Bill as Introduced

SB 424- AS INTRODUCED

2000 SESSION

00-2681
01/09

SENATE BILL ***424***

AN ACT relative to controlled substances used for terminally ill persons.

SPONSORS: Sen. Wheeler, Dist 21; Rep. Wendelboe, Belk 2

COMMITTEE: Public Institutions, Health and Human Services

ANALYSIS

This bill clarifies the professional use of controlled substances for pain management for terminally ill persons.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears ~~[in brackets and struckthrough.]~~
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

SB 424- AS INTRODUCED

00-2681
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand

AN ACT relative to controlled substances used for terminally ill persons.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Statement of Purpose. The state of New Hampshire recognizes that principles of quality medical practice dictate that the people of the state of New Hampshire have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as to reduce the morbidity, and costs associated with untreated or inappropriately treated pain. The state of New Hampshire encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic. It is especially important for patients who experience pain as a result of terminal illness.

2 New Paragraph; Professional Use of Controlled Substances. Amend RSA 318-B:10 by inserting after paragraph VI the following new paragraph:

VI-a. In addition to the provisions of paragraph VI and notwithstanding any other law or rule to the contrary, if, in the judgment of a physician licensed under RSA 329, appropriate pain management warrants a high dosage of controlled dangerous drugs and the benefit of the relief expected outweighs the risk of the high dosage, the licensed physician may administer such a dosage, even if its use may increase the risk of death, so long as it is not also furnished for the purpose of causing, or the purpose of assisting in causing, death for any reason and so long as it falls within rules of the board of medicine.

3 New Paragraph; Rulemaking Added. Amend RSA 329:9 by inserting after paragraph XV the following new paragraph:

XV-a. Procedures for appropriate pain management pursuant to RSA 318-B:10, VI-a.

4 Effective Date. This act shall take effect 60 days after its passage.

Amendments

Public Institutions, Health and Human Services
February 23, 2000
2000-3581s
01/10

Amendment to SB 424

Amend the title of the bill by replacing it with the following:

AN ACT relative to controlled substances used for pain management.

Amend the bill by replacing section 2 with the following:

2 New Paragraph; Professional Use of Controlled Substances. Amend RSA 318-B:10 by inserting after paragraph VI the following new paragraph:

VI-a. In addition to the provisions of paragraph VI and notwithstanding any other law or rule to the contrary, if, in the judgment of a physician licensed under RSA 329, appropriate pain management warrants a high dosage of controlled drugs and the benefit of the relief expected outweighs the risk of the high dosage, the licensed physician may administer or cause to be administered such a dosage, even if its use may increase the risk of death, so long as it is not furnished for the purpose of causing, or the purpose of assisting in causing, death for any reason and so long as it falls within rules of the board of medicine.

2000-3581s

AMENDED ANALYSIS

This bill clarifies the professional use of controlled substances for pain management.

Committee Minutes

Date: February 22, 2000
Time: 1:00 PM
Room: LOB 102

The Senate Committee on Public Institutions/Health Human Services held a hearing on the following:

SB 424 relative to controlled substances used for terminally ill persons.

Members of Committee present:
Senator Squires
Senator Wheeler
Senator Fernald
Senator Gordon
Senator McCarley
Senator Pignatelli

The Chair, Senator James Squires, opened the hearing.

Senator Katherine W. Wheeler, D. 21: Thank you very much Mr. Chair and members of the Committee. I am Senator Katie Wheeler representing Senate District 21 and I'm proud to be a sponsor of Senate Bill 424 about controlled substances. I do have an amendment though it's not here now. It's a small amendment. It doesn't change the bill substantively but it does remove the terminally ill definition from the title. It makes just a few suggestions that were brought to my attention by one of the doctors who deals with pain treatment and pain medication. We don't want to do anything to stop treatments that are being given right now. So we don't want the wording of the legislation to inhibit what's already being done that's good. What we want to do, with this piece of legislation, is to educate both patients and the caregivers about the importance of pain alleviation in care, that it is a significant part of medicine that we need to be addressing.

You will notice in the statement of purpose, on line 6 and 7, that it says *"the state of New Hampshire encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic."* I think this is long been a goal of people practicing medicine in New Hampshire to expand their knowledge of pain medicine, to use it effectively and we want to make sure that this encouragement

continues and that we are addressing the issue in a way that clarifies the existing statutes with regard to responsibility for the use of pain medication.

I know that we are all aware that the end of life care is getting increasing importance in our discussions and this is one part of end of life care. I heard a really sad piece on public radio, it's not the sort of thing we want to think even in terminally ill children and the importance of having appropriate pain medication in those circumstances also.

So, I think this is a very important bill and a dear friend of mine died of colon cancer in November. The first question after I expressed my sympathy to her husband when he called me was what about pain? She had had good pain medication, didn't totally help but it was good. I think this is on all of our minds so we hope that this piece of legislation will continue the progress that has already been made in making us all realize the importance of pain management.

Thank you and the amendment will be over shortly but I think we can still testify to the bill before the amendment comes because it's not a substantive change.

Senator Caroline McCarley, D. 6: Senator Wheeler, I understand though that the amendment does take out the last sentence on line 8? Did I misunderstand?

Senator Katherine W. Wheeler, D. 21: No. I don't think it takes that out. I can't remember what the amendment does except that it changes the title so that we're not limiting it to controlled substances for terminally ill.

Senator Caroline McCarley, D. 6: Alright.

Senator James W. Squires, D. 12: Any other questions?

Senator Katherine W. Wheeler, D. 21: I can give you the amendment now. **See Attachment A.** There's extra copies for people. The title is changed so it says *"relative to controlled substances used for pain management,"* and Section 2 is replaced but it doesn't change the statement of purpose at all.

Senator Debora B. Pignatelli, D. 13: So this relates more than to people who are terminally ill? This relates to people who are chronically in pain or acutely in pain as a result of something, a procedure in a hospital or an accident outside a hospital?

Senator Katherine W. Wheeler, D. 21: Yes. We already have pain management for people who are more than chronically ill. We don't want to alter that.

Senator James W. Squires, D. 12: Representative Wendelboe.

Representative Francine Wendelboe, Belk. D. 2: Thank you Mr. Chairman. Good afternoon. I know a lot of people looked at this bill and when they saw Representative Wendelboe and Senator Wheeler on it, they thought it should be interesting. (laughter)

I think, after having heard the debate over the assisted suicide bill, I think it became pretty apparent to many people who are very concerned about their terminally ill not having appropriate pain management and that's why I think this piece of legislation is very important.

Let me give a personal example, my mother passed away three years ago terminally ill with congestive heart failure. When she got to her final days we made a decision as a family that we wanted her comfortable and we had a physician that was not afraid to give her appropriate pain management. However, if one of us after the fact had changed our mind, after the death had occurred, starting thinking "well gee. I wonder if mom could have turned around." It leaves physicians hanging and concerned that doing appropriate pain management could bring litigation. The biggest thing that struck me after my mother's death was the nurse came in and asked me if we wanted an autopsy done. I would never have dreamed that in a case of somebody being terminally ill, very obviously death and the reasons for it that they would even think of doing an autopsy. But if one of the family members had said yes and if by chance as part of that it came back that perhaps the actual cause of death was suppressed breathing because of an over dosage, all it would take would be one of them to say "wow. Here's a potential lawsuit." I think it's very appropriate that physicians not have that concern if in the best interest of the management of pain of the patient that they don't have lawsuits worrying them when they are sincerely managing pain.

I'd be more than happy to answer any questions.

Senator James W. Squires, D. 12: Any questions? Senator Wheeler.

Senator Katherine W. Wheeler, D. 21: Thank you. Representative Wendelboe, just for the purposes of clarification since you hadn't had a chance to see the amendment and I had forgotten what it said. If you would just tell everybody that it does as I said. It takes terminally ill out of the title and says *"relative to controlled substances used for pain management"* and

the only other thing it does, if you'll look at line 13 of the bill and line 10 of the amendment, it removes the word *dangerous*. So it says "*controlled drug*". Dangerous was an odd thing to put in there anyway.

Representative Wendelboe: I have no problems with the amendment, Senator Wheeler. Thank you.

Senator Katherine W. Wheeler, D. 21: Thank you.

Senator James W. Squires, D. 12: Thank you. Attorney General McLaughlin.

Philip McLaughlin, Attorney General: Thank you Senator Squires. My name is Philip McLaughlin. I'm the Attorney General of the State. I've discussed this bill with several people who are in the room and I have a few comments which I would like to make that I hope are relevant and they begin as follows:

I don't think anybody would be in anyway surprised if I were to come before a Senate or House Committee and speak about issues of drug enforcement. The public policy of the state of New Hampshire is that we vigorously enforce our drug laws and that is expected of me. At the same time I think everyone who was involved in the process of vigorous drug enforcement recognizes that public education and treatment are also two other parts of the triad of how we deal with drugs. I suspect it was a perception that I was responsible for drug enforcement that caused a couple of doctors to speak with me about the issue of pain management which, of course, involves the administration of drugs for the purpose of addressing frequently end of life issues pain management.

I heard the Senator and Representative allude to personal experiences and personal experiences in dealing with the death of family or friends or patients is something that when you get to be our age, we all experience and I think in the back of our minds we always ask ourselves the question of who will be there for us when our time comes to deal with these issues tomorrow or next year or in ten years.

It was the comments of these couple of doctors that caused me to recognize that sometimes public perceptions matter. Another way of expressing the concept of public perception is to speak of it in terms of public policy. My perception is that **ALL** doctors conscientiously treatment to their patient's needs. My perception would be that **ALL** would treat to the needs of their terminally ill or desperately ill patients who are suffering pain. And yet despite the fact that was my dominant and is dominant perception, still and nonetheless, I was engaged in these conversations about what some docs

considered to be concerns that existed, whether I thought they were rational or not, within the medical community that could bear upon the discretion exercised by doctors in their pain management. I do not have **ANY** significant insight into the universe of doctors. I do not casually talk with any large number of doctors. I do not know what their thoughts are. I do not know about their conversations as they balance their obligations to their patients with whatever society concerns they may have about the policy of the community of which in a different context was very much opposed to any kind of abuse of drugs whatsoever.

And thus when this bill became fashioned as it did, and when it focuses and makes a clear statement of public policy I think that it is a bill that deserves support. There are some who I think feel that the bill is surplusage, that it speaks to ways and cultures that doctors already embody. But I don't it's surplusage. I think that a statement of public policy which recognizes the particular plight of the gravely or terminally ill who are experiencing pain and which publicly proclaims the policy of the citizens of this State to encourage their medical community to treat directly and ambiguously with that issue is a very, very, very good thing and it does not pose any kind of threat whatsoever, from my enforcement perspective, to the Attorney General's Office or to law enforcement of the state of New Hampshire.

That is the message I wish to give. I think it is an uplifting message of public policy and would be welcomed to the community as a whole and is the very best kind of statement that we, the living, make essentially to those who are in the process of departing, hopefully, as painlessly as possible. I thank you for the time. If there are questions I'd gladly answer them.

Senator James W. Squires, D. 12: Any questions? Thank you. Charlotte Chamberlain.

Charlotte Chamberlain: I do not wish to speak.

Senator James W. Squires, D. 12: I'm sorry Charlotte. Rebecca Nyer.

Rebecca Nyer: Thank you. I've been before many of you several times before and I'm here because I had hoped that Senate Bill 44 would have passed but perhaps the first part of long journey is the first step. I, at 31, was diagnosed with breast cancer and underwent a mastectomy and a year of treatment. One year after that I was diagnosed with acute myeloid leukemia which was caused by that chemotherapy. I was in the hospital in Boston six months undergoing treatment. During which time I was so gravely ill I almost died and prior to that second illness I wouldn't have considered the end of life experience because the breast cancer I knew from the beginning I'd beat it

but with the leukemia where I nearly died, that was no longer the case and previously having testified in hopes that you'd pass the other bills, my primary concern was is that I didn't want my children to see me in my final days as I've seen many of my friends pass away in excruciating pain. We're not talking older people because I'm not old. So it's not an issue of the aging or the disabled. It's a personal choice. My physician, I believe in the heart he'd help me but this bill would enable him to do that without fear of prosecution or lawsuits where he may give me the dosage that would require to kill the pain and if that stopped my breathing or stopped my heart, so be it. I believe, they argue that this should be between a doctor and his patient but it hasn't been and it won't be until a bill like this is passed that will enable a patient to come to an agreement as far as their care and what they expect without fear of repercussions once you're gone. That's why - the legality of that I don't know – how it would work or anything but I do know that it's time has come and if it doesn't pass this time I'll be back again. I'll keep coming back until people realize that this is an issue that is not going to go away. I would only hope that something like this wold pass so that if I were to become ill again, that my care would be my choice and not anybody else's. Thank you for your time.

Senator James W. Squires, D. 12: Thank you. John Dalco.

Dr. John Dalco, NH Medical Society: Written testimony handed in. **See Attachment B.**

Senator Debora B. Pignatelli, D. 13: I'm certainly going to support this bill but I have a question regarding people who are not terminally ill. I had the privilege of taking care of my sister last month when she had surgery, not in New Hampshire, but I'm just wondering why patient's need to beg for medication when they're in pain or either she had to beg for her medication or she had to ask me to go out to the nurse's station and beg for more pain medication. Although she wasn't terminally ill and you probably can't comment specifically but I understand that this happens a lot.

Dr. Dalco: Like I say, I work in Pain Management for Blue Cross Blue Shield in Massachusetts. What we see are two things: the fear of regulation on the part of the physicians so they back off and the lack of knowledge about the use of narcotics adequately. The narcotics are not given in an adequate doses, they're not given at set intervals, they're given by PRN. You have to start begging for the pain medication about an hour before you're going to get it so you begin to learn to manipulate the system by starting to cry for your pain medication anticipating that in an hour you're going to need it and it's going to take that long for you to get it.

Senator Debora B. Pignatelli, D. 13: And it takes you a few days to learn that.

Dr. Dalco: There are rare situations. Not everybody requires and probably the majority of people who require some sort of chronic pain management are not going to terminally ill. These are the patients with AIDS, sickle-cell disease, rheumatoid arthritis. There's a whole list of chronic pain conditions where you're not going to die in six months. What we're looking for is to improve your function and your quality of life, if you will, and this can be done.

Senator Debora B. Pignatelli, D. 13: Thank you.

Senator James W. Squires, D. 12: Thank you. Dr. Charlesworth.

Dr. Charlesworth, NH Medical Society: Mr. Chairman, members of the Committee. My name is David Charlesworth. I'm a cardiac surgeon at Catholic Medical Center (CMC) in Manchester, New Hampshire and I will speak briefly to the question of Senator Pignatelli just asked with regard to pain management. I'm sure you're aware there are more modern ways of managing pain and one of those is called PCA, or patient control analgesia. We use it in all our cardiac surgery patients so that when the patient is awake and alert to be aware of his or her own pain, the patient can push a button and deliver the amount of pain medication that he or she sees fit. That's how to alleviate pain. We think that that's very effective and modern appropriate way so the patient determines how much medication he or she needs at the time of pain and not the other way around. I think there are lots of ways to effectively treat pain. I think we're getting better at it. I think we have a lot to learn and we're definitely trying to make the patient part of the process. That's all the testimony I wish to make.

Senator James W. Squires, D. 12: Any questions? Thank you. Dr. Tuttle.

Dr. Georgia Tuttle, NH Medical Society: My name is Dr. Georgia Tuttle and I'm the immediate past-President of the NH Medical Society and testifying on behalf of the Society. I would be in support of this amendment. I think as Dr. Charlesworth said we've gotten better at learning to management pain. The American Medical Association has started a program nationally called EPEC and that stands for Educating Physicians on the End of life Care. It is a team approach to pain management which involves nurses, funeral directors, clergy, attorneys and physicians and families in helping to help those at the end of life figure out the best ways to manage the end of their life in a positive way.

I think this amendment would go a long way to helping physicians who train through that EPEC program to achieve the goals for pain management at the end of life so that the quality can be maintained right to the end. So I would be in support of this amendment. Thank you.

Senator James W. Squires, D. 12: Any questions? Thank you. Monica Haley.

Monica Haley, Northeast Pain Consultants: Good afternoon. My name is Monica Haley. I'm an RN and I work with Northeast Pain Consultants in Somersworth and Merrimack. The physicians and health care providers of Northeast Pain Consultants are thoroughly delighted to see legislation come around which will support adequate pain management for the citizens of this state. We urge you to support and if there is any questions or anything I can do to help in you in your quest for knowledge with this, we would be more than delighted to help you. We do deal with acute, chronic and cancer pain patients.

Senator Pignatelli, I feel very badly for your sister. There are studies that are out there from 1975 done by Margot McCaffrey who is the Nursing Guru of pain management in this Country who show how the nurse's knowledge and attitudes about pain management from 1975 to essentially 1995 have been unchanged and perhaps this is the interest that we need to increase our own health care professional's knowledge about what can be done for these patients. Thank you. (turn over tape)

Senator James W. Squires, D. 12: Any questions? Thank you. Palmer Jones.

Palmer Jones, NH Medical Society: My name is Palmer Jones and I'm with the NH Medical Society and we are glad to be here today. This has been a long time coming. I've been working here in New Hampshire for the last 12 years and we have not, in any way, adequately addressed the issue of pain and the end of life care. The hope today is this is part of one of many things that we are doing to try help solve this particular problem.

As you heard earlier from the Attorney General he had an experience with a number of physicians regarding how they felt about how they would be treated should they exceed what they think was an appropriate dosage. His explanation to us was very, very helpful when we sat with him he went through this experience and it's not uncommon to what a lot of people go through. Physicians are terrified of this issue and are very suspect and they take their time. They just don't over prescribe these kinds of pain medications.

We went forward with our pain management group and we looked at a number of state laws that would be something that would fit nicely in New Hampshire. The first on we looked at came from the state of Michigan and that had more of an emphasis on terminally ill as opposed to really taking care of people who have chronic pain in any stage of their particular life. So then we researched it and we found that this particular piece of legislation came from Oklahoma where they were having good success and the physicians in this state were starting to respond in a positive way to the pain management. So, we took the model from Oklahoma, we ran that through our pain management committee which is about nine people, a good mix of doctors, nurses, people from the Board of Pharmacy, so that we could feel comfortable. As we did we made these minor adjustments that Senator Wheeler had talked about and we eliminated the word *dangerous*. We also made a reference to that the licensed physician may administer or cause to be administered because in many cases he writes the order and we wanted to protect those people who may give that particular injections. We wanted to make sure that they were covered properly. So a physician will write the order and we feel that that's the proper way to go about that.

Dr. Tuttle talked to you about EPEC. EPEC is a project which we looked at nationwide. I think we've finally come to terms that the medical schools of today are starting to understand that maybe we didn't do as good a job in the areas of what we've done in the past about pain management. And so little by little, organized medicine through the AMA has really (cough). One of the quick steps was to create this EPEC program. Dr. Tuttle has the program. It's about that thick. It's like reading the telephone and yellow pages of the Manhattan phone directory and we're very glad she didn't bring that up. (laughter) But what it did is looked at this issue in nine different ways and what we're doing right now is that there are eight physicians in the state of New Hampshire who went away to have this training in EPEC. They are now back in New Hampshire and they are working with the continuing medical education programs throughout the State at the hospitals trying to get those modules and explain these issues. We won't solve that problem in one year or two years but it's an ongoing educational program that we will continue to work with so that the people will understand and hopefully next year we'll be able to send eight or more physicians to this educational program being put on by the AMA. But again, it's a program that will be ongoing. The EPEC program will be delivered to as many practicing physicians as we can in New Hampshire through the continuing medical education programs that are offered at the hospitals. Our goal is to try to educate as quickly as we can but this piece of legislation will allow physicians to feel a lot more comfortable about the issue when they get into pain and pain management.

I don't know if I can add anything else but we were very delighted to have the Attorney General work with us on this project and I know that Dr. Squires talked with me for a while about that particular issue and we had a good chance to have some give and take and better understand this issue. So, I think it's a good piece of legislation. We think you should support this and we hope you will pass it.

Senator James W. Squires, D. 12: Any questions? Would anyone else like to speak to this bill? If not, I will close the hearing on Senate Bill 424.

Hearing closed at 1:40 pm.

Respectfully submitted,

Merideth A. Chandler,
Committee Secretary

Attachment A

Sen. Wheeler, Dist. 21
February 16, 2000
2000-3512s
01/09

Amendment to SB 424

Amend the title of the bill by replacing it with the following:

AN ACT relative to controlled substances used for pain management.

Amend the bill by replacing section 2 with the following:

2. New Paragraph; Professional Use of Controlled Substances. Amend RSA 318-B:10 by inserting after paragraph VI the following new paragraph:

VI-a. In addition to the provisions of paragraph VI and notwithstanding any other law or rule to the contrary, if, in the judgment of a physician licensed under RSA 329, appropriate pain management warrants a high dosage of controlled drugs and the benefit of the relief expected outweighs the risk of the high dosage, the licensed physician may administer or cause to be administered such a dosage, even if its use may increase the risk of death, so long as it is not furnished for the purpose of causing, or the purpose of assisting in causing, death for any reason and so long as it falls within rules of the board of medicine.

2000-3512s

AMENDED ANALYSIS

This bill clarifies the professional use of controlled substances for pain management.

Attachment B

RECEIVED
MAR 2 1998
BOARD OF LICENSURE IN

February 24, 1998

THE FEDERATION OF
STATE MEDICAL BOARDS
OF THE UNITED STATES, INC.

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Dear Colleague:

Enclosed are pain management guidelines proposed by the Federation of State Medical Boards' Research and Education Foundation. Supported by a grant from the Robert Wood Johnson Foundation, these guidelines have been created to assist state medical boards and other health care regulatory agencies in promoting appropriate parameters for prescribing controlled substances in the management of chronic pain. As indicated in my invitation for you to attend the Federation's March 17, 1998 symposium, *Pain Management and State Regulatory Policy*, this document is for your review in order that the Federation may solicit your comments and opinions regarding accessible and adequate methods of pain management.

If you are unable to attend the symposium, I encourage you to submit a written commentary to the Federation by March 10 so that your contribution may be included for discussion at the meeting.

I look forward to your participation at the symposium or to receiving your written comments on this important topic.

Sincerely,

James R. Winn, M.D.

James R. Winn, MD
Executive Vice President

JRW/pcm

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THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.

PROPOSED MODEL GUIDELINES FOR THE USE OF CONTROLLED SUBSTANCES IN THE TREATMENT OF PAIN

Section I: Preamble

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

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

The Board recognizes that controlled substances, including opioid analgesics, are essential in the treatment of acute pain due to trauma, surgery, and chronic pain due to cancer and other progressive diseases. Physicians are referred to the US Agency for Health Care and Research Clinical Practice Guidelines for a sound approach to the management of acute[1] and cancer-related pain.[2]

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[1] Acute Pain Management Guideline Panel. Acute Pain Management: Operative or Medical Procedures and Trauma. Clinical Practice Guideline. AHCPR Publication No. 92-0032. Rockville, MD. Agency for Health Care Policy and Research. US Department of Health and Human Resources, Public Health Service. February 1992.

[2] Jacox A, Carr DB, Payne R, et al. Management of Cancer Pain. Clinical Practice Guideline No. 9. AHCPR Publication No. 94-0592. Rockville, MD. Agency for Health Care Policy and Research, US Department of Health and Human Resources, Public Health Service. March 1994.

The medical management of pain should be based upon current knowledge and research and includes the use of both pharmaceutical and non-pharmaceutical modalities. Pain should be assessed and treated promptly 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.

The (*state medical board*) is obligated under the laws of the State of (*name of state*) to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate and nonmedical uses.

Physicians should not fear disciplinary action from the Board or other state regulatory or enforcement agency for prescribing, dispensing, or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board will consider prescribing, ordering, administering, or dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain and in compliance of applicable state or federal law.

The Board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goal is to treat 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 guidelines are not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of professional practice.

Section II: Guidelines

The Board has adopted the following guidelines when evaluating the use of controlled substances for pain control:

1. Evaluation of the Patient

A complete medical history and physical examination must be conducted and documented in the medical record. The medical record should document the nature and intensity of the pain, evaluate underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record should also document the presence of one or more recognized medical indications for the use of a controlled substance.

2. Treatment Plan

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

3. Informed Consent and Agreement for Treatment

The physician should discuss the risks and benefits of the use of controlled substances with the patient, significant other(s) or guardian. The patient should receive prescriptions from one physician and one pharmacy where possible. 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 (1) urine/serum medication levels screening when requested (2) number and frequency of all prescription refills and (3) reasons for which drug therapy may be discontinued (i.e. violation of agreement).

4. Periodic Review

At reasonable intervals based upon the individual circumstance of the patient, the physician should review the course of opioid treatment and any new information about the etiology of the pain. Continuation or modification of opioid therapy should depend on the physician's evaluation of progress toward stated treatment objectives such as improvement in patient's pain intensity and improved physical and/or psychosocial function, such as ability to work, need of health care resources, activities of daily living, and quality of social life. If reasonable treatment goals are not being achieved, despite medication adjustments, the physician should re-evaluate the appropriateness of continued opioid treatment.. The physician should monitor patient compliance in medication usage and related treatment plans.

5. Consultation

The physician should be willing to refer the patient as necessary for additional evaluation and treatment 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 comorbid psychiatric disorder 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 (1) the medical history and physical examination (2) diagnostic, therapeutic and laboratory results (3) evaluations and consultations (4) treatment objectives (5) discussion of risks and benefits (6) treatments (7) medications (including date, type, dosage, and quantity prescribed) (8) instructions and agreements and (9) periodic reviews. Records should remain current and be maintained in an accessible manner and readily available for review.

7. Compliance with Controlled Substances Laws and Regulations

To prescribe controlled substances, the physician must be licensed in the state, have a valid controlled substances registration and comply with federal and state regulations for issuing controlled substances prescriptions. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and (*any relevant documents issued by the state medical board*) for specific rules governing issuance of controlled substances prescriptions as well as applicable state regulations.

Section III: Definitions

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

Acute pain: Acute pain is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time limited and is responsive to opioid therapy, among other therapies.

Addiction: Addiction is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

Chronic Pain: A pain state that is persistent and in which the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

Physical Dependence: Physical dependence is a physiologic state of neuroadaptation to an opioid which is characterized by the emergence of a withdrawal syndrome if the opioid use is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by re-administration of the opioid. Physical dependence

appears to be an inevitable result of opioid use. Physical dependence, by itself, does not equate with addiction.

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

Tolerance: Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose. Tolerance occurs to different degrees for various drug effects, including sedation, analgesia and constipation. Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Speakers

SENATE PI-HHS COMMITTEE

Date 2/22/00 Time 1:00 PM Public Hearing on SB 424

Appearing in FAVOR: (Please print) **Please check box at left to speak:**

Speaking?	Name	Address	Representing
☐	Charlotte Chamberlain	Hanersville, NH 96 Chesham Rd.	self
☑	Rebecca Rupe	Hillsboro	self
☑	John C. Dalsimo	NH State Council	NH Med Soc.
☑	Fran Wendelboe	Belknap Dist 2	
☑	Georgia Tuttle, MD	Lebanon N.H.	N.H Meds. Soc.
☑	DAVID C. Charleswath MD	Bedford, N.H.	N.H. Med. Soc
☑	Richard M Zeylikman	Just Dept	A.G.
☑	Monica Haley	255 Rt. 108 Somersworth, NH	Northeast Pain Consultants
☑	Sen Katie Wheeler		
☑	PALMER JONES		NH Med Soc.

Appearing in OPPOSITION: (Please Print) **Please check box at left to speak:**

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Committee Report

Date: February 22, 2000 Time: 1:00 pm

The Senate Committee on Public Institutions/Health Human Services held its hearing in Room 102, LOB, Concord, New Hampshire.

BILL NO.: SB 424 TITLE: relative to controlled substances used for terminally ill persons.

Members of the Committee present:

Senator Squires
Senator Wheeler
Senator Fernald
Senator Gordon
Senator McCarley
Senator Pignatelli

Those appearing in favor:

Name and Address	Representing
See Attached.	

Those appearing in opposition:

Name and Address	Representing
See Attached.	

REPORT OF THE COMMITTEE:

- ☐ Ought to Pass
- ☒ Ought to Pass w/ Amendment
- ☐ Inexpedient to Legislate
- ☐ Rereferred
- ☐ Interim Study
- ☐ Continued Hearing
- ☐ Postponed Hearing

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: February 23, 2000

THE COMMITTEE ON Public Institutions/Health Human Services

to which was referred Senate Bill 424

AN ACT relative to controlled substances used for terminally ill persons.

VOTE: 6-0

2000-3581s

Having considered the same, report the same with the following amendment and recommend that the bill: **AS AMENDED OUGHT TO PASS.**

Senator Katie Wheeler
For the Committee