Prescribing Perils including - drugs of dependence
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Background

- Most medical practitioners especially GPs prescribe medications during each consulting session
- A prescription is a legal document with the prescriber taking legal responsibility for its content
- You should have a clear clinical indication for prescribing irrespective whether another doctor has previously written a prescription for that medication

**Adverse events**

- Adverse events from prescribing can result in problems for the patient and the prescriber
- Problems for the prescriber can result in a visit to the coroner’s court, a disciplinary body (AHPRA) or civil proceedings

**Prescribing errors**

- Prescribing errors are common, most can be avoided by adhering to good system protocols
Complaints due to adverse events – that result from prescribing

- Drug side-effects
- Drug interactions
- Wrong person
- Wrong drug
- Wrong dose

Legal requirements

A brief overview
How do I know what is a Schedule 8 poison?

> Poisons Standard 2015

– Pursuant to Paragraph 52D(2)(b) of the Therapeutic Goods Act 1989 (Cth)

Requirements for Schedule 8 prescribing

> Each State and territory has separate legislation

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<td>Medicines, Poisons and Therapeutic Goods Act 2008</td>
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<td>New South Wales</td>
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<td>Western Australia</td>
<td>Poisons Regulations 1965</td>
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</table>
Requirements for Schedule 8 prescribing

> Victoria as an example…

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Requirements for Schedule 8 permit

> MUST apply for a permit
  
  – BEFORE prescribing to a drug-dependent person
  
  – BEFORE prescribing any of the following*:
     
     – Methadone; or
     – Dexamphetamine; or
     – Methylphenidate.
  
  – BEFORE prescribing for more than 8 weeks’ duration in other circumstances

*Must be an authorised prescriber
Exceptions to these requirements

> Exceptions:

– Treatment of cancer-related pain
– Treatment in a residential aged care facility

Consequences of not complying with legislation

>Liable to prosecution

– Uncommon unless
  – repeated breaches despite warnings
  – Unable to reasonably justify breaches
Writing prescriptions

The doctor writing the prescription assumes responsibility for the prescription and its compliance with legislation

Irrespective of whether

– another doctor at the practice primarily prescribes; or
– specialist has recommended the treatment

Prescribe only for the medical treatment of patients under your care (regulation 8)

Other requirements

Need to establish that a “genuine therapeutic need” exists

Beware of:

– new patients
– unconvincing stories
– drugs commonly targeted by drug-seekers
– patients asking for private scripts

Need to establish the identity of the patient
Notification of drug-dependent person

Section 33

- Doctor **must** notify Secretary of Department of Health
  - When a medical practitioner has “reason to believe” a person is drug-dependent and the person is seeking a drug of dependence

- NB. Privacy legislation does not consider this to be a breach of the patient’s privacy

Self-administration

Regulation 48

- Doctor **must** not use, prescribe, sell or supply a Schedule 4 poison, a Schedule 8 poison or a Schedule 9 poison (as the case requires) for the purpose of self-administration
Documentation

Section 32 Drugs, Poisons, Controlled Substances Act 1981 (Vic)

Record keeping in relation to sale or supply of drugs of addiction

(1) A person who is licensed under this Part to manufacture, sell, supply or distribute any Schedule 8 poison or Schedule 9 poison must record or cause to be recorded, in accordance with subsection (2)—

(a) details of any Schedule 8 poison or Schedule 9 poison obtained by the person; and

(b) quantities of those poisons used, sold, supplied or otherwise disposed of; and

(c) such other particulars as are prescribed.

60 penalty units

Documentation (cont)

Requirement to keep records of destruction:

> Regulation 40(1)(f) requires medical practitioner to record:
  – name, strength and quantity of Schedule 8 poison destroyed; and
  – place and method of destruction; and
  – the name of the person carrying out the destruction; and
  – names of any witnesses.
**Destruction of Schedule 8 poisons**

Wilful destruction of Schedule 8 poisons prohibited unless:

- Regulation 51(3) - destroyed in the presence of another registered health practitioner.
- Regulation 40(1)(f) – records retained

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**Coronial investigations**

Coroner is increasingly taking an interest in deaths associated with prescription of Schedule 8 medications:

- Did you contact the patient’s previous prescriber before prescribing [Schedule 8 medication] for this patient?
- Were you aware that this patient was engaged in prescription shopping for a range of benzodiazepines?
- Were you aware that this patient was receiving opioid replacement therapy at another clinic?
- Did you ever contact the Prescription Shopping Information Service or the Department of Health regarding this patient?
### Useful resources

> Each State and territory Department of Health has guidelines

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### 4 cases for discussion

Each group should select a person to present briefly the results of their discussions
Case 1 for discussion

Progressive renal failure

> A male patient aged 54 treated for insulin dependent diabetes
> Presents with severe pain in the distribution of the ophthalmic branch of the facial nerve
> He also complains of blurred vision
> Examination reveals the beginnings of a rash in this distribution consistent with herpes zoster
> Aciclovir 800mg x5 daily orally is prescribed for one week
> He next presents with progressive renal failure
Discussion

> What are the issues?

> What other information should have been elicited prior to prescribing Aciclovir?

> What are the lessons to be learnt?

> What could have been done differently?

Case 2 for discussion
**Case 2 – wrong patient, wrong drug**

Visit 1
> Female aged 32 presents complaining of tiredness
> Apart from heavy periods no relevant history
> Apart from pallor no physical signs
> FBE arranged

Visit 2
> Doctor notes lab result consistent with hypothyroidism
> Thyroxine prescribed

Visit 3.
> Patient still pale and tired but anxious and shaky
> Review of file reveals Visit 2 lab results belong to another patient

**Discussion**

> What are the issues?

> What other information should have been elicited prior to prescribing thyroxine?

> What are the lessons to be learnt?

> What could have been done differently?
Case 3 for discussion

Susan aged 38 – iatrogenic dependence

> Opioids were commenced after a soft tissue injury
> Opioids continued following conflict with her supervisor when she returned to work
> For months she received prescriptions for opioids and she also used OTC analgesics (codeine)
> Depression became a major problem
> Her prescriber went on leave and a locum attempted to place a ceiling on her daily dose
> Drug withdrawal/craving occurred when drug dosage was reduced
Discussion

> What are the issues?

> What other information should have been elicited prior to ongoing prescribing?

> What are the lessons to be learnt?

> What could have been done differently?

Case 4 for discussion
Mary – iatrogenic benzodiazepine dependence

Mary aged 38 is a single working mother of 3 children. She presents with anxiety symptoms including panic following the death of her mother who regularly assisted with child care.

- She is prescribed alprazolam (Xanax) – 0.5 mg bd
- Over the next few months the dose is increased to 6mg daily for her persistent symptoms.
- One day she asks for more or a different drug as she notes “they are not working”
- Last weekend she “ran out of tablets”, became anxious and began to hallucinate

Discussion

- What factors are relevant to this problem developing?
- Why is she hallucinating?
- How could the doctor have responded when “they are not working”?
- What could have been done differently?
Discussion of Cases

Background

> Opioid Medications
  – Prescriptions for opioid medications for chronic non malignant pain have increased worldwide since long acting formulations were made available
> Benzodiazepines
  – Short term use can result in symptom improvement
  – Long term use usually leads to clinical problems
> Antipsychotics
  – Prescription volume high. No reliable survey data
> Prescription drug toxicity
  – More deaths are caused by these drugs of dependence than by illicit drugs
Deaths from prescription drugs - Australia

Australia
• Oxycodone deaths rose threefold (2002-2007)

Victoria
• Oxycodone deaths rose 21 fold (2000-2009) – approx. half unintentional

338 deaths* due to drug toxicity in 2010

Deaths from prescription drugs - Australia

367* deaths in 2012

Prescription Drugs 77% deaths
Opioids 27%
Benzodiazepine 50%
Illicit drugs 44%

*In many deaths more than one drug was involved
How big is the benzodiazepine problem?

> Australia
  – Prescriptions for alprazolam increased by 28% (2002-2009).
  – Harm associated led to reclassification as S8, 2014
  – Non medical use resulted in traffic accidents, aggressive behaviour and withdrawal difficulties

Long term opioid use

> 1 in 4 misuse
> 1 in 10 addicted
  – Vowles et al Pain 2015 156 : 569-576
Importance for prescribers of drugs of dependence

Recognition when escalating doses may lead to dependence

Recognition and dealing with patients who seek drugs for non medical purposes?

Recognition and dealing with patients who have chronic pain but who may be:- Overusing or misusing

TIPS IN PRESCRIBING DRUGS OF DEPENDENCE
What do I tell the patient?

- What you are prescribing
- The anticipated benefit
- The potential risks including dependence
- How the response will be monitored
- The proposed duration of the trial of treatment
- Discuss alternatives to prescribing a drug of dependence

A monitoring strategy for opioid prescribing

> Utilise non medication treatment
> Consider an opioid contract that includes semi-objective pain measurement
> Review when requests for extra medication.
  - See more frequently
  - Review a behavioural contract
  - Dispense medications at shorter intervals
  - Chemical monitoring – urine drug tests
  - Switch to opioid substitution program – with supervised dispensing of methadone
Resources

- Second opinions
  - Pain management, Addiction medicine, psychiatrist
- Drug and Alcohol telephone advisory service
- Prescription shopping information service
- Department of Health - Drug regulation Group
- Voluntary release of patient's PBS prescription details – 1800 420 074
- "Good medical practice – a code of conduct"

PRESCRIPTION SHOPPING SERVICE
Prescription shopping information service
“doctor shoppers hotline”

> Phone 1800 631 181
> Register with the service*
> Determine whether your patient is “on the list”
> If your patient is on the list, he is a doctor shopper – has seen 6+ doctors in a
  3 month period and procured 25+ prescriptions for PBS “targeted item”

This is a high threshold
> If your patient is not on the list he may still be a doctor shopper
> *the service does not include private scripts, DVA scripts and TAC scripts

REAL TIME MONITORING
- will this help prevent prescribing problems?
Summary

- Prescribing of opioids is increasing
- Non medical use of prescription drugs is increasing
- There is no appropriate evidence base for prescribing opioids long term for persistent non malignant pain.
- There is no appropriate evidence base for the long term use of benzodiazepines for anxiety disorders
- Clinicians need to be able to recognise and manage prescription shoppers and patients requesting/needng drugs of dependence.
- Regulation including "real time" drug monitoring needed
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