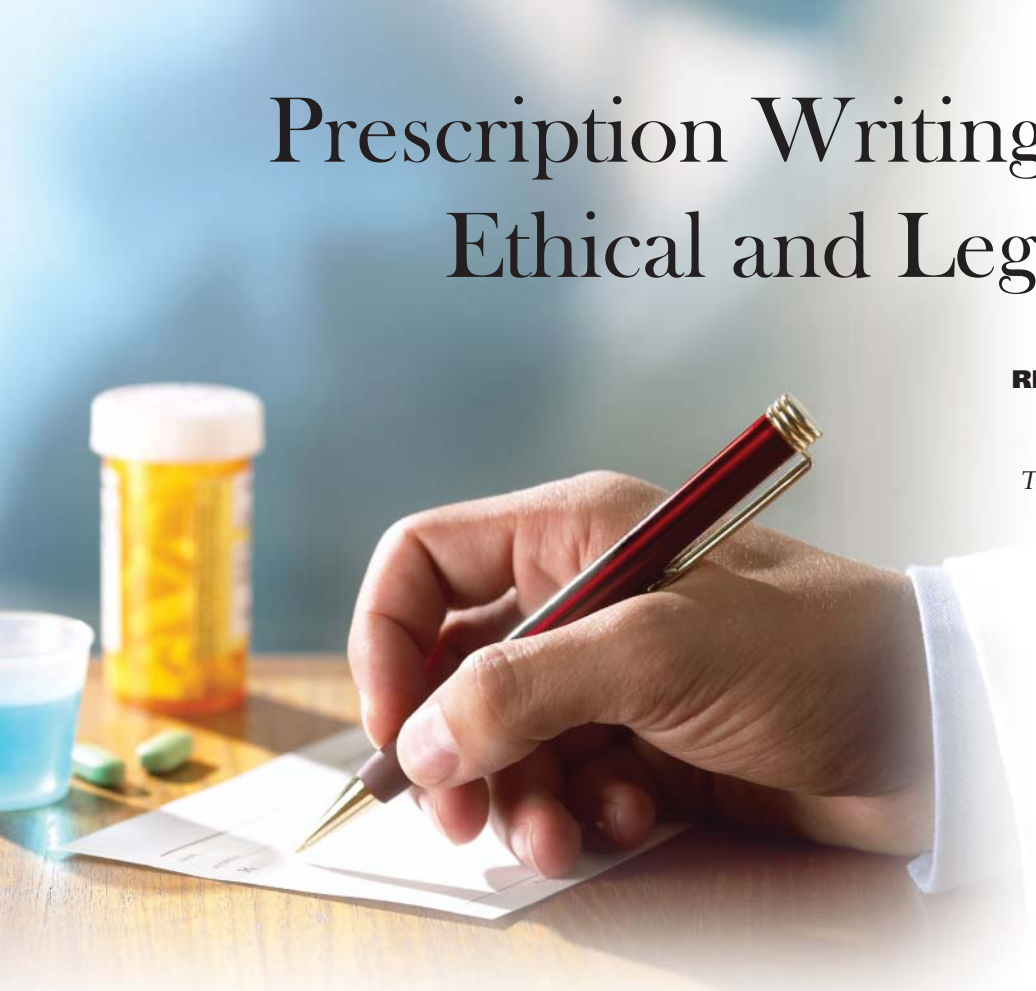
Prescription Writing for Dentists: Ethical and Legal Guidelines



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Prescription-writing privileges provide dentistry with one of its most powerful therapeutic tools. Privileges for prescribing noncontrolled medication are automatically conferred once state dental licensure is obtained. Upon further application by a licensed dentist, controlled-substance prescribing privileges are granted federally by the Drug Enforcement Administration (DEA) and statewide by departments of public health. Each state has its own dental practice act and licensing board regulations, which delineate the scope of prescription-writing authority granted to licensees. This review focuses on the myriad dilemmas that confront the everyday dental practitioner with ethical, legal, and professional questions surrounding the writing of prescriptions.

Scope of Authority

The scope of prescription-writing authority granted to dentists by the states is not limited to certain classes of drugs; rather, the states generally impose a two-part validity test. First, the prescription must be issued in good faith for a legitimate dental purpose, and second, the prescription must be issued by a practitioner in the usual course of his/her practice.[1] If a written prescription satisfies both parts of the validity test, there are no further restrictions on what a licensed dentist may prescribe.

Implicit within the good faith aspect of the validity test are ethical, legal, and professional obligations on the part of the prescriber to comply with record keeping and therapeutic standards of care. Accordingly, 21st-century practitioners commonly prescribe from a wide range of drug classes such as antifungals, antianxiety, antidepressants, analgesics, and antibiotics.

Responsibilities

Responsibilities attach to the dental practitioner not only when medication is prescribed, but also when current medications are reviewed during medical history updates. Rapid advances within the pharmaceutical industry result in many new medications entering the health care arena yearly, creating an ethical duty to continue our pharmacology education post-dental school. Familiarization with the pharmacology of prescription drugs is important not only to understand their physiological effects on our patients, but also to appreciate when and if our dental treatment plans should be modified. It is not uncommon for patients today to report taking between seven and 10 different medications. Indeed, the conscientious dental practitioner has a daunting task staying up to date with new trends in pharmacology in an attempt to avoid inflicting drug interactions or adverse affects on a patient's health.

A current medical history is required to ascertain not only a patient's present drug regimen, but also any medical problems that affect drug metabolism, such as hepatic and renal dysfunction. A positive response to chemical dependency, addiction, or recovery in the patient's medical history may contraindicate the prescribing of any controlled substances.

As with any aspect of your treatment plan, you want to recommend a medication regimen in conjunction with adequate

consultation, therapeutic rationale, and a forum conducive to discussion and questions. A prescription is an integral component to your treatment plan and deserves the same attention to patient communication as your restorative or periodontal recommendations. As a result, the patient will benefit from enhanced compliance when taking prescriptions as directed, lessening the chances of inappropriate cessation of medication, dosing errors, and complications.

Common Prescribing Issues

Self-Prescribing

Many state dental boards have regulations that prohibit self-prescribing. Massachusetts, for example, has regulations in place that prohibit the prescribing of controlled substances for personal use.[1] In an effort to circumvent detection, dental providers have been disciplined for issuing prescriptions under fictitious names or for an individual who is not the intended recipient of the medication. Common sense tells us that the information on a prescription must be truthful and that any deviation is considered unprofessional, unethical, and illegal.

Non-Patients: No Treatment Record

Prescribing for non-patients—even for legitimate dental purposes—is inappropriate because the lack of record keeping renders it impossible to follow at least the minimum professional standards consistent with a proper doctor-patient relationship.[2] The prescribing of medication is *prima facie* therapeutic treatment in and of itself.[3] Any dental procedure or prescription requires a treatment record, which documents findings, diagnoses, and treatment plans. Further, no record is complete without a medical history. Even in first-time emergency visit situations, minimum record-keeping guidelines must be followed.

Prescribing for Non-Dental Purposes

Prescriptions are valid only if issued for legitimate dental purposes. The prescribing of antibiotics and analgesics, although employed daily in dental practices, are inappropriate when prescribed for medical conditions outside the scope of dental practice. Even for long-term patients of record, prescribing Vicodin, for example, for non-dental pain is unethical because the patient's treatment record would not be supported by proper dental findings, diagnoses, and treatment plans. A prescribing dentist would be unable to logically justify a prescription for oral contraceptives issued to a front desk staff member or amoxicillin suspension prescribed for his or her dental assistant's daughter to hold her over until her pediatrician's appointment.

Prescription Pad Safeguards

Safeguard your prescription pads as you would your personal credit cards or checkbook. Leaving prescription pads in plain view invites theft and forgery. Sophisticated drug abusers possess the skill to convincingly forge a prescription that can avoid detection at the retail pharmacy. Report all stolen pads to law enforcement and to your state's Board of Pharmacy. Simply stocking minimum quantities of prescription pads and keeping them under lock and key will often deter theft and avoid time-consuming resolution of identity theft issues.

The quantity of medication to be dispensed should always be written out to prevent altering a prescription. For example, when prescribing 12 tablets of Tylenol #3, spell out the number "twelve" to prevent patients from adding a zero, changing the quantity to be dispensed from 12 to 120 tablets. Keep a copy of all prescriptions written in the patient chart and do not preprint your DEA number on pads. Avoid rubber stamping your prescription pads with your signature. Adopt a habit of personally signing each and every new prescription whether written from a prescription pad or generated from an electronic record-keeping system. Date all prescriptions the day they are issued, as predating and postdating are considered unethical attempts to circumvent insurance or pharmacy regulations. Except in unusual situations, prescribe only two or three days' supply of controlled substances and consider limiting refills accordingly.

Exploitation by the Chemically Dependent Patient

Chemically dependent patients can be knowledgeable and sophisticated when it comes to obtaining controlled substances from unsuspecting dental practitioners acting in good faith. Drug-dependent patients frequently approach the honest dental practitioner for the specific purpose of obtaining drugs for their dependency or misuse.

The sophisticated drug-dependent patient knows that dental patients may present in pain without observable signs. Dental problems can be convincingly simulated by the drug-seeking patient.[4] Observed pathology does not always determine the existence or intensity of pain. Distinguishing between the drug-seeking and sincere patient can be challenging because of exaggerated or feigned symptoms. For example, a patient may present with a fractured amalgam or large carious lesion, feigning pain in an attempt to manipulate the dentist into prescribing unnecessary medications.

Patients may attempt to obtain medication for themselves, but occasionally they are not the drug abuser at all; rather, they are seeking it for a friend or family member. Beware of a new patient who presents with a "toothache" and actually schedules an appointment for treatment as the practitioner recommends. The patient will request an antibiotic and pain medication to "hold [them] over" until

Table 1. Ten Guidelines for Better Prescription Writing

1. Prescribe for legitimate dental purposes only.
2. Prescribe for patients of record only.
3. Review medical history prior to prescribing.
4. Periodically update pharmacology and pain management training.
5. Counsel and follow up with patients regarding proper compliance.
6. Avoid self-prescribing.
7. Issue prescriptions in a truthful manner.
8. Never prescribe without proper treatment records.
9. Safeguard prescription pads.
10. Learn to identify high-risk substance abuse patients.

he or she presents for treatment. Unless you have an established history with this patient, there really is no way to determine if the patient is sincere or will be a no-show.

Drug-seeking patients will present claiming to have specific allergies to nonsteroidal anti-inflammatory drugs (NSAIDS) and request an opioid, such as Percocet or Vicodin. A request for a specific narcotic medication by name should act as a red flag that the patient is more interested in obtaining drugs than obtaining dental services.

Most dentists in practice more than a few years have had the request from "out-of-town" patients just passing through, looking for some pain medication to hold them over until they see their hometown dentist. Other common attempts to obtain controlled substances from practitioners include early refill requests and duplicate prescriptions to replace "lost medication."[5]

A useful deterrent to being manipulated into prescribing controlled substances unnecessarily is to offer an immediate appointment for the new or transient patient calling in pain. When a patient is offered a "come right in" appointment instead of a prescription, further attempts to procure inappropriate medication may be minimized. When a suspicious patient presents to your office, request photo identification that can be copied and include it in the patient record.[6]

Also, "emergency" phone calls immediately prior to closing or over the weekend can often indicate that the caller is more interested in obtaining controlled substances than caring for an authentic dental problem. Situations arise from hostile patients who attempt to intimidate dental practitioners by demanding pain medication in a threatening or bullying manner.[7]

On occasion, even the most conscientious dentist will be duped by the sophisticated drug seeker. Proper record keeping will demonstrate that the practitioner has made good faith efforts to differentiate between real and fictitious emergencies. Documentation of findings, tests, X-rays, diagnoses, and treatment plans will help defend the dental practitioner should the patient record be reviewed by the Board of Registration in Dentistry (BORID).

Successful assessment and control of pain depend in large part on establishing good communication between the dentist and the patient. Pain is subjective, and although it is our ethical duty to apply some intelligent skepticism and avoid prescribing medication unnecessarily, we must generally accept patients' self-reporting as accurate and reliable. A good premise to follow is that pain is whatever the experiencing patient says it is and exists whenever he or she says it does. Otherwise, ethical or legal claims of underprescribing may be alleged.

In November 2010, the Commonwealth of Massachusetts amended the Controlled Substances Act, M.G.L. Chapter 94C Section 18(e), requiring health care providers who prescribe controlled substances, as a prerequisite to obtaining or renewing their license, to complete appropriate training relative to: effective pain management; identification of patients at high risk for substance abuse; and counseling of patients about side effects, addictive nature, and proper storage and disposal of medication.[8]

Additional Prescription Issues

Off-Label Use

The Food and Drug Administration (FDA) is responsible for protecting consumer health by ensuring the safety, quality, and efficacy of pharmaceuticals.[9] This includes approving the content of drug package inserts, which, among other things, list indications for which the FDA has approved each drug. Once a new drug, with its approved package insert has been shipped to various pharmacies, the FDA, as a policy, has a hands-off approach when medical practitioners choose to prescribe medication for non-approved uses—also known as "off-label use" (OLU). Clinicians may lawfully and ethically prescribe a drug for treatment regimens not specified in the approved labeling or package insert. More than one out of five prescriptions issued in the United States are for OLU.[10] Drugs commonly used off label in dentistry are Amitriptiline for temporomandibular joint disorder and Diphenhydramine and Promethezine as palliative coating agent rinses.

Ethically, medications may be prescribed for supported off-label use in the same manner as they would be for on-label use. Such prescribing is appropriate as long as there exists adequate literature-based evidence of the risks and benefits. Avoid OLU of drugs on the market with limited safety data and drugs that have been in clinical use for less than five years. As always, avoid all drugs that have exhibited serious adverse side effects.

Dispensing Rules

Administering medication contemporaneous with dental treatment (i.e., antibiotic premedication or analgesics) is appropriate as long as proper documentation appears in the patient's treatment record. If the dental practitioner decides to send the patient home with a regimen of medication, he or she will be held to the same labeling, record-keeping, and childproof packaging requirements as a registered pharmacist. The quantity of any controlled substance dispensed, however, should not exceed the quantity of a controlled substance necessary for the immediate and proper treatment of the patient until it is possible for the prescription to be filled at the pharmacy.

Dentists are required to keep records of all acquisition and dispensing of medications consistent with state regulations. Additional responsibilities attach regarding security and safe storage of medications. As a public service, dental practitioners may wish to accept the additional onerous regulations that accompany dispensing medication, especially if they practice in a rural or public health environment. Otherwise, they should limit dispensing to immediate chairside treatment only.[11]

Smoking Cessation

Dentists may prescribe medication for smoking cessation if the dentist is treating the patient for a dental condition and it is determined that it would be helpful to that condition to stop smoking. Documenting the patient's diagnosis (e.g., periodontitis) and treatment plan (e.g., scaling, root planing) will ethically support a prescription for smoking cessation.[12] Prescribing medication for smoking cessation can be ethically supported by our commitment to beneficence and nonmaleficence as outlined in the American Dental Association Principles of Ethics and Code of Professional Conduct.[13] Smoking-cessation medications are effective and have few adverse reactions. Further, the proven effectiveness of such treatment is evidence-based, cost effective, simple, and of short duration.

Long-established trusted relationships between dentists and patients provide a unique opportunity to decrease tobacco-related disease or death.

Antibiotic Prophylaxis

Patients with artificial joints and some types of heart problems require antibiotic prophylaxis prior to dental treatment, according to the American Academy of Orthopedic Surgeons (AAOS) and the American Heart Association (AHA). These recommendations, adopted by the dental profession as the standard of care, provide guidance to practitioners as to when and how to premedicate patients to reduce the possibility of infection. These recommendations have developed, in part, from analyses that compare the risks associated with antibiotics to the benefits of preventing infection.[14]

On occasion, a patient will present for treatment requesting premedication for a condition outside the guidelines of the AAOS and AHA. The patient may be requesting premedication as a result of an outdated recommendation by the primary care physician or a recent unnecessary recommendation. In view of the potential for adverse drug reactions and the concern about development of drug-resistant bacteria, antibiotic requests falling outside the AAOS and AHA guidelines should be referred to the patient's physician.

Conclusion

No amount of training completely insulates the dentist from problems surrounding prescribing privileges. Practicing in good faith within the standard of care and following the guidelines presented above will help minimize prescription-related problems. As with other aspects of dentistry, experience, education, documentation, ethics, and common sense will go a long way in guiding you to make correct prescribing decisions. ■

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