



# Pine Grove

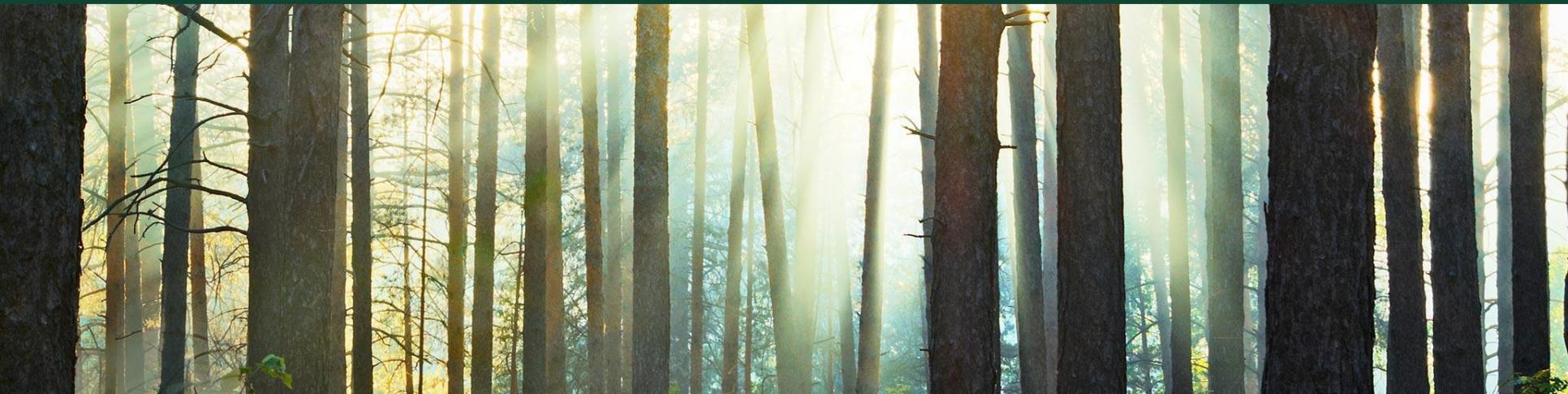
**Behavioral Health & Addiction Services**

Forrest Health®

## Ethical Considerations for Safe Prescribing

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# Why This Topic Matters

- Prescribing in addiction care carries elevated ethical and legal risk
- Boundary erosion is common under pressure, scarcity, and emotional intensity
- Most violations begin with good intentions

# Objectives

- At the conclusion of this activity, participants will be able to:
  1. Identify and manage ethical and boundary issues that commonly arise in prescribing practices
  2. Recognize and appropriately respond to high-risk patient behaviors that may compromise clinical judgment or professional integrity
  3. Evaluate how stress, fatigue, and burnout contribute to boundary violations and unsafe prescribing patterns

# Prescribing in Mississippi: Context

- High prevalence of substance use disorders
- Limited access to specialty care, particularly in rural areas
- Increased likelihood of dual relationships
- Active oversight by Mississippi licensing boards, DEA, and Medicaid
- Emphasis on documentation, scope of practice, and medical necessity

# Ethics Are Not About Intentions

- Ethical risk arises under pressure
- “Helping” can unintentionally cause harm
- Ethics = behavior, boundaries, consistency

# Core Ethical & Regulatory Foundations

- Beneficence and nonmaleficence
- Justice and consistency of care
- Fidelity to professional role
- Adherence to scope of practice
- Compliance with state and federal prescribing regulations

# Common Boundary Challenges in Prescribing

- Treating family, friends, or colleagues
- Prescribing outside scope or comfort
- Informal refills or favors
- Dual relationships in small communities

# Dual Relationships

- More common in rural settings
- Can impair objectivity
- Require heightened caution, documentation, and consultation

# Medication-Seeking vs Clinical Need

- Not always manipulation
- Still requires firm boundaries
- Compassion without capitulation

# Case #1

- **Scenario:** A 42-year-old patient with opioid use disorder has been stable on buprenorphine for 14 months with negative drug screens. They report increasing panic symptoms after a recent divorce and job loss. Their PCP previously prescribed clonazepam, but discontinued it due to concerns about co-prescribing. The patient requests a short-term benzodiazepine prescription, stating, “If I can’t sleep, I’m going to relapse.” PDMP confirms prior benzodiazepine use, last filled 6 weeks ago.

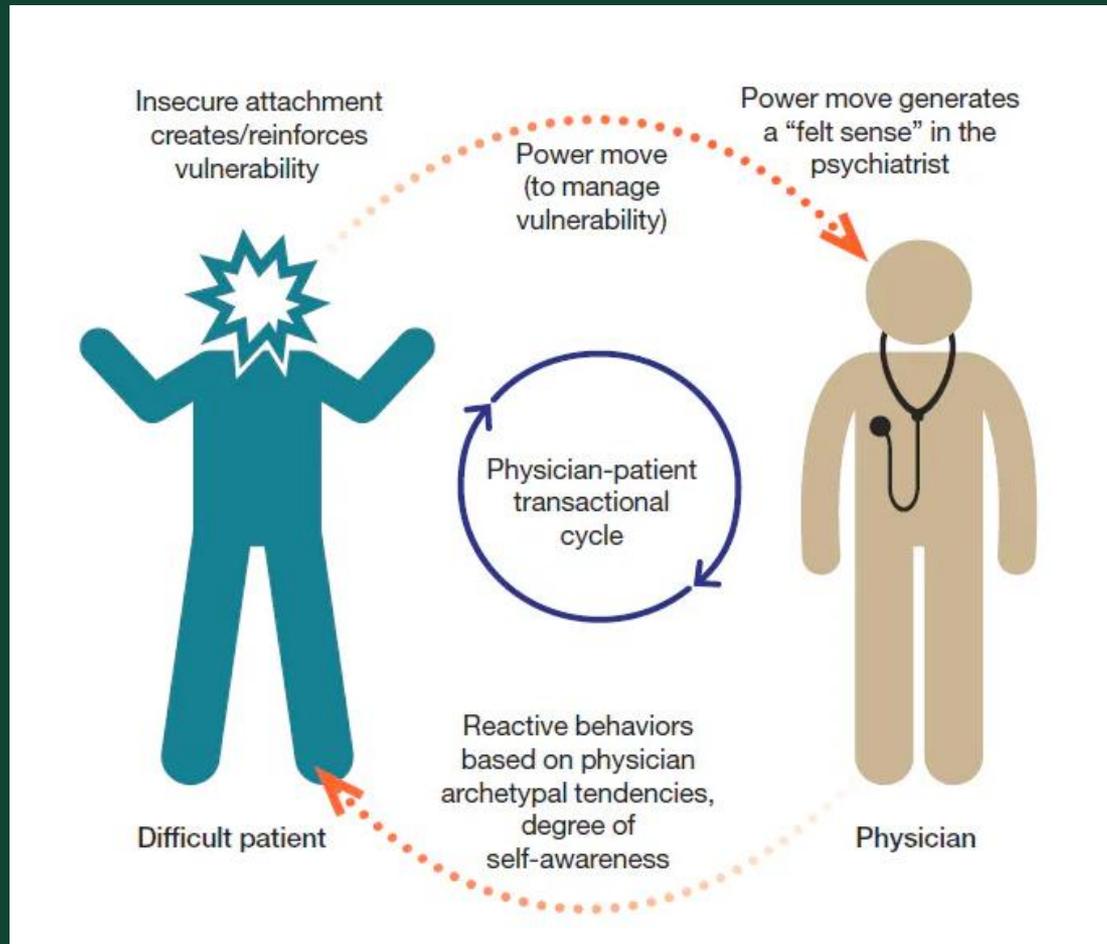
# Case #1 Discussion

- What are the clinical risks of co-prescribing in this case?
- How do beneficence and nonmaleficence conflict here?
- What Mississippi Board or DEA concerns are implicated?
- What alternatives and documentation would support a defensible decision?

# High-Risk Patient Behaviors

- Escalating demands
- Emotional pressure or threats
- Splitting providers
- Crisis framing
- Non-adherence presented as urgency

# Provider/Patient Relationship



# Threats & Emotional Leverage

- “I’m afraid I’ll relapse if you don’t...”
- “You’re the only one who helps me”
- Emotional distress  $\neq$  clinical indication

# Setting Treatment Limits (Board-Safe Practice)

- Treatment limits are a clinical intervention
- Limits must be:
  - Clearly communicated
  - Consistently applied
  - Clinically justified
  - Setting limits does not constitute patient abandonment when alternative care and resources are offered

# BOUNDARIES

# What is a Boundary?

- Not bright lines subject to clear and unambiguous observation and understanding
- Movable
- Highly context-dependent
- Not hard and fast
- Their placement depends on a number of factors in the clinical situation

Gutheil and Gabbard, 1993

# Signs of Weak Boundaries

- Feeling confused about professional relationship protocol
- Accepting responsibility for other people's actions and responses
- Being overly responsible or irresponsible
- Giving away your power or taking too much power
- Having no sense of privacy in a relationship
- Emotionally dependent

# Rigid Boundaries

- Unable to change views or perspectives
- Unable to accept that you are wrong
- Unwilling to hear out others
- Blaming others
- Same emotion surfaces every time
- Wanting to win at other's detriment

# Healthy Boundaries

- Flexible/Movable
- Assertive
- Clear
- Consistent

# Language That Holds Boundaries

- “I can’t prescribe that because...”
- “Here’s what I can do...”
- Focus on safety and policy

# Burnout, Fatigue, and Ethical Drift

- Burnout does not excuse unsafe practice
- Fatigue increases variability and exceptions
- Mississippi Boards expect clinicians to recognize impairment and seek support
- Ethical risk increases when providers feel solely responsible for patient outcomes

# Warning Signs in Providers

- Dreading specific patients
- Making exceptions repeatedly
- Feeling solely responsible for outcomes

# Self-Reflection Check

- Where do you feel the most pressure?
- What situations are hardest to say no?

# Ethical & Regulatory Safeguards

- Clear clinic and prescribing policies
- Peer consultation and supervision
- Use of Prescription Drug Monitoring Program (PDMP) as required
- Adherence to DEA and state regulations
- Ongoing self-monitoring for impairment

# Documentation as Protection

- Mississippi Board & DEA Expectations
  - Document clinical rationale for prescribing decisions
  - Note assessment of risk vs benefit
  - Record patient education and informed consent
  - Document alternatives offered and referrals made
  - Avoid emotionally charged or punitive language

# Weak vs Strong Documentation

- **Weak:**

“Patient upset about decision.”

- **Strong:**

Clear rationale, risks discussed, plan outlined

# The “Would I Defend This?” Test

- Would this decision be defensible to:
  - Mississippi Board of Medical Examiners?
  - DEA auditor?
  - Peer reviewer?
  - Court or jury?

# Personal Red Lines

- Medications you will not prescribe
- Situations requiring consultation
- Signs you need to pause

# Case #2

**Scenario:** A long-term patient with stimulant use disorder and ADHD has been treated with a controlled stimulant for several years. Over the past three months, they have requested early refills twice, citing lost medication and travel. PDMP shows prescriptions from an urgent care in a neighboring county. When confronted, the patient becomes tearful and states that without medication they cannot function and will lose custody of their children. They threaten to file a complaint if medication is withheld.

# Case #2 Discussion

- What red flags are present?
- How does coercion impact informed clinical decision-making?
- What steps reduce regulatory and patient safety risk?
- When is tapering, referral, or discontinuation indicated?

# Risk Mitigation: When to Step Back

- Escalating conflict or coercive behavior
- Loss of clinical objectivity
- Requests outside scope or standard of care
- Safety concerns for patient or provider
- Ethical discomfort requiring consultation or referral

# Ethical Prescribing Is a Team Effort

- Consultation is strength
- Policies reduce pressure
- Shared responsibility

# Key Takeaways

- Ethical prescribing requires both clinical judgment and regulatory awareness
- Clear boundaries and documentation protect patients and providers
- Burnout and stress increase vulnerability to unsafe prescribing

Final Thought...

**YOUR ROLE IS NOT TO RESCUE — IT IS  
TO PRACTICE SAFELY, CONSISTENTLY,  
AND ETHICALLY.**



**QUESTIONS??**