

MD Bd

Federation of
STATE
MEDICAL
BOARDS



June 11, 2013

Noel Taxin, MS
Bureau Manager
Utah Physicians & Surgeons Licensing Board
PO Box 146741
Salt Lake City, UT 84114-6741

Dear Ms. Taxin:

I am privileged and fortunate to have been elected to the FSMB Board of Directors at the last meeting in Boston in April. I am especially eager to reach out to you as the liaison from the BOD to your Utah regulatory board as one of my activities as a board member. I will be able to provide a special personal contact directly to the FSMB for concerns or activities to help make your important position better in some way. I am cognizant that your ideas and suggestions taken back to the BOD may enhance the ability of the FSMB to provide better service to the other member boards also.

I look forward to communicating with you throughout the coming year. Please feel free to contact me directly at work 615-222-3442, mobile 615-330-1371, via email at mzanolli@mac.com or through the Federation's Offices using the contact information as listed below:

Michael Zanolli, MD
President, TN BME
Member, Board of Directors
Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, TX 76039
(817) 868-4060
phuffman@fsmb.org

I would appreciate being of service to you and your Board. Please do not hesitate to contact me or Pam Huffman at the FSMB offices. Thank you for your time and consideration.

Sincerely yours,

Michael Zanolli, MD

Michael Zanolli, MD
Signed in absentia to expedite delivery
MZ / psh

MZ

Federation of
STATE
MEDICAL
BOARDS

May 14, 2013

Noel Taxin, MS
Utah Physicians Licensing Board
PO Box 146741
Salt Lake City, UT 84114-6741

RECEIVED
MAY 17 2013
DIVISION OF OCCUPATIONAL
& PROFESSIONAL LICENSING

Dear Ms. Taxin:

The objective of the FSMB Board of Directors' state medical board liaison program is to build and strengthen FSMB's relationships with our member boards by promoting two-way communication between the FSMB board of directors and our member board leadership.

Through the Liaison Program, we hope to better serve our members by:

- Responding to individual board issues/needs/requests;
- Supporting the assessment of member needs and their strategic planning activities;
- Promoting a better understanding of FSMB services and products; and
- Providing a forum to gain member feedback regarding 1) the utility of FSMB products and services and their impact on member boards, and 2) alignment of FSMB strategic initiatives with member needs;
- Identifying and discussing with Board members possible interest in FSMB involvement.

Each of the directors on our board has been matched with several member boards with whom he/she will communicate. The director will also join one of FSMB's executive staff on any personal visits scheduled during the year with those particular boards.

Your liaison director, Dr. Michael Zanolli, will contact you in the coming weeks and begin responding to any questions or concerns you may have. We encourage a frank and open dialogue to assist us in serving you.

On behalf of the FSMB board of directors, I want to extend our appreciation of your membership and look forward to a very productive and rewarding year.

Sincerely,



Jon V. Thomas, MD, MBA
FSMB Chair

JVT/psh

CC: Michael D. Zanolli, MD



Karen McCall <kmccall@utah.gov>

Fwd: Important JAMA editorial on opioid prescribing

no image

Noel Taxin <ntaxin@utah.gov>
To: Karen McCall <kmccall@utah.gov>

Tue, May 14, 2013 at 2:38 PM

Put on MD/DO agendas as correspondence.
Thank you,
Noel

----- Forwarded message -----

From: **Andrew Kolodny** <AKolodny@maimonidesmed.org>
Date: Thu, May 9, 2013 at 12:02 PM
Subject: Important JAMA editorial on opioid prescribing
To: Andrew Kolodny <AKolodny@maimonidesmed.org>

Dear Medical Board Director,

Attached is an editorial published in JAMA on the topic of opioid prescribing. Please share this article with members of your medical board.

Sincerely,

Andrew Kolodny, MD

President, Physicians for Responsible Opioid Prescribing

www.supportPROP.org

Chair, Department of Psychiatry

Maimonides Medical Center

920 48th St., Brooklyn, NY 11219

Tel: 718 283-7557; Fax: 718 283-6540

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Noel Taxin, M.S./Bureau Manager
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 **jama.2013.5794[1].pdf**
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ONLINE FIRST

Opioid Analgesics—Risky Drugs, Not Risky Patients

Deborah Dowell, MD, MPH

Hillary V. Kunins, MD, MPH, MS

Thomas A. Farley, MD, MPH

FROM 1999 TO 2010 THE NUMBER OF PEOPLE IN the United States dying annually from opioid analgesic-related overdoses quadrupled, from 4030 to 16 651.¹ Patients' predisposition to overdose could not have changed substantially in that time; what has changed substantially is their exposure to opioids. During this same time, the amount of opioids prescribed also quadrupled.¹ The increase in prescribing occurred in the context of a greater emphasis on treating pain following efforts by the American Pain Society, the Veterans Health Administration, The Joint Commission, and others to increase recognition and management of pain, as well as advocacy by pain societies urging physicians to use opioids more readily for patients with chronic noncancer pain.

Even though it is well known that prescription opioid use can lead to addiction or overdose, some opioid manufacturers and pain specialists suggest that few patients are susceptible to these risks.^{2,3} To distinguish low-risk from high-risk patients, use of screening tools, including the Screener and Opioid Assessment for Patients with Pain, has been advocated.⁴ Medication guides include statements such as "the chance [of abuse or addiction] is higher if you are, or have been, addicted to or abused other medicines, street drugs, or alcohol, or if you have a history of mental problems."⁵ While there is likely to be a gradient of risk across patients, this statement may reassure clinicians that people with opioid addiction are different from most patients for whom they provide care.

However, opioid dependence is much more common than previously believed and has been estimated to affect more than one-third of patients with chronic pain.⁶ No screening tool has sufficiently high sensitivity to rule out problems with opioids. Reported sensitivities of these tests for observed "aberrant drug-related behavior" (eg, dose escalation outside the treatment plan or forging prescriptions)⁴ among patients with chronic pain are generally within a range between 70% and 90%,⁴ which means that they miss 10% to 30% of patients at high risk of misuse or addiction.

In addition, some industry-sponsored educational brochures suggest that physicians should ignore signs of opioid dependence in low-risk patients.⁷ For instance, some patients might not be considered at high risk of misuse even though they may use more opioids than prescribed (one definition of misuse). Some authors have stated that behaviors such as taking more opioids than prescribed may represent pseudoaddiction,⁷ a concept introduced in a case report in 1989⁸ as "abnormal behavior developing as a direct consequence of inadequate pain management."⁸ However, this concept remains untested, without scientific studies validating diagnostic criteria or describing long-term clinical outcomes. Nonetheless, some pain societies have promoted this concept⁹ and suggest that some patients demonstrating behaviors typical of opioid addiction may actually require higher doses.⁹

Rather than representing iatrogenic undertreatment of pain, however, behaviors described as pseudoaddiction may represent predictable responses to opioid exposure. Long-term opioid use typically results in tolerance. A standard clinical solution is to increase opioid dose. However, contrary to the view that there is no maximum safe dose if opioids are increased gradually over time, death from opioid overdose becomes more likely at higher doses.

The most important risk factor for opioid analgesic-associated dependence or overdose is not a feature of any individual patient but instead simply involves receiving a prescription for opioids. For example, newly prescribed opioids after short-stay surgery are associated with a 44% increase in risk of becoming a long-term opioid user within 1 year.¹⁰

Another potential complication of screening for risk of opioid abuse is that identifying patients who should not receive opioids can stigmatize them, leading to consequences that do not help them. Patients who are questioned about substance use and then excluded from an expected treatment may feel embarrassed or abandoned. The decision to address a patient's pain should not depend on

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substance use history. Screening should be used primarily to identify and offer treatment to patients with opioid addiction.

Before prescribing opioids, a more useful and important question than a patient's likelihood of dependence is whether benefits of opioids in relieving pain are likely to outweigh the risks of the drugs. For pain control at the end of life, the answer to this question is often yes. If the indication for opioids is chronic noncancer pain, the answer to this question will be no much more often than many physicians may realize. Despite widely held views about the efficacy of opioids for pain control, systematic reviews have not found sufficient evidence that long-term opioid use controls noncancer pain more effectively than other treatments.

Physicians have a professional and ethical responsibility to understand the expected benefits and risks of medications and to balance these appropriately. When benefits of opioids are likely to outweigh risks, such as in severe acute pain unlikely to respond to other therapies, it is appropriate to use opioids, prescribing the lowest effective dose and with a duration limited to the likely duration of the acute pain. However, when risks outweigh benefits, as will often be the case for chronic pain, opioid use should be avoided in favor of other treatments.

Some physicians may think that only a small fraction of their patients are put at risk by taking high doses of opioids. However, the risk of opioids stems primarily from these drugs, not from patients. Low-risk patients given large enough doses will have a high risk of overdose. Patients given moderate doses for prolonged periods will have a high risk

of opioid dependence. While a patient's estimated individual risk should be considered, physicians should pay close attention to the drug dose and duration. All patients exposed to opioids would benefit from judicious prescribing and close follow-up.

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Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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