

TITLE 22. EXAMINING BOARDS
PART 9. TEXAS MEDICAL BOARD
CHAPTER 170. PAIN MANAGEMENT

22 TAC § 170.1-170.3

§ 170.1. Purpose

The treatment of pain is a vital part of the practice of medicine. Patients look to physicians not only to cure disease, but also to try to relieve their pain. Physicians should be able to treat their patients' pain using sound clinical judgment without fear that the board will pursue disciplinary action. This Rule sets forth the board's policy for the proper treatment of pain. The board's intent is to protect the public and give guidance to physicians. The principles underlying this policy include:

(1) Pain is a medical condition that every physician sees regularly. It is an integral part of the practice of medicine. Patients deserve to have medical treatment for their pain, whether the pain is acute or chronic, mild or severe. The goal of pain management is to treat the patient's pain in relation to overall health, including physical function, psychological, social, and work-related factors.

(2) The regulatory atmosphere must support a physician's ability to treat pain, no matter how difficult the case, using whatever tools are most appropriate. Drugs, including opiates, are essential tools for the treatment of pain.

(3) The board is charged by the Legislature with the responsibility to assure that drugs are used in a therapeutic manner. A license to practice medicine gives a physician legal authority to prescribe drugs for pain. The physician has a duty to use that authority to help, and not to harm patients and the public.

(4) Harm can result when a physician does not use sound clinical judgment in using drug therapy. If the physician fails to apply sufficient drug therapy, the patient will likely suffer continued pain and may demonstrate relief-seeking behavior, known as pseudoaddiction. On the other hand, non-therapeutic drug therapy may lead to or contribute to abuse, addiction, and/or diversion of drugs. As with everything in the practice of medicine, physicians must be well informed of and carefully assess the risks and the benefits as they apply to each case.

(5) Physicians should not fear board action if they provide proper pain treatment. The board will not look solely at the quantity or duration of drug therapy. Proper pain treatment is not a matter of how much drug therapy is used, as long as that therapy is based on sound clinical judgment. Sound clinical judgment results from evidence-based medicine and/or the use of generally accepted standards.

(6) A physician can demonstrate sound clinical judgment by recording the physician's rationale for the treatment plan and maintaining medical records that are legible, complete, accurate and current for each patient.

(7) The extent of medical records should be reasonable for each case. A treatment plan for acute, episodic pain may note only the dosage and frequency of drugs prescribed and that no further treatment is planned.

(8) Treatment of chronic pain requires a reasonably detailed and documented plan to assure that the treatment is monitored. An explanation of the physician's rationale is especially required for cases in which treatment with scheduled drugs is difficult to relate to the patients objective physical, radiographic, or laboratory findings.

(9) The intent of these guidelines is not to impose regulatory burdens on the practice of medicine. Rather, these guidelines are intended to set forth those items expected to be done by any reasonable physician involved in the treatment of pain. The use of the word "shall" in these guidelines is used to identify those items a physician is required to perform in all such cases. The word "should" and the phrase "it is the responsibility of the physician" in these guidelines are used to identify those actions that a prudent physician will either do and document in the treatment of pain or be able to provide a thoughtful explanation as to why the physician did not do so.

§ 170.2. Definitions

In this Chapter:

(1) "Abuse" or "substance abuse"--the essential feature of substance abuse is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

(2) "Acute pain"--the normal, predicted, physiological response to a stimulus such as trauma, disease, and operative procedures. Acute pain is time limited.

(3) "Addiction"--a primary, chronic, neurobiological disease characterized by craving and compulsive use of drugs. Addiction is often characterized by impaired control over drug use, including taking more drugs more often than prescribed by a physician. It may also be characterized by continued use despite harm to oneself or others. Genetic, psychosocial, and environmental factors may influence the development and manifestation of addiction. Physical dependence and tolerance are normal physiological consequences of extended drug therapy for pain and, alone, do not indicate addiction.

(4) "Chronic pain"--a state in which pain persists beyond the usual course of an acute disease or healing of an injury. Chronic pain may be associated with a chronic pathological. process that causes continuous or intermittent pain over months or years.

(5) "Dangerous drugs"--medications defined by the Texas Dangerous Drug Act, Chapter 483, Texas Health and Safety Code. Dangerous drugs require a prescription, but are not included in the list of scheduled drugs. A dangerous drug bears the legend "Caution: federal law prohibits dispensing without a prescription" or "Prescription Only."

(6) "Diversion"--the use of drugs by anyone other than the person for whom the drug was prescribed.

(7) "Escalation"--increasing the dosage and/or frequency of the use of drugs.

(8) "Improper pain treatment"--includes over treatment, under treatment, no treatment, and the prescription of drugs for purposes other than the proper treatment of pain.

(9) "Non-therapeutic"--is defined in § 164.053(a)(5), *Texas Occupations Code* and includes improper pain treatment.

(10) "Pain"--An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

(11) "Physical dependence"--A state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, alone, does not indicate addiction.

(12) "Pseudoaddiction"--the iatrogenic syndrome resulting from the misinterpretation of relief seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief seeking behaviors resolve upon institution of effective analgesic therapy.

(13) "Scheduled drugs" (sometimes referred to as "Controlled Substances")--medications defined by the Texas Controlled Substances Act, Chapter 481, Texas Health and Safety Code. This Act establishes five categories, or schedules of drugs, based on risk of abuse and addiction. (Schedule I includes drugs that carry an extremely high risk of abuse and addiction and have no legitimate medical use. Schedule V includes drugs that have the lowest abuse/addiction risk).

(14) "Tolerance" (tachyphylaxis)--a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance does not necessarily occur during opioid treatment and does not, alone, indicate addiction.

(15) "Withdrawal"--the physiological and mental readjustment that accompanies discontinuation of a drug for which a person has established a physical dependence.

§ 170.3. Guidelines

(a) The Texas Medical Board will use these guidelines to assess a physician's treatment of pain.

(1) Evaluation of the patient.

(A) A physician is responsible for obtaining a medical history and a physical examination that includes a problem-focused exam specific to the chief presenting complaint of the patient.

(B) The medical record shall document the medical history and physical examination. In the case of chronic pain, the medical record should document:

- (i) the nature and intensity of the pain,
- (ii) current and past treatments for pain,
- (iii) underlying or coexisting diseases and conditions,
- (iv) the effect of the pain on physical and psychological function,
- (v) any history and potential for substance abuse, and
- (vi) the presence of one or more recognized medical indications for the use of a dangerous or scheduled drug.

(2) Treatment plan for chronic pain. The physician is responsible for a written treatment plan that is documented in the medical records. The medical record should include:

- (A) How the medication relates to the chief presenting complaint of chronic pain;
- (B) dosage and frequency of any drugs prescribed,
- (C) further testing and diagnostic evaluations to be ordered,
- (D) other treatments that are planned or considered,
- (E) periodic reviews planned, and

(F) objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function.

(3) Informed consent. It is the physician's responsibility to discuss the risks and benefits of the use of controlled substances for the treatment of chronic pain with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. This discussion should be documented by either a written signed document maintained in the records or a contemporaneous notation included in the medical records. Discussion of risks and benefits should include an explanation of the:

- (A) diagnosis;
- (B) treatment plan;
- (C) anticipated therapeutic results, including the realistic expectations for sustained pain relief and improved functioning and possibilities for lack of pain relief
- (D) therapies in addition to or instead of drug therapy, including physical therapy or psychological techniques;
- (E) potential side effects and how to manage them;
- (F) adverse effects, including the potential for dependence, addiction, tolerance, and withdrawal; and
- (G) potential for impairment of judgment and motor skills.

(4) Agreement for treatment of chronic pain. A proper patient-physician relationship for treatment of chronic pain requires the physician to establish and inform the patient of the physician's expectations that are necessary for patient compliance. If the treatment plan includes extended drug therapy, the physician should consider the use of a written pain management agreement between the physician and the patient outlining patient responsibilities, including the following provisions:

- (A) the physician may require laboratory tests for drug levels upon request;
 - (B) the physician may limit the number and frequency of prescription refills;
 - (C) only one physician will prescribe dangerous and scheduled drugs;
 - (D) only one pharmacy will be used for prescriptions, and
 - (E) reasons for which drug therapy may be discontinued (e.g. violation of agreement).
- (5) Periodic review of the treatment of chronic pain.

(A) The physician should see the patient for periodic review at reasonable intervals in view of the individual circumstances of the patient.

(B) Periodic review should assess progress toward reaching treatment objectives, taking into consideration the history of medication usage, as well as any new information about the etiology of the pain.

(C) Each periodic visit shall be documented in the medical records.

(D) Contemporaneous to the periodic reviews, the physician should note in the medical records any adjustment in the treatment plan based on the individual medical needs of the patient.

(E) A physician should continue or modify the use of dangerous and scheduled drugs for pain management based on an evaluation of progress toward treatment objectives.

(i) Progress or the lack of progress in relieving pain should be documented in the patient's record.

(ii) Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, and/or improved quality of life.

(iii) Objective evidence of improved or diminished function should be monitored. Information from family members or other caregivers should be considered in determining the patient's response to treatment.

(iv) If the patient's progress is unsatisfactory, the physician should reassess the current treatment plan and consider the use of other therapeutic modalities.

(6) Consultation and Referral. The physician should refer a patient with chronic pain for further evaluation and treatment as necessary. Patients who are at-risk for abuse or addiction require special attention. Patients with chronic pain and histories of substance abuse or with co-morbid psychiatric disorders require even more care. A consult with or referral to an expert in the management of such patients should be considered in their treatment.

(7) Medical records. The medical records shall document the physician's rationale for the treatment plan and the prescription of drugs for the chief complaint of chronic pain and show that the physician has followed these guidelines. Specifically the records should include:

(A) the medical history and the physical examination;

(B) diagnostic, therapeutic and laboratory results;

(C) evaluations and consultations;

(D) treatment objectives;

(E) discussion of risks and benefits;

(F) informed consent;

(G) treatments;

(H) medications (including date, type, dosage and quantity prescribed);

(I) instructions and agreements; and

(J) periodic reviews.

(b) It is not the board's policy to take disciplinary action against a physician solely for not adhering strictly to these guidelines if the physician's rationale for the treatment indicates sound clinical judgment documented in the medical records. Each case of prescribing for pain will be evaluated on an individual basis. The physician's conduct will be evaluated by considering:

(1) the treatment objectives, including any improvement in functioning,

(2) whether the drug used is pharmacologically recognized to be appropriate for the diagnosis as determined by a consensus of medical practitioners in the State or by recognized experts in the field for which the drug is being used,

(3) the patient's individual needs, and

(4) that some types of pain cannot be completely relieved.