

# LOUISIANA STATE BOARD OF MEDICAL EXAMINERS NEWSLETTER



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## 1991 Legislation

### HIV practice restrictions, confidentiality, other measures enacted

During its 1991 Regular Session, the Louisiana Legislature adopted a number of measures affecting physicians and other health care practitioners. For the information of Board licensees, some of the more notable enactments are summarized here.

■ **HIV PRACTICE, REPORTING.** To protect the public from the transmission of hepatitis B virus (HBV) and human immunodeficiency virus (HIV), Act 1009, enacting R.S. 37:1746-1747, directs the Board of Medical Examiners (along with several other health practitioner licensing boards) to adopt rules and regulations prescribing practice restrictions and self-reporting requirements for physicians and other licensed health care practitioners who are "carriers" of such viruses. The law directs that such rules be "based on" recently-published guidelines of the Federal Centers for Disease Control, which contemplate that physicians who have tested positively for HIV antigens or HBV would be prohibited from performing certain invasive procedures considered to be "exposure-prone." The guidelines do not, however, recommend mandatory testing of all physicians. The law also accords immunity from liability for physicians and others who report HIV or HBV seropositive physicians who perform invasive procedures.

The Board is in the process of developing rules to implement the statutory mandate and has, as of the publication date of this NEWSLETTER, promulgated preliminary draft rules for practitioner and public comment. A copy of the exposure draft may be obtained from the Board office. The Board currently anticipates publishing a notice of intent to adopt rules in the January 20, 1992, edition of the *Louisiana Register*, following which there will be further opportunity for public hearing and comment before final rules are adopted.

■ **HIV TESTING.** With an expressed intent of encouraging the expansion of voluntary confidential testing for HIV, Act 1054, to be codified at R.S. 37:1299.190-.195, prescribes the conditions and circumstances under which a physician may order the performance of tests for the presence of HIV antibodies or antigens and provides for the maintenance of confidentiality with respect to the results of such tests. Generally, an HIV test may be ordered and performed only with a patient's informed consent, which must be obtained pursuant to an explanation to the patient of the nature of acquired immune deficiency syndrome and HIV-related illness and behavior known to pose

risks for transmission and contraction of HIV infection. The law recognizes several specific exceptions to the necessity for patient informed consent, including instances, as previously authorized by R.S. 40:1299.40(D), in which a hospital infection control committee determines that a physician, agent or employee of the hospital has been exposed to the blood or bodily fluids of a patient, in which case the patient's blood may be tested for HIV without the patient's consent.

Subject to some 14 specific exceptions, the law prohibits the disclosure of confidential HIV test results by any person who obtains, retains or becomes the recipient of such results in the course of providing health care services. Physicians are, however, authorized to disclose positive HIV results to a sex-sharing, needle-sharing or other at risk "contact" of the patient, when the physician reasonably believes there is significant risk of infection to the contact, the physician has counseled the patient regarding the need to notify the contact, and the physician reasonably believes that the patient will not inform the contact.

The law also empowers and directs the office of public health of the Department of Health and Hospitals (DHH) to promulgate rules and regulations implementing and interpreting the law and to develop forms and informational materials to be used for written informed consent and authorized disclosure of test results. Patient execution of a DHH-promulgated form (but not any other form) will create a legal presumption that consent to HIV testing was validly obtained.

It should be emphasized that these new statutory provisions are detailed and complex. Licensees should not rely on this brief summary of the law, but should consult the text of the statutes directly and seek the advice of legal counsel as appropriate on its interpretation, application and implications.

■ **NOTICE TO PROVIDERS.** In yet another measure treating the threat of HIV/AIDS to health care practitioners, Act 968 amends existing law to require that when a patient known to be infected with HIV or hepatitis B virus, pulmonary tuberculosis, or acute meningococcal meningitis is admitted to or treated at a hospital or nursing home, the hospital or nursing home must give notice of the patient's condition to all health care providers involved in the treatment of the patient.

■ **PUBLIC CHOLESTEROL SCREENING.** In an effort to "ensure high standards for cholesterol screening by mobile cholesterol screening units"—defined as a unit or operation that travels from one location to another and provides cholesterol screening services to the public without referral from a physician—Act 411, enacting R.S. 40:1299.181-1299.185, mandates, subject to criminal penalties, that such mobile screening services satisfy specified standards: the services must be organized and provided under the supervision of a licensed

clinical laboratory or qualified physician; systems and instruments must be properly and periodically calibrated, fingerstick testing may be performed only by properly qualified personnel; and no person administering the tests may purport to interpret the clinical significance of results or render a medical diagnosis. Physicians and certain other qualified health care professionals are exempted from application of the law. Rules and regulations to implement the law are to be promulgated by the Department of Health and Hospitals. The statutory standards are consistent with the Board's February 1990 statement on the conduct of nonphysician cholesterol screening and clinical laboratory testing (reprinted in Vol. 4, No. 1 of the NEWSLETTER).

■ **LIVING WILLS.** Louisiana's "Living Will" law, originally enacted in 1984 to prescribe the procedure by which a person may declare an intent to have life-sustaining procedures withheld or withdrawn in the event of a terminal and irreversible condition, R.S. 40:1299.58.1 to 58.10, has been amended and refined in several respects. An open question under the law was settled by Act 320, which expressly includes "invasive administration of nutrition and hydration" among the life-sustaining procedures which a qualified patient or his representative may direct to be withheld or withdrawn. Another measure, Act 320, amended the legal definition of "terminal and irreversible condition" to embrace "a continual profound comatose state with no reasonable chance of recovery" and concurrently modified the statutory declaration form in acknowledgment of the amended definition. Act 325 recognizes an individual's right to authorize one or more designated persons to make a declaration for the individual in the event that a declaration has not been made when the individual is qualified, but physically or mentally incompetent, to make a declaration; a person so appointed takes precedence over all other classes authorized to act on behalf of the patient (e.g., tutors, spouses, children, parents, siblings). Finally, the Legislature established, within the office of the Secretary of State, a registry for the filing of written declarations concerning life-sustaining procedures. Act 194, creating the registry, also prescribed the procedures for filing with and access of the registry.

■ **ANABOLIC STEROIDS, NUBAIN.** The NEWSLETTER previously reported (Vol. 4, No. 2) that in 1990 the Legislature had designated anabolic steroids as Schedule II controlled dangerous substances. Act 513 of 1991 has now reclassified anabolic steroids as Schedule III Controlled Substances effective September 6, 1991. As before, the law continues to provide that anabolic steroids may only be prescribed or administered for a valid medical purpose and that "[b]odybuilding, muscle enhancement, or increasing muscle bulk or strength through the use of an anabolic steroid by a person who is in good health is...not a valid medical purpose."

R.S. 40:964 was amended by Act 842 of 1991 to add Nubain (nalbuphine hydrochloride) to Schedule IV of the Louisiana Controlled Substances Act.

■ **BURN REPORTING.** Physicians are required, under Act 657, amending R.S. 14:403.4(B), (C)(1), to orally report to the state fire marshal, within 24 hours of the examination of a victim, every case of a burn injury with second or third degree burns to five percent or more of the body, burns to the upper respiratory tract or laryngeal edema due to inhalation of superheated air, and every burn which is likely to or may result in death. ■

## Board Policies

### Patient sexual exploitation, examinations; prescribing controlled substances

From time to time, for the information and guidance of practitioners, the Board attempts to articulate its views on problems and issues which are recurring or of broad concern and applicability. The Board has recently approved the following statements of its position and suggested guidelines relative to sexual exploitation of patients and the considerations which should bear upon the prescription of controlled substances:

#### Sexual Exploitation of Patients; Physical Examinations

It is the position of the Louisiana State Board of Medical Examiners that entering into a sexual relationship with a patient, consensual or otherwise, while a physician/patient relationship exists, is unprofessional conduct and grounds for the suspension or revocation of a physician's license.

Proper care is needed to avoid charges of sexual misconduct by physicians. Patient complaints of sexual misconduct by physicians are the most sensitive and difficult matters the Board investigates. In order to prevent misunderstandings and protect physicians and their patients from allegations of sexual misconduct, the Board offers the following guidelines:

◆ Maintaining patient dignity should be foremost in the physician's mind when undertaking a physical examination. The patient should be assured of adequate auditory and visual privacy, and should never be asked to disrobe in the physician's immediate presence. Examining rooms should be safe, clean, and well maintained, and should be equipped with appropriate furniture for the examination and treatment. Gowns, sheets and other appropriate apparel should be made available to protect patient dignity and decrease embarrassment to the patient while promoting a thorough and professional examination.

◆ A third party should be readily available at all times during a physical examination, and it is suggested that the third party be actually present when the physician performs an examination of the sexual and reproductive organs or rectum. It is incumbent upon the physician to inform the patient of the option to have a third party present. This precaution is essential regardless of physician/patient gender.

◆ The physician should individualize the approach to physical examinations so that the patient's apprehension, fear, and embarrassment are diminished as much as possible. An explanation of the necessity of a complete physical examination, the components of that examination, and the purpose of disrobing may be necessary in order to minimize the patient's apprehension and possible misunderstanding.

◆ The physician and staff should exercise the same degree of professionalism and caution when performing diagnostic procedures (i.e., electrocardiograms, electromyograms, endoscopic procedures and radiological studies, etc.) as well as surgical procedures and post-surgical follow-up examinations when the patient is in varying stages of consciousness.

◆ The physician should be alert to suggestive or flirtatious behavior or mannerisms on the part of the patient, and should not be in a compromising position.

◆ The physician should not exploit the physician/patient relationship for sexual or any other purposes. Moreover, such an allegation against a physician constitutes grounds for investigation on the basis of unprofessional conduct.

#### **Prescriptions for Controlled Substances; Prescribing for Family Members**

Prescriptions for controlled substances or mood-altering chemicals should be issued for a patient in ink or indelible pencil or typewritten and should be manually signed by the practitioner at the time of issuance. No prescription for controlled substances or mood-altering chemicals should be issued by a practitioner for himself. No prescription for controlled substances or mood-altering chemicals should be issued for a patient in the absence of a documented physician/patient relationship.

A valid physician/patient relationship is documented by the presence of medical records and should always contain: (1) an appropriate history and physical or mental examination for the patient's chief complaint as appropriate to the specialty; (2) diagnostic tests when indicated; (3) a working diagnosis; (4) treatment; and (5) documentation by date of all prescriptions written for drugs, with name of medication, strength, dosage, quantity and number of refills.

Generally, a physician should not prescribe for family members. Treating one's family is not illegal, but the Board reminds physicians that such prescribing practices may readily lead to problems. Written records of all prescriptions for controlled substances and the medical indications for them should be maintained, but in many instances such recording is neglected. Also, any prescriptions issued should be within the scope of the physician's medical practice. Physicians should delegate their own medical care and that of their family members to one or more of their colleagues in order to preclude involvement with governmental regulatory agencies who monitor physicians' prescribing practices. Treatment of the immediate family member should be reserved for minor illnesses, temporary or emergency situations. Appropriate consultations should be obtained for the management of major or extended periods of illness. No Schedule II, III, or IV controlled substances should be given or prescribed except in emergency situations, in which case records should be maintained of written prescriptions or administration of any Schedule II-IV controlled substance.

#### **Prescribing Addictive or Dependency-Inducing Drugs**

A significant number of physicians who appear before the Board in disciplinary proceedings are required to do so because of their lack of information about the management and responsibilities involved in prescribing controlled substances. The inadvertent offender is frequently a physician with a warm heart and a desire to relieve pain and misery, who is always pressed for time and finds himself prescribing controlled drugs on demand over prolonged periods and without adequate documentation. Controlled substances are often prescribed promiscuously for chronic ailments such as headache, arthritis, old injuries, chronic orthopedic problems, backache and anxiety.

The following information is offered by the Board to promote physician reevaluation of their practices in prescribing controlled substances. At the outset, the Board observes that

what a physician prescribes is not as important as how well the physician manages the patient's care and documents such care in legible form. The Board thus operates on the expectation that physicians will create a record which evidences a proper indication for the use of drug or other therapy, ongoing monitoring of the patient where necessary, the patient's response to therapy on follow-up visits, and the rationale for continuation or modification of the therapy. More particularly:

1. First and foremost, any prescription for any medication must be predicated on a diagnosis which is supported by history, physical findings, and by the results of any appropriate tests. Too many times a doctor is asked why he or she prescribed a particular drug, and the response is, "Because the patient has arthritis." When the doctor is asked, "How did you determine that?" the answer is, "Because that's what the patient complained of." Nothing in the record or in the doctor's recollection supports the diagnosis except the patient's assertion. Do a work-up sufficient to support a diagnosis, including all necessary tests.

2. Create a treatment plan which includes the use of appropriate non-addictive modalities, and make referrals to appropriate specialists. The results of the referral should be included in the patient's chart.

3. Before beginning a regimen of controlled drugs, make a determination through trial or through a documented history that non-addictive modalities aren't appropriate or they don't work. A finding of intolerance or allergy to non-addictive drugs is one thing, but the assertion of the patient that, "Nothing seems to work like that Percodan stuff" is quite another. Too many of the doctors the Board has seen have started a treatment program with powerful controlled substances without ever considering other forms of treatment.

4. Make sure you are not dealing with a drug-seeking patient. If you know the patient, review the prescription records in the patient's chart and discuss the patient's chemical history before prescribing a controlled drug. If the patient is new or otherwise unknown to you, at a minimum, obtain an oral drug history, and discuss chemical use and family chemical history with the patient.

5. It's a good idea to obtain the informed consent of the patient before using a drug that has the potential to cause dependency problems. Take the time to explain the relative risks and benefits of the drug and record in the chart the fact that this was done. When embarking on what appears to be the long term use of a potentially addictive substance, it may be wise to hold a family conference and explain the relative risks of dependency or addiction and what that may mean to the patient and to the patient's family. Refusal of the patient to permit a family conference may be significant information.

6. Maintain regular monitoring of the patient, including frequent physical monitoring. If the regimen is for prolonged drug use, it is very important to monitor the patient for the root condition which necessitates the drug, and for the side effects of the drug itself. This is true no matter what type of controlled substance is used or what schedule it belongs to. Remember, too, that with certain conditions, drug holidays are appropriate. This allows you to check to see whether the original symptoms recur when the drug is not given—indicating a continuing legitimate need for the drug—or whether withdrawal symptoms occur, indicating drug dependence.

7. Make sure *you* are in control of the supply of the drug. To do this, at a minimum, you must keep detailed records of the

type, dose, and amount of the drug prescribed. You must also monitor, record and personally control all refills. Do not authorize your office personnel to refill prescriptions without consulting you. One good way to accomplish this is to require the patient to return to obtain refill authorization, at least part of the time. Records of cumulative dosage and average daily dosage are especially valuable. Another important part of controlling the supply of drugs is to check on whether the patient is obtaining drugs from other physicians. Checking with pharmacies and pharmacy chains may tell you whether a patient is obtaining extra drugs or obtaining the same or similar drugs from other physicians.

8. Maintaining regular contact with the patient's family is a valuable source of information on the patient's response to the therapy regimen, and may be much more accurate and objective than feedback from the patient alone. The family is a much better source of information on behavioral changes, especially dysfunctional behavior, than is the patient. Dysfunctional changes may be observable when the patient is taking the drug, or when the drug is withdrawn. These changes, at either time, may be symptoms of dependency or addiction. The family is also a good source of information on whether the patient is obtaining drugs from other sources, or is self-

medicating with other drugs or alcohol.

9. To reiterate, one of the most frequent problems faced by a physician when he or she comes before the Board is inadequate records. It may well be that the doctor did everything correctly in managing a case, but without records which reflect all the steps involved in the process, the job of demonstrating it to any outside reviewer becomes many times more difficult.

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### A new look for the NEWSLETTER

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**W**ith this issue, the NEWSLETTER sports a new look—one we hope improves not only its appearance but its readability. The Board is always interested in knowing what you think of the NEWSLETTER—what you like and don't like about it, what you find most useful or informative and what you may find superfluous or irrelevant. Let us know what you would like to see in the NEWSLETTER and we'll try to address your suggestions in future issues.

In particular, while the Board replies directly to formal requests for interpretive opinions, if you have a question which may be of general interest to a wide range of practitioners, address it to the NEWSLETTER, and we'll try to answer it in an upcoming issue. ■

# Don't Delay— Renew Today.

All licenses expire December 31.  
Penalty fees are applicable to re-  
newal applications received on or  
after January 1, 1992.

## LSBME NEWSLETTER

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