



# Utah Medical Association

*Still the greatest profession*

July 18, 2016

Division of Occupational and Professional Licensing  
Attn: Physician and Surgeon Licensing Board

Re: Physician Self-Prescribing and Prescribing for Family Members

To Whom It May Concern:

The Utah Medical Association (UMA) Board of Directors and the Council of Trustees, representing multiple physician specialties and counties across Utah, thoroughly discussed the topic of physician self-prescribing and prescribing for family members that we knew the DOPL licensing boards would be talking about in June and/or July. We noticed that this topic and a proposed "policy" is on the agenda for the July 20<sup>th</sup> meeting and we would like to submit these comments in writing and ask that our UMA President, William (Bill) Hamilton be allowed to address the Board at that meeting in response to this proposed rule.

We understand the need to have some direction and guidance for investigators so that they are all on the same page when it comes to their investigations into inappropriate prescribing for self and family members of physicians when they receive a complaint about a physician. With that said, we are concerned about the scope and breadth of what is being proposed and the potential detrimental effect on healthcare both in increased costs and decreased care. Also remember that these practices have been in place for many, many years since physicians have been prescribing with few if any adverse effects to family members and many benefits.

We will tailor our comments by section to the proposed policy to make it easier to follow.

**Governing Law:** We have no comments on this section other than to say that we understand the intent behind proposing some type of policy.

**Self prescribing:**

1. We agree with number one that there should be no prescribing to self of schedule II or III drugs.
2. Self-prescribing other medications for specific medical indications should be admissible as long as it is properly documented as to why the medication was prescribed but this should be an exception to the rule and not a common practice. For example, long term care of chronic conditions should probably be discouraged but not prohibited altogether. Things

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3. like regulating thyroid, if you have thyroid labs to back up the medications prescribed, etc. would be admissible.
4. We agree that generally physicians should not self prescribe, but again there are acceptable circumstances as long as #4 is followed.
5. Agree that they should document their treatment generally. If a physician self-prescribes for a particular incident, for example, a one-time Z-Pak to combat an infection and it is detailed on the prescription what the prescription is for, it does not necessarily need to be documented. This should not be a point for disciplinary action even if the prescribing incident is not documented to the satisfaction of the investigators, particularly if a physician is out of town when the prescription is needed.

**Prescribing for Family (This section should only be referring to "immediate family members and that should be noted)**

1. While we agree with this sentiment for the most part if it were ongoing care, there are many instances when a family member receives a prescription because special circumstances from a family member physician. For example, the family is on a vacation and something happens (grandchild forgot their medication, has an allergic reaction and needs an epi-pen, etc.) and there is no chart and there are extenuating circumstances. Family members are different than a regular patient in that they do not pay the physician for the care and the physician is already well acquainted with the family member and knows the family member, their history, etc. Treating a family member is more closely related to the charity care system of the "Good Samaritan" law except you already know much more about the family member, their history and everything about them. Their care, because it is not paid for, should fall under the category of the "Good Samaritan" law and really should Not need to be documented with rare exceptions such as if the care is ongoing.
2. Sometimes physicians treat family members for routine and non-routine instances. We have a shortage of psychiatrists in Utah, for example, if a family member needs medication for depression, treating a family member for depression and documenting that treatment should not be punishable.
3. For the most part, we would agree that normal, routine instances should be treated by someone other than a family member but a physician helping out a family member occasionally:
  - a. Reduces healthcare costs (they don't charge for the visits)
  - b. Reduces the strain on the system that may be overburdened (shortage of mental health care providers for instance)
  - c. Usually provides for pretty good care because the physician already knows the family member and cares about the family member
  - d. Helps the family member out in a time of need

We would argue that limiting prescribing to only emergency settings, unless you make that a pretty broad definition, would be too limited and to say that where there is "no other qualified physician" is also too limiting unless you say that there is no other qualified physician in that home or on that vacation or in that particular setting. We would disagree with limiting this more than that.

For the most part, we would agree with no controlled substances with the **exception** of if in an emergency situation a family member left their medication at home or lost it and are not able to get to their regular physician for a short term situation, such as one fill, a physician should be able to call in a refill for that family member.

**Application of Code:**

1. If possible, we would say document, but again as explained in different situations above and if it is only for a one time situation such as something happened on a camping trip and a child needed a prescription we would say you may not need to document. We would agree with documenting in a personal chart why the prescription was given in normal circumstances as needed and if not for a one time situation that is situationally, such as a prescription to counteract a rash. We do not think the documenting has to be as detailed as a regular patient chart. The physician already knows the family member and does not need help knowing about the "patient" or for billing or insurance purposes which is many times why details are put into a chart.
2. Physician should be safe from sanction if he/she has acted in a reasonable manner in their professional judgement and documented only if necessary. If this needs to be fleshed out more, we are happy to help do so but we do NOT believe that everything has to be documented. We believe that puts too much burden on the physician for basically providing an uncompensated service that is a "good Samaritan" act that relieves the overall healthcare system of much of the care and cost that would otherwise be directed there.
3. If there is a pattern of ongoing regular treatment of family members, they should not be sanctioned unless they are not documenting and even then it should depend on the circumstance. There should be a chart but if the chart states the reason for care and no remuneration is being received, that should be sufficient. This should particularly be true, if a family member is being treated because they have no insurance and no access to care; if they are being treated because it is a minor ailment that can be handled by the physician family member and it is being documented, etc. there should be NO threat of sanctions. There should also be an exemption for ongoing regular treatment of family members if there is documentation in the area of mental health services for family members since we have such a shortage of mental health professionals who can treat patients in the state of