Institution of a 'No Narcotics' Policy for After-Hours Telephone Calls

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Prescription drug abuse is a major component of the drug problem in this country. Prescription drugs are involved in almost 60% of all drug-related emergency room cases and 70% of all drug-related deaths.[1] An estimated 3% of the US population deliberately misuse or abuse prescription drugs.[2]

There are two main types of prescription drug abusers. Entrepreneurial drug seekers obtain them by feigning illness or by other deceptions. They use small quantities of prescription drugs for recreational purposes and sell the rest.[2,3] Other patients develop iatrogenic drug dependence because of improper prescribing practices, the use of multiple physicians, or noncompliance with physician directions.[2] Physicians are challenged to identify the clever and manipulative entrepreneurial drug seeker and to prevent iatrogenic dependence by following recommended prescribing guidelines for controlled drugs,[1] while at the same time avoiding the underprescribing of these very useful drugs.

Maintaining this delicate balance between overprescribing and underprescribing controlled drugs is even more difficult when the prescribing is done by telephone. Telephone prescribing is extremely common in the United States.[4] Moreover, psychotropic medications are among the most common classes of drugs prescribed by family physicians over the telephone.[4,5]

Physicians are particularly vulnerable after clinic hours to the manipulative tactics of prescription drug abusers. The patient record is often unavailable, the caller is frequently unknown to the physician, and the drug seeker usually has a very convincing story to support his or her request for a controlled drug.

A clinic policy forbidding the prescription of controlled drugs by telephone after hours is one approach to discouraging such calls. In June 1989 such a departmental policy was initiated at the Ramsey Family Practice Residency in St Paul, Minnesota. Residents believed that they could more easily refuse these requests by citing such a policy. This report describes the effects of a "no narcotics" policy on resident telephone prescribing habits.

Methods

The Ramsey Family Practice residency is a community-based program in St Paul, Minnesota. Residents in their third year of postgraduate training answer after-hours telephone calls for patients from the residency clinic as well as from three other community clinics. All after-hours telephone calls are documented by the residents and later placed in the patients' clinic chart.

The residents typically record the date, caller's name, telephone number, primary clinic, and a brief summary of the complaint, assessment, and treatment plan.

In June of 1989, a "no narcotics" policy was written and distributed to all residents and faculty and to the lead physicians of the three community clinics. The policy stated: "It is our clinic policy not to prescribe or renew prescriptions for narcotics or other controlled substances by phone contacts after hours. Patients contacting the on-call person with such requests should be informed that this is the clinic policy." Residents were not specifically instructed to document that the caller was informed of the policy. Compliance with the policy was monitored for the following year by a review of all of the documented patient telephone calls received after hours.

An attempt was made to review the clinic charts of all patients who called after hours requesting controlled drugs. Charts were reviewed by the author for evidence of prescription drug abuse or other substance abuse problems, as well as for patient demographics. Patients were considered to be substance abusers if this diagnosis

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was noted on the problem list or progress notes, or if multiple requests for controlled drugs were documented.

Compliance with the policy was reviewed at five quality assurance meetings during the year. Physician feedback was given in an attempt to improve compliance with the policy. Discussions of nonnarcotic management of pain were also held. At the end of the year, the third-year residents answered an anonymous six-item questionnaire about their experiences with the "no narcotics" policy.

Results

Notes taken during 2495 after-hours telephone calls were reviewed. Sixty-two notes (2%) documented a patient request for a controlled drug. Most of the requests occurred on the weekends, with 40% on Saturday and 17% on Sunday. Seventy-nine percent of the requesters were women, and their mean age was 35 years. Sixty percent of requesters stated that they received medical care from the residency site. The remainder reported receiving care from one of the affiliated community clinics. Seven people made repeated requests for controlled drugs. The number of repeat requests ranged from two to five.

The number of requests was highest when the policy was initiated and decreased throughout the following academic year. Twenty-three requests were documented in the first quarter, which decreased to 11, 9, and 16 in the three subsequent quarters, respectively. Three of the fourth-quarter requests were from a single patient new to the practice. This patient repeatedly requested diphenoxylate and was later hospitalized after taking an overdose of this drug in an attempt to commit suicide. The dates of three requests were not documented.

Despite the "no narcotics" policy, 15 patients received prescriptions for controlled drugs by telephone after clinic hours. The overall controlled-drug prescription refusal rate was 76%. Refusal rates did not change significantly throughout the year. Individual residents' refusal rates varied markedly, however (100% to 25%). Only 3 of the 10 residents followed the policy consistently.

Residents specifically noted that the patient was told about the "no narcotics" policy in 34% of the refusals. The policy was used incorrectly in two cases in which prescription refill requests for tablets containing caffeine and ergotamine, both uncontrolled drugs, were refused.

The patients' symptoms are shown in Table 1. Headache was the most common complaint for which patients requested controlled drugs. The medications requested are shown in Table 2. Acetaminophen with codeine was the most common medication specifically requested. Patients did not always request a particular drug, but usually stated that they had already taken nonnarcotic pain medications, which had not relieved their symptoms, and they needed something stronger.

Table 1. Symptoms Reported by Patients Who Called After Hours and Requested a Prescription for a Controlled Drug

Symptom	No. of Patients
Headache	15
Toothache	7
Back pain	6
Cough	5
Anxiety	4
Diarrhea	4
Post-operative pain	3
Sore throat	2
Colic	2
Other pain	14
Total	62

The medications actually prescribed are also shown in Table 2. Acetaminophen with codeine was the most frequently prescribed controlled drug. When controlled drugs were prescribed, a limited amount was usually dispensed. Various nonsteroidal anti-inflammatory medications were frequently prescribed as nonnarcotic alternatives for pain control. Forty-four percent of patients were not given any medication.

The charts of 53 of the 62 patients were available for

Table 2. Medications Requested and Received by Patients Who Called After Hours

Medication	No. of Patients
Requested	
Unspecified pain medication	27
Acetaminophen and codeine	10
Hydrocodone and chlorpheniramine suspension	4
Diphenoxylate	3
Propoxyphene	3
Unspecified anxiolytic	3
Hydrocodone	2
Paregoric	2
Alprazolam	2
Other codeine preparations	2
Miscellaneous	4
Total	62
Received*	
Controlled (average amount)	
Acetaminophen and codeine (9 tablets)	6
Diphenoxylate (16 tablets)	3
Propoxyphene (7 tablets)	3
Guaifenesin and codeine (4 oz)	1
Paregoric (5 mL)	1
Hydrocodone (16 tablets)	1
Uncontrolled	
Nonsteroidal anti-inflammatory drugs	14
Diphenhydramine	2
Miscellaneous	4

**27 patients received no medications.*

review of prescription drug abuse or other substance abuse problems. Nine patients who called requesting controlled drugs were not registered patients at any of the four study sites. Twenty-eight (53%) of the callers whose charts were reviewed were identified as having a substance abuse problem. Twenty-three of the patients had been previously diagnosed as substance abusers by their clinic physicians. Five patients' charts revealed multiple requests for controlled medications but no specific diagnosis of substance abuse.

The 28 patients identified as substance abusers did not differ significantly from nonabusers in terms of age, sex, primary clinic, day of call, symptom, or whether a specific medication was requested.

Eight of the ten residents completed a questionnaire about their experience with the "no narcotics" policy. In response to the question, "What do you think of the 'no narcotics after-hours' policy?" the residents uniformly responded that the policy was very useful and made it easier to refuse patient requests for controlled drugs. The quality assurance meeting discussions were believed to be educational. All residents recommended that the policy be continued, although two residents stated that exceptions should be made if the physician personally knows the patient. All but one resident recommended continued monitoring of compliance with the policy, at least periodically. The residents stated that after graduation they planned to never prescribe narcotics after hours or to prescribe only to patients whom they knew personally.

Discussion

Little is known about physician prescribing of controlled drugs by telephone after clinic hours. Two studies of family practice telephone prescribing habits indicate that psychotropic medications are frequently prescribed.[4,5] These studies did not indicate, however, whether any of these psychotropic medications were prescribed after clinic hours or to new patients. In a recent survey of Minnesota physicians, 89% of respondents reported that they never issue prescriptions for controlled drugs for new patients over the telephone.[6]

The institution of the "no narcotics" policy did not completely eliminate the prescribing of controlled medications after clinic hours. On chart review, 3 of the 15 patients to whom controlled drugs were prescribed were found to have a substance abuse problem. One resident prescribed controlled drugs in three out of four requests, which was clearly excessive. The most common reason offered at quality assurance meetings for resident noncompliance was that the patient's story was convincing and the request seemed reasonable. Some study physicians were not aware that diphenoxylate is a controlled drug in Minnesota.

An important limitation of this study is the lack of a specific definition of substance abuse. Although most patients were diagnosed as substance abusers by their own clinic physicians, the criteria used to make the diagnosis are unknown and probably highly variable.

Institution of the policy was associated with an encouraging decrease in the number of requests for controlled drugs. The decrease in requests continued, with only 21 requests made after hours for controlled drugs during the first 6 months following the study. The number of requests for controlled drugs before the policy was instituted is unknown; therefore, the true impact of the policy on the number of requests cannot be determined.

The typical controlled drug requester in this study was the 35-year-old woman with a history of substance abuse who receives care from the residents' clinic and wants acetaminophen with codeine for headaches. The symptoms reported by the callers are nearly identical to the disorders previously reported to be frequently feigned by drug seekers.[3]

Unfortunately, there were no characteristics by which controlled drug requesters with substance abuse problems could be clearly identified. Moreover, the demographics of these requesters are similar to those of many after-hours callers. In a report of all after-hours calls to another family practice residency, 62% of callers were female and 37% of callers were in the age range of 25 to 44 years.[7] In that study, however, headache and back pain were relatively infrequent symptoms, reported by only 4% and 2.9% of callers, respectively. Fever was the most common symptom, reported by 12% of callers.

Overall, the "no narcotics" policy was well received by physicians and appeared effective. Other practice sites should consider instituting a similar "no narcotics" policy as a simple way to discourage prescription drug abuse.

Key words. Substance abuse; prescriptions, drug.

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