For details on federal controlled substance regulations, please see the *DEA Practitioner's Manual*, available at http://www.deadiversion.usdoj.gov/pubs/manuals/pract/index.html. For information on state regulations, please see the Texas Health and Safety Code Sections 481, 482 and 483 available at http://tlo2.tlc.state.tx.us/statutes/hs.toc.htm. and the Texas Administrative Code Title 37 Part 1 Chapter 13 available at http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC.)

The prescription requirements for Schedule II controlled substances are more stringent than those for "dangerous drugs" or Schedule III, IV or V substances. Schedule II requirements include the following. [9,11] Again, please note that this list is not all inclusive.

- A Texas physician who prescribes a Schedule II substance must use an official prescription form issued by the DPS under the Texas Prescription Program. [12] The exception to this rule is for a medication order written for an individual who is an inpatient when the order is written. [9]
- In Texas, as of March 2008, a prescription written for a Schedule II controlled substance must be filled within 21 days after the date the prescription was issued.

New DPS regulations affect Schedule II-V controlled substances

In response to legislation passed in 2007, the DPS will begin collecting additional information on prescriptions for Schedule II-V controlled substances. Beginning September 1, 2008, these prescriptions must contain the following information to be considered valid:

- quantity of substance prescribed (written both as a number and word);
- date of issue (cannot be postdated);
- name, address, and birthdate of the patient;
- name and strength of the drug;
- directions for use of the drug;
- intended use of the drug, unless the physician determines furnishing this information is not in the patient's best interest;
- printed or stamped name, address, DEA registration number, telephone number of the physician's usual place of business;
- the physician's signature unless called into the pharmacy; and
- the physician's current, valid DPS registration number. For Schedule III-V drugs, the prescriber may be a properly registered physician's assistant or an advanced practice nurse. [13]

The new law, Senate Bill 1879, was enacted to help reduce prescription drug diversion. "The bill aims to establish an electronic monitoring system for all Schedule II-V drugs that physicians, pharmacists, and others with prescriptive authority can access to monitor their own prescribing patterns and patients who may be using multiple prescribers for narcotics." [13]

The electronic monitoring system is not yet in place, but the DPS will begin collecting the information on September 1. [13]

(Before March 2008, Schedule II prescriptions had to be filled within 7 days after the prescription was issued.) [9]

• Prescription refills are prohibited for Schedule II drugs.

• For Schedule II substances, physicians may call in a prescription to the pharmacy only in an emergency. The pharmacist may dispense the prescription provided that the quantity is limited to the amount adequate to treat the patient during the emergency period. The physician must provide a written and signed prescription to the pharmacist within seven days and the pharmacist must notify the DEA if the prescription is not received. [11]

• To expedite the filling of a prescription, a physician may transmit a prescription for a Schedule II substance to the pharmacy by fax. The original prescription must be presented to the pharmacist for review before the actual dispensing of the Schedule II substance. There are exceptions to these Schedule II fax requirements. [11]

Prescriptions for substances on Schedules III, IV, and V may be issued by a physician orally, in writing, or by fax to the pharmacist. A fax is considered to be equivalent to an original prescription. A prescription for a Schedule III, IV or V drug may be refilled as authorized on the prescription or by call in. However, Schedule III, IV, and V drugs may only be refilled up to five times within six months. After five refills or six months, whichever occurs first, a new prescription is required. [11]

The DEA is currently reviewing a petition to increase the regulatory controls on hydrocodone combination products from Schedule III to Schedule II. [14]

Other applicable regulations

Electronic prescribing

Currently, prescriptions for controlled substances cannot be transmitted to a pharmacy electronically. "The DEA currently prohibits electronic submission of controlled substance prescriptions, but it is currently working on a system for secure electronic transmission of Schedule II drugs, which it calls the Electronic Prescriptions for Controlled Substances project. All persons authorized to prescribe controlled substances would be issued digital certificates by the DEA, which function as authentication of a practitioner's authority to prescribe and digitally sign prescriptions for controlled substances." Guidelines for the project are being developed, and the DEA is working with the Veterans Administration to test the concept. [15]

Tamper-resistant prescription pads

Effective April 1, 2008, physicians were required to use a tamper-resistant prescription pad when writing prescriptions for Medicaid recipients. Effective October 1, 2008, these prescription pads must meet all of the following characteristics in order to be considered tamper resistant under federal law. These characteristics include:

"• prevents the unauthorized copying of completed or blank prescription forms;
• prevents erasure or modification of information written on the prescription form; and
• prevents the use of counterfeit prescription forms." [16]

Also beginning October 1, physician practices that print prescriptions on plain blank paper through electronic medical records (EMR) systems must begin using paper with at least one security feature from each of the three compliance categories listed above. The National Council for Prescription Drug Programs has developed guidance, examples of best practices, and examples of tamper-resistant prescriptions (handwritten and EMR generated), available at http://www.txvendordrug.com/tamper_resistant_rx.html. [17]

This regulation does not apply to prescription orders transmitted to a pharmacy by telephone, fax, or electronically. [17]

The Centers for Medicare and Medicaid Services has determined that the prescription forms for Schedule II drugs issued by the DPS under the Texas Prescription Program meet the characteristics for tamper-resistant prescribing. "Providers should continue using these pads for all prescriptions for Schedule II controlled substances. These pads should not be used to write prescriptions for non-Schedule II drugs." [16]

Prescription monitoring programs

Texas is one of 26 states that operates a prescription monitoring program. These programs collect prescription data from pharmacies and review and analyze the data for education, public health, investigative, and law enforcement purposes. "States have found that prescription monitoring programs are among the most effective tools available to identify and prevent drug diversion at the prescriber, pharmacy, and patient levels." [18]

In Texas, the DPS manages the state's prescription monitoring program that tracks prescriptions for Schedule II substances. Physicians who prescribe Schedule II drugs must use official prescription forms issued by the DPS. Pharmacists then transmit records of these prescriptions to the DPS. The DPS securely maintains the prescription records, and access to the information is restricted by state law to regulatory and law enforcement personnel and physicians and pharmacists who are inquiring about patients or potential patients. Physicians and pharmacists can also verify their own prescription records. This information can be requested by completing a form available at http://www.txdps.state.tx.us/criminal_law_enforcement/prescription_program/preforms.htm. [12, 18]

"Prescription monitoring programs serve as tools that facilitate the locating of evidence with minimal or no intrusion on prescribers and pharmacies. Therefore, the main impact of programs on law enforcement is to provide a mechanism for increased efficiency in conducting investigations." [18] While both state and federal law enforcement officials believe prescription monitoring programs to be an efficient and effective way to deter diversion, several disadvantages to these programs have been described. [15] "Very few PMPs have been adequately evaluated to determine their impact on the availability of controlled substances for legitimate medical purposes or the subsequent incidence of drug abuse and diversion." [15]

In 2005, the National All Schedules Prescription Electronic Reporting Act (NASPER) was passed. It authorized the creation of federal grants at the U.S. Department of Health and Human Services to establish or improve state prescription drug monitoring programs and allow for communication between state programs. "Unfortunately, NASPER has not moved as no funding has been committed either in 2006 or in 2007, in addition, there is no proposed funding in 2008." [5]

Diversion by patients

"Doctor shopping" is one of the most common methods of obtaining prescription drugs for illegal use. "Although it's important to trust your patients and accept what they tell you at face value, it is also important to maintain a healthy degree of skepticism. Diverters come in many forms, so appearances may be deceptive. Better

indicators are their behaviors and their stories, which are often similar." [19] The following are signs to watch for.

Strange stories — these can include claims that the patient is traveling through town on business or visiting relatives. Diverters can also claim that they have lost a paper prescription, forgotten to pack their medication, had their medication stolen, or spilled their medication down the sink. These individuals may request to be seen right away or request appointments at the end of the day. [19]

Unwilling to cooperate — drug seekers may refuse a physical exam and show no interest in a diagnosis. They may fail to keep appointments for diagnostic testing or refuse to see another physician for consultation. Often, the patient may refuse to sign an authorization to release medical records from a previous physician. "If pressed, they may claim they cannot precisely remember where they were last treated or that the previous clinic, hospital, or provider has gone out of business." [19]

Exaggerated or feigned symptoms — diverters may claim to have back pain, kidney stones, migraine headaches, toothaches, or post-herpetic neuralgia to obtain opioid medications. [19] They may also feign anxiety, insomnia, fatigue, or depression to obtain stimulants or depressants. [4]

Specific drug requests — diverters may request a specific medication and state that specific, non-narcotic analgesics do not work or that he or she is allergic to them. "Be alert when patients appear to be extremely well-informed about specific medications. While it is true that people who have been sick for a long time often learn much about their disease process and know the medications that work best for them, this is also true of diverters. They often appear to have a familiarity with diseases that comes straight from textbooks rather than real life. Some diverters may feign naiveté by deliberately mispronouncing medication names or seeming to be uninformed about their underlying medical condition." [19]

In an article published in *Pain Medicine*, the authors reported on interviews and focus group data collected on four separate populations of prescription drug abusers. The data suggested that there were "numerous active street markets" involving patients. "Many of these individuals have conditions that have been appropriately diagnosed and addressed with a proper course of treatment, but are selling their prescription drugs for profit, or exchanging them for illicit drugs." [2]

A national survey of physicians found that 53.8% do not ask about prescription drug abuse when taking a patient's health history. Further, 54.5% either always or most of the time call or obtain records from the patient's previous or other treating physicians before prescribing controlled substances on a long-term basis. [4]

"You should contact previous health care providers and pharmacists to confirm the information provided by each new patient. Obtaining the previous providers' telephone numbers directly from directory assistance or other national sources, rather than from the patients, provides a reasonable assurance that real providers are being contacted (not just confederates of drug-seeking individuals)." [19]

In addition to "doctor shopping," prescription forgery is also fairly common. This can include altering a prescription, stealing blank prescriptions pads, or calling pharmacies for prescriptions without authorization from the physician. [4]

Diversion by physician staff

TMLT risk management staff frequently receive calls from physicians who have discovered that an employee is diverting prescription drugs from the office. Typically, this involves an employee calling a pharmacy and ordering a controlled substance under the physician's signature. Other instances have included staff members creating medical records for fictitious patients and calling in or printing out prescriptions for that patient. "Unpleasant as it is to consider, people who work for you, other physicians, friends, and even family members may be diverting pain medications." [19]

One way to prevent this type of diversion and address it if it occurs is to implement and follow a medication refill policy in the practice. This policy will describe in detail what types of medications can be refilled without a physician's authorization. "To be effective, these policies must be very specific. They must state who is authorized to refill what kinds of medications and under what conditions," says Jane Holeman, vice president of risk management at TMLT. "It is also advisable for these policies to state that refills for any controlled substance must be cleared by the physician."

Once the policy is established, educate staff about the policy and have them sign a copy of it. "This will help protect the physician if it is later discovered that an employee is diverting drugs. The physician can show that the employee was doing so in violation of the practice policy," says Holeman. Additionally, physicians are advised to state in their employee policies and procedures that any violation of the medication refill policy is grounds for disciplinary action up to and including termination and reporting any diversion to the authorities. While it can be difficult, it is advisable to terminate any staff member who engages in this behavior.

Physicians are often reluctant to report incidents involving prescription diversion by staff to law enforcement officials. However, according to the DPS and the Texas Administrative Code, physicians must report a "discrepancy, loss, or theft of a controlled or other regulated item or substance or other situation involving a potential for diversion" to local law enforcement officials. This includes controlled substances and stolen or forged prescriptions. [20] According to the Texas Controlled Substance Act a person commits fraud if that person knowingly "possesses, obtains, or attempts to possess or obtain a controlled substance or an increased quantity of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge through the use of a fraudulent prescription form or through the use of a fraudulent oral or telephonically communicated prescription . . ." [21]

In overcoming their hesitation to report an employee, physicians should also consider the possibility that this person could find employment at another physician's office or hospital and could continue diverting drugs. "If the employee is not reported, then the incident will not show up on any criminal background check that a potential employer could conduct," says Holeman. "This person could end up working in the pediatric clinic across town. It is in the best interests of other physicians in the community to report the incident to the police."

Risk management considerations

The following guidelines may help reduce the likelihood of prescription drug diversion occurring in your practice:

- If you keep controlled substances in your office, be familiar with federal and

state law regarding the storage and disposal of these substances. Follow federal guidelines for monitoring both drug inventory and access to the controlled substance storage area. More information is available at http://www.deadiversion.usdoj.gov/pubs/manuals/pract/index.html.

• Follow these same guidelines for samples of controlled substances. Do not keep samples of controlled substances in an unsecured sample closet. "Think about how easy it is for someone to get access to your samples—and that could be a patient, a patient's child, or a staff member." [22]

• Create and follow a medication refill policy in your practice. Have strict practice policies in place regarding who can initiate and refill a prescription for a controlled substance. Educate employees about this policy and have them sign a copy of it.

• Develop relationships with pharmacists. "Often it is the pharmacist who first detects a diversion attempt. Diverters may try to call in their own prescriptions by claiming to represent a physician's office and providing his or her personal telephone number for call-back information. A close, working relationship between your office and local area pharmacies may help to prevent these maneuvers from succeeding." [19]

• Make criminal background checks part of the hiring process. According to the DEA Practitioner's Manual, physicians "should not employ as an agent or employee who has access to controlled substances:

1. Any person who has been convicted of a felony offense related to controlled substances
2. Any person who has been denied a DEA registration
3. Any person who has had a DEA registration revoked
4. Any person who has surrendered a DEA registration for cause." [11]

• Before prescribing controlled drugs on a long-term basis, obtain the records from the patient's previous physician. Be wary of any patient who will not sign an authorization to release medical records from a previous physician. Consider asking about prescription drug abuse when taking a patient's health history.

• If you suspect a patient may be abusing or diverting controlled substances, document your impressions in the medical record. "Document everything you see, think, feel, and hear about the patient without resorting to judgmental or pejorative labels (being mindful that accurate and complete medical records allow subsequent readers or reviewers to understand how you made medical decisions.)" [19] Document any conversations you have with a third party, such as a pharmacist, about your suspicions.

• Consider terminating the physician-patient relationship if a patient is diverting prescription drugs. "While this can be a difficult situation, the physician is putting himself or herself at risk by continuing to prescribe to a patient who has stolen a prescription pad or who is obtaining the same medication from multiple physicians," says Holeman. If you choose to dismiss the patient, follow a standardized process, such as the one described in the May-June 2008 issue of *the Reporter* (available at http://www.tmlt.org/publications/resources/).

• Do not prescribe, dispense, or administer controlled substances outside the scope of your practice or in the absence of a formal physician-patient relationship.

• Use secure prescription pads. Though federal regulations now require that physicians begin using tamper-resistant prescription pads when prescribing for Medicaid patients, it is also recommended that physicians use these pads (or tamper-resistant printer paper for those using an EMR) for all patients. Be sure to purchase these pads and paper from approved printers. (For a list of approved printers, please visit http://www.texmed.org/Template.aspx?id=6495.)

• Do not store prescription pads in accessible areas, such as countertops or exam rooms. Use prescription pads only for prescribing. Write notes or patient instructions on office stationery. Never sign blank prescriptions in advance.

• Report any theft or significant loss of a controlled substance from a physician's office to the DEA immediately upon discovery. Notification can be accomplished by completing DEA Form 106, found at www.deadiversion.usdoj.gov. Texas physicians are also required to report theft or loss to the Narcotics Service of the Texas DPS. A DPS form is available at http://www.txdps.state.tx.us/criminal_law_enforcement/prescription_program/preforms.htm or a copy of the DEA form can also be submitted.

• Report any theft of Schedule II prescription pads to the Texas Prescription Service, PO Box 4087, Austin, Texas 78773-0439; (phone) 512-424-2189; (fax) 512-424-5373; (email) tppcsr@txdps.state.tx.us.

• Report any suspected prescription drug diversion by staff or patients to local law enforcement officials.

Conclusion

Physicians have an important role to play in minimizing the abuse or diversion of prescription drugs. "You can do a lot to prevent diversion in your practice by simply maintaining standards of good medical practice and professional ethics. Never prescribe controlled substances to patients unless clinically indicated. Inform patients that it is illegal for you to prescribe opioid analgesics without performing a meaningful physical examination. Follow a protocol of history taking, performing a physical examination and ordering necessary diagnostic tests before prescribing opioid analgesics. And when you or your staff suspect patients of attempting to obtain medications for nontherapeutic purposes or trying to steal prescription pads, notify the local police." [19]

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Laura Brockway can be reached at laura-brockway@tmlt.org.

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Laura Brockway can be reached at laura-brockway@tmlt.org.