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# Prescription Drug Abuse



Prescription drug abuse continues to be a big problem in Kentucky, and throughout the nation. This edition of the *Journal of the Kentucky Medical Association* is devoted to this important subject.

It is discouraging that Kentucky continues to be highlighted on this issue since our state led the nation with the adoption of the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system, which is quite popular with physicians who prescribe scheduled drugs.

When it was first rolled out in Kentucky, the system was overwhelmed with requests for a patient's history of obtaining narcotics and continues to be accessed by physicians. KMA receives inquiries from members regularly on issues associated with KASPER including, "How do I store the report I receive from KASPER?" and "Can I report a patient I suspect of abusing prescriptions?" Interesting questions, and something I will return to at the end of this article.

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*Despite our colleagues' best intentions . . . the public tends to "blame the doctors" for the amount of abuse.*

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Unfortunately, despite our colleagues' best intentions on this issue, the public tends to "blame the doctors" for the amount of abuse. Diversion, however, is a big issue and something that our society must address. Reports of planes flying to Florida to pick up large

quantities of narcotics and fly them back to Kentucky to be sold have been reported. The Internet has not helped, allowing most anyone to obtain what are touted as "narcotics" but may not even meet FDA standards. In both instances, the medical community alone can do little to address the issue.

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*KASPER has been updated and should be updated again . . .*

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KASPER has been updated and should be updated again to provide real-time information to physicians. Information that might be even a week old may not be enough to stop someone seeking narcotics for a non-medical use. KASPER data does not include data from other states, although the Kentucky Board of Medical Licensure published information on how to obtain such data recently. And HIPAA looms as an issue preventing adequate access to necessary information. This was emphasized in a recent ruling by the Veteran's Administration that prevented physicians and other providers from providing information to KASPER or accessing data on a patient [see the editorial in this issue].

So what can the medical profession do? We do a great deal already, including efforts by the KMA to address the topic through legislative, regulatory, and policy measures, as well through significant public education activities. Physicians want to do what is best for patients and society, and will continue to be on the frontlines of this issue.

In an effort to get your thoughts, please let me know what questions you might have on prescription drug abuse in Kentucky. Do you have questions about KASPER or how to address patients you believe have addiction problems? Email me your thoughts to [member@kyma.org](mailto:member@kyma.org) or drop me a note to the KMA headquarters office.

I encourage you to attend *KMA Day at the Capitol* on Wednesday, January 27, in Frankfort. There will be a lunch and CME program that afternoon on prescription drug abuse at the Governor's Mansion, and the

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*Please let me know what questions you might have on prescription drug abuse in Kentucky.*

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Governor will be attending. There will also be a reception for physicians and legislators that evening at the Berry Hill Mansion in Frankfort. KMA will be pushing an ambitious legislative agenda centered on health insurance reform and economic credentialing. This will therefore be a good opportunity to talk with legislators about these and other important issues. Please fill out the registration form on the following page and plan to attend.

**John R. White, MD**  
*President*



# **KMA Day at the Capitol**

**Wednesday, January 27, 2010**

**Advocacy & Education**

**Meet with Legislators at the Capitol &  
Earn CME at the Governor's Mansion**

Plan to attend KMA Day at the Capitol on January 27 to demonstrate your support for KMA's 2010 legislative agenda. You can also earn CME credits by attending a program at the Governor's Mansion about a plague ravaging Kentucky – prescription drug abuse. The day will conclude with a Legislative Reception at Frankfort's Berry Hill Mansion. Attend one event or stay all day - it's an opportunity for physicians to flex their political muscle and demonstrate their concern about prescription drug abuse in Kentucky.

### **KMA Day Schedule of Activities:**

- 9:00 am - 1:00 pm – Meet with legislators and attend legislative committee meetings
- 9:30 - 10:30 am – Receive KMA Legislative Talking Points - Capitol Annex Room 125
- 12:30 - 2:00 pm – Lunch and Legislative Committee Meeting - Governor's Mansion
- 2:00 - 4:00 pm – Prescription Drug Abuse CME - Governor's Mansion
- 4:30 - 7:00 pm – Legislative Reception - Berry Hill Mansion (shuttle available)

### **Important Facts about KMA Day:**

- To make an appointment with your legislators, call (502) 564-8100.
- The Governor's Mansion is walking distance from the Capitol and Capitol Annex.
- KMA Legislative Committee will meet during lunch at the Governor's Mansion. All are invited to attend. Security at the Mansion requires notification of attendees. Only 70 will be allowed to attend on a first to register, first to attend basis.
- A shuttle is available from the Governor's Mansion to the Berry Hill Mansion.
- When requesting an appointment, personally invite your legislators to the Legislative Reception.

**Complete the Response Sheet Below and Fax it to KMA Indicating your participation in**



**KMA Day at the Capitol!**



**Registration Form (Fax to: 502/426-6877)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax/E-mail: \_\_\_\_\_

What do you plan to attend? All events\_\_\_\_ Meetings with legislators\_\_\_\_

CME at Governor's Mansion\_\_\_\_ Lunch at Governor's Mansion\_\_\_\_

Legislative Reception\_\_\_\_ I will take the shuttle to the Legislative Reception?\_\_\_\_

**You may also register and contact legislators online at [www.kmaactioncenter.org](http://www.kmaactioncenter.org)!**

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*Practices That Set The Standard*

# Prescription Drug Abuse in Kentucky—A Call to Action

**B**y now, most physicians throughout the Commonwealth have likely seen the media headlines that Kentucky is in the midst of a prescription drug abuse epidemic. For many physicians it comes as no surprise to see the reports that Kentucky has one of the highest rates of prescription drug abuse in the nation. These are sobering facts, indeed, but they are facts faced by many physicians in Kentucky as they serve on the front line in combating this problem. As physicians, we recognize that the utilization of controlled substances may be essential in the treatment of acute and chronic pain. The Kentucky Board of Medical Licensure (KBML) has repeatedly encouraged and reassured the medical community that it is appropriate and good, compassionate practice to treat patients with chronic pain. However, physicians are now faced with the realization that increasingly more Kentuckians are becoming involved in the diversion of controlled substances through either obtaining them illegally or taking them from family and friends.

While the KBML has long been concerned about this issue, it recently—along with the Kentucky Medical Association—became an active member in a coalition that joined its resources to address Kentucky's prescription drug abuse problem and offer comprehensive

solutions through education. Coinciding with this theme, the KMA has graciously devoted this issue of the *Journal of the KMA* to the topic of substance abuse. In the following pages, you will find a series of articles covering the spectrum on substance abuse ranging from the KBML's Opinion on Prescribing for Chronic Pain, an Overview of the KASPER system, and the KBML's Opinion on the Use of KASPER Reports, to an insightful article on substance abuse and workers compensation, and an article offering some guidance to physicians on protecting their practices and identifying potential drug diversion tactics. This series provides an excellent reference tool as well as practical value for physicians. While much of this information has been made available to physicians in the past, this is the first time it has been brought together at a central location.

Our hope is that every physician in the state will hear the call to act on this issue and incorporate the items in this series into their daily practice. By doing so, you can help to prevent the diversion of controlled substances and improve the health of Kentucky's citizens.

**Preston P. Nunnelley, MD**  
*President, Kentucky Board of  
 Medical Licensure*

## Acknowledgement

Kentucky For Responsible Rx is an informal coalition of state agencies, health care and insurance representatives, treatment providers and pharmacists formed in 2009 to work together to educate providers and the public in appropriate prescription drug use and the problems of misuse—addiction, abuse, diversion, and their potential solutions.

We would like to acknowledge the following groups and organizations which have supported the collaborative effort:

- Anthem
- Benefit Insurance Marketing
- Blue-Grass Family Health
- Humana
- Kentucky Academy of Family Practice

## SPECIAL SERIES ON PRESCRIPTION DRUG ABUSE

- Kentucky Board of Medical Licensure
- Kentucky Cabinet for Health and Family Services, Office of Inspector General
- Kentucky Dental Association
- Kentucky Department of Mental Health & Substance Abuse
- Kentucky Department of Workmen's Compensation
- Kentucky Hospital Association
- Kentucky Justice & Public Safety Cabinet
- Kentucky Long Term Policy Research
- Kentucky Medicaid
- Kentucky Medical Association
- Kentucky Office of Drug Control Policy
- Kentucky Pharmacy Association
- Louisville Metro Police
- Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs
- Mt. Sterling Chamber & Industrial Authority
- Nurse Practitioners and Nurse Midwives
- Office of the Attorney General
- Self-Refind
- United Healthcare
- University of Kentucky
- West Care
- Western Baptist Hospital

# Protecting Your Practice

Van Ingram

The information contained in the following pages is designed to give the prescriber information on what to look for and how to respond to minimize the risks associated with prescription drug abuse and diversion.

## WHERE SHOULD CONTROLLED SUBSTANCES BE STORED?

Individual practitioners must store controlled substances in a securely locked, substantially constructed cabinet or safe. Access to the storage area should be restricted to persons specifically authorized to handle the controlled substances. This includes restricting the number and accessibility of keys or passwords.

Any loss or theft of controlled substances or DEA 222 order forms must be reported to the DEA; loss report forms are different for each agency. A copy of the form should be sent to the Office of Drug Enforcement and Professional Practices Branch in the Cabinet for Health and Family Services. Thefts of controlled substances should be reported to your local law enforcement agency.

## HOW TO PREVENT DIVERSION AND ABUSE OF PRESCRIPTION DRUGS

Adherence to State and Federal regulations goes a long way in protecting your practice from becoming a source of drug diversion and prescription drug abuse. The best practice is to have set policies and procedures and instruct your staff to follow them. The practitioner must provide supervision to see that the policies are enforced.

## SUGGESTIONS FOR PRACTITIONERS ON HOW TO PROTECT THEIR PRACTICE AND PATIENTS

1. Keep all prescription pads secured and not left out where people may obtain them to forge prescriptions.

*From the Office of Drug Control Policy  
Justice and Public Safety Cabinet  
125 Holmes Street  
Frankfort, KY 40601  
vaningram@ky.gov  
502.564.9564; <http://odcp.ky.gov/>*

2. Only the registered practitioner should be allowed to call in or place orders for new inventory of controlled substances.
3. If the practitioner is too busy and ordering new inventory is delegated, only one employee should have the right to place orders. Do not let all staff members place orders.
4. When controlled drugs arrive in the practice, they should be opened, checked in, and added to inventory by at least two licensed professionals. Do not let one person do this alone. Do not let the same two people do it all the time.
5. The person who pays the bills should not be allowed to order drugs. The person who orders drugs should not be allowed to write checks. This prevents someone from ordering drugs and paying the bill without the practitioner's knowledge. The person who orders the drugs should communicate with the person who verifies what drugs the practice has received. The receipt for drugs and bills should be reviewed by the practitioner.
6. Only certain staff should be allowed to call in telephoned prescriptions to area pharmacies. The practitioner's staff may wish to designate a special "code word" or "secret password" with the pharmacy so the pharmacy knows the call is valid.
7. Use your continuing administration log as a perpetual inventory so you know how many dosage units have been dispensed and how many units remain on a daily basis.

8. As a practitioner, review the administration log to make sure you recognize the patient names and that no fictitious patient has been invented.
9. Only licensed professionals should have access to the locked drug cabinets. Periodically, ask a local pharmacy for a print out of all the controlled substance prescriptions they have filled, that you issued. Look at the print out and make sure you recognize the names as your patients. Follow up on any names that seem strange or unfamiliar.
10. Set up a rotating self-inspection where, on a monthly basis, the office manager or practitioner inspects the practice. Check the current inventory to make sure it is locked up. Review the inventory and current balance. Review what has been ordered. Review what bills have been paid. Look at the administration log to make sure all the required information is recorded.
11. Make sure your controlled substances are inventoried at least once a year and recorded in your files. An inventory is required annually.
12. Set up a policy of random drug testing for employees.
13. If practitioners choose to treat their own family members or staff, they must keep charts and records on their family and staff just like any other patient. Allowing staff to take office medications on the job may lead to serious violations.
14. **UTILIZE KENTUCKY'S PRESCRIPTION DRUG MONITORING PROGRAM KASPER!**

## WHAT ARE COMMON CHARACTERISTICS PATIENTS THAT MAY BE ABUSING/DIVERTING CONTROLLED SUBSTANCES?

Patients seek to obtain medication from their physician for one of two reasons. Most patients simply wish to obtain medication to treat a legitimate illness or condition, but some patients visit a physician to obtain controlled substance medications for a non-therapeutic reason. Unfortunately, even some patients with legitimate medical conditions



"I totally understand how your dog could have eaten your last three prescriptions. Here's a new stock bottle to get you through the week. Just call next time, there's no need to come in."

may attempt to see multiple physicians or utilize multiple pharmacies to obtain medications. They may do this because the dose or type of medication they receive does not adequately treat their pain, or they may simply be embarrassed by their need for medication to treat legitimate pain adequately; it is termed pseudo addiction as the patient is not truly addicted, but exhibits one or more of the behaviors typical of a patient addicted to narcotics or other controlled substance medications.

Periodic evaluations, good communication skills, safe and *effective* therapy, good record-keeping, and KASPER usage all contribute to preventing this type of problem.

The true drug-seeking patient, also known as a "professional patient," is usually unfamiliar to the practitioner, but may become a regular patient if he or she finds the practitioner easy to manipulate in obtaining desired medications. The person may claim to be a patient of a practitioner who is cur-

## PROTECTING YOUR PRACTICE

rently unavailable, and ask for a prescription renewal. Those involved in abuse and diversion generally have no interest in diagnosis, fail to keep appointments for further diagnostic tests, or refuse to see another practitioner for consultation. These patients may involve children or the elderly in their scams.

### MANIPULATIVE APPROACHES OFTEN USED BY THE PATIENTS ABUSING OR DIVERTING DRUGS INCLUDE:

- Feigning physical problems, such as back pain, a kidney stone, or headache in an effort to obtain narcotic drugs.
- Feigning psychological problems, such as anxiety, insomnia, fatigue, or depression in an effort to obtain stimulants or depressants.
- Deceiving a practitioner, such as requesting refills more often than originally prescribed.
- Pressuring the practitioner by eliciting sympathy or guilt, or by direct threats.
- Feigning narcolepsy in an effort to obtain amphetamines or methylphenidate.

### WHAT SHOULD A PRACTITIONER DO WHEN CONFRONTED BY A PATIENT SUSPECTED TO BE ABUSING/DIVERTING DRUGS?

1. Be alert for scams
2. Watch for possible signs:
  - Patient's residence is distant from your office
  - Patient claims to be referred by another practitioner
  - Unusual behavior in waiting room
  - Patient frequently appears when you are about to commence rounds or frequently requests to be seen late in the day or on a Friday afternoon
  - Inconsistent signs of acute pain—no signs displayed while waiting, but the patient commences to show symptoms when in examination room
  - Physical exam shows evidence of treatment by other practitioners or abuse of controlled substances (ie, needle tracks)

- Patient shows unusual knowledge of controlled substances
  - Patient requests a specific controlled drug
  - Patient is reluctant to try a different drug
3. Examination and documentation:
    - Always perform a thorough exam appropriate to the patient's condition
    - Always document examination results and questions you asked the patient
    - Professional patients seek the practitioners that ask the least questions. If you don't ask questions, they don't have to lie or mislead you
    - Always seek a KASPER report on patients you suspect of abuse or diversion.
    - **Questions the treating physician should ask:**
      - What other practitioners are you currently seeing or have seen for this or any other condition?
      - When did you last see the other practitioner?
      - What drugs have previously been prescribed for the condition?
      - Are you currently taking any controlled drugs? What drugs, strength, and frequency?
      - Which pharmacy(s) do you use?
      - What over-the-counter drugs are you currently taking?
      - Have you ever been treated for alcohol or chemical dependency?
    - **Other Suggestions**
      - Written answers to these questions on a patient history form are helpful.
      - Discuss standard procedure for evaluating new patients requiring controlled drugs.
      - Request picture identification, and Social Security number; copy and include in chart.
      - Call previous practitioner, pharmacist, or hospital to confirm.
      - Confirm telephone number if provided by patient.
      - Write prescriptions for limited quantities.
      - Ask your patients to update personal and medical information on a periodic basis.

4. Sharing information on patients:
- Attempting to obtain a controlled substance by fraud, deceit, or misrepresentation is a felony, and information communicated to a practitioner under these circumstances is not considered privileged or confidential.
  - Communicate with the pharmacist about medications a patient is receiving. They are part of the health care team.
  - Persons who provide information to law enforcement in good faith are not subject to civil damages as a result.
  - Acts of fraud are not protected by HIPAA.
  - By Kentucky law, law enforcement has the right to see controlled substance records. Law enforcement is exempt from HIPAA.

### **KNOW YOURSELF AND YOUR PRACTICE—ARE YOU A SOURCE OF DRUG DIVERSION?**

The American Medical Association outlines four types of practitioners, the “Four D’s,” who are sources of drug diversion. If you or a colleague fit one of these categories, it is time to evaluate your practice, participate in some continuing medical education (CME), or demonstrate peer concern.

- Dishonest or script practitioners, who willfully and knowingly prescribe controlled drugs for purposes of abuse and usually for profit (frequently termed “script mills”).
- Disabled or impaired practitioners, whose professional competence has been impaired by substance abuse, alcoholism, or other physical or mental disorders.
- Deceived practitioners who acquiesce to patient’s insistent demands for medication. Typically, these practitioners prescribe drugs in larger amounts or for longer periods of time than are medically indicated. They also continually authorize refills earlier than what the instructions for administration would require.
- Dated practitioners who have not kept pace with developments in pharmacology, drug

therapy, or health care policies. These practitioners are poor prescribers, not because they intend to be, but because they lack information or understanding. They may be prescribing types of drugs that are not indicated for the condition or prescribing drugs when another type of therapy is indicated. Continuing medical education (CME) is the key to this problem.

### **HELPFUL WEBSITES— CONTROLLED SUBSTANCE**

Kentucky Drug Laws—

<http://www.lrc.ky.gov/krs/218A00/chapter.htm>

Kentucky’s Prescription Monitoring Program—

<http://www.chfs.ky.gov/os/oig/KASPER.htm>

Kentucky Board of Pharmacy—

<http://www.pharmacy.ky.gov/>

Find a Drug Treatment Facility—

<http://dasis3.samhsa.gov>

To view the DEA website—

<http://www.deadiversion.usdoj.gov/>

To view common scams go to:

<http://www.dhss.mo.gov/BNDD/PreventingPrescriptionFraud.doc>

### **CAUTION**

The purpose of this information is to educate and inform the prescriber of the regulations and statutes pertaining to controlled substances and make recommendations to assist the practitioner in protecting his or her practice and patients from diversion, drug abuse, and misuse. It is not the intent to reduce or deny the use of controlled substances where medically indicated. Nothing in this material shall be construed as authorizing or permitting any person to do any act that is not authorized or permitted under federal or state laws. In addition, none of the policy and information in this material may be construed as authorizing or permitting any person to do any act that is not authorized, or refuse to meet any requirements imposed under the regulations published in the most recent publication of the Code of State Regulations or the Revised Statutes of Kentucky.

# Opinion Regarding the Use of Controlled Substances in Pain Treatment

*Kentucky Board of Medical Licensure*

## LEGAL AUTHORITY

This is a Board opinion issued pursuant to the Board's statute, KRS 311.602, to assist licensees in determining what actions would constitute unacceptable conduct under the provisions of KRS 311.595. The Board has decided to publish this opinion because it addresses issues of significant public and medical interest. This opinion is not a statute or administrative regulation, and does not have the force of law.

The Board has determined that the following principles constitute the standards of acceptable and prevailing medical practice relating to a physician's use of controlled substances in the treatment of chronic, non-malignant pain. If the Board should receive a grievance that a physician has departed from the acceptable and prevailing standards of medical practice, the Board and its Hearing Officer will consider the grievance in light of these standards, the actual patient records and expert testimony specific to the physician's practice.

## INTRODUCTION

The Kentucky Board of Medical Licensure (KBML) recognizes that principles of quality medical practice dictate that the people of Kentucky have access to appropriate and effective pain relief. The appropriate application of state-of-the-art treatment modalities can serve not only to improve the quality of life for those patients who suffer from pain, but also can reduce the morbidity and costs associated with inappropriately treated pain. The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic. Pain management is particularly important for patients who experience

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Louisville, KY 40222; 502.429.7150;*

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*Contact: Michael S. Rodman,  
Assistant Executive Director,  
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pain as a result of terminal illness and can be difficult for patients with chronic non-terminal pain. It is imperative that physicians become knowledgeable about effective methods of pain treatment, as well as statutory requirements for prescribing controlled substances.

Inadequate pain control may result either from physicians' lack of knowledge about pain management or their misunderstanding of addiction. Fears of investigation or sanction by federal, state, and local regulatory agencies may also result in inappropriate or inadequate treatment of the pain patient. Accordingly, **this Opinion has been developed to clarify the Board's position on pain control, especially as related to the use of controlled substances for non-terminal/non-malignant chronic pain, in order to alleviate physician uncertainty and to encourage better pain management.**

The Board recognizes that controlled substances (including opioid analgesics, benzodiazepines, and stimulants) may be essential in the treatment of acute pain and chronic pain, whether due to cancer or non-cancer origins. The medical management of pain should be based on current knowledge and research and includes the use of both pharmacological and non-pharmacological modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be

adjusted according to the intensity and duration of the pain. Physicians should recognize that *tolerance* and *physical dependence* are normal consequences of sustained use of opioid analgesics and are not synonymous with *addiction*. *Addiction* refers to both dependence on the use of substances for the drugs' psychic effects and compulsive use of the drug despite consequences.

The KBML is obligated under the laws of the state of Kentucky to protect the public health and safety. The Board recognizes that the inappropriate prescribing of controlled substances may lead to drug diversion and abuse by individuals who seek the drugs for other than legitimate medical use. Physicians must be diligent in preventing the diversion of drugs for illegitimate purposes. The Board believes the adoption of this Opinion will protect legitimate medical uses of controlled substances, while helping to prevent drug diversion and eliminating inappropriate prescribing practices.

Physicians should not fear disciplinary action from the Board for prescribing controlled substances for a legitimate medical purpose and in the usual course of professional practice. The Board will consider the prescribing of controlled substances for pain a legitimate medical purpose, if such prescribing is (1) based on accepted scientific knowledge of pain treatment and (2) if based on sound clinical grounds. All such prescribing must be grounded in clear documentation of unrelieved pain and in compliance with applicable state or federal law.

Each case of prescribing for pain will be evaluated on an individual basis if and when brought to the Board's attention. The Board does not take disciplinary action against a physician who fails to adhere strictly to the provisions of this Opinion, if good cause is shown for such deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account: (1) whether or not the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis; (2) the patient's individual needs—including improvement in functioning; and (3) a recognition

that some types of pain cannot be completely relieved.

The Board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than only the quantity and chronicity of prescribing. The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors. The following Opinion is not intended to define complete or best practice, but rather to communicate what the Board considers to be within acceptable boundaries of professional practice when prescribing for recurrent or persistent chronic pain. An Opinion regarding the prescribing for acute pain would be appropriately less stringent but, in principle, the same.

### BOARD OPINION

The Kentucky Board of Medical Licensure has adopted the following Opinion for evaluating the use of controlled substances for control of **recurrent or chronic pain**.

#### 1. Evaluation of the Patient

A complete medical history and physical examination must be conducted and documented in the medical record. A Family History should be documented with particular reference to any history of first degree relative with chemical dependence problems. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of any substance abuse. The medical record also should document the presence of one or more recognized medical indication(s) for the use of a controlled substance.

By definition, pain is a *subjective* statement of a patient's perception of actual or potential tissue damage. The distinction between pain and suffering should be established. A patient may suffer due to pain, but may have other reasons for suffering as well. The assessment of a patient's overall condition should be made at the initial evaluation

## OPINION REGARDING THE USE OF CONTROLLED SUBSTANCES IN PAIN TREATMENT

and thereafter. It is the goal of the physician to assist in the relief of suffering no matter the cause. Financial, emotional, mental, physical, and spiritual factors may contribute to the patient's suffering. Relief of the underlying reasons for suffering as well as the pain will lead to optimal treatment and utilization of controlled substances.

Before beginning a regiment of controlled drugs, the physician must determine, through actual clinical trial or through patient records and history that non-addictive medication regimens have been inadequate or are unacceptable for solid clinical reasons. Speaking with the patient's significant other or conducting a family conference can be helpful if there is any doubt regarding the patient's integrity. Utilizing the Kentucky All Schedule Prescription Electronic Reporting [ie, KASPER Report] initially can also aid in documenting the patient's history of drug utilization.

### 2. Treatment Plan

The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations, consultations, 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 Consents and Treatment Agreements

The physician should discuss the risks and benefits of the use of controlled substances with the patient or his/her surrogate, including the risk of tolerance and drug dependence. If the patient is determined to be at *high risk* for medication abuse or have a history of substance abuse, the physician may employ the use of a written *agreement* between physician and patient outlining patient responsibilities, including:

- One prescribing doctor and one designated pharmacy
- Urine/serum drug screening when requested
- No early refills and no medications called in. If medications are lost or stolen, then a police report could be required before considering additional prescriptions.
- The reasons for which drug therapy may be discontinued such as violation of a documented doctor-patient *agreement*

### 4. Periodic Review

At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician's evaluation of progress toward stated treatment objectives such as reduction in patient's pain intensity and improved physical and/or psychosocial function (ie, ability to work), need of health care resources, activities of daily living, and quality of social life. If treatment goals are not being achieved despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans. Periodic requests for a **KASPER Report** could be utilized.

### 5. Consultation

The physician should be willing to refer the patient as clinically indicated for additional evaluation and in order to achieve 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 coexisting psychiatric disorder may require extra care, monitoring, documentation, and consultation with or referral to an expert in the management of such patients.

### 6. Medical Records

The physician should keep accurate and complete records to include:

- The medical history and physical examination;
- Diagnostic, therapeutic, and laboratory results;
- Evaluations and consultations;
- Treatment objectives;
- Discussion of risk, benefits, and limitations of treatments;
- Treatments;
- Medications (including date, type, dosage, and quantity prescribed);
- Instructions and agreements;
- Periodic reviews; and
- Records should remain current and be maintained in an accessible manner and readily available for review.

Initial or periodic **KASPER Report(s)** should *not* be part of the patient's records and should not be released to the patient or a third party.

### **7. Compliance with Controlled Substances Laws and Regulations**

To prescribe, dispense, or administer controlled substances, the physician must have

an active license in the state and comply with applicable federal and state regulations.

Physicians should studiously **avoid** prescribing scheduled drugs for themselves, immediate family, or staff in accordance with the American Medical Association's Code of Medical Ethics and the KRS Medical Practice Act.

### **CONCLUSION**

By publishing this Opinion, the KBML wishes to encourage physicians to utilize adequate medications to treat their patients with serious pain complaints without undue fear of legal or licensure repercussions. Concurrently, the Board strives to prevent, as much as possible, drug diversion and inappropriate prescribing practices.

*Standards originally adopted and published by Board: 03-22-01. Standards modified and published: 09-18-03. Published as Board Opinion: 10-10-08.*

# KASPER and the Fight against Controlled Substance Abuse and Diversion in Kentucky

David R. Hopkins

*The abuse and diversion of controlled pharmaceutical substances represent a significant threat to the health and safety of Kentucky citizens. The Kentucky All Schedule Prescription Electronic Reporting (KASPER) system provides physicians with a tool to help them identify when a patient may be at risk of a controlled substance abuse or addiction problem, as well as when a patient may be illegally selling or diverting prescribed controlled substances. While KASPER provides a valuable tool for physicians, it must be used in accordance with Kentucky statutes to protect provider practices and to ensure the viability of the KASPER system.*

## WHAT IS KASPER?

**M**isuse, abuse, and illegal sale of controlled pharmaceutical substances represent a serious threat to patient safety in the Commonwealth of Kentucky. The Commonwealth provides the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system to health care providers for assistance in identifying patients who may be at risk. KASPER catalogs most of the Schedule II-V controlled substance prescriptions written and dispensed within the state. A KASPER report shows all scheduled prescriptions dispensed to a patient in a specified time period, the prescriber who prescribed them, as well as the name of the dispenser. KASPER is designed to be:

- A source of information for practitioners and pharmacists.
  - An investigative tool for law enforcement.
- KASPER is not intended to:
- Prevent people from obtaining needed prescription drugs.
  - Decrease the number of doses dispensed.

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KASPER is housed within the Drug Enforcement and Professional Practices Branch in the Cabinet for Health and Family Services Office of Inspector General.

## WHO CAN REQUEST A KASPER REPORT?

Under KRS §218A.202, KASPER reports may be obtained by:

- Practitioners and pharmacists for medical treatment of a current patient.
- Law enforcement officers for a bona fide drug related investigation.
- Licensure boards for a licensee.
- The Medicaid program for a member or provider.
- Subpoena by a grand jury.
- A judge or probation or parole officer administering a drug diversion or probation program.

The Office of Inspector General estimates that at the end of 2009, 31% of the controlled substance prescribers in Kentucky had established KASPER accounts. While the number of prescriber accounts continues to increase, the expectation is that a much higher percentage of prescribers should be utilizing KASPER as a tool to assist with their patient treatment.

**WHAT CAN A PHYSICIAN DO WITH A KASPER REPORT?**

KRS §218A.202 specifies allowable disclosures of information contained in KASPER along with the penalties for inappropriate disclosure. The Kentucky Board of Medical Licensure has published a legal opinion entitled *Standards of Acceptable Medical Practice Relating to a Physician’s Use of KASPER Reports*. This legal opinion is included in this issue, and it is available in the Opinions and Policies section of the KBML website. Please refer to the legal opinion for Board guidance regarding proper use and controls on KASPER reports.

**HOW CAN A PHYSICIAN RECOGNIZE SOMEONE WHO MAY BE MISUSING OR ABUSING PRESCRIPTION DRUGS?**

The following chart lists typical behaviors associated with individuals who may be misusing or abusing prescription drugs, or “doctor shopping.” While two or three of these behaviors alone may not be indicative of doctor shopping, observing three or more of these behaviors may be reason for further inquiry into the patient’s controlled substance use.

**Table 1.** Controlled Pharmaceutical “Doctor Shopping”

| <b>Patient Behaviors</b>  | <b>Examples</b>  |
|---|--|
| Multiple providers of the same type   | 3 or more general practitioners, dentists, etc   |
| Dispensers and prescribers are in different localities from each other and the patient’s home address | Patient lives in Fayette county; prescriber in Franklin county; dispenser in Jessamine County  |
| Overlapping prescriptions of the same drug from different prescriber types                            | Oxycodone scripts from dentist, family physician, and pain management doctor within 30 days  |
| Excessive emergency room visits for non-emergency issues  | 3 or more emergency room visits in a month for chronic pain conditions   |
| Requesting replacement for lost medications regularly   | Patient states that controlled substance is lost and requests new prescription   |
| Requesting early refills  | Patient requests early refills due to extended out-of-state trip   |
| Pressuring prescribers to prescribe controlled substances for the patient’s family members.           | Patient requests the pediatrician prescribe cough syrup with codeine for his or her child, stating that it is needed for the child to sleep better |
| Using multiple names, social security numbers, addresses, etc   | Patient fills three scripts under three different names  |
| Seeking referrals to multiple pain management clinics   | Patient requests referrals to pain management clinics without a specific diagnosis   |
| Associating with others known to be pharmaceutical controlled substance provider shopping             | Patient travels to clinic with another patient exhibiting shopping behavior and requests similar prescription                                      |
| Self-mutilation   | Patient presents with potential self-inflicted wound   |
| Cash transactions   | Patient prefers to pay cash when insurance is available  |
| Requesting partial dispensing of controlled substance script  | Patient requests half of the script and returns for the rest of the script within 72 hours   |
| After-hour, weekend, and holiday calls for prescriptions  | Patient calls prescriber at midnight on Friday to request a controlled substance script  |

## KASPER AND THE FIGHT AGAINST CONTROLLED SUBSTANCE ABUSE

### WHAT PROVIDERS DO "DOCTOR SHOPPERS" TARGET?

While any practitioner may be targeted by individuals engaged in "doctor shopping," some drug seekers may focus on certain categories of health care providers. These categories include:

- New providers
- Senior providers
- Diet clinic providers
- Providers who are perceived to keep sub-standard records
- Pain management providers

### WHAT SHOULD A PHYSICIAN DO IF THEY SUSPECT ILLEGAL SALE OR DIVERSION OF PRESCRIPTION DRUGS?

Drug diverters and dealers can be extremely dangerous. If you suspect a patient is illegally selling or diverting controlled substances, please contact your local law enforcement or the Drug Enforcement and Professional Practices Branch at 502.564.7985 for assistance.

### HOW CAN A PHYSICIAN REQUEST KASPER REPORTS?

KASPER is a secure Web-based system. To access the system, a practitioner with a DEA license must first establish a KASPER account via the account request website at

<https://ekasper.chfs.ky.gov/accessrequest/accessrequest.aspx>. A set of step-by-step instructions is available on the website to guide you through the process of establishing your KASPER account. Once an account has been established, you may log on to KASPER to obtain reports via the report request website at: <https://portal.chfs.ky.gov/login/login.aspx>.

### WHAT CAN PHYSICIANS DO TO HELP?

- Recommend that other practitioners and pharmacists obtain a KASPER report if you have concerns about a patient
- Become familiar with the signs and symptoms of controlled substance abuse and addiction, as well as intervention processes and tools
- Remain vigilant for patients that may be seeking controlled substance prescriptions for abuse, or for the purpose of illegal sale or distribution. If you suspect an individual is involved in diverting prescription drugs, please report them to proper law enforcement officials. If you are unsure whom to contact, you can contact the Drug Enforcement and Professional Practices Branch at 502.564.7985.

With your cooperation and support, we can make a real difference in Kentucky's fight against prescription drug abuse and diversion. For more information, please visit the KASPER website at [www.chfs.ky.gov/kasper](http://www.chfs.ky.gov/kasper).

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# Opinion Relating to the Use of KASPER Reports

*Kentucky Board of Medical Licensure*

## LEGAL AUTHORITY

This is a Board opinion issued pursuant to the Board's statute, KRS 311.602, to assist licensees in determining what actions would constitute unacceptable conduct under the provisions of KRS 311.595. The Board has decided to publish this opinion because it addresses issues of significant public and medical interest.

This opinion is not a statute or regulation and does not have the force of law.

## STANDARDS OF ACCEPTABLE AND PREVAILING MEDICAL PRACTICE RELATING TO A PHYSICIAN'S USE OF KASPER REPORTS

The Board has determined that the following principles constitute the standards of acceptable and prevailing medical practice relating to a physician's use of KASPER reports.

The statute governing the use of KASPER reports, KRS 218A.202, makes it a Class D felony to obtain KASPER reports for an unauthorized reason or to release those reports to persons who are not authorized by statute to receive them. At the same time, the Opinion Regarding the Use of Controlled Substances in Pain Treatment, adopted by the Board of Medical Licensure, provides, in part, "Utilizing the Kentucky All Schedule Prescription Electronic Reporting [ie, the **KASPER Report**] initially can also aid in documenting the patient's history of drug utilization . . . The physician should monitor patient compliance in medication usage and related treatment plans. Periodic requests for a **KASPER Report** could be utilized . . . Initial or periodic **KASPER Report(s)** should *not* be part of the

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patient's records and should not be released to the patient or a third party."

The Board offers the following guidance regarding the appropriate use and storage of KASPER Reports.

## LAWFULLY OBTAINING A KASPER REPORT

1. The only legally authorized reason a physician may obtain a KASPER report is "for the purpose of providing medical treatment to a bona fide current patient."
2. These terms are given their normal everyday meaning. "For the purpose of providing medical treatment" is broad enough to include professional decisions as to what medications to prescribe, whether to continue previous prescriptions and whether a patient is properly taking prescribed medications. This term also includes the professional determination of what medications a new patient is currently taking.
3. All existing patients are considered "bona fide current patients." In addition, a person is considered a "bona fide current patient" if they have made an appointment for treatment. Therefore, a physician may obtain a KASPER report for use during the initial patient encounter, to determine what medications the new patient is taking and whether to continue current medications

and/or to prescribe new or additional medications.

4. However, both conditions must be present for a physician to lawfully obtain a KASPER report—it must be for the purposes of treatment *and* the treatment must be for a bona fide current patient. A physician MAY NOT lawfully obtain a KASPER report for personal reasons even if it involves a bona fide current patient. Similarly, a physician MAY NOT lawfully obtain a KASPER report, even if it is for treatment, if the treatment is for someone other than a bona fide current patient. Physicians have been prosecuted for obtaining KASPER reports for their personal use or for the use of friends or associates.
5. A physician MAY NOT legally obtain a KASPER report to assist them in responding to an investigation by the Board or by law enforcement agents. This is true even though the investigation may involve bona fide current patients. Obtaining a KASPER report for such purposes is a felony and physicians have been prosecuted criminally for such.
6. If a physician is faced with defending a disciplinary action by the Board or a criminal prosecution, and the KASPER information is an essential part of the Board's case or the prosecution's case, the physician may seek a court order to obtain a copy of the relevant KASPER report for use in their defense. In such circumstances, the Board will enter into a standard Agreed Order to assist the physician in obtaining a court order authorizing the physician to obtain a copy of the KASPER report.

### RELEASE OF A KASPER REPORT

1. The patient, or his/her attorney, is NOT entitled to a copy of the report [see KRS 218A.202(6)].
2. Unauthorized disclosure is a felony [KRS 218A.202(10)].
3. If relevant to treatment decisions, the physician may *discuss relevant information* from the KASPER report with a patient (ie, evidence of "doctor shopping" or inappropriate use of prescriptions). However, the physician may not lawfully provide a copy of the KASPER report to the patient. If the physician considers it essential to provide the patient with written proof of the information, the physician should obtain a copy of the actual prescription from the dispensing pharmacy. It is not illegal to provide a copy of the actual prescription to a patient.
4. Physicians should utilize this report for their own purposes, such as compliance with the Guidelines, but should not share (give a copy of) the report outside their practice; that is, they may share with other practitioners within the same group/practice when all utilize the same patient chart, but they should not share with a practitioner or pharmacist outside the group.
5. Physicians may discuss *information* from the report with other practitioners (outside their group) or pharmacists. However, if one of them wants a copy, that person should obtain his or her own copy. (Every practitioner or pharmacist who treats a patient is entitled to request a KASPER report.) This protects the physician against issues of unauthorized disclosure.
6. If anyone submits a grievance to the Board of Medical Licensure claiming that a physician is prescribing controlled substances in an inappropriate or excessive manner, the Board's investigators and/or consultants will attempt to determine, through a review of the patient records and available KASPER reports, whether the physician properly utilized controlled substances in the treatment of each patient.
7. In order to protect against an unauthorized disclosure while maintaining the necessary records for patient care and/or Board review, the physician should consider one of the following methods for maintaining the KASPER report(s):
  - a. filing it separately from the chart;
  - b. filing it in a segregated section of the chart that is marked "Not to be Released"; or
  - c. noting the number of the KASPER report and then properly destroying the report. If necessary, the Cabinet can use the report number to recreate the report at any time in the future.

## OPINION RELATING TO THE USE OF KASPER REPORTS

8. If the physician retains the KASPER report and the report becomes relevant to a Board or law enforcement investigation, the physician may provide the report to: a) a Board investigator upon written confirmation by the investigator that the physician is the subject of a "bona fide specific investigation" or, b) a law enforcement agent upon written confirmation by the agent that they are engaged in "a bona fide specific investigation involving a designated person."

### PROFESSIONAL USE OF KASPER REPORT

1. The physician should document in each patient's record each occasion when a KASPER report is obtained and used as part of the patient's treatment.
2. If "red flags" for diversion and/or abuse of controlled substances are identified during a review of any KASPER report, those "red flags" should be identified in the patient record as part of the KASPER review. The patient record should also include: a sum-

mary of the physician's discussion of those issues with the patient and the patient's response; the physician's determination whether the "red flags" indicate abuse and/or diversion and, if so, the physician's response to that information (ie, an admonition; increased scrutiny by KASPER review; execution of a controlled substances contract; modification or cessation of the controlled substances prescribing; termination of the physician-patient relationship; or no action, along with a brief explanation for that course of conduct). The appropriate course of action is a matter of professional judgment, subject to review.

3. If the physician chooses to continue providing controlled substances to the patient after "red flags" are identified through a KASPER review, subsequent KASPER reviews should reference the previous note(s) and should include relevant details about later reviews and the physician's response to those reviews.

*Adopted: March 2009*

# Treatment with Controlled Substances and Prescription Reminders

Cindy Shuck, RPh, MBA; Kelly Lenhart, RPh

**P**roper use of opioid analgesics is an important piece of quality healthcare. Inappropriate use can contribute to poor health outcomes. Prescription opioids are an essential part in the treatment of moderate to severe pain. However, these drugs are subject to abuse and diversion.

As a physician, it is important to be aware of the internal struggle patients may be having due to substance abuse. There are typically 5 levels of change for an individual regarding substance abuse according to Prochaska. [For more information on Prochaska's level of change, see *Changing for Good* by James O. Prochaska, PhD; John Norcross, PhD; and Carlo Diclemente, PhD (September 1, 1995).]

1. Precontemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance

It is important to realize that individuals go through several cognitive changes, but their behavior remains the same. It is small steps to eventually ceasing the addictive habit.

## EFFECTIVELY ASSESSING THE PATIENT FOR SUBSTANCE ABUSE:

- Be understanding
- Ask the patient direct, nonintrusive questions
  - For instance, "How are your symptoms affecting your personal life, social life, occupation, and family life?"
- Ask direct questions about substance abuse
  - For example, "I am getting a better understanding how this issue is affecting your life, and I am wondering, has there been any alcohol or any drug use?"

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In those cases where substance abuse appears to be an issue, you may prefer to have a behavioral health specialist evaluate and treat the patient.

## PRESCRIBING CONTROLLED SUBSTANCES REMINDERS

- Prescriptions for controlled substances must be dated as of, and signed on, the day when issued
  - Must **never** post date a prescription
- Must include full name and address of patient, drug name, dosage form, strength, quantity, and directions for use
- Must include the name, address, and registration number of practitioner
- Must be written with ink, indelible pencil, or typewriter and be manually signed by the practitioner
- Issuance of multiple prescriptions for Schedule II controlled substances:
  - DEA's regulations allow practitioners to provide individual patients with multiple prescriptions for a specific Schedule II controlled substance, written on the same date, to be filled sequentially.
  - The combined effect of such sequential multiple prescriptions is that it allows a patient to receive over time up to a 90-day supply of that controlled substance.

## TREATMENT WITH CONTROLLED SUBSTANCES AND PRESCRIPTION REMINDERS

- A pharmacist cannot fill a prescription issued as one in a series of multiple prescriptions prior to the date written by the prescribing physician
- Sequential prescriptions up to a 90-day supply of a Schedule II controlled substance are permitted.
  - *Example:* Writing three prescriptions to be dispensed every 30 days by the pharmacist (all prescriptions have the same date of issuance)
  - Write one prescription for one third of the total quantity of controlled substance to be prescribed
  - Write a second prescription for one third of the total quantity of controlled substance to be prescribed. Write **DO NOT FILL UNTIL \_\_/\_\_/\_\_** on the second prescription with the date 30 days after the first prescription date of issue.
  - Write a third prescription for one third of the total quantity of controlled substance to be prescribed. Write **DO NOT FILL UNTIL \_\_/\_\_/\_\_** on the third prescription, with the date 60 days after the first prescription date of issue.
- Treat prescription pads like a personal checkbook.
- Maintain adequate security for prescription pads.
- Stock only a minimum number of prescription pads.
- Keep prescription pads in your possession when you are actively using them.
- Do not leave prescription pads “unattended.” When not in use, place them in a locked desk or cabinet.
- Store surplus prescription pads in a locked drawer or a safe, appropriate area.
- Report any prescription pad theft to local pharmacies as well as the State Board of Pharmacy.
- Be specific on instructions for combination Opioid/Acetaminophen products to limit to no more than 4000mg (4 grams) per 24-hour period. Pharmacist and prescriber should remind patient that many over the counter products also contain acetaminophen. If it is necessary to use higher doses, use combinations with lower amounts of acetaminophen to prevent exceeding this 4

gram limit. Opioid combinations vary from 325mg acetaminophen to 750mg acetaminophen. This should be considered when selecting controlled substance prescribed and dosing interval.

It may be necessary to switch to a single-ingredient product to avoid acetaminophen toxicity issues, especially with use of these products over a longer time period. For example: Vicodin (5mg hydrocodone/500mg acetaminophen), Vicodin ES (7.5mg hydrocodone/750mg acetaminophen), and Vicodin HP (10mg hydrocodone/660mg acetaminophen). Be sure to adjust product selection and be aware of this safety concern. There are a myriad of these combinations and this is a frequently seen prescribing concern.

- Write out quantity to prevent alteration of quantity—Example: #40 (forty)
- Physicians should avoid prescribing of any controlled substance or any drug with addictive potential to self, immediate family, or staff.

### Know the Risks



### A Prescription to Stop Abuse

The abuse of prescription drugs is a serious problem. Help prevent an accidental injury and do your part to stop the possible theft, misuse or abuse of prescription medicines.

-  Keep your medicines secure and out of the hands of a child, teenager or stranger. A locked storage area may be the best choice.
-  Be alert and take precautions when transporting or traveling with your prescriptions.
-  Be sure to follow the directions on the prescription bottle and use medicines only as they are prescribed.
-  Keep track of your medications. Routinely count your pills and don't forget to factor any remaining pills when you add refills.
-  Discard any remaining pills immediately upon completing treatment and periodically look for leftover prescriptions in your home. If you have questions about how to dispose old or unused medicines, follow the specific instructions on the prescription or ask your pharmacist.
-  If you have any questions about your medicines, talk to your doctor or pharmacist.

Working together, we can help prevent prescription abuse and preserve access for patients who legitimately need prescription drugs to treat pain, illness and disease.

Provided By:  
The Kentucky Pharmacists Association

Supported by an Educational Grant from Endo Pharmaceuticals, Inc.

# Demonstrating Social Responsibility Has Its Financial Benefits

*Lucretia Johnson*

**M**aintaining a drug-free workplace demonstrates an employer's willingness to promote social responsibility while providing a safe working environment for the employees and, in exchange, the employer may be eligible and receive economic benefits such as a 5% discount on the workers' compensation insurance premium, a decrease in absenteeism, and an increase in work production.

On June 5, 2008, the legislature approved adoption of Kentucky Administrative Regulation 803 KAR 25:280, which established the requirements for employers to voluntarily apply and become certified by the Department of Workers' Claims for implementing a drug-free workplace program. <http://labor.ky.gov/NR/rdonlyres/FFC98693-2DB2-416D-A375-C7831C51951D/0/CertificationofDrugfreeWorkplace.pdf>

Some of the requirements of a drug-free workplace program include provisions for conducting breath and alcohol drug testing, providing education and training to employees, and maintaining an employee assistance program. Employers may establish a consortium program with other employers in order to be able to provide cost-effective services to

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their employees and assist them with complying with the requirements.

The DWC Commissioner Dwight Lovan, has certified 94 employers as having a drug-free workplace. Most recently, Hardin County became the first county in the state of Kentucky to apply for and become certified as a drug-free workplace—providing monetary savings of \$23,645 to the taxpayers of Hardin County.

The Department of Workers' Claims is available to offer free training and education to employers regarding the application and certification process. For more information, you may contact Tara Aziz, Drug-Free Coordinator, or Lucretia Johnson, Division Director at 502.564.5550, or [Tara.Aziz@ky.gov](mailto:Tara.Aziz@ky.gov) or [Lucretia.Johnson@ky.gov](mailto:Lucretia.Johnson@ky.gov).

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# The Chronic Non-malignant Pain “Ladder”—A Novel Approach to Prescribing Opioids for Chronic Pain

*James Patrick Murphy, MD*

*As the number of patients needing care for chronic pain continues to grow, the goal of effective treatment with opioids that minimizes the risks of addiction, abuse, and diversion can pose a challenge for physicians. Many helpful guidelines and resources are now available. This article makes note of several such resources with particular attention to “The Chronic Non-malignant Pain Ladder.”*

Chronic pain afflicts about one out of every three Americans. More than one-half of patients treated for chronic pain by their family doctors continue to have pain despite treatment.<sup>1</sup> As our population ages, physicians can expect the demand for the treatment of chronic pain to continue to rise. Over the past 25 years there has been a growing consensus that opioids have an essential role in the treatment of chronic pain.<sup>2</sup> In 2009 the American Geriatrics Society published guidelines regarding the treatment of persistent pain and boldly made the “strong” recommendation: “All patients with moderate to severe pain, pain-related functional impairment, or diminished quality of life due to pain should be considered for opioid therapy.”<sup>3</sup>

Using opioids and other controlled substances for the treatment of chronic pain can be challenging. Many physicians severely limit their use of opioids due to concerns regarding side-effects, addiction potential, unlawful diversion, and heavy-handed scrutiny by medical boards and law enforcement. These concerns often compel physicians to shift the responsibility of prescribing pain medications from their own practices to the pain clinics, even though pain clinics cannot possibly absorb all of these patients. In reality, many pain clinics focus on interventional procedures to treat pain (ie, spinal injections, nerve blocks, surgical implants). While pain clinics

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may initially take on the task of medication management, they are often “overly cautious” and abruptly dismiss patients because of an aberrant behavior (ie, failing a drug screen, doctor shopping).<sup>4</sup> When this happens, the patient will often return to their referring physician still in pain, still needing medications, only now with the added “baggage” of having been discharged from a pain clinic due to an unseemly circumstance.

The Kentucky Board of Medical Licensure addressed this phenomenon in their Fall 2008 newsletter and, in an effort to encourage physicians to continue to treat chronic pain, opined:

“Quite simply, a letter from a Pain Clinic back to the referring physician reassuring the physician that prescribing a controlled substance is appropriate would help alleviate the situation of the patient being left without access to relief.”<sup>4</sup>

The Kentucky Board of Medical Licensure’s understanding of the physician’s plight is further evidenced by language in the updated “Board Opinion” published on their website [and in this issue]: “By publishing this Opinion, the KBML wishes to encourage physicians to utilize adequate medications to treat their patients with serious pain complaints

## THE CHRONIC NON-MALIGNANT PAIN “LADDER”

**Table 1.** Resources for physicians regarding the proper use of controlled substances in the treatment of chronic pain.

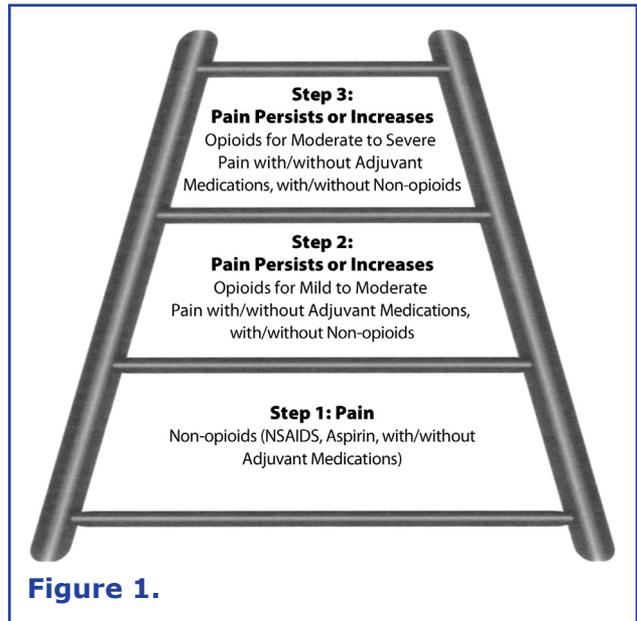
| Society                             | Link   |
|-------------------------------------|--|
| American Academy of Pain Medicine   | <a href="http://www.painmed.org">www.painmed.org</a>                                       |
| American Pain Society               | <a href="http://www.ampainsoc.org">www.ampainsoc.org</a>                                   |
| Federation of State Medical Boards  | <a href="http://www.fsmb.org/RE/PAIN/resource.html">www.fsmb.org/RE/PAIN/resource.html</a> |
| American Academy of Pain Management | <a href="http://www.aapainmanage.org">www.aapainmanage.org</a>                             |
| Kentucky Board of Medical Licensure | <a href="http://kbml.ky.gov/board/policies.htm">kbml.ky.gov/board/policies.htm</a>         |

without undue fear of legal or licensure repercussions.”<sup>5</sup>

Kentucky physicians might take additional comfort in the knowledge that the state’s ranking has recently descended from its perennial position among the nation’s top five with respect to the rate of serious disciplinary actions by the medical board, to the more moderate position of twenty-fourth.<sup>6</sup> Since this move is not likely due to Kentucky’s board becoming complacent, hopefully it reflects an improvement in physicians’ understanding of how to treat pain within the boundaries of accepted guidelines. There are, in fact, many resources now available for physicians to utilize for support and education regarding the proper use of controlled substances in the treatment of chronic pain. Table 1 lists a few of these resources.

Clearly, there are other medications besides opiates that are useful in treating chronic pain, but the most difficult decision for physicians usually involves the implementation of an opioid regimen. One must not only evaluate the patient but also do a critical self-evaluation, answering the questions: Would opioid therapy in this case be considered a conventional approach by peer review? Have a sufficient number of other modalities been given an adequate trial? Can the patient tolerate the potential side-effects? Is the patient at risk for addiction or diversion? Is the practice set up to adequately monitor the patient? Strategies for the successful use of opioids in the treatment of chronic pain involve: a universal precautions approach to monitoring,<sup>7</sup> effective documentation, and prescribing in a manner which would be considered “usual and customary” whenever possible.<sup>8</sup>

The World Health Organization Guidelines for the Treatment of Cancer Pain describe a step-wise “ladder” approach to treating malignant pain with opioids (Figure 1).<sup>9</sup>



**Figure 1.**

## WHO THERAPEUTIC LADDER FOR CANCER PAIN MANAGEMENT

1. First step: non-opioid and adjuvant medications
2. Second step: weak opioid for mild to moderate pain (+/- non-opioids and adjuvants)
3. Third step: strong opioid for moderate to severe pain (+/- non-opioids and adjuvants)

Unfortunately, the WHO malignant pain “ladder” is often inadequate when applied to the treatment of patients with chronic non-malignant pain (CNP). The WHO ladder assumes there is no upper limit for the dos-

age, as long as side effects are tolerable. Following this logic can lead to dispensing an enormous number of pills, which may create problems. The greater the number of opioid dosage units dispensed into the community (ie, pills), the greater it appears is the rate of opioid abuse.<sup>2</sup> Also, a major factor determining a drug's potential as an addictive agent is its availability.<sup>10</sup>

In cases of chronic non-malignant pain one must consider the long term effects of therapeutic interventions. Aside from the obvious concerns (ie, tolerance, abuse, addiction, and diversion) long-term opioid use can potentially contribute to hormonal abnormalities, immunological deficiencies, and worsening of pain due to opioid-induced hypersensitivity.<sup>11,12</sup> Therefore, it behooves the physician to prescribe a regimen that is appropriate for the intensity of the pain, tailored to the temporal pattern, at the lowest effective dose, and with the fewest number of pills.

Fortunately, in the past 15 years or so a number of innovative opioid preparations have come on the market that can help achieve these goals. Examples include: 24-hour morphine sulfate, extended-release oxycodone, 72-hour fentanyl transdermal patches, and extended-release oxycodone. At one time it was thought that extended-release opioid preparations would have less potential for addiction, but this has never been proven in clinical trials.<sup>13</sup>

A sublingual buprenorphine and naloxone preparation has lately come on the scene as another option besides methadone for the treatment of opiate addiction and pain. Recently on the market is a new morphine pill that contains the opiate antagonist naltrexone embedded within, which is released only if the pill is crushed in an abusive manner. Methadone's pharmacokinetic and pharmacodynamic interpatient variability makes it impractical to classify it as either a long-acting or short-acting pain medication. Methadone must be used with extreme caution and only after becoming very cognizant of its unique properties and risks—not the least of which is the potential for prolongation of the electrocardiogram Q-T interval

and the increased risk of Torsades de Pointes dysrhythmias.<sup>14</sup>

With the emergence of multiple opioid choices, having varying durations of action and varying affinities for the numerous central nervous system opiate receptors (polymorphism), the clinician can literally tailor the choice of opiate to the specific needs of the patient in much the same way an anti-hypertensive or antibiotic regimen is chosen.

When prescribing opioids, some tips to remember are: always try to start *low*, titrate *slow*, and use the lowest clinically effective dose. Especially in the early going, require frequent follow-up visits, and therefore less medication need be prescribed per visit. When in doubt, always give less medication and follow up more frequently. Every opioid prescription should be considered a "trial," subject to continuous reevaluation.

In many respects, the most difficult issue regarding the use of opioids pertains to the dose. Many references attest to the fact that there are no "ceiling" doses for opioids; ie, there are no maximum dosages.<sup>15</sup> Other clinicians advocate not exceeding an arbitrary "moderate" maximum dose, such as 195 milligrams of morphine or its equivalent.<sup>8,16</sup> Actually, a therapeutic dose is highly individualized and is based on a number of factors, with the patient's ability to function at the forefront of importance. Unfortunately, level of functioning can be difficult to measure and does not always need to improve to justify the use of the medications. In fact, sometimes the best one can hope for is to slow the rate of decline. Regardless, the practitioner often finds it problematic when determining how high, how low, and how many opioids are appropriate.

The following is a suggested method for determining a reasonable opioid regimen for chronic non-malignant pain (CNP) that was inspired by the WHO ladder for malignant pain.<sup>17</sup> When this chronic non-malignant pain "ladder" is followed, the maximum number of pills that would be prescribed in a 30-day month is 90. The maximum strength of each pill would be determined by what is FDA approved and available from the manufacturer.

## THE CHRONIC NON-MALIGNANT PAIN “LADDER”

### BASIC RULES FOR THE CNP LADDER

#### Rule #1—Prescribe only one type of opioid at a time.

Different opioids have varying affinities for the numerous types of opioid receptors. Therefore, this rule theoretically allows one to take advantage of opiate receptor polymorphism, if rotating to another class of opioid is the chosen strategy to address the development of drug tolerance. Also, prescribing only one type of opioid makes it easier to monitor for compliance with urine drug screens.

#### Rule #2—Prescribe only one unit of medication per dose (eg, one pill per dose).

#### Rule #3—Prescribe a maximum of three doses per day and only as often as the manufacturer recommends (eg, the FDA approved interval).

Tailor the medication choice to the pattern of pain and the patient’s functional goals. If the pain is round-the-clock, consider extended-release drugs (ie, duration of action = eight hours or more per dose). If the pain is episodic or related to activity, consider an immediate-release drug (ie, duration of action is less than eight hours).

“Breakthrough” opioid medications can be used sparingly during the titration period. However, the goal should be to avoid “breakthrough” opioids when the patient’s pain is stable and acceptable. Consider instead the NSAIDs, muscle relaxants, physical medicine remedies (ice packs, heat, TENS, etc), and selected anti-convulsants.<sup>18</sup>

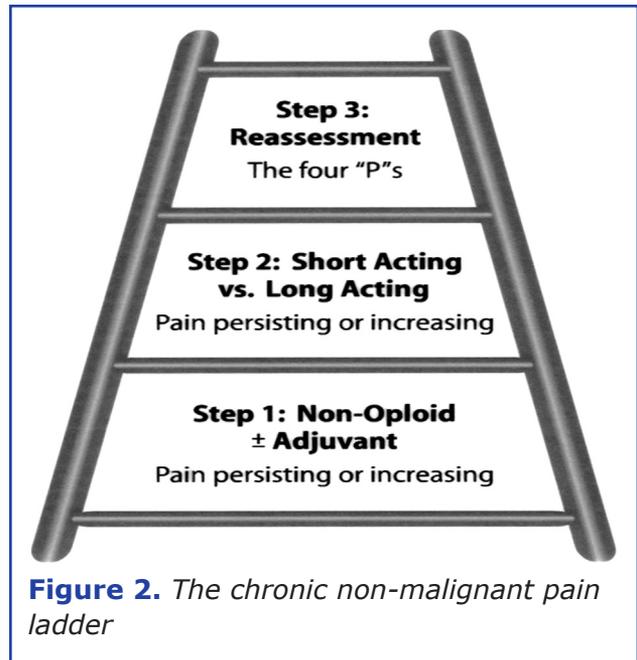
## THE CHRONIC NON-MALIGNANT PAIN LADDER

### STEP ONE

Non-opioid medication(s) and modalities (eg, physical therapy, psychological support)

### STEP TWO—Long-Acting vs Short-Acting

Decide which type of opioid is most appropriate



**Figure 2.** *The chronic non-malignant pain ladder*

### STEP THREE—Reassessment (The Four P’s)

If the opioid regimen becomes ineffective, consider as reasons “the Four P’s”:

**PPPP**—the differential diagnosis when the medications become inadequate. Generally, somewhere within these four categories (the four P’s) lies the reason the prescribed medications have become inadequate.<sup>19</sup>

**P = Pathological.** *Has the painful condition worsened? Is there a new disease to consider. Are the medications not suited to the type of pain (eg, opioid resistant / neuropathic pain)?*

**P = Pharmaceutical.** *Has tolerance developed? Is the dose too low? Are the medications contributing to the pain (side-effects, drug interactions, toxicities)?*

**P = Psychological.** *Is there developing depression, anxiety, or addiction?*

**P = Police.** *Are the drugs being unlawfully diverted?*

When a patient’s pain cannot be adequately managed “on the ladder,” and an opioid rotation is not feasible, it may become necessary to go “off the ladder” by prescribing more medication than these guidelines recommend. In this event, consider pre-

senting the case to a colleague. Besides the inherent value of a second opinion, having a peer or consultant opinion on the chart that supports the decision to prescribe additional medication is a useful method by which liability can be shared amongst providers as opposed to "going it alone."

Any practitioner who prescribes controlled substances for chronic pain understands the attention this practice draws from regulatory agencies. Over the past ten years "overprescribing" is the number one reason disciplinary action has been taken against physicians.<sup>20</sup> Available documentation is the primary source of evidence reviewing experts consider when investigating allegations of prescribing irregularities. The main reason physicians are unable to defend themselves before regulatory agencies is their lack of documentation. The COMPLIANCE mnemonic summarizes documentation reviewers are likely to require. As often as practical, the prescribing physician should review the chart to determine if there is enough documentation to justify the chosen therapeutic regimen.<sup>21</sup>

## COMPLIANCE

A summary of the documentation reviewing experts may find requisite:

**C = Compliance.** Compliance is monitored with findings leading to appropriate actions (eg, drug screens, pill counts, family conferences, prescription monitoring Programs, KASPER).

**O = Often assessed.** The patient is seen often enough to assess: analgesia level, activity level, adverse reactions, and aberrant behavior.

**M = Medical records.** Records are accurate, legible, complete, and accessible.

**P = Plan.** Plan of treatment has objectives and goals to determine functional status.

**L = Legitimate.** Legitimate diagnosis of a recognized chronic painful condition

**I = Informed consent.** Informed consent (*Treatment Agreement* is optional)

**A = Addiction.** Addiction risk assessment, past and current use, family history, psychological and social issues

**N = Non-addicting.** Non-addicting medications have proven inadequate or unacceptable (either through clinical trial or review of medical history).

**C = Consultation.** Consultation(s) have been obtained when necessary and other health care concerns are addressed.

**E = Evaluation.** Evaluation is thorough (history and physical) reflecting the complexity of the case.

For the foreseeable future, appropriate medication management of chronic pain will include the use of opioids. While the need to simultaneously address pain, addiction, and diversion can make treating chronic pain with opioids seem like a juggling act, the chronic non-malignant pain ladder, as well as other tools like the ones presented here, can help physicians avoid dropping the ball. More confidently will they fulfill their obligation to provide comfort to suffering patients when they have the knowledge and resources to prescribe in a manner that is safe for the patient, the community, and their practices.

*Note: Lack of strict adherence to these therapeutic guidelines does not imply that a particular practice is outside the scope of legitimate medical practice. This information is not intended to be used as medical practice guidelines or standards or as legal advice with regard to specific practices, nor is it endorsed by any entity. Practitioners, law enforcement, and regulators should always keep abreast of changes in federal and state statutes, in regulations, and in other policies relevant to pain management.*

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Donna Stewart, MD

# VAMC Policy and Scheduled Drug Monitoring Databases

**M**y editorial is to alert all health care providers to a very important policy recently established by the General Counsel of the VAMC in Louisville (VHALOU) sent to their health care providers and pharmacists on September 03 and 30, 2009, regarding querying scheduled drug monitoring databases, such as the KASPER/OGC Drug databases. I believe that this type of policy, initially directed only to the VA sector, may ultimately impact nonfederal health care provider prescribing practices in the future.

It reads:

*Healthcare Providers,*

*The LVAMC has received the following answer from the VA Office of General Counsel regarding our inquiry about whether we could make consent to access the KASPER database part of the opioid agreement:*

*The present guidance is that, pending a policy directive from VHA, VA personnel should not, under any circumstances, participate in any state drug monitoring program, whether by reporting to the program or querying the database. Thus, while it may theoretically be possible to craft an effective patient consent, such a consent will not be effective to circumvent the cease-and-desist that is currently in place.*

*Please understand that this was not a local decision. The inquiry was taken up to the VA Office of General Counsel and the response is clear: VA Providers are not to participate in KASPER or any similar program.*

**VA SHOULD NOT PARTICIPATE IN KASPER**

*We have received several inquiries regarding participation by VA pharmacists/physicians in state prescription drug monitoring databases (PDMPs). Our understand-*

*ing is that VHA is drafting policy guidance regarding the circumstances—if any—under which VA medical practitioners can participate in such programs. In the interim, we advise against participating in PDMPs, without regard to whether such participation involves reporting to such programs or merely involves querying their databases for information regarding a veteran patient.*

*Given the laws that govern VA, while it may be feasible to participate in PDMPs in limited circumstances, such participation is not possible in most instances, practically speaking. Absent veteran consent, the only potentially applicable exception to 38 USC 5701 is disclosure of names and addresses of veterans to PDMPs pursuant to a law enforcement request. Thus, at a minimum, VA would have to conduct a state-by-state analysis to determine whether a particular state's PDMP had law enforcement authority. Further, even assuming reporting authority is present under Section 5701, we still cannot disclose to PDMPs information protected by Section 7332. Section 7332 would also prohibit VA medical personnel from querying databases if the subject of the inquiry is being treated for a condition covered by 7332 and the query input is PII, unless we obtain valid patient consent.*

*Thus again, owing to the difficulty of determining whether a particular PDMP has law enforcement authority and whether databases can be queried or reported to in a manner that does not violate Section 7332, and also to the lack of policy on the part of VHA, OGC advises that regional counsel advise against participation in these programs. At the very least, there are numerous legal, administrative and policy issues that need to be worked out before we can participate in a manner that*

*complies with the law. As a practical matter, however, given our understanding of the way these programs are administered, there is probably no way that we can participate and comply with 5701 and 7332 in every instance.*

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*I believe that this type of policy . . . may ultimately impact nonfederal health care provider prescribing practices.*

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We all know that prescription drug abuse continues to permeate the United States as it infiltrates all levels of society. According to The National Center on Addiction and Substance Abuse at Columbia University (CASA), the number of US citizens abusing controlled prescription drugs increased 94% between 1992 and 2003, which is double the increased number of people abusing marijuana, five times cocaine, and sixty times heroin (the US population increased 14% during this time). OxyContin, Valium, and Ritalin are considered the 4th most abused substances in US, trailing tobacco, alcohol, and marijuana.

Prescription drug abuse and its resultant morbidity and mortality have reached epidemic proportions in Kentucky and Indiana, and drug diversion has become a major source of unlawful income for individuals, in addition to illicit drug dealing. According to CASA's 2008 report, 15.1 million people admit to abusing prescription drugs (increased from 7.8 million in 1992), which is greater than those who admit to abusing cocaine (5.9 million), hallucinogens (4.0 million), inhalants (2.1 million), and heroin (0.3 million) combined. Approximately 25.3% of controlled prescription drug abusers report only abusing prescription drugs.

Record numbers of children and adolescents are becoming addicted or dying from early exposure to narcotic usage and abuse. From 1992 to 2003, 2.3 million (a 212% increase in the number) 12-year-old to 17-year-old teenagers abusing controlled

prescription drugs have been discovered. New abuse of prescription narcotics among teenagers has increased 542%, which is more than four times the rate of increase in adults. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2007-2008 report, 55.9% of persons aged 12 or older who used prescription analgesics nonmedically in the past 12 months got their medications for free from a friend or relative. Almost 9% bought them from a friend or relative, 5.4% stole them, 4.3% bought them from a drug dealer or other stranger, and 0.4% bought them on the Internet. Eighteen percent of these individuals received drugs through a prescription from one physician.

Prescription drug deaths have surpassed cocaine, heroin, phencyclidine, and methamphetamine/amphetamine drug deaths in the United States. According to 2007 US Department of Health and Human Services Drug Abuse Warning Network (DAWN) research data taken from regional coroner and medical examiner systems, there are 13.5 drug-related deaths per 100,000 persons in the Louisville KY-Jefferson IN region. The number of deaths per 100,000 persons is attributed to each of the following drug classes: antidepressants (28); benzodiazepines (30); miscellaneous anxiolytics, sedatives, hypnotics (20); opiates (76) including methadone (37), and other non-heroin opiates (37).

Finally, what does substance abuse and addiction cost our society in dollars? According to the most recent CASA report, federal, state, and local governments have spent at least \$467.7 billion in 2005.

To combat controlled substance abuse and diversion, state-wide PDMP, such as Kentucky All Scheduled Drug Electronic Record (KASPER) and Indiana Scheduled Prescription Electronic Collection and Tracking (INSPECT), have been developed to aid physicians, pharmacists, and law enforcement personnel to help identify the potential of multi-drug scheduled drug prescription practices in order to reduce the possibility of drug addiction and drug diversion. Thirty-three states have PDMPs, and five more states have passed legislation to create a program.

In 1999, the Office of the Inspector General's (OIG) Division of Fraud, Waste & Abuse Identification and Prevention within the Cabinet for Health and Family Services was challenged to establish a program to track the incidence of "legal" prescription drugs being diverted into illegal sectors. KASPER, effectuated in July 1999, tracks Schedule II-V controlled substance prescriptions dispensed within the state which are reported by pharmacies and other dispensers. As a Web-accessed computerized database, KASPER provides prescription information for health care professionals and is utilized as an investigative tool for law enforcement to prevent misuse and diversion of these drugs. KASPER was not designed to stop or decrease legal prescription drug dispensing.

Under KRS 218A.202 (6), the following individuals can access KASPER reports:

- Healthcare practitioners for medical treatment; Pharmacists for pharmaceutical treatment
- Law enforcement officials for drug investigations that are certified by an investigator and a supervisor
- Licensing boards for licensees only
- Medicaid for a recipient
- Grand Juries by subpoena
- A judge or a probation/parole officer administering a drug diversion or probation program

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*I believe that it is a violation of our rights, as physicians, not to be able to use the sources available to ensure proper controlled medication practices.*

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Around 2003 the Lexington VA hospital started reporting to KASPER. In 2006 the Huntington and Louisville VA hospitals started reporting. Data was being drawn from these sources when the Washington VA Administrators halted the process. The personnel from KASPER were surprised when the VA General Counsel ruled that no VA medical

personnel could even use the system. Several of the VA health care providers and pharmacists are upset by this recent policy and want to access KASPER, but they feel powerless to do anything about it. In fact, they believe that there could be severe repercussions, even loss of their jobs, if they utilize the system. Apparently, the policy is not just to restrict access to KASPER but to all the PDMPs in the country. The Office of Drug Control Policy is in the process of contacting the entire Kentucky congressional contingent regarding the VA opinion. However, is this action enough?

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*I see this as a severe violation of our patients' rights to be treated effectively.*

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My editorial is written with the intent to warn Kentucky health care providers and pharmacists of this major action. It may not initially appear to be a hit to our community outside of the VA hospital system, but I can promise you this is a BIG DEAL, and we need to voice our concerns regarding how this undermines our ability to effectively treat our patients. It is well-known that many of our veterans are obtaining prescription narcotics from both the VA and from community physicians.

I believe that it is a violation of our rights, as physicians, not to be able to use the sources available to ensure proper controlled medication practices for our patients. It is the duty of a physician to take part in the diagnosis and treatment of disease or injury states in order to care for his/her patient. It is also the duty of physician to report abuse and neglect or specific contagious infectious diseases in these patients. From CASA's research, approximately 57% of physicians feel that they have primary responsibility for preventing prescription drug abuse and diversion activities.

In fulfilling the physician's Hippocratic Oath ["I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone.

I will not *give a lethal drug to anyone if I am asked*, nor will I advise such a plan”], physicians not only have a right, but a duty to review all medications that their patients are taking, and that includes reviewing a drug-monitoring database, especially if the patient receives a mixture of scheduled drugs.

It appears that this VA decision is addressing veterans’ rights as a type of personal information protection under the Health Insurance Portability and Accountability Act (HIPAA) enacted by Congress in 1996. However, this VA policy is a violation of our rights as physicians to treat our patients effectively, instead of infringing the veterans’ rights to privacy. More importantly, I see this as a *severe violation of our patients’ rights* to be treated effectively. We could actually do more harm than good if we cannot access all the tools necessary, such as a PDMP, to take care of them adequately. I am afraid if this is finalized in the VA system across the country as a federal institution, then it may be implemented in the private sector in the future.

Such obvious blind sightedness by the federal government will bring more narcotics into our community to affect not only our patients, but their family members and acquaintances, to ultimately seep into illegal drug markets. More morbidity and mortality will inevitably occur.

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*\*The statements contained herein represent the opinion of the writer and do not necessarily reflect the official position of the Office of the Kentucky State Medical Examiner or the USAF.*

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*these pages. If you wish to submit a Letter to the Editor, it should be written in clear, concise language, and the length should not exceed approximately two typed, double-spaced pages. Letters will be published in part, or in their entirety, at the discretion of the Editorial Board.*



## For A Change. . . . Me First!

**H**ow about a real change this year? It is obvious that those who choose medicine for a career have motives that differ from most other professions. We were taught from early childhood to share with others unselfishly, to wait for our turn and to not push our way to the front of the line. But college and career work-life causes many young professionals to force their way up the ladder by any means, putting away those early teachings. In medicine, though, hospital call and the needs of their patients mean that physicians must routinely put their needs last. Grabbing a quick bite on the way to the clinic, sleep deprivation—even after residency—missing a son or daughter’s dance recital, soccer game, or even Christmas dinner, are all evidence of making patients’ needs the highest priority.

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*Too many physicians find that . . . as the years go on, they still do not take care of themselves.*

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What about You? I know! There isn’t time for a leisurely meal when you’re on call. Your family understands, or should, that medicine is your first priority. Unfortunately, too many physicians find that even when there might be more time as the years go on, they still do not take care of themselves. I once asked a physician if he had a good doctor for himself and his answer, “I have a fool for a doctor,” indicating that he was acting as his own physician. Many Alliance members will agree that their physician spouses do not make their own health and well-being a priority. Perhaps we can help.

How about “For A Change . . . Me First! What if that walk or ride on the exercise bike early in the morning gave you more energy

for your day? What if a healthy breakfast or protein shake gave you stamina for the 5-hour surgery. What if a regular checkup by a physician you trusted more than yourself helped to put you on the road to a healthier you and a longer life in which to enjoy your family or leisure time activities? Here are some tips for the New Year. Stock up on small packages of cholesterol-busting almonds to carry in your pocket. Take that walk with your spouse for time together and exercise. Toss some blueberries or other fruit into that protein shake. Get that check-up and take “your doctor’s” advice. Give your heart a boost by using the stairs instead of the elevator and why not park in the outer lot so you can walk the extra 50 yards? Choose the salad with chicken instead of the hamburger and French fries. Try eating more slowly—it’s suggested to put your fork down in between bites to help with this.

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*Let’s ask what it means to make ourselves the priority . . . for a change . . .*

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Most of us know *what to do and why*, but the difficulty is to make time for adjustments to our routines. We have all heard the good words, “Love your neighbor, as you love yourself.” Let’s ask what it means to make ourselves the priority . . . for a change . . . to cause the change we need.

KMA Alliance wishes you and your families a happy and healthy New Year and one that gives you more time and more energy for the busy lives you lead.

**Anita Garrison**  
*KMA Alliance President*

Dear Editor:

### **One Mammogram, Hold the Bureaucracy, Please**

*"The 'common good' of a collective—a race, a class, a state—was the claim and justification of every tyranny ever established over men. Every major horror of history was committed in the name of an altruistic motive . . . It was accepted that man must be sacrificed for other men. Actors change, but the course of the tragedy remains the same. A humanitarian who starts with declarations of love for mankind and ends with a sea of blood . . . It is an ancient conflict . . . the individual against the collective."*

- Howard Roark in *The Fountainhead*  
by Ayn Rand

Reading the article in the latest issue of the *Annals of Internal Medicine*, which contains the recommendations of the United States Preventive Services Task Force (USPSTF) regarding screening for breast cancer,<sup>1</sup> the heretofore largely unknown bureaucratic body, is lost in a tangle of contradictions. Their central premise is hardly original—it is generally accepted that all screening tests (including mammography) result in a certain amount of "overdiagnosis" (detection of clinically insignificant disease). The task force, however, is "uncertain" about the level of overdiagnosis of breast cancer and admits that methods for measuring overdiagnosis are "not well established." Moreover, the USPSTF acknowledges that our ability to fully understand how breast cancers develop is "limited" and the likelihood of identifying which precancers will progress to invasive cancers is "unknown." Their solution? Simply stop looking for cancers in women who are slightly younger than those who present with "cost-effective" breast cancer.

Although in this report, the USPSTF did not go as far as to place an absolute value on an individual human life, I eagerly await that recommendation in a future publication. For now, it should be understood that their proposal to eliminate mammography for women in their 40s is based on the following: to realize the same life-saving benefit of screen-

ing 10 women aged 50-59 years, one must screen 14 women aged 40-49 years.

Let us now follow this line of thinking to a set of logical conclusions. Since the confidence intervals in the statistical analysis of the benefits of mammography in these two age groups overlap, it stands to reason that they have just as much "evidence" to eliminate mammography for women in their 50s as well. Subsequently, cost-effective, quality-of-life year analyses could easily be used to justify not screening the "elderly" (women 60 years and older). They have already proclaimed a "low certainty" of any benefit to screening for women over the age of 74.

Combine all of this with the USPSTF's recommendation "against clinicians teaching women" how to perform a proper breast self-exam, and, presto! Welcome back to the 1960s. The USPSTF will have successfully "bent the curve" of the incidence of breast cancer downward, approximating what it was 50 years ago. Those of us in cancer medicine can then stop providing expensive, tailored, and multidisciplinary combination therapy with curative intent for early-stage breast cancers. We will no longer need to treat or even have scientific curiosity about the natural history of ductal carcinoma in-situ (DCIS); it will just be relegated to a pathologist's addendum to a report of a mastectomy specimen containing a 5cm tumor.

Palliative measures for the locally advanced breast cancer patient will be much less expensive, and patients' rapid demise will, in-turn, save cost to "society." The pesky dilemma that collectivists encounter is that screening tests lead to costly procedures, which lead to better odds of cure, which lead to longer life spans, which lead to greater consumption of "limited resources."

The subsequent firestorm of controversy generated by the USPSTF's study is just as much about the original premises of their report as it is about their lack of clinical expertise (not one member of the USPSTF is a nationally-recognized thought leader in the science of breast cancer). The authors defended themselves, stating that they do not even mention "cost" or "resource allocation" in their article. But what, then, could possibly

have been the purpose of their study? This should serve as a "wake-up call" to all health care providers who believe in the value of early detection and preventative patient care.

Our medical system, with all of its warts, is still one primarily focused in the principles of individualism. In these days of uncertainty and "reform," our patients expect us to be their guardians against the forces that threaten these ethical fundamentals. Perhaps a proper answer to the USPSTF's question of, "Who needs mammograms?" would be, "Who needs the USPSTF?" That has certainly been the sentiment of my outraged population of patients who originally presented in their 40s with mammographically-detected breast cancer and are now disease-free. The indignation of these inspiring women, facing cancer in the prime of life, reminds me of the tenacious spirit embodied by Howard Roark. Written in 1943, Ayn Rand's *The Fountainhead* is the fictional story of Roark, an architect in constant conflict with bureaucrats of his day. In the end, on trial for his life, Roark's words are a frighteningly prescient defense of the individual.

"Now, in our age, collectivism, the ancient monster, has broken loose and is running amuck. It has brought men to a level of intellectual indecency never equaled on earth . . . It has poisoned every mind [and] is engulfing our country . . . I came here to say that I do not recognize anyone's right to one minute of my life. No matter who makes the claim, how large their number or how great their need . . . I recognize no obligations toward men except one: to respect their freedom . . . The only good which men can do to one another and the only statement of their proper relationship is—Hands off!"

**Anthony E. Dragun, MD**

*Department of Radiation Oncology  
Multidisciplinary Breast Cancer Program  
James Graham Brown Cancer Center  
University of Louisville School of Medicine  
Louisville, KY*

*The following letter was received in response to a Letter to the Editor from Steven Lippmann, MD, on the issue of the safety and price of guns in Kentucky, which appeared in the November 2009 issue.*

*Dear Editor:*

I read with interest the letter to the editor entitled "The Safety and Price of Guns in Kentucky" by Stephen Lippmann, MD.

The article was mistitled, as it did not deal with gun safety or cost.

It is a tragic reflection of our society that suicide is such a common cause of death and that 14.5% of high school students reported that they had considered suicide during the last twelve months. According to the CDC website, firearms are the most commonly used method for males (57.6%), but poisoning is the most common method for females (39.1%).

While firearms are the most common method used in successful suicides, there are 25 attempts for every successful suicide. In Kentucky during 2006 there were 2,088 hospitalized attempts. Poisoning accounted for 1,956 of these admissions. The average cost was 48.146 per case. From 1999-2006, 531 residents died by suicide each year. The cost to the system was \$3,671 per case.

Violence, crime, and suicide are unfortunate attributes of today's society. These problems are of interest to physicians who should seek to evaluate and help solve the multiple contributing factors. However, to attribute these significant problems to guns is an incomplete and uninformed oversimplification.

Like automobiles, guns are inanimate objects, incapable of casualty. However, when used in an inappropriate or irresponsible manner, they are both dangerous and deadly.

**Harry W. Carloss, MD, MACP**  
*Paducah, KY*

1. Screening for Breast Cancer: US Preventive Services Task Force Recommendation Statement. *Ann Intern Med.* 2009;151:716-726.

### ***Responsible Opioid Prescribing: A Physician's Guide***

Scott M. Fishman, MD  
Waterford Life Sciences  
Washington, DC  
202.299.0600  
CME activity 2009 University of Wisconsin  
Board of Regents  
\$12.95  
Copies: [www.fsmb.org](http://www.fsmb.org)

Published as both a stand-alone book and a continuing medical education activity, this work lives well in each house. With the pervasive problem of substance abuse, in the public and in the medical world, physicians are impacted and compelled to be learned and vigilant about the use and abuse of these medications.

Enlisting a comfortable writing style and packing 137 highly legible pages with facts, suggestions, and guidelines, the author bridges the gap between acquisition of knowledge and governmental regulation. Chapters include patient evaluation, risk assessment, treatment planning with referral options, structuring contracts and consents, documentation standards with periodic review, and law compliance. Some bullets are used for emphasis, but for the most part, this is just to be read as a reference book.

A handy appendix dramatically entitled "Resources for Pharmacovigilance and Pain Management" is loaded with very on-point places to go, despite bearing quite a neologism. Another recalls the "Federation of State Medical Boards Model Policy for the Use of Controlled Substances for the Treatment of Pain." Very handy as a reference and a must read for those using pain-controlling medication, this paperback rewards the owner with nuts-and-bolts medicine and continuing medical education credit.

### ***Outrunning My Shadow: Surviving Open-Heart Surgery & Battling Obesity The Decision to Change My Life***

Keith Ahrens  
Nihao Press  
[www.NihaoPress.com](http://www.NihaoPress.com)  
2009  
ISBN: 978-0-9824490-0-5  
Copies: [www.outrunningmyshadow.com](http://www.outrunningmyshadow.com)

Winnowing at least 195 pounds from his 414-pound body, without weight loss surgery, Mr Ahrens proudly pens a self-help partial autobiography, chronicling his journey from obesity to an athletic frame. Throughout this small paperback are stories, pictures, photocopies, tables, charts, and many different fonts, bringing the reader a diverse, and certainly not typical, book. His purpose is to lead by example, with the written and spoken word, making this information, and I am certain many additional anecdotes, available for public speeches.

Even without a personal audience or being in training, a reader gets some first-hand knowledge of what it takes and what is possible with will. Such encouragement can be used in tandem with other weight-losing and health-promoting programs. Even surgical post-ops can find some suggestions germane to their changing bodies, with the hope of converting to a better health gestalt. An up book, and an easy and breezy read, this contribution to the medical literature is worth a look.

**Stephen Z. Smith, MD**  
*Editor, Journal of the  
Kentucky Medical Association*

## Life Members

*The Kentucky Medical Association would like to recognize physicians who have recently become Life Members of the Association.*

### BOYD

**Gary L. Barker, MD**  
Ashland KY

### CALLOWAY

**R. Gary Marquardt, MD**  
Murray KY

### CAMPBELL

**Hooshang Silanee, MD**  
Highland Heights KY

### DAVISS

**Charles H. McKelvey, MD**  
Owensboro KY

### FAYETTE

**James C. King, MD**  
Lexington KY

**William D. Weitzel, MD**  
Lexington KY

### HARDIN

**William C. DeVries, MD**  
Rockville MD

### JEFFERSON

**S. Pearson Auerbach, MD**  
Louisville KY

**Norbert J. Burzynski, DMD**  
Louisville KY

**Charles L. Dannaher, MD**  
Louisville KY

**W.B. Owen Edelen, MD**  
Louisville KY

**Maria E. Manion, MD**  
Prospect KY

**B. Preston Thomas, MD**  
Louisville KY

**George H. Zenger, MD**  
Louisville KY

### KENTON

**Howard A. Heringer, MD**  
Lakeside Park KY

### MCCRACKEN

**John W. Kraus, MD**  
Paducah KY

### PULASKI

**William O. Massey, MD**  
Burnside KY

## New Members

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

### BOYD

**Mary E. Edgecomb, DO** **HC**  
Ashland  
1998, Lake Erie Coll of Osteopathic Med

### BOYLE

**Neil S. Weintraub, MD** **VGS**  
Danville  
1979, U of Chicago

### CLAY

**Craig H. Leicht, MD** **APM**  
Manchester  
1982, Loma Linda U

### DAVISS

**Andrea P. Johnston, MD** **PD**  
Owensboro  
2005, U of Louisville

### FAYETTE

**B. Mark Evers, MD** **S**  
Lexington  
1983, U of Tennessee

### FLOYD

**Phillip Parker Crace, M** **S**  
Prestonsburg  
2003, U of Kentucky

# PEOPLE

## HARDIN

**Benjamin L. Proctor, MD**

Elizabethtown  
2004, U of Kentucky

**Gregory C. Schmieder, MD**

Louisville  
2001, Southern Illinois U

**Todd S. Shanks, MD**

Louisville  
2002, U of Louisville

**Charles B Stevenson, MD**

Louisville  
2001, Vanderbilt U

**Elizabeth M. Trengove, MD**

Jeffersonville

## JEFFERSON

**Rachel J. Chase, MD**

Louisville  
2003, U of Kentucky

**Jennifer Lash Crisp, MD**

Louisville  
2002, U of Louisville

**Erich Ernspeker, MD**

Shelbyville  
2003, U of Louisville

**Hazel L. Joseph, MD**

Marion  
1995, U of Louisville

**Arash R. Kalebasty, MD**

Louisville  
1998, Faculty of Med  
Shahid Beheshti U, Teheran

**Aasim S. Kazmi, MD**

Louisville  
2003, U of Dominica, Ross U

**Hui Bae H. Lee, MD**

Louisville  
2003, U of Tennessee

**Jarrold A. Little, MD**

Prospect  
2002, U of Texas  
Med Sch at Houston

**Meredith B. Loveless, MD**

Louisville  
2000, U of South Alabama

**Michael Milam, MD**

Louisville

**Geoffrey Mills, MD, DMD**

Louisville  
2003

**Matthew D. Morris, MD**

Prospect  
2006, U of Louisville

**Alan P. Northington, MD**

Louisville  
2003, U of Louisville

**Sarah E. Parsons, DO**

Louisville  
2004, Pikeville Coll  
Sch of Osteopathic Med

**Guilherme Rabinowits, MD**

Louisville  
2000, Fundacao Faculdade Federal  
de Ciencias Med de Porto Alegre

**David H. Rosenbaum, MD**

Jeffersonville  
2003, U of Louisville

**Logan E. Turner, MD**

Louisville  
2005, U of Louisville

## KENTON

**Michael Dusing, MD**

Edgewood  
2003, U of Louisville

## PERRY

Joe Eagle Kingery, DO  
Hazard

2006, Pikeville Coll  
Sch of Osteopathic Med

## PULASKI

Robert A. Phillips, MD  
Somerset

1981, U of Alabama

## ROCKCASTLE

**David S. Bullock, MD**

Mt Vernon  
2004, U of Kentucky

## IN TRAINING

## FAYETTE

**Swapna Allamreddy, MBBS**

**Eric Ashford, MD**

**Abdo Bachoura, MD**

**Matthew Bruce Bailey, MD**

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# PEOPLE

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|---------------------------|-----|-------------------------|------|
| Matthew L. Baker, MD      | AN  | Darren J. Monroe, MD    | PTH  |
| Wendy Ballenger, DO       | PD  | Heather Murphy, MD      | OBG  |
| Brock Alan Barnes, MD     | FM  | Lydia Mustafic, MD      | FM   |
| Katayoun Behbahani, MD    | IM  | Philip Overall, MD      | EM   |
| Josh Bigham, DO           | AN  | Joseph Wilson Owen, MD  | R    |
| John Birgiolas, MD        | AN  | Mary H. Patrick, MD     | P    |
| Shrinivas Bishu, MD       | IM  | Duan R. Perry, DO       | PMR  |
| Caralee Blair, DO         | PD  | L. Pleasant-Gintin, MD  | PD   |
| Alexandra Boske, MD       | N   | Megan Becker Powell, MD | IM   |
| Ashley Bowen, MD          | PD  | Protima Rayapati, MBBS  | PTH  |
| John R. Brandenburg, DO   | IM  | Tandy Sutton Repass, MD | D    |
| Katherine E. Campbell, MD | S   | Michael T. Reymann, MD  | ID   |
| Sree V. Chamarthi, MBBS   | FM  | Annette Reynolds, MD    | P    |
| Yu Hsin (Amy) Cheng, MD   | IM  | Kimberly Robinson, MD   | PD   |
| Kimberly Collins, MD      | FM  | Edgar R. Salas, MD      | IM   |
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| Amanda L. Dempsey, MD     | ORS | Nastaran Sharifian, MD  | IM   |
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| William F. Dotson, MD     | N   | Kara Lynn Stebbins, MD  | P    |
| Erin D. Drenkhahn, MD     | FM  | Gregoy E. Stewart, MD   | U    |
| Jennifer Dudek, MD        | IM  | Ashley R. Stoker, MD    | EM   |
| Kris L Durbin, MD         | AN  | Kent Taylor, MD         | IM   |
| Danielle Foster, DO       | PD  | Kyle Thompson, MD       | OPH  |
| Katherine Freedman, MD    | IM  | Henry F. Todd, MD       | S    |
| Gaby Gabriel, MD          | S   | Jennifer Fay True, MD   | R    |
| Garfield Grandison, MBBS  | GE  | Trent Tucker, DDS       | OMS  |
| Martha Grace Green, MD    | OPH | John Bradley Turner, MD | PS   |
| Luke Grupke, MD           | NS  | Priya Veeraraghavan, MD | IM   |
| Sateesh Gupthapu, MBBS    | S   | John C. Watson, MD      | IM   |
| Marshall Hall, MD         | EM  | Rachel Waxman, MD       | PD   |
| Joshua L. Hare, DO        | AN  | Christopher Waynick, MD | EM   |
| Elizabeth Hay, MD         | P   | Kimberly P. Wells, MD   | EM   |
| Rudy J. Judhan, MBBS      | S   | William A. Wilson, MD   | RO   |
| Theodore L. Katner, MD    | N   | Cole Wootton, MD        | U    |
| Firas Kawtharani, MD      | S   |                         |      |
| John R. Kotter, MD        | IM  | <b>JEFFERSON</b>        |      |
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| Kristen Lady, MD          | OBG | Shawn Gao, MD           | IM   |
| Wendy Latunik, MD         | FM  | Trevor W. Grubbs, MD    | EM   |
| Clark C. Lester, MD       | P   | Joseph L. Hudgens, MD   | OBG  |
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| Michael Paul Lynch, MD    | PS  | Jeremy Stapleton, DO    | GE   |
| Jonathan Mannas, MD       | NS  |                         |      |
| Jeremiah Martin, MB Bch   | C   | <b>PERRY</b>            |      |
| Ruth Masciarelli, MD      | AN  | Bhoodev P. Sharma, MD   | FM   |
| Heather S. McKee, MD      | N   |                         |      |
| John T. Meehan, MD        | PD  |                         |      |
| Rabab Mohsin, MD          | IM  |                         |      |

Obituaries

Harold W. Bradshaw, MD
Louisville, KY
1922 - 2009

Harold Bradshaw, MD, a retired general surgeon, died September 17, 2009. A 1950 graduate of the University of Louisville School of Medicine, Dr Bradshaw was a life member of the KMA.

Richard R. Crutcher, MD
Linville, NC
1912 - 2009

Richard R. Crutcher, MD, a retired general surgeon, died November 14, 2009. Dr Crutcher graduated from the Vanderbilt University School of Medicine in 1937 and was a life member of the KMA.

Kenneth P. Haywood, MD
Georgetown, KY
1923 - 2009

Kenneth P. Haywood, MD, a retired family physician, died October 28, 2009. A 1956 graduate of the University of Louisville School of Medicine, Dr Haywood was a life member of the KMA.

James K. Horton, MD
Louisville, KY
1949 - 2009

James K. Horton, MD, a family physician, died October 7, 2009. Dr Horton graduated from Howard University College of Medicine in 1976 and was a life member of the KMA.

Roy J. Moser, MD
Edgewood, KY
1924 - 2009

Roy J. Moser, MD, a retired internist, died October 11, 2009. A 1954 graduate of Loyola University, Stritch School of Medicine, Dr Moser was a life member of the KMA.

Claude W. Trapp, MD
Lexington, KY
1922 - 2009

Claude W. Trapp, MD, a retired ophthalmologist, died December 13, 2009. Dr Trapp graduated from Indiana University School of Medicine in 1950 and was a life member of the KMA.

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