Carson Strong, Stephanie Connelly, and Laura R. Sprabery, "Prescribing for Coworkers: Practices and Attitudes of Faculty and Residents," *The Journal of Clinical Ethics* 24, no. 1 (Spring 2013): 41-9.

Prescribing for Co-Workers: Practices and Attitudes of Faculty and Residents

Carson Strong, Stephanie Connelly, and Laura R. Sprabery

ABSTRACT

Background

Physicians sometimes are asked by co-workers for prescriptions to deal with their medical problems. These "hallway" requests typically occur outside a formal doctor-patient relationship. There are professional guidelines on serving as physician for family members and friends, but no guidelines address writing prescriptions for co-workers. The frequency of these requests and the factors physicians consider in responding to them have not been examined.

Objectives

To obtain data on the frequency of these requests and physicians' attitudes and practices in responding to them, and to explore the ethical considerations in writing prescriptions for co-workers.

Design

A survey was administered to all physician faculty and residents in an academic department of internal medicine. The questions included whether the respondent had ever been asked for a prescription by a co-worker and how often the respondent had received such requests and written such prescriptions in the previous three months. Respondents also were asked to rate how likely they would be to write such a prescription in 15 hypothetical scenarios.

Results

Of the 113 respondents who completed surveys, 68 percent reported having been asked for a prescription by a co-worker. Among those who had ever been asked, 59 percent had been asked one or more times during the previous three months and 88 percent had ever written such a prescription. Also, 88 percent of all respondents stated they were "very likely" or "likely" to write the prescription in one or more of the hypothetical scenarios.

Conclusions

Most physicians in our sample had been asked for prescriptions by co-workers, and most had written such prescriptions. Many respondents indicated a willingness to write such prescriptions in a variety of scenarios, despite the absence of a formal doctor-patient relationship. Further discussion of the ethical considerations in writing prescriptions for co-workers is needed.

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INTRODUCTION

Physicians sometimes are asked for prescriptions by co-workers such as nurses, secretaries, and other physicians. These requests typically occur in circumstances that lack certain features of a formal doctor-patient relationship, such as a thorough history and physical examination and planned follow up to assess the effectiveness and side-effects of therapy. Without these normal interactions, there is a risk of prescribing an inappropriate medication or not responding in a timely manner to adverse reactions. These considerations raise the ethical question of whether physicians should write such prescriptions. There are professional guidelines that caution physicians against serving as a doctor for family members and friends.[1] However, because there is an absence of guidelines dealing specifically with requests for prescriptions from co-workers, there is a need for further discussion of such prescription writing.

Previous studies have reported that 49 percent to 83 percent of physicians write prescriptions for themselves or family members.[2] At least two surveys of physicians have included questions on prescribing for co-workers. Clark and colleagues surveyed 565 house officers concerning prescriptions for residents, medical students, hospital or clinic staff members, family members, friends, and themselves during an eight-month period.[3] Among 339 respondents, 23 percent wrote at least one such prescription for a psychoactive medication. A total of 1,229 prescriptions were written for nonpsychoactive medications, but the reported results do not state the percentage of house officers who wrote such prescriptions. Of all of the prescriptions written in this study, 27 percent were for psychoactive prescriptions and 16 percent were for fellow residents. Nurses, technicians, and other allied health workers received 21 percent of all prescriptions and 17 percent of the psychoactive prescriptions. The reported results do not permit a determination of the frequency of requests by co-workers, variation in the frequency of requests among house officers, nor the percentage who had refused such requests. Aboff and colleagues surveyed 92 internal medicine and family practice residents at a Wilmington, Delaware, hospital in 1997 concerning their prescription writing for family members, friends, and co-workers.[4] Among the 74 respondents, 85 percent had written at least one such prescription. The reported results do not distinguish the categories of family member, friend, and co-worker and therefore do not permit a determination of the number or percentage of prescriptions written for co-workers.

These studies leave a number of questions unanswered, including the percentage of physicians who receive requests from co-workers, how frequently they receive such requests, how frequently physicians write such prescriptions, and the factors physicians take into account in deciding whether to write them. We examined these questions in a sample of internal medicine faculty and residents. The purpose of the study was to explore these and other aspects of the issue of prescription writing for co-workers.

METHODS

A survey instrument was designed by the authors to collect data on physicians' practices and attitudes in regard to writing prescriptions for co-workers. The study was approved by the institutional review board of the University of Tennessee Health Science Center in Memphis. A self-administered seven-page questionnaire and a cover letter were placed in the mailboxes of all faculty members and residents in the Department of Internal Medicine during May and June 2011. A second and third distribution of the questionnaire to nonresponders was made using an online survey method. In the questionnaire, "co-worker" was defined as "anyone who works where you work, including physicians, other health professionals, secretaries, etc., *and* is not seeing you by appointment in your office or clinic and is not a hospital patient." The questionnaire was completed anonymously and included the following questions:

1. Whether the respondent has ever been asked for a prescription by a co-worker,
2. How often the respondent has received such requests during the previous three months,

3. Whether the respondent has ever written such a prescription,
4. How often the respondent has written such prescriptions in the previous three months,
5. The types of medications for which the respondent has written such a prescription, and
6. Whether the respondent has ever refused a request by a co-worker.

In addition, the survey included 15 hypothetical scenarios in which physicians were asked for prescriptions by co-workers (see figure 1). In the scenarios, a number of factors were varied that might affect the likelihood of prescribing for a co-worker. Using a four-point Likert scale (very likely, likely, unlikely, very unlikely), respondents were asked to rate how likely it was that they would write a prescription. For each scenario, there was an open-ended question asking respondents to list factors present in the scenario that influenced their decision. Also, questions asking for brief demographic information were included. Associations between demographic variables were analyzed using *chi*-square for categorical data. Comparisons between scenarios were analyzed using the Friedman nonparametric test for ordinal data.

RESULTS

Of 111 faculty physicians, 67 (60 percent), and 46 of 136 residents (34 percent) completed the survey; 68 percent of respondents were male (see table 1). Among all respondents, 77 (68 percent) reported having ever been asked for a prescription by a co-worker; 77 percent of faculty and 52 percent of residents had been asked, and this difference was statistically significant (p=.006). Among those who had ever been asked, 59 percent had been asked one or more times during the previous three months: 51 percent were asked one to two times, 5 percent two to five times, and 3 percent five to 10 times. Among respondents who had ever been asked, 88 percent reported having ever written such a prescription and 61 percent stated they had refused such a request one or more times. In a comparison of gender, 52 percent of males and 79 percent of females reported having ever refused, and this difference was statistically significant (p=.025).

Among respondents who had been asked in the previous three months, 17 percent had written zero times, 72 percent had written one to two times, 9 percent had written two to five times, and 2 percent had written five to 10 times. Among the eight types of medications listed in the survey, respondents who had ever written reported most commonly writing for antibiotics (87 percent of respondents), followed by nonsteroidal anti-inflammatory drugs (21 percent), antihistamines (19 percent), birth control pills (9 percent), muscle relaxants (3 percent), antidepressants (2 percent), narcotics (2 percent), and benzodiazepines (0 percent).

Among the 15 hypothetical scenarios, there was considerable variation in the percentage of physicians likely to write a prescription (see table 2). In three scenarios (Scenario 3, Scenario 5, and Scenario 9), a majority of respondents would "very likely" or "likely" write the prescription. Two of these cases involved a co-worker who complained of cellulitis who was not yet covered by insurance. In one of these scenarios, the co-worker is "a physician recently hired into your group practice"; the other involves "your new medical assistant." In the physician scenario, 67 percent of respondents chose "very likely" or "likely." For those who listed one or more factors, the most frequently listed (30 percent) was that the requester was a physician. A number of these responses elaborated that the requester's medical knowledge would enable her or him to know the risks of antibiotics and to diagnose a worsening of his or her condition. In the medical assistant case, 56 percent selected "very likely" or "likely." In both cases, factors listed included: a high likelihood of follow up, given a close working relationship; the straightforward nature of the diagnosis; and a lack of insurance. Respondents were more likely to prescribe for the physician than for the medical assistant, and the difference was statistically significant (p<.001). The other case involved a nurse who requested warfarin and was unable to reach her physician.

FIGURE 1 Hypothetical scenarios involving prescription requests by co-workers

1. A secretary who works down the hall from your academic office, and who you know only casually, asks you about her dental abscess. She asks if you can prescribe something. Would you prescribe antibiotics for her?

2. Your nurse, with whom you have worked for several years, asks your advice. She complains of loss of appetite, inability to initiate and maintain sleep, and "feeling blue." She was successfully treated in the past with Zoloft (sertraline hydrochloride), and she asks you to prescribe it until she can see her primary care physician. Would you prescribe this medication for her?

3. A physician recently hired into your group practice complains of cellulitis at the site of a recent mosquito bite. On exam she has an 8 x 6 cm area on her right forearm which is red, warm, and painful. In the center is a small ulcer with purulent drainage. There is no fluctuance.* She is not yet covered on the group insurance plan. She asks you for antibiotics. Would you prescribe antibiotics for her?

4. You and your secretary have worked together for years and interact socially as well as professionally. She complains to you about insomnia because of problems at home, and asks you to prescribe Ambien (zolpidem tartrate). Would you prescribe this medication for her?

5. Your nurse is about out of her warfarin, which she takes because of protein C deficiency and a history of 2 pulmonary emboli. She has left several messages with her physician's office, to no avail. She tells you that her INR was 2.7** three weeks ago and she has had no abnormal bleeding. She asks you to refill her warfarin. Would you prescribe this medication for her?

6. The medical student assigned to your rotation comes to work sick, complaining of fever, severe sore throat, and malaise. You examine him and find his temperature is 102 and his pulse 110. Examination of his oropharynx reveals enlarged erythematous tonsils with purulent exudates.*** He has several 1-2 cm cervical lymph nodes. He asks you for an antibiotic prescription. Would you prescribe antibiotics for him?

7. A nurse aid who works in your office returns after two weeks of recovering from a knee injury. He is still using a crutch, and after a day of work he is in a lot of pain. He tells you Percocet (acetaminophen with oxycodone hydrochloride) worked at home during his recovery but now he is out. He asks you to write a prescription for Percocet to use after work. Would you prescribe Percocet for him?

8. A 59-year-old nurse complains of lower back pain. She states she's never had back pain before and thinks she overdid it at the gym. She has exercised 5-6 times per week for many years. She asks for a prescription for a muscle relaxant to see if that helps. Would you prescribe a muscle relaxant for her?

9. Your new medical assistant complains of cellulitis at the site of a recent mosquito bite. On exam she has an 8 x 6 cm area on her right forearm which is red, warm, and painful. In the center is a small ulcer with purulent drainage. There is no fluctuance.* She is not yet covered on the group insurance plan. She asks you for antibiotics. Would you prescribe antibiotics for her?

10. The receptionist in your office calls you on Saturday to ask for a refill of her Wellbutrin (buproprion) she takes for anxiety. She ran out yesterday and is starting to get anxious. She can't get in contact with her psychiatrist. Would you prescribe this medication for her?

11. A nurse in your office is diagnosed with hypertension, and her doctor puts her on an angiotensin receptor blocker. Her medication has the highest co-pay at $75 per month. She asks you to write a prescription for something that meets the $10 co-pay amount. Would you write this prescription for her?

12. A nurse you work with is 20 weeks pregnant, has had an upper respiratory infection for several days with fever, and needs some relief. She tells you a Z-Pak (azithromycin) is generally considered safe for pregnant women. Would you write her a prescription for this medication?

13. A 55-year-old hospital chaplain who you see time to time on rounds pages you. He states he has a history of gout but hasn't had an attack for years. He now thinks he is having an attack, and he can't even get his shoe on. His doctor retired some months ago and he is hoping you will prescribe indomethacin, which always worked in the past. Would you prescribe this medication?

14. Your physician partner calls you on Saturday to ask for a refill of her Wellbutrin (buproprion) she takes for anxiety. She ran out yesterday and is starting to get anxious. She can't get in contact with her psychiatrist. Would you prescribe this medication for her?

15. A respiratory therapist at your hospital who you have known for years asks you for a Z-Pak (azithromycin). She is 50 years old and complains of a 3-day history of runny nose, malaise, scratchy throat, and a cough productive of yellow sputum. She denies fever, chills, and dyspnea. On your exam, her temperature is 101. Her throat is red but without exudate, and she has paranasal sinus tenderness. Would you prescribe antibiotics for her?

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* The area is not boggy to the touch, which would indicate a collection of pus under the skin.

** This means that she had a normal blood level of anticoagulation medication.

*** The tonsils were covered with purulent fluid.

Among respondents who chose "very likely" or "likely" and listed one or more factors, the most frequently listed factor (33 percent) was the risk to the nurse in not having prompt access to the medication.

In another group of scenarios, respondents leaned heavily toward not writing the prescription, with 75 percent or more choosing "unlikely" or "very unlikely." This group (in order, Scenarios 10, 11, 2, 1, 4, 8, 12, and 7) has several features worth noting. Almost all of the scenarios that involved medications that were either controlled or psychoactive were in this group. Among respondents who listed factors in scenarios involving these drugs, many listed either legal concerns or the potential for abuse of the medications. This indicates that a medication's being controlled or psychoactive was often given strong weight against prescribing for a co-worker. Among the scenarios in this group that did not involve controlled or psychoactive medications, one involved a dental abscess and one involved a pregnant woman. Many of the respondents who chose "unlikely" or "very unlikely" in these two cases listed as factors that the medical condition was outside of their expertise. The remaining case in this group involved a request for a medication with a lower co-pay than the one prescribed by the co-worker's physician. A number of respondents who stated "unlikely" or "very unlikely" listed as a factor that the prescribing would constitute an interference with the practice of the other physician. Other factors against prescribing that were listed in these scenarios included not knowing the requester well (dental abscess case), the need for a more complete evaluation, and the need for follow up.

In other scenarios (14, 6, 13, and 15), a majority of respondents indicated that they would not prescribe, but the percentages indicate a considerable amount of controversy about these cases. Factors against prescribing identified by respondents for these scenarios included the following: alternatives were readily available (for example, student health for the medical student), a need to know more about the patient's history, and uncertainty concerning whether there is a need for the requested medication. A factor identified in support of prescribing in some cases was the low risk of side-effects for the medication in question. For the scenario involving buproprion for a physician partner, 44 percent chose "very likely" or "likely." Many of these listed as factors that the requester was known well and that the requester was a physician. In a parallel case involving buproprion for a receptionist, only 25 percent chose "very likely" or "likely"; the difference between the two cases is statistically significant ($p<.001$).

Taking into consideration all 15 scenarios, the factors mentioned frequently by respondents are listed in figure 2. Many of these factors were stated in multiple scenarios.

TABLE 1 Demographics and responses to questions

Characteristics and questions	No. responding "yes"	(%)
Gender (*n*=113)*		
Male	75	68
Female	36	32
Level (*n*=113)		
Faculty	67	59
Resident	46	41
Have you ever been asked for a prescription by a co-worker? (*n*=113)	77	68
Have you ever written a prescription for a co-worker who asked you for one? (*n*=77)**	67	88
Have you been asked to write a prescription for a co-worker in the past 3 months? (*n*=77)**	45	59
Have you written a prescription for a co-worker in the past 3 months? (*n*=45)	38	84
Have you ever refused to write a prescription for a co-worker? (*n*=77)**	46	61

* 2 respondents did not indicate their gender.
** 1 respondent did not answer.

DISCUSSION

Our study reveals that most physicians in our sample (68 percent) have been asked for

prescriptions by co-workers. Among those who have been asked, a large percentage (88 percent) reported having written such a prescription. For three of our scenarios, a majority of respondents indicated that they probably would write the prescription. In four other scenarios, approximately 30 to 40 percent of respondents indicated that they probably would prescribe. These results indicate a willingness of many faculty and residents to write prescriptions for co-workers, at least in selected cases. This willingness to write exists despite ethical concerns that can be raised when there is not a thorough history, examination, or testing to confirm a diagnosis. These results invite discussion of whether it is ethical to write prescriptions for co-workers, and, if so, under what circumstances.

To explore the ethics of prescription writing for co-workers, it is important to identify the arguments for and against this practice, but there has been little discussion of such arguments in the literature. However, previous discussions of the related issue of serving as physician for family members and friends provide some relevant considerations. Like prescribing for co-workers, being a doctor for family or friends can differ from a normal doctor-patient relationship in several important ways. The American Medical Association (AMA) guidelines on this topic state, "Physicians generally should not treat themselves or members of their immediate families."[5] The AMA gives several reasons in support of this position:

1. Objectivity may be compromised if the physician's personal feelings unduly influence professional judgment,
2. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination,
3. Physicians may be inclined to treat problems that are beyond their expertise or training, and
4. If there is a negative medical outcome, tension may develop in the family relationship.

The AMA recognizes exceptions to the guideline in emergencies, in isolated settings in

TABLE 2 Likelihood of physician writing a prescription in hypothetical scenarios

Vignette #	Type of co-worker	Medical condition	Medication requested	Circumstances	Physicians "very likely" or "likely" to write rescription (%)
3	Physician partner	Cellulitis	Antibiotics	Awaiting insurance	67
5	Your clinic nurse	Hypercoagulability	Warfarin	MD has not returned call	56
9	Medical assistant	Cellulitis	Antibiotics	Awaiting insurance	56
14	Physician partner	Anxiety	Buproprion	Weekend	44
6	Medical student	Pharyngitis	Antibiotics	--	39
13	Chaplain	Gout	Indomethacin	Former MD has retired	35
15	Respiratory therapist	URI	Azithromycin	--	31
10	Receptionist	Anxiety	Buproprion	Weekend	25
11	Nurse	Hypertension	ARB	Desires lower co-pay	21
2	Nurse, known well	Depression	Sertraline	Drug worked in past	20
1	Secretary	Dental abscess	Antibiotics	--	16
4	Secretary, known well	Insomnia	Zolpidem	Problems at home	13
8	Nurse	Lower back pain	Muscle relaxant	Age >50	9
12	Nurse	URI	Azithromycin	Pregnancy	9
7	Nurse's aid	Knee injury	Acetominophen & oxycodone	--	4

which no other physician is available, and for treatment of short-term, minor problems. The guidelines of the American College of Physicians (ACP) are similar to those of the AMA.[6] The ACP agrees with the reasons given by the AMA against writing such prescriptions, and it adds that counseling on sensitive issues may be incomplete when a physician treats family or friends.

These guidelines include several points that reasonably can be carried over to prescribing for co-workers. Objectivity could be compromised, particularly if there is a close relationship with the co-worker. The medical history and physical examination may be cursory or not performed. Physicians might be asked to prescribe for medical conditions they do not ordinarily treat. A negative medical outcome could cause tension in the co-worker relationship. Moreover, counseling on sensitive issues could be incomplete. In a given situation, some or all of these reasons might apply to a request from a co-worker. Some of the exceptions noted by the AMA in regard to doctoring family and friends could also apply to requests from co-workers. There could be emergencies in the work setting, and co-workers sometimes work together in remote areas.

When we apply these considerations to prescribing for co-workers, it seems reasonable to conclude that generally there are important reasons against such prescribing, but also that there can be situations in which an exception is justifiable. Only 12 percent of our respondents selected "very unlikely" or "unlikely" in every scenario. Thus, most respondents seemed to be taking an approach of deciding on a case-by-case basis. Given this data and the apparent reasonableness of allowing at least some exceptions, we suggest that it is important to identify the factors that should be considered in deciding whether to write such a prescription. We suggest these include all of the factors in figure 2.

FIGURE 2 Factors to consider in responding to requests

Ease of access to alternative physician
My area of competency
The need to know more about co-worker's medical history
The need for a more thorough examination
Whether more is needed than just a medication (e.g., tests, treatments)
Urgency of co-worker's need
Risks of the requested medication
Controlled drug or psychoactive drug with risk of abuse
The need for follow up
Whether I see the co-worker regularly at work
Co-worker's level of medical knowledge
Whether co-worker has health insurance
How well I know the co-worker
Impact on future relationship with co-worker
Impact on work setting (e.g., quick recovery puts co-worker back to work)
Interfering with another physician's care
Liability risk

One of the relevant factors is the legal implication of writing such a prescription. By legal standards, beginning a course of treatment, such as writing a prescription, entails that a doctor-patient relationship exists.[7] This means that the physician is subject to liability if there is an adverse outcome resulting from failure to follow the standard of care. Additional legal concerns arise when a controlled substance is requested. Federal laws pertaining to the prescribing of controlled substances are based on the Controlled Substances Act of 1970.[8] A key provision of this law is that physicians are expected to write prescriptions for controlled substances for *a legitima*te medical purpose while acting in the usual course of professional practice.[9] Many states incorporate this federal standard into their medical licensing board regulations.[10] Some states interpret "acting in the usual course of professional practice" to require a diagnosis based on a documented medical history and physical examination, a written treatment plan tailored to the individual needs of the patient, and complete and accurate records of the care provided.[11] In these jurisdictions, physicians who prescribe controlled substances to co-workers are potentially subject to disciplinary action by their state boards.

To promote further discussion of this issue, the authors propose an approach to handling

requests for prescriptions from co-workers (see figure 3). First, when a co-worker makes a request, an attempt should be made to determine whether alternative treatment is readily available. Alternatives might include the following: the co-worker visits an emergency department, minor care clinic, or student health; the co-worker makes an appointment with a personal physician; or the physician recommends an over-the-counter medication until the co-worker can see a personal physician. If an alternative is agreed upon, the physician could offer help if applicable in carrying out the alternative.

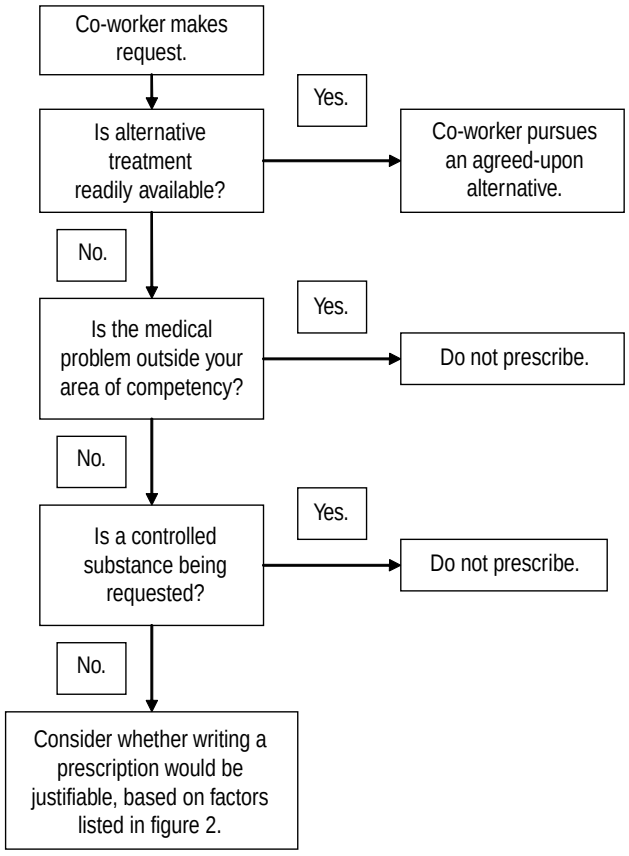
Second, if none of the alternatives mentioned above is feasible, consider whether the medical problem is outside one's area of competency. If it is, then the physician should not prescribe. A referral could be made to a qualified physician, if the co-worker so wishes.

Third, if the medical problem is within the physician's area of competency but involves a request for a controlled substance, the physician should not prescribe. The legal and ethical reasons for not prescribing could be discussed with the co-worker. A referral to a qualified physician, if needed, would be appropriate.

Fourth, if the requested medication is not a controlled substance, the physician should consider whether the case constitutes an exception in which writing the prescription would be ethically justifiable. Such a judgment should take into consideration the factors in the particular case. Relevant factors that might be present in a given case are listed in figure 2. Various combinations of factors could potentially make prescribing justifiable. For example, if not treating carries significant risks to the requester, the risks of the medication are reasonable in comparison to not treating, and an ongoing working relationship would permit follow up, then prescribing could be justifiable. An illustration might be the warfarin case (Scenario 5), provided an appropriate test of coagulation is obtained. On the other hand, various combinations of factors could make prescribing inadvisable. For example, if the medication has significant side-effects and the diagnosis is questionable, then prescribing would not be warranted. An example might be the nurse's request for a muscle relaxant (Scenario 8).

Our study has several limitations. The response rate from residents was low, and the nonresponders may have had different experiences and attitudes compared to responders. We surveyed only internal medicine faculty and residents at a single institution; this sample may not reflect geographical variations or practices in nonacademic settings; 40 percent of our respondents were residents, who may not have as many years of experience to be asked by a co-worker to write a prescription, compared to faculty members. Also, responses in actual situations may differ from what respondents state they would do in hypothetical scenarios. Moreover, some of the study questions depended on recall by respondents, which may not have been accurate. Finally, the study obtained self-reports

FIGURE 3 Proposed process for handling requests for prescriptions for co-workers



about activities that may have been perceived as controversial; despite the anonymity of the study, this may result in underreporting of prescribing activities.

ACKNOWLEDGMENTS

There are no sources of funding to report.

CONFLICT OF INTEREST

The authors declare that they do not have a conflict of interest.

NOTES

1. American Medical Association, *Code of Medical Ethics*, "Opinion 8.19—Self-Treatment or Treatment of Immediate Family Members," *http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page?*, accessed 22 March 2012; American College of Physicians, *ACP Ethics Manual*, 6th ed., *http://www.acponline.org/running_ practice/ethics/manual/*, accessed 22 March 2012.

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5. American Medical Association, "Opinion 8.19," see note 1 above.

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10. Bolen, see note 8 above, 76.

11. *Tennessee Rules and Regulations*, "Chapter 0880-02—General Rules and Regulations Governing the Practice of Medicine," Section 0880-02-.14; Massachusetts Medical Society, "Did You Know: Physicians Should Not Prescribe for Friends and Family Members," *Vital Signs* May 2001, *http://www.massmed.org/Content/NavigationMenu3/Back Issues/2001/May2001/InsideMMS/Physicians_Should_N.htm*, accessed 22 March 2012; Texas Medical Board, *Board Rules*, "Chapter 170—Pain Management," Section 170.3—Guidelines, *http://www.tmb.state.tx.us/rules/rules/bdrules. php*, accessed 22 March 2012.